

**The Finnish experience of primary health care; municipal comprehensive health centers from 1972, but what next?**

**Presentation in Vienna Healthcare lectures,**

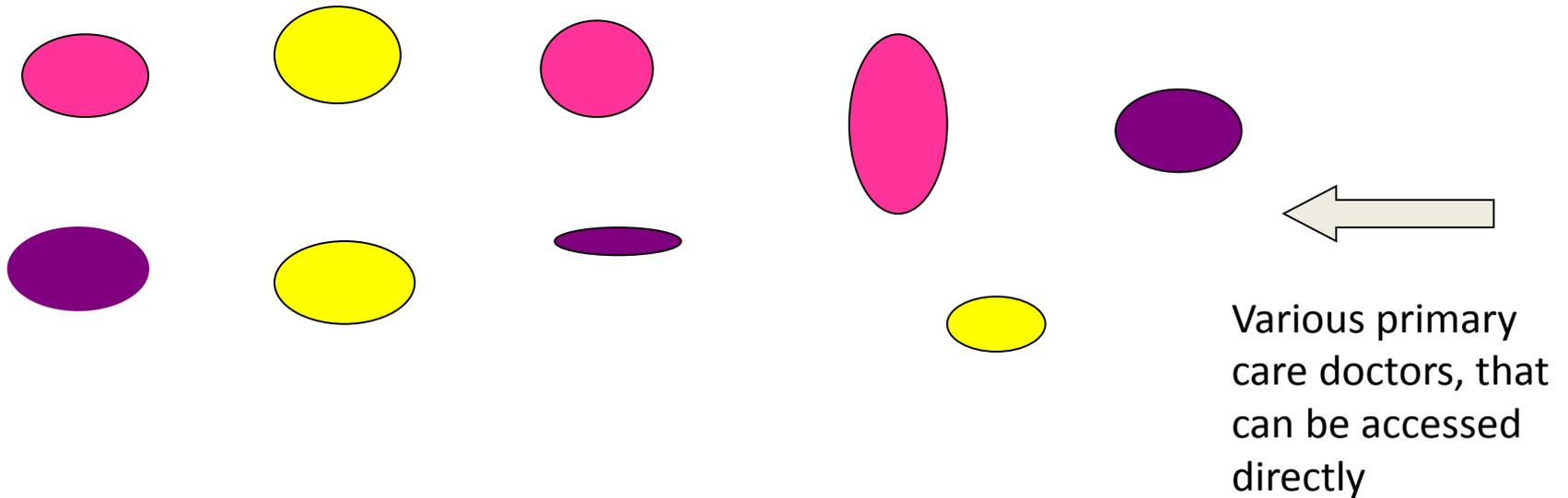
**September 7,2016**

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# Primary health care (PHC) comes in variable shapes and structures

