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Development of Primary Health Care in Finland

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Executive summary

The systematic development of the health care system in Finland started relatively late compared to other western European countries. The health insurance system was established in 1964 and a uniform national primary health care system has been run by municipalities (local governments) since 1972. Large parts of the country are sparsely populated, and rural areas have experienced depopulation in recent decades. Securing an adequate supply of regional health services has been an important government objective.

Since the late 19th century, municipalities have been legally obliged to offer some health services to their inhabitants, with the scope of services provided increasing gradually over time. By the early 1960s, the hospital sector was relatively well developed, and municipalities organised preventive services including school and maternal and child health care. They were also obliged to employ physicians to provide preventive services and attend municipal hospital wards. Municipalities received some compensation from the central government but most of the costs were covered by municipal taxes. For ambulatory care, municipal physicians were paid a fee for service by clients. In general, the number of physicians was low, and they mainly worked in hospitals and urban areas.

The introduction of the National Sickness Insurance Scheme in 1964 aimed to achieve universal coverage, providing reimbursements of up to 60% of fees for all care (excluding dental care), compensation for loss of earnings, maternity allowance, reimbursement of costs for medicines, ambulance and other travel costs. The government also invested in the medical workforce by establishing new medical schools, sending students to study abroad, and increasing enrolment in medical schools and other health care personnel training institutes. The insurance reform led to an increase in the use of outpatient services, but this was mainly in urban areas only. Poor supply of services in rural areas continued to prevent access to services.

This was changed with the 1972 Primary Health Care Act, which made municipalities responsible for organising all health services. Administratively, the reform brought together all primary preventive and curative services, including local hospitals that had previously been run separately, under locally integrated municipal primary health care authorities. All municipal health care staff, including physicians, became salaried employees. A national planning system was implemented for both primary and specialised care. Municipalities were required to make rolling five-year plans for primary care, which were to be revised annually and approved by the central government. The plans covered allocation of new investments and staff, but also included softer policy goals. The reform also equalised the levels of funding for different services and defining state subsidies (39%–70%) according to the financial status of the municipality, favouring poor areas. The new planning and subsidy system provided the central government with a powerful tool to channel new resources to underserved areas in particular in the northern and eastern parts of the country.

During the late 1980s, the planning and subsidy system was criticised for its heavy regulation and complex administration, as well as for directing the focus of municipal planning on new resources with disregard for the efficient use of existing capacity. In the 1993, reforms led to the dismantlement of the planning system and the municipalities were granted greater freedom to organise health services. In financing, the cost-based state subsidy system was replaced with subsidies for a proportion of anticipated spending on various municipal services. The subsidy for health care to each municipality was estimated using six criteria: population size, age structure, density, morbidity, land area and financial status. Similar estimation rules were defined for other

municipal services. The subsidies were then paid as a block grant to the municipalities, who were able use the money as they wished and keep any efficiency-gains. The criteria for estimating anticipated spending have since been refined, but in principle the system still defines the state transfers to the municipalities.

Cost-containment was not a primary goal in the preparation of the 1993 reform, however, the concurrent recession changed the state's financial situation and there were substantial cuts in government transfers to the municipalities. The reform also prompted other changes in primary health care, partly motivated by cost containment, such as break-ups in collaborations in service provision between municipalities and attempts to adopt some specialised services in health centres.

When the pre-recession level of total health care spending was restored in 2000, the drawbacks of the 1993 reform surfaced. The reform had decentralised health care decision-making and minimised the central government steering power. With differences in municipalities' financial capacities, this led to regional disparities in municipal health services. In addition, the power balance between mostly small municipalities and regionalised hospital authorities led to decisions directing new resources mainly to specialised care. Further challenges for municipal primary care were created by private sector services who were partly supported by the national health insurance scheme and the occupational health services also providing curative services. These uncoordinated parallel systems intensified competition for qualified health care professionals and contributed to recruitment difficulties and staff shortages in primary health care.

The municipalities have attempted to overcome these challenges in various ways. In terms of work arrangements, the health centres have developed professional skill-mix and adopted advanced roles for nurse practitioners as well as consolidated their urgent and emergency care service with local specialised care hospitals. In some municipalities, services have been contracted out to private providers. In several regions, municipalities have voluntarily implemented local reforms drawing on integration of primary and specialist health and social services and regional consolidation of these administrations. Since 2010, in 8 out of 20 regions, health and social services have been organised by such joint regional integrated authorities.

Recent central governments have also adopted policies to support regional consolidation of health and social services. In 2021, the Finnish Parliament passed a legislative package establishing a new regional administrative layer and reforming the organization of health care, social welfare, and rescue services. The legislation is to enter into force in January 2023 and to establish regional health and social care authorities called "wellbeing services counties." The reform is to bring all primary and specialised health and social services regionally under single administration. It will also strengthen the central government stewardship on health and social services as well as change the financing of services. The central government will confirm the strategic objectives of the services and approve the plans of the counties on major investments. The financing of the counties is to be obtained from the central government and, for a minor part, from client fees. The funding for health and social services will be based on a pre-determined set of service need factors, with some allowances in terms of health and wellbeing performance and current level of regional funding. To reorganise primary health care in municipal health centres, the government has launched a programme for developing future health and social services centres, promoting integrated care, improving access to and continuity of services, shifting the emphasis to preventive and proactive work, and promoting a multidisciplinary approach.

