

# Finnish experiences of services to communities with declining and ageing populations

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## The Finnish setting and development of primary care services

Primary Health Care is provided by structures called health centers, which are maintained by the local municipalities. The whole structure of municipalities and health centers is right now in transition, as the governmental policies seek to reduce the numbers through mergers. Until the end of 2008, there were 415 municipalities and about 230 health centers. The year 2009 begins a four-year period of radical structural changes. In the summer of 2009 there are 347 municipalities and 196 health centers. The number of health centers is expected to be reduced to about 120 by year 2013, due to a new legal ruling of the minimum catchment population of 20000 for primary health care and closely related social services. The health policy aim is to achieve a well-functioning primary health care and occupational health service, correct division of tasks between primary health care and specialised care and an appropriate ratio between outpatient and inpatient services.

Local municipalities may organise the services as municipal service by themselves or together with other municipalities or municipal federations, or by purchasing services from private service providers or from overseas. They may also use the practice of giving service vouchers to the service's users for purchasing the services from a private provider approved by the local authority. Government will introduce a bill for a new law of the service voucher covering all social and health services in 2009. Municipalities can themselves define the value of service voucher and in which services they use it. This will be an all new service alternative, which may have effects on the availability and recruitment of staff.

Social services, which traditionally have included most of elderly care services and services to persons with disabilities, are tasks of the municipalities. Through an extensive process of integration primary level social and health services will be brought under the same administrative roof in most of Finland, and in most cases there will be genuine formation of joint teams. Already now, three out of four municipalities have merged the home care services (coming from the social sector) and home nursing services (coming from the primary health care sector) under a joint administrative roof.

The Finnish primary health centers represent globally rare examples of offering a broad range of PHC services from one service provision organisation. The range of health professionals is perhaps the broadest in the whole world. Also the numbers of staff (per catchment population) are also among the highest, but this is much due to the fact that the health centers have got in addition to the ambulatory services also general practitioner level local hospitals, which provide both long-term and short term care mainly to older people.

Public authorities fund the municipal health services mainly through municipal taxes, which are predominantly income taxes. The state participates in the funding by paying the local authorities a general, not earmarked, state subsidy, which is, on average, 33 per cent of costs. The state subsidy percentage varies by the wealth of the municipality so that poorer municipalities with lower tax income have a high percentage. The user fees for social and health care is 7 – 8 per cent. The percentage varies with the services involved. For primary health care, the share of households amounted to 9.9 %, in inpatient care for the elderly 18 %, and in home care 14,5 %. The municipal system and mandatory national sickness insurance system use several separate payment ceilings, which reduce the cost burden on clients. Prescription drugs are not included in the municipal services or benefits. The sickness insurance system pays a refund, which varies between 50 and 100 % according to the type of medication and diagnosis for prescription drugs.

Finland is a sparsely populated country with a population in demographic transition. Currently, the proportion of aged Finns is on an average European level, but the numbers are expected to rise very steeply, as the exceptionally large age cohorts of those born after the II World War become old (75 and over) after 2020. The country used to have a proportionally large rural population still in the 1950-70's. Now, the rural communities are becoming places for older people to live in, which constitutes a major challenge to organising services.

The Finnish health centers were built – both in terms of the organisations and the actual buildings – in the 1970's beginning then from the rural areas in Northern and Eastern parts of the country. During the past decades, generations of Finns learned that primary health care services are usually good – and for a long time even better than in the urban cities – in rural communities.

Since the end of 1990's, there has been a rapidly growing shortage of medical doctors and dentists in the health centers, especially in the most remote rural areas. The reasons are much the same that professor Maynard describes in his paper. Both the images of the work itself and the of the idea of living in communities with decreasing numbers of working-aged people and jobs and with limited opportunities for life outside work – especially during the long winter months, are behind this development. A full range of remedies, incentives and attractions have been tried, but without sustainable success. The main winners are enterprises which rent doctors' and dentists' services for a considerable price, and often provide only temporary help by inexperienced staff. The development of the need for health care staff is regularly monitored. It is estimated that 43 per cent of those municipal social welfare and health care workers will retire by 2020. Efforts have been made to compensate for the expected increased retirement of employees by increasing the entry numbers for medical and dental training.