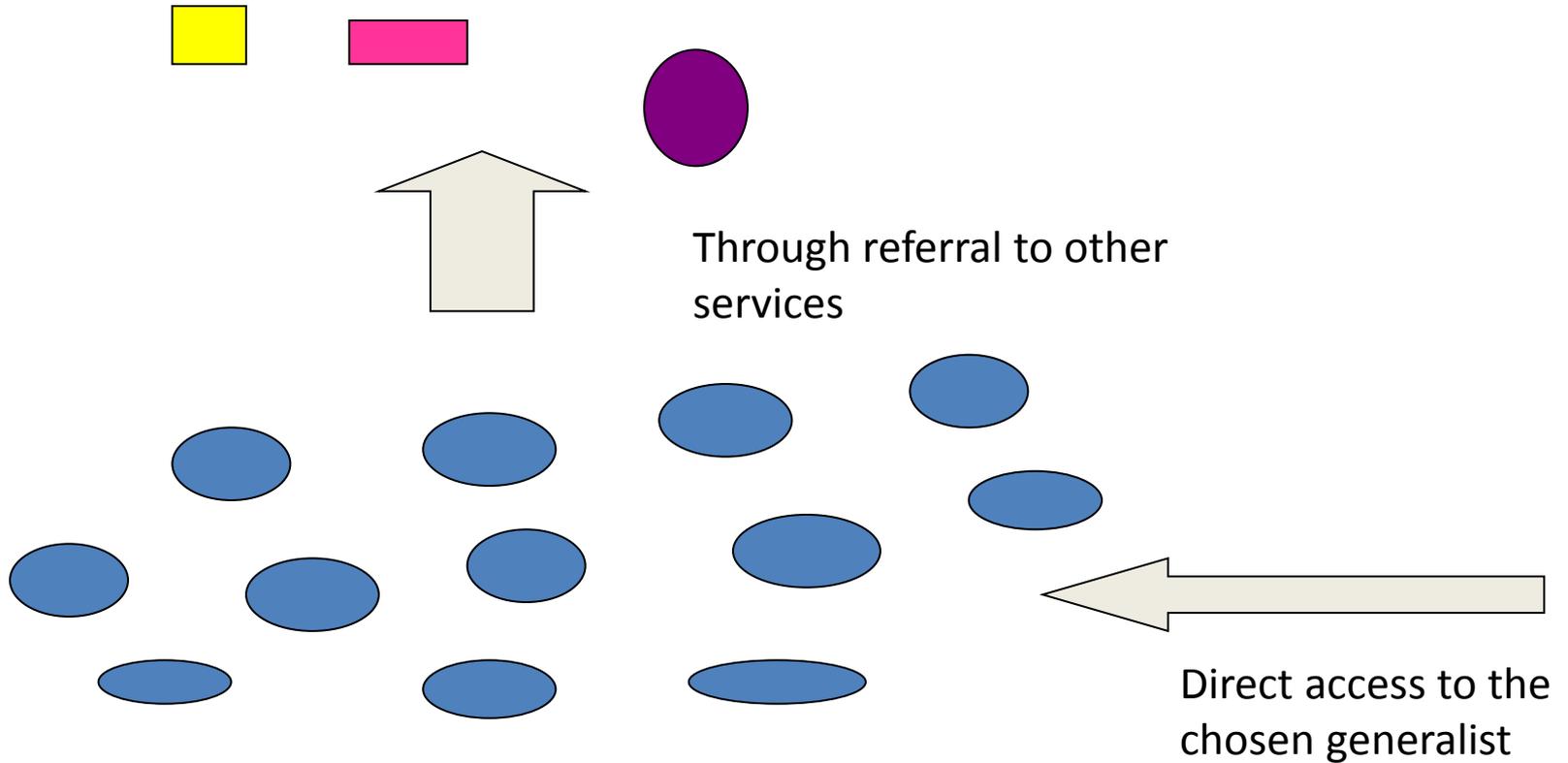
- Experience from an EU project on the PHC of seven countries
- The purpose was to find a simplified answer on how the structures and design of functions of PHC are related to quality and cost of care
- This fundamental question was left without a conclusive answer, but trying to find answers turned out to be an interesting and useful exercise
- The key question was: what is (included) in PHC in different countries
- The following 5 models were used to describe and classify

## "Solo practice" basic model based mainly on specialists' services



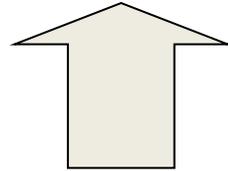
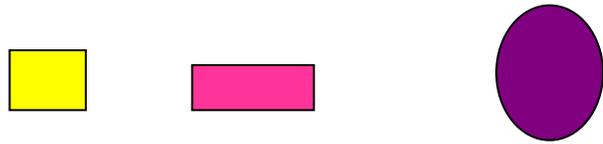
Local health services; preventive services, elderly care, some public health functions, etc.