Introduction

In the European context, Finland is a large country with a land area of 340,000 km^2, which makes it nearly equal in size to Germany. The population of Finland has slowly increased but is still only around 5.5 million compared to Germany's 83 million. Large areas of Finland have been sparsely populated, exacerbated by migration and rural depopulation in recent decades. Adding to the late industrialisation and modernisation of the country, a particular challenge in term of health services has been to secure adequate health care resources and access to services in all parts of the country. Since the 1950s, which marked the start of the intensive development of the Finnish health care system, the equal regional distribution of health services, use of care according to the need, and levelling the costs of illness, have been major health policy objectives.

The uniform national primary health care system run by the municipalities (local governments) was established in Finland as late as in 1972, preceded by the establishment of a health insurance system only eight years earlier in 1964. Compared to other Nordic countries, the development of the health care system in Finland took place late. For instance, in Sweden the National Health Insurance Act was passed in 1946 (Glenngård et al. 2005).

The late development of services can be explained by historical and political changes in Finland. However, the financing and planning system, linking the local initiatives of the municipalities and the central government stewardship and incentives, succeeded in building up universal and comprehensive primary health care services across the whole country.

This report reviews the development of primary health services, focussing on the changes in financing and planning of the services. In addition to highlighting the success of establishing a comprehensive primary health care system in a relatively short time, challenges related to less successful health care policy decisions are analysed to underline lessons to learn from the Finnish experience.

Box 1. Principal structure of the health care system in Finland

The Finnish health system is highly decentralised. It includes multiple funding sources, with municipalities, National Health Insurance (NHI), employers and households together financing municipal, private and occupational health services.

The main actors in the Finnish health care system are the municipalities, the private sector, the national health insurance system and employers. The role of central government is to oversee and steer the system's functioning through legislation, decrees, and the provision of information.

Municipalities (local governments) form the core of the system: they are responsible for financing public primary and specialised care. There are three separate avenues for delivering first-contact care: public primary health care, private providers, and occupational health services. Federations of municipalities form 20 hospital districts, which own the public hospital network. The municipalities and hospital districts also run and finance a network of primary and secondary care facilities, as well as separate psychiatric care institutions. The reform of the public health care is underway and by 2023 it is envisaged that all public primary and specialised health and social services will be organised by regional "wellbeing services counties".

Health care coverage in Finland is fragmented. All residents are covered by municipal health care, but availability of services, in particular primary care, varies across municipalities. Employees are additionally covered by occupational health care, but the scope of what is covered also varies.

Source: Keskimäki et al. (2019)

Historical background

Finland became an independent republic in 1917 during the First World War. Finland had been under Swedish rule for 600 years but was conquered by the Russian Empire in the early 1800s. In the annex pact, Finland was allowed to keep most of its own legislation dating back to the Swedish rule, which gave relatively large autonomy to the country. This is one reason why the Finnish administrative structure resembles the Swedish one to some extent. In terms of health care, decisive steps were taken in the 1860s: firstly, with the separation of municipalities and parishes in rural areas, and later at the end of the decade, the organisation of health services was defined as a responsibility of the municipalities. The decision was important because it helped to set a path leading to the central role of the municipalities in the provision of health services as well other public services including schools, social services, children's day care and libraries, a role that the municipalities continue to play.

In terms of health care, the next step was the 1879 statute which further specified the responsibilities of the municipalities in organising and supervising health care for their inhabitants, and which predetermined the central role of municipalities in organising health and other public services even today in Finland. By the end of the century the municipal health services were gradually developed. For instance, a municipal doctor system and state subsidies for municipalities for their costs were launched in the 188Os and they operated until the 1970s. However, health care in Finland remained poorly developed due to lack of resources as well as occasional difficulties to get proposals accepted by the Russian administration and unwillingness of the central government and municipalities to adopt and invest in measures to improve health care (Mattila 2011). An illustrative description of the state of health services is that in the year 1900 there were only 360 medical doctors in Finland serving a population of 2.7 million inhabitants (Vauhkonen 1978).

After independence, several factors continued to slow down the development of health care. In the aftermath of the Civil War in 1918, Finnish society was deeply divided and earlier plans for social reform had lost support. The economic recession in the 1930s and the Second World War further blocked most social reforms. Finland's economy also remained largely based on agriculture. In 1950, around 40% of the workforce was still employed in farming and forestry (Mattila 2011). In contrast to earlier inaction, the end of the 1950s and early 1960s were a game-changer which boosted a rapid development and modernisation of health care and overall of health and social policies. A good indication of the progressive ideas of the time was Pekka Kuusi's 'Social policy for the sixties' which was authored as a comprehensive plan for Finnish social policy at the request of the Finnish Social Policy Association (Kuusi 1964, p. 235). The book was published originally in Finnish in 1961 and drafted reforms for policy areas such as employment, housing, family, old age and disability, and health and social care. Regarding health care, the book presented preliminary drafts for the organisation of municipal health centres which was then realised in the 1970s.

