In-depth reform of the healthcare system in Finland

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Social welfare and healthcare, as well as regional administration, will be totally reformed in Finland in the next years. The centre-right government will unify all public services of social welfare and healthcare, introduce freedom of choice between public and private primary care and abolish the present multi-channel funding in healthcare. New legislation is under preparation and is to be adopted in the autumn of 2016.

Description

Healthcare services are universal in Finland: all residents are covered by public healthcare and are reimbursed for the costs of medicine and the use of private healthcare services. Despite the universal characteristics, the present healthcare system is decentralised, gets funding from different public sources and operates at several levels. First, municipalities are responsible for providing and financing primary care in that they can form joint authorities to share costs and run regional hospitals. Second, the country is divided into 21 healthcare districts with their own "district hospitals" that are responsible for specialised, extensive care. Funds are collected from municipalities. Third, there are five university hospitals for very demanding care not available in district hospitals such as coronary artery bypass surgery, transplantations and other demanding operations and care (costs are covered by the state and municipalities). Fourth, there is a publicly subsidised (private) occupational healthcare system covering all the labour force, but excluding the unemployed. Finally, the Social Insurance Institution (Kela) reimburses private healthcare and dental care and the costs of medicine (Kela-reimbursements).

Finns are quite satisfied with their healthcare system (Kangas & Kainu 2016) and the Finnish system performs well. For example, when comparing ischemic stroke, cervical, breast and colorectal cancer survival rates in 24 OECD countries, Finland's position is the 4th, 6th, 4th and 7th best, respectively; infant mortality is the second lowest (OECD 2015: 25 and 59).

However, there are two reasons why a reform of the system is needed. First, the Finnish healthcare system is socio-economically unequal and biased in favour of high-income groups (OECD 2015: 125-129). Inequalities are due to the long waiting lists for public healthcare, fast-lanes for occupational healthcare, as well as regional differences in access to and quality of care. Second, due to population aging healthcare expenses are increasing quickly. Healthcare spending in relation to the GDP increased from 6.9% (€14 billion in fixed 2014 prices) in 2000 to 9.6% (€21 billion) in 2015; this is slightly higher than the OECD average (9.1%) (OECD 2016). The main objectives of the reform are to reduce social and geographical inequalities in access, and simultaneously to combat the cost expansion. The reform is expected to save €3 billion annually by the year 2030 (Kinnula & al. 2015).

Earlier political attempts to reform the system have failed. The current Government proposes that healthcare services are to be run by larger entities (social and healthcare regions) rather

than municipalities. In addition to social, long-term and healthcare services, these regions should be responsible for many other public tasks. If the reform is carried out, the Finnish public administration will be organised at three levels: the state, regions (five new social and healthcare (SOTE) areas) and municipalities. Occupational healthcare will be left intact, but Kela-reimbursements for private healthcare will be abolished, i.e. private care will no longer be subsidised from the public purse.

Services will be combined at all levels to create seamless service chains in healthcare services. The SOTE areas will be responsible for arranging all public social welfare and healthcare services, and the regional SOTE area decisions will be made by elected councils, which are a new element in the Finnish public administration.

SOTE areas will be allowed to provide services themselves, or alternatively use private or third sector service providers. To provide services themselves, a SOTE will have to establish a separate (public) limited company to compete with the other providers. The Government encourages initiatives from private and third sector providers in order to increase competition. There are hopes that the competition will make service production more effective and combat cost expansion.

The money-follows-the-patient principle will be applied: state funding to SOTE-areas will be a fixed-sum based on the area's population and estimated needs (needs-based capitation). Freedom of choice will be introduced: the clients themselves can choose between public or private primary care. There will be health centres run by public, private or third sector actors. Residents would sign up with a centre of their choice for a period of at least six months. The chosen healthcare centre would act as a "gatekeeper", assessing the needs of citizens and their rights to further health services (Brommels et al. 2016).

Outlook & Commentary

The ongoing reform is the biggest in the history of social welfare and healthcare in Finland. Organising social and healthcare services into areas bigger than municipalities will moderate regional differences in access to and quality of care. However, social policy and healthcare experts are critical against the heavy reliance on private providers and the unclear administrative structure (e.g. YLE (the Finnish Broadcasting Company) 29.5.2016; Merikanto 2016). According to the critics, there is a danger that there will be a private monopoly of multinational corporations, excluding national and small-scale actors. Furthermore, there is criticism of the Government's priorities. Instead of putting freedom of choice and private services in the first place, the first priority should be the coordination of basic public social and healthcare services. The second priority should be the unification of multichannel funding into one channel, and only then, an increase in freedom of choice and the diversification of the services produced.

Further reading

Brommels, M. & al. (2016): Valinnanvapaus ja monikanavarahoituksen yksinkertaistaminen [Freedom of choice and the simplification of multi-channel funding]. http://urn.fi/URN:ISBN:978-952-00-3821-2

Kangas, O. & Kainu, M. (2016): Mainettaan parempi [Better than its reputation]. http://blogit.utu.fi/tita/wp-content/uploads/sites/45/2015/12/PB2.pdf

Kinnula, P., Malmi, T. & Vauramo, E. (2015): Miten sote-uudistus toteutetaan? [How to carry out the sote-reform?] Helsinki: KAKS.

Merikanto, T (2016): SOTE tulee taas kerran, valmista ei ole [SOTE is coming once again, nothing is clear]. Yle uutiset (Finnish Broadcasting Company News) 30 June 2016.

OECD (2015): Health at a Glance. Paris: OECD.

OECD (2016): Health expenditure and financing. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.

Prime Minister's Office (2016): Government outlines on healthcare, social welfare and regional government reform package. URL.

YLE (Finnish Broadcasting Company) 29 May 2016. URL.

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