# "Solo practice" basic model based mainly on generalists' services

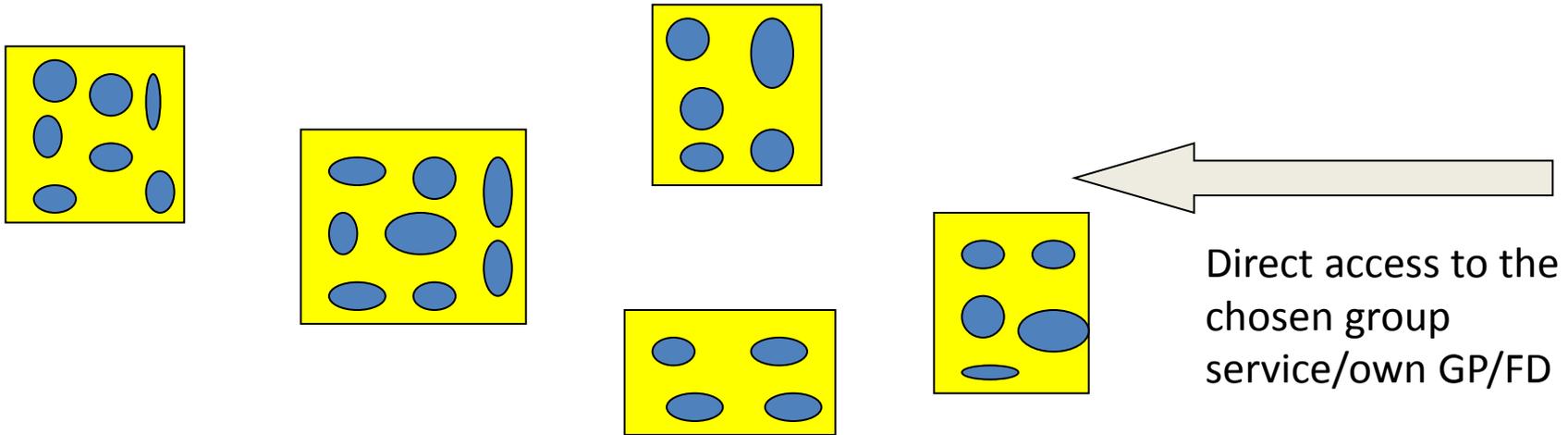


Local health services; preventive services, elderly care, some public health functions, etc.