Primary health care in the 1960s

The main problem identified in Finnish health care policy in the 1950s and 1960s was the inadequate supply and regional distribution of primary health care, especially general practitioners' services. Until the 1960s, health policy actions were mainly directed towards developing the hospital network. Municipalities had a legal obligation to employ physicians and to provide some preventive services such as school health and maternal and child health care. In the early 1960s, the number of doctors in the country was only one per 1,700 inhabitants, but in rural municipalities, particularly in the northern and eastern part of the country, this service ratio was even worse at one physician for nearly 9,000 inhabitants (Kuusi 1964, p. 225). Municipal physicians were mainly paid for their preventive work and for attending municipal hospital wards. For these purposes the municipalities received some compensation from the government but mainly the costs were covered by municipal taxes. When treating ambulatory patients, the municipal physicians were paid a fee for service directly by their clients. For patients, ambulatory medical care was difficult and often expensive to obtain.

The National Sickness Insurance Scheme was introduced in 1964, very late compared to other European countries. The scheme intended to reimburse up to 60% of fees and to include compensation for loss of earnings, maternity allowance, and reimbursement for the cost of medicines, ambulance charges and other travel costs. A marked exception was coverage for the costs of dental care, which were compensated only in cases where treatment was necessary for curing other than a purely dental disease (Kaitaranta 1974).

Unlike in many countries, the Finnish scheme aimed to provide universal coverage to all residents and entitlement to benefits was not dependant on contributions (Kaitaranta 1974). These provisions were likely due to the dominant position of the agrarian political party at the time who felt that an insurance scheme based on employment would have left many potential supporters without benefits (Kangas 1991. p. 153—155). It was supposed that lowering the economic barriers to access would increase the utilization of ambulatory services and decrease the differences in service use across regions and population groups. On the supply side, new medical schools were established, enrolment in medical schools and other institutions for training health care personnel increased, and many students were sent abroad to medical schools (Melkas 1987).

After the insurance reform, the use of outpatient services increased, mostly among the low-income categories and in urban areas. In rural areas the inadequate supply of services still prevented efficient access to services (Purola 1971; Huuhka et al. 1996). While the number of beds in specialised hospitals increased by 24% in the 1960s, hospitals continued to absorb new personnel (Vauhkonen and Bäckman 1973. p. 134). In the early 1970s, one fifth of the municipal physicians' positions were not filled and only 8.2% of health care expenditure was spent on ambulatory primary care (Pekurinen et al. 1987; Harjula 2015. p. 149).

Of primary care services, maternal and child health care was well established in the 1960s. Municipalities had received state subsidies for organising midwife and community health nurse services since the 1920s. However, these services were mainly developed by NGOs prior to 1944 when a law on maternity and child clinics obliged the municipalities to organise these services. Services were particularly promoted in rural areas. Municipalities were required and supported to find specific facilities, 'terveystalo' (health house), to provide maternity and child health as well as other preventive services. Midwifes and community nurses were salaried municipal employees, and services were provided free of charge for municipal residents.

Primary health care reform in 1972

To solve the challenges related to poor availability of medical services, a primary health care reform was launched in 1972. The reform had been debated since the 1950s (Kuusi 1964). An important driver was the poor state of the population health and particularly the high mortality of working age men in Finland, revealed by international comparative research (e.g., Keys et al. 1966). In 1960, the Government nominated a Public Health Committee to prepare measures to increase the effectiveness of public health activities. The Committee focused on fragmented legislation on municipal primary health care and proposed to unify approximately 20 different laws into a single act on municipal primary health care, but the proposal did not bring out any notable structural reform and did not lead to legislation. However, the Government concluded that the preparation of a public health act should be continued and in 1967 it nominated another committee to explore a need for a legal reform on municipal primary care. In 1969 the Committee proposed a comprehensive municipal primary health care reform. As a key feature, the proposal included framework legislation on municipal services only, defining general guidelines on organising service provision through health centres and types of services to be provided. Unlike earlier laws giving strict resource criteria, the proposal was based on municipal decision making and initiative, supported by central government incentives and supervision (Vauhkonen 1978).

The Committee proposal led to the 1972 Primary Health Care Act which was unanimously accepted by Parliament. According to the proposal, the new Act contained three supply-side reforms relating to administration, financing and planning systems. In the administrative reform, all primary care activities, such as municipal surgeries, maternal and child health, and school health care, as well as local hospitals that had previously run separately, were organized under locally integrated management and planning into a network of health centres (Table 1). Over the years, most health centres also established laboratories and X-ray facilities. From the start, health centres were not only physical premises to provide municipal primary health services, but the health centre was the name for the administrative branch of health services in the municipalities – similar to a primary health care authority. In many cases, health centres operated at several health stations (Kokko 2009).

Table 1: Primary health care services provided by the municipal health centres

The law sets the following tasks:

- health education
- maternal and child health care
- prevention and treatment of communicable diseases
- screenings
- ambulances
- home care
- dental care
- school health care
- occupational health care
- outpatient care at health centres
- inpatient care at health centres

Source: Pekurinen et al. 1987

For most employees in municipal health care, the reform did not markedly impact their position. Municipal physicians were an exception. While they were previously remunerated by fee for service by their patients, they became salaried employees like other personnel groups in health centres. The Finnish Medical Association had been critical towards the change because of the

perceived loss of clinical autonomy and trust between the patient and doctor, as well as abolishment of fee for service payments which could be very lucrative for physicians. On the other hand, the reform also brought in stricter regulation of basic working hours according to the general municipal collective agreements and compensation for extra work hours and on-call duties (Saarinen 2008).

As part of the reform, larger municipalities organized their health centres by themselves whereas small municipalities were legally required to form federations to run health centres. A population served by a health centre, excluding the sparsely populated areas, was supposed to number approximately 10,000 inhabitants. In general, the municipalities were small with less than 5,000 inhabitants on average; fewer than a hundred of approximately 480 municipalities were able to establish their own health centre authority.

The planning system for the 1972 reform was to cover all publicly run health care services, i.e., health centres and hospitals. The guidelines from the central government required health care institutions to make rolling five-year plans, to be revised annually and approved by the central government (National Board of Health). The main content of these plans was the allocation of new resources, i.e., investments and new personnel. The government's national plans also included other policy goals, but their content was often superficial, and execution was not rigorously supervised.

While prior to 1972 the levels of state subsidies in health care varied according to the health care service sector, these levels were equalized in the reform. The level of reimbursement varied according to the financial status of the municipality and was 39%–70% in the early 1970s. It was paid directly to health care institutions which then billed the net costs (gross costs minus state subsidy) to the municipalities. On average, the reform raised the level of subsidies for the municipalities and the proportion of the central government of the overall health care spending increased. The subsidy was the same for running and capital costs in both primary and specialised care. Unlike earlier, with higher state subsidies for hospital care, the municipalities no longer had a financial incentive to prefer inpatient to primary ambulatory care (Pekurinen et al. 1987).

In principle, health centres and hospitals could also opt for investments or new personnel which had not been approved in the national plan, but the expenditure for these resources was not subsidised by the state. Since the state subsidies accounted for a significant proportion of the running costs of health care, municipalities were rarely prepared to maintain non-subsidised activities. Accordingly, the planning and subsidy system created a powerful tool for central government to allocate health care resources. In the first years, new resources were channelled to areas with a poor supply of health services in the northern and eastern part of the country. However, it is complex to assess the specific impact of the reform on access to services in remote areas. In the 1960s and 1970s, Finland experienced rapid economic changes resulting in migration from rural to urban areas and abroad. While the reform and increased investments in health services did increase the supply of services in all regions of the country, the levelling of service supply between regions and rural and urban areas can mainly be explained by the depopulation of rural areas (Kalimo et al. 1982, Ohtonen et al. 1983). The reform did, however, secure an increase of health care resources in rural areas which would not necessarily have been granted otherwise.

The 1972 reform did not alter the sickness insurance scheme, which financed municipal health services by refunding health centres according to similar rates to those for private services. This

refund system was discontinued after 1983, although it continued to reimburse the private services and mandatory occupational health care established by the 1978 Occupational Health Care Act. This meant that the sickness insurance scheme formed a parallel system for financing health care services uncoordinated with the public health care system (WHO 1991, p. 8—88). Until the 1990s the only significant change in the principles of the scheme was to expand coverage of dental services for those born in 1956 or later.

The 1972 Primary Health Care Act stipulated that primary care services should, in principle, be free of charge. This principle was considered to have important health policy significance; for the first time there was a formal commitment that everyone should have equal benefits of health services regardless of their economic circumstances (Kaipainen 1975). However, the legislation allowed a long transition period, and most charges were only finally abolished in 1981. In 1973, patients covered 11% of the costs of health centres for ambulatory care, while the proportions of the state, municipalities and national sickness insurance were 37%, 39% and 13% respectively. For the costs of inpatient care in health centre community hospitals, patients covered 11.7%, the state 55.5% and the municipalities 32.8%. Out-of-pocket payments for health centre services were mainly nominal and they were not increased in the 1970s, resulting in a decrease in the share of patients' funding due to high inflation rates (Vauhkonen 1978; Harjula 2015).

In the 1980s, decision-making in the national health planning system was gradually decentralized to provincial governments, and towards the end of the decade the specificity of the national plans decreased. However, this decentralization was largely nominal as central government still decided on investments, new personnel and regional allocations. In 1984, social services were included in the planning and subsidy system, and the subsidy levels were equalised between the sectors. Aside from these changes, the formal principles of the health care planning and financing system remained virtually unchanged until the 1990s.

Finnish health care in the 1990s: the 1993 reform and the economic recession

The early 1990s were characterised by several administrative and financing changes in Finnish health care. These included the 1991 unification of the fragmented administrative structure of hospital care, and the 1993 state subsidy reform promoting the position of municipalities. The 1991–1993 economic crisis also substantially influenced health care throughout the whole decade.