# "Group practice type of arrangement"



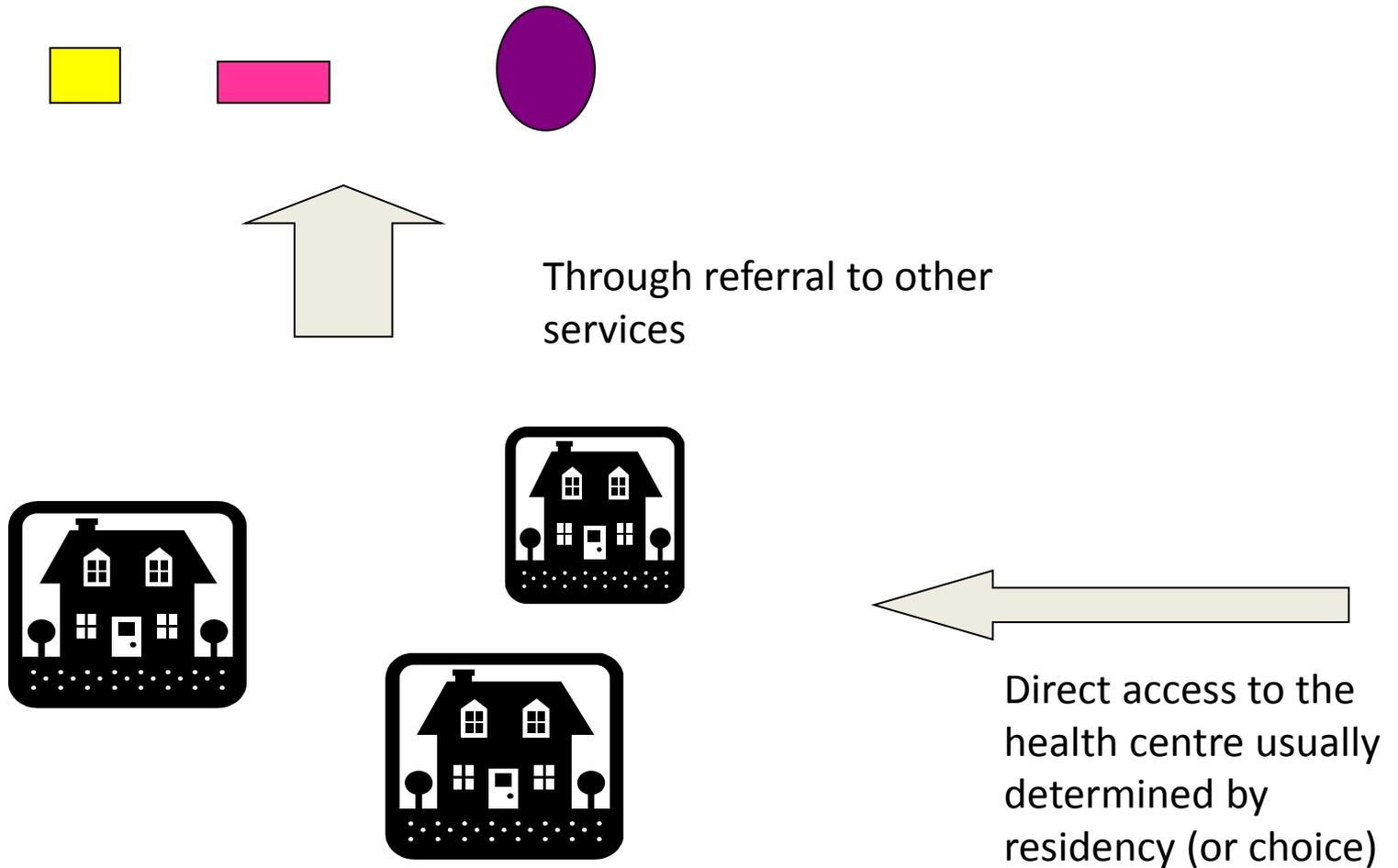
Through referral to other services



Direct access to the chosen group service/own GP/FD

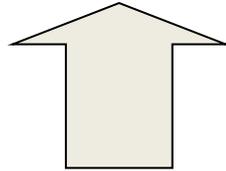
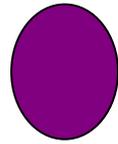
Local health services; preventive services, elderly care, some public health functions, etc.

# "Health centre type of arrangement"

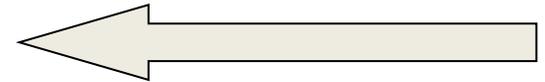


Usually no separate local health services, apart from possibly local public health services

# "Policlinic-based arrangement"



Through referral to other services not covered by the policlinic



Direct access to the policlinic with primary and secondary services

Usually no separate local health services, apart from possibly local public health services

## **Models are somewhat tied to alternatives in funding – and hard to change anyway**

- Old dream vision of private doctors in solo practice: no interference or minimal interference from the payer
- However most serious strategies to control costs (and also value for money) are based on interference (managed care, prospective payments, group practice budgets etc.)
- As the number of older people increases, the incidence and prevalence of chronic illnesses and complex comorbidity increase
- Heavy reliance on medical doctors means shutting doors to necessary developments of quality and cost control – why?

# Crucial choices in the Finnish development of PHC

- 1972: Transition from slightly regulated municipal doctors and other separate professionals to health center employees
- 1991 Releasing of the lock between public funding from taxes and public provision
- Shortages of doctors and dentists from the late 1990's on: rental firms selling doctor-time
- Attempts to remove the bottleneck of long-duration waiting to get appointments
- Broad employment of nurses in gradually more and more independent roles in the health centers
- Reform of 2019: free choice of service provider – center of team?

## Tasks of Finnish health centers - now