In the 1980s, economic growth in Finland was greater than the OECD average. However, deregulation of the financial markets in the late 1980s generated a credit boom, indebting many companies and individuals. The collapse of trade with the former Soviet Union in 1992 led to a steep fall in exports. In 1991–1993, Finland experienced a decrease of 12% in GDP, which resulted in an unemployment rate of 18% and a rise in the state debt to 50% of GDP. National expenditure on health care was slashed by 12% between 1991 and 1994. In health centre ambulatory and inpatient care, the decline in expenditure at constant prices was 13%. In specialised care, the reduction was even higher (18%) although mostly in psychiatric care, while somatic hospitals lost only 5% of their budget (Linna and Häkkinen 1996; Social Insurance Institution 1996, p. 25–30). The overall economy recovered quickly, however. For instance, foreign exports passed the pre-recession level in 1993 following the effective devaluation of around 40% of the Finnish currency

in 1991-1992. In contrast, budget cuts in the public sector had a much longer impact. In health care, total expenditure only returned to early 1990 levels in 2000.

The 1993 state subsidy reform sought to simplify the former system that was heavily regulated, complex and laborious to administer. While municipal responsibilities to provide public services had gradually broadened, the wide scope of services, including community planning, schools, libraries, and social services along with health care, were regulated and financed according to separate, sector specific legislation. In terms of primary health care, it was considered that the financing and planning system in place hindered municipalities from taking local circumstances into account in organising health services. In addition, the planning system was considered to have directed municipal planning to focus on new resources and personnel and to disregard the efficient use of existing capacity. An important objective of the reform was to increase the accountability of the municipalities in terms of costs and outcomes. The reform also intended to further reduce variations in the financial positions of municipalities (Niemelä 2008).

The 1993 reform granted municipalities greater freedom to organize health services for their inhabitants, at least in principle. The deregulation included several reforms including a reduction of control over the use of state subsidies and new powers to determine user fees. However, for many legal and practical restrictions, the impact of the reforms was limited. Deregulation was criticized as potentially widening variations in the availability of health services between municipalities although there was no systematic evidence to support this criticism. There were, however, occasional reports of difficulties in access to services for specific groups, such as people with disabilities and those with substance addictions (Kalland 1996). The overall impacts of the reform are difficult to assess because budget cuts in many health and social care programmes influenced service provision at the same time.

In terms of municipal funding, the retrospective cost-based state subsidy system was replaced by a prospective grant system to fund welfare and other municipal services, such as health and social care, education, and libraries. In the reformed system, state subsidies for health care were non-earmarked lump sum grants, calculated prospectively using a capitation formula based on six criteria: population size, age structure, density, morbidity (as approximated by standardized mortality), land area, and financial status. Similar estimation rules were put in place for subsidies for other municipal services. Although the subsidies were defined for individual services, they were paid as a lump sum to the municipalities, who were able use the funds as they wished and to keep any efficiency-gains. In addition, centralised planning was further reduced, and, after the reform, national plans were limited to setting policy priorities and the allocation of major health care investments. Over the years, the criteria for the subsidies have changed. For instance, relative morbidity has in recent years been estimated using the prevalence of 12 chronic conditions and early retirement due to disability, but the principles of the allocation system have remained the same.

The 1993 reform was prepared in the late 1980s, before the economic recession struck and when cost containment was not a primary objective of the government. Like in some other European countries, such as the UK and Netherlands, the health policy debate in Finland at that time promoted ideas around managed care and internal markets to improve the efficiency and quality of health care services. For example, municipalities were supposed to act as purchasers in the new model. However, the reform did not create a 'true' purchaser-provider split, and municipalities remained the owners of both health centres and public hospitals either directly or through joint authorities or federations. They also remained responsible for covering potential losses of the public providers (Tynkkynen et al. 2013).

Although the 1993 reform could not anticipate the economic crisis and the budget cuts implemented by the central government, the new approach to municipal funding made the cuts technically easy to implement. This was because there was no longer a need for multiple adjustments of cost-based sectoral transfers; instead, only a decision on the total amount of municipal transfers was needed. Central government used this opportunity to cut transfers and the state proportion of total health care financing halved from 35.6% in 1990 to 17.8% in 2001. The municipalities sought to soften the impact of these cuts and increased their share from 34.7% to a high of 42.5% in 1998 (STAKES 2005). A marked change also occurred in patients' out-of-pocket expenditure, which almost doubled from 12.6% of total health care expenditure in 1991 to 20.8% in 1994. Approximately one third of the rise was due to changes in taxation, namely that people were no longer able to claim tax rebates on personal health care expenses, but the rest was accounted for by increases in user charges and reduced social insurance reimbursement rates for medicines (Social Insurance Institution 1996, p. 25–27). In terms of primary health care, an important change of principle was the re-introduction of user fees for health centre visits in 1993, only 12 years after they had been abolished.

After the state subsidy reform, some municipalities withdrew from their health centre federations and by the mid-1990s, only 60% of municipalities (a reduction from 80%) managed their primary care services together with other municipalities. An important reason for the break-up of many joint primary health care authorities was an expectation by municipalities that they would be able to organise services for their inhabitants more cost-efficiently on their own. There were also disputes about how to allocate health care facilities and costs between municipalities. Evaluations suggest that the new separated health centres might have made some efficiency gains immediately after the break-up, but these were only short-lived and often followed by substantial growth in expenditure (Luoma et al. 2007).

The reform also prompted other changes in health centres. Some municipalities broadened service provision by adding specialised services and introducing ambulatory psychiatric services or merging a local specialised hospital with their health centres. In general, health centres continued to develop their activities by introducing ambulatory services based on personal doctor models, drawing on family medicine and GP models in the UK and other countries to improve access to services and continuity of care (Saltman 1992; Aro et al. 1995; Kokko 1997).

A second major change was introduced by the 1991 amendment of the Specialised Hospital Act, which brought central, regional and mental hospitals within a health care region under a single management. The impact of this process was, however, limited, as central hospital districts had already united the planning and coordination of specialised care within their regions, and some districts had merged specialised care before the amendment took effect.

The state subsidy reform did not markedly influence the status of hospital care providers or their relations to municipalities. With regards to funding, before the reform public hospitals received some subsidies directly from the state. Afterwards, these were allocated by municipalities who received state subsidies for specialised care as a part of their block grant. As noted, a true purchaser-provider split was never implemented. On the other hand, the unification of the specialised care administration created regional monopolies and as most municipalities were relatively small, they did not have sufficient power or expertise to negotiate prices for hospital care or to push hospital districts to compete (Pekurinen 1995). Furthermore, as membership of hospital health care districts continued to be mandatory for the municipalities, they also remained liable for the district's health care costs in the case of a deficit, restricting the ability of the municipalities to exert the increased power they were given by the 1993 reform.

The 2000s: increasing challenges for municipal primary care

Around the year 2000, spending on health in Finland had recovered to pre-recession levels. Yet, while health spending increased overall, this rise was not shared equally across the country. There was an increasing gap in the financial capacity to invest in health services between municipalities and in the availability of health care, particularly in municipal primary care. There are several reasons for this development.

Post-recession economic growth and structural change of the Finnish economy accelerated internal migration, and depopulation and aging of rural areas, which reduced municipal revenues and increased an imbalance between need for and supply of services in affected areas. In addition, the power imbalance between municipalities and hospital districts created by the 1991 and 1993 reforms started to have an impact on resource allocation between municipal run primary health care and hospitals. In public health care, growth in spending has disproportionately been directed to specialist care since 2000: between 2000 and 2019, expenditure on public specialised care increased by 71%, whereas in primary care the corresponding increase was only 17% (THL 2021). This imbalance between specialised and primary care is also illustrated by a faster growth of doctors employed in municipal hospitals while the number of doctors in primary health care stagnated.

Increased spending on hospital care was mainly a regional decision, following the decentralisation of health care decision making in the 1993 reform. This meant that the central government has had no real leverage to directly influence spending decisions on primary and hospital care. Instead, from the early 2000s, it used soft steering tools, such as information guidance and development programmes, with little effect. The introduction of maximum waiting times for services in 2005 was another attempt to help balance service provision. This required that patients contacting their primary health care centre should have their need for care assessed within a maximum of three weekdays and that those referred to hospital must be assessed within a maximum of three weeks following referral (Vuorenkoski et al. 2008). According to the population surveys, patient perceived access to health centre physicians' consultations did improve (Klavus 2010), but the imbalance between the resourcing of primary and specialised care did not really change, and particularly long waiting times to non-urgent GPs' appointments in general as well as their regional variation have remained a challenge (Rissanen 2019).

Aside from the administrative separation of primary and hospital care, a key challenge faced by municipal primary health care in Finland is the basic structure of system, which has essentially created three parallel avenues for delivering services in first-contact care: public health centre services, private sector services and occupational health services, which also provide curative services (see Box 1).

As previously noted, the national health insurance system, established in 1964, covers part of the costs for the use of private services, including private GP services. And although insurance reimburses currently only about 14% of private physician visits (having gradually decreased from the originally intended 60% in the 1960s) and co-payment levels are relatively high, the sector accounts for a comparatively large share of ambulatory care appointments.

National Health Insurance (NHI) also part-covers occupational health services, which employers must organise for their employees as per the 1978 Occupational Health Care Act. The primary aim of the legislation was to strengthen preventive measures to reduce and eliminate health hazards and risks related to work and the working environment. However, over time, occupational health care has expanded to also include curative services, effectively becoming a fringe benefit for employees. The costs are covered through funds NHI collects from employees' and employers' social insurance contributions. The average reimbursement level on the employers' costs is about 43% (Social Insurance Institution 2020), and the system covers over 80% of the workforce. For the employees, the services are provided without any direct payments.

Although it was proposed that the occupational health care system should use public health services, the 1978 Act eventually permitted employers free choice of provider (Haatainen and Karisto 1991). Initially, large companies ran their own occupational health centres but gradually services moved to the private sector. Municipal health centres continue to provide occupational health care for municipal sector employees and, in rural areas, for small companies and entrepreneurs.

Taken together, occupational health services and the private sector accounted for about a half of ambulatory care physician visits in 2014, excluding outpatient visits to public hospitals (Finnish Medical Association 2016). Although the parallel use of the municipal, private and occupational health services is common, users of these services differ to some extent, with those of lower social status, older people and families with children usually consulting municipal health centre GPs. Employees tend to use occupational health services while the private sector is mostly used by wealthier people living in urban areas.

The parallel system has led to inequitable access to first contact care (OECD 2013; Manderbacka et al. 2019) and is also causing allocative inefficiencies in the health care system, with, for instance, occupational health services providing easier access to services for people who are on average healthier than the general population (OECD and European Observatory on Health Systems and Policies 2019). Further, the parallel system has intensified competition for qualified health care professionals, particularly physicians but also nurses.

In the early 2000s, primary care authorities experienced increasing difficulties in recruiting physicians to work at public health centres. A general shortage of physicians at that time was, in part, the consequence of the government's decision to cut enrolment into medical schools following the economic recession of the 1990s. In response, some municipalities began to contract services to the private sector, initially to provide out-of-hours care only but gradually moving to contracting out all municipal health and social care services, as well as establishing public-private joint ventures. Outsourcing services to the private sector was also considered a means to contain costs, and, more recently, in anticipation of the planned health and social care reforms (please see below). At the time of writing, some 10% of municipalities have outsourced the provision of their municipal health and social services to a private provider or to a joint venture with a private company (Association of Finnish Municipalities 2021).

The increasing private involvement in public health care occurred in parallel with, and was supported by, a wider consolidation of the private sector in Finland, with national and international investment companies entering the market and the successive takeover of smaller companies. This led to a substantial change in the market for medical services. Most private health companies are small, however, with 97% employing less than 5 people, and there are currently only three large companies that operate countrywide and which account for around a

third of the total turnover of the whole branch (Tevameri 2020). This rapid change has been made possible by the large penetration of private medical services in general and in occupational health care.

To address the shortage of physicians in primary health centres and contain costs, the government has begun to develop new working arrangements promoting more advanced roles for nurses. While the role of nurses in Finland has traditionally been broader and the nurse-to-doctor ratio higher than in many other countries, this move involved measures such as launching post-registration training programmes for advanced nurse practitioners, and introducing prescription by nurses. Many public health centres have also developed multi-professional team-work models, including physicians who partly remain in a consulting role (Ensiö et al. 2019).

Recent changes to the way public primary care is delivered also include the consolidation of urgent and emergency care units. Increasingly, public health centres have moved away from directly providing out-of-hours services; instead, these are now being provided by emergency care units typically located at local hospital premises while organised jointly by hospital districts and health centres (Keskimäki et al. 2019).

Recent developments: long history of the national reform and regional reforms of integration

From the mid-2000s onwards, successive governments have attempted, and failed, to more fundamentally reform Finland's health and care system towards a more integrated one. Details are provided by Keskimäki et al. (2019). In brief, these reform efforts have been motivated by attempts to consolidate and restructure the fragmented local administration of municipal and regional authorities. They can be seen to have been in response to an ageing population and associated increased demand for services, challenging smaller rural municipalities in their ability to provide adequate services that are equitable and sustainable (Keskimäki et al. 2018). For example, more than half of the over 300 municipalities in Finland have fewer than 6,000 residents. Small municipalities account for about half of the land area, but only for 15% of the population and about 10% of all jobs.[1]

The reform proposals have been politically controversial due to the fact that any substantial reform of Finnish health and social care would strongly influence the position of the municipalities and their viability. However, gradually the reform proposals have adopted the idea of shifting responsibility for organising services from municipalities to regional authorities and strengthening the integration of primary and specialised care and social services.

Finally, after failed proposals by earlier governments, in 2021 the Finnish Parliament passed a legislative package which established a new regional administrative layer and reformed the organisation of health care, social welfare and rescue services. The legislation will enter into force by January 2023 and will replace the 170 primary care and 20 specialist care authorities with 22 health and social care authorities called "wellbeing services counties". These new authorities will be responsible for organising all public health and social care services in their

[1] Reference: https://www.localfinland.fi/finnish-municipalities-and-regions

region. They are separate from the municipalities and form semi-autonomous administrative districts with elected councils. The health and social care authorities will not have a right to levy taxes, at least initially, but will receive funding from the central government with some marginal revenues from user fees and transfer payments for services provided to service users from other districts.

The reform also strengthens the central government stewardship on health and social services. The government will confirm the strategic objectives of the services every four years and the responsible ministries will hold annual strategic level negotiations to monitor, assess and direct the organization of services with each county. The central government will also approve the annual investment plans of the counties.

The idea that districts or counties operate integrated services is not new, with local efforts to implement related structural changes dating to the mid 2000s (Kokko 2009). Municipalities in several regions began to voluntarily form integrated joint authorities to organise all public health and social services for their population as a means to enhance the coordination of services, in particular for people with complex care needs, such as those with chronic conditions and older people, while also bringing in family, psychosocial and substance abuse services. Before the health and social care reform, eight out of the 20 hospital districts in Finland had already established integrated authorities, bringing together the financing and provision of public health and social services under a single administration including financing and human resources management. The integration of services is often supported by shared client information systems. There is currently little robust evidence on the impact of these authorities, with six of the eight only commencing operation in 2018–2019. There is however indicative evidence suggesting improved efficiency and quality. Examples include integrated services for children and young people, which were shown to have reduced expensive child protection services and psychiatric hospitals stays. Other indicative evidence points to integrated health and welfare centres having introduced more efficient care pathways and shortened waiting times and reduce the number of formal referrals (Keskimäki et al. 2018; Nummela et al. 2019; Tiirinki et al. 2022).

By and large these regional efforts to integrate care have followed government policies to support service integration and basic services, further supported by governmental programmes to develop different aspects of integrated primary care provision. The government has also launched a programme for developing future health and social services centres (Ministry of Social Affairs and Health 2020). The programme promotes practices implemented by integrated health and social care authorities and focuses on improving access to and continuity of services, shifting the emphasis to preventive and proactive work, and promoting a multidisciplinary approach. In practice, the programme funds regional projects to design the concept of the future health and social care centre and its operations models for local circumstances and population needs. The general idea is that this future centre model based on integrated services will replace current primary health care centres.

Conclusions

The history of primary health care in Finland has been determined on one hand by path dependency and on the other hand by a series of incremental reforms. We have seen that municipalities in Finland already held a strong and independent position in public services from the mid-19th century, with gradually increasing responsibilities in poverty relief, public health and schooling, and it was predictable that they would subsequently assume a dominant position in providing health services and primary health care. In the same way, the fragmented structure of the health care system was determined by earlier health and social policy institutions. The health insurance system had been planned for decades before it was finally introduced in 1964 to be based on the existing social insurance and pension system, and the establishment of the formal occupational health care system in 1978 also build on a much longer history of large companies providing related services for their employees (Mattila 2011). The hospital system also builds on the federation model that municipalities had used to collaboratively operate local hospitals. All these successive health system reforms – the health insurance system in 1964, municipal primary health care and health system planning in 1972, occupational health care in 1978, unification of specialised care in 1990, and the state subsidy system in 1993 – were rational and aimed at mending obvious weaknesses. However, when the reforms focused on the separate structural features of the system, they mostly left the other parts of the health systems unaltered, resulting in a fragmented and poorly coordinated system.

Primary health care reform was highly successful in incentivising municipalities to invest in the development of primary care services in the 1970s. The reform was also highly progressive in integrating a wide scope of services, such as curative and preventive care, general practitioners, public health nurses, maternal and childcare, vaccinations and community hospitals with diagnostic facilities as well as environmental health, under one administration. In addition, the planning system coordinated by the central government and state subsidies guaranteed that poor rural municipalities were able to establish these services and that the establishment of health care centres started with communities with the greatest need.

However, the decision to separate municipal specialised care administration from primary health care administrations has caused serious challenges for the provision of primary health services. It created an imbalance that became evident after the 1993 state subsidy reform which dismantled the central planning system and decentralised virtually all health care decision making to municipalities. While strong primary health care services remained a key health policy objective, the majority of new resources were diverted to the hospital sector. In the absence of uniform regional planning and governance, the service structure in many regions became distorted and sub-optimal in favour of specialised care.

The occupational and private health services, which are partly subsidised by the national insurance system have weakened the health care system further. In addition to increasing competition for health care professionals, these services have altered the customer base of municipal health centres towards older people and those without employment, thereby indirectly undermining popular voices to develop municipal primary health care.

Finland has experienced continued difficulties in reforming the current system. Public services, including health care, are considered as a cornerstone of municipal autonomic administration, which is, according to the Finnish Constitution, based on the self-government of the municipal residents. Health and social care services constitute about 50% of the municipal budgets. Any attempt to reform health and social care implicates changes in municipalities and their capacity

to influence local investments, employment and economic viability. As a consequence, although the need for reform has been widely acknowledged, political consensus on the reform has been difficult to achieve (Keskimäki et al. 2019). A further challenge has been that within the Finnish constitutional framework the municipalities should be treated equally, but in fact their circumstances vary from large growing cities to small municipalities with aging populations of less than a thousand inhabitants.

Despite the challenges mentioned above, recent governments have made a virtue out of necessity and proposed reforms that shift the responsibility for organising health and social services from mainly small municipalities to regional level. As a consequence, the long-anticipated reform has been finally reached and the regional authorities integrating primary care, specialised care and social services under a single administration have been decided to be established in 2023.

Alongside the reform, a new type of primary services centre has been developed. Several municipalities have already implemented related changes by forming joint health and social care authorities and operating innovative service units which integrate multi-professional primary health care and preventive approaches, and a wide range of rehabilitative, home care or psychosocial services (Keskimäki et al. 2018). In the Finnish context, with the aging population and depopulation of rural communities on one side, and threat of social segregation in urban areas on the other side, these types of integrated services look to be the most promising way to further develop primary health care.

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