These changes have lead to developments that are in the core of professor Maynard's paper and of this consultation. Finland has acquired a lengthy and versatile experience of non doctor inputs into the provision of primary care. We have developed in the Northern parts of the country information technology which enables connecting service providers and users hundreds of kilometres apart and we are in the constant process of seeking new ways to offer services in the actual homes of older people, instead of resorting to hospitalization or to nursing home type of care – both of which have been dominant ways of solving problems in the near past in Finland.

The Finnish Government is in its program committed to developing primary health care and the health centers. A National Action Programme for Health Centers is steering and supporting the development of primary care services since 2008. The further development of public health in a favourable direction requires constant efforts. Even if our health care system works mainly well,

the basic problems are the health differences between population groups and the shortage of medical doctors and dentists, also social workers and even now nurses. Recourses must be directed to health promotion and preventive work. The action program includes measures to further develop and define the division of tasks and responsibilities between physicians and nurses and other health professionals in the health centers. There is also much debate of the overall load and profile of tasks that have been handed over to the health centers. Many voices in the debate are now calling for limiting or redefining the borders of responsibility in primary care, because of the continuous expansion and subsequent overloading of the centers and their staff. Problems of flexible and timely access to the health centers have been a bottleneck of the Finnish services for decades. Now, one key objective is to ensure that the patients can have easy access to the centers both through the telephone and in the future through a range of electronic means. Until now, the residents of a municipality have had the right to use only the services provided by their own municipal health center in non-urgent need. In the future, the users will have the right to choose the health center, the hospital and to some extent also the doctor or other carer.

For decades, primary care and specialized care have had their separate legislations. A reform, which will merge the two laws into a joint law on health services, is currently under preparation. Plans for renewing the legislation on social services are also being launched. As the world of organising health and social services is becoming more and more complex, a special joint law on the administration of public social and health services will be needed to govern the entire field. From the standpoint of the patients, it is essential to receive high-standard services as close to home as possible. The target of the ongoing reforms of local services is to further develop and rationalize the production methods and organisation of services in order to ensure regional equity in access to services. This reform should improve the availability of health care services and clarify the regulations in legislation. Specific clauses of "care guarantee" were added to the legislation in 2005. They stipulate the maximum times in which the users must have access to non-urgent care.

To put the old age policy into the broader context of social and health policy, the National Development Programme for Social Welfare and Health Care 2008–2011 (KASTE) has a strong emphasis on actions that are preventive or promote the health and functional capacity of older people. The KASTE program is the statutory strategic steering tool of the Ministry of Social Affairs and Health in managing social welfare and healthcare policy. The program defines the aims and priority areas of development in social welfare and healthcare policy in Finland in 2008–2011, as well as the reforms and legislative projects, guidelines and recommendations in support of the implementation of these. The program seeks to reduce social exclusion and to enhance the inclusion, wellbeing and health of municipal residents, and also to narrow regional and demographic disparities in health and wellbeing.

### **Non doctor inputs in the provision of primary care**

The leading professional in this development has been the practice nurse. Finland has a long tradition of employing public health nurses in local communities. Their tasks began initially with tuberculosis care, but soon the main task area was to offer preventive services to children at different ages and antenatal care to expecting mothers. Gradually the lists of tasks to people of all ages grew with such tasks as hypertension control, diabetes care and a number of tasks related to coordination of care of old people or people with multiple chronic illnesses. The past decades have also seen the differentiation of nurses' tasks. Some nurses became diabetes nurses,

asthma nurses, nurses who work in rheumatoid arthritis care. Psychiatric nurses were also soon placed under the roofs of health centers, and following a development in the 1990's, also under the primary health care administration. Home care nursing gradually became an area of expertise of its own.

Until the 1990's the doctors' receptions employed receptionists but the nurses were not systematically involved with acute care or assessment of new problems presented. Such assessment was spurred by the need of the population to present medical certificates for sick leaves. Nurses were granted rights to issue certificates for short absences. The health centers also learned that expansion of service through telephone was helpful with the bottleneck of access. Nurses were needed to give professional telephone advice.

As the shortage of doctors became worse by the end of 1990's, many rural health centers had to rely on the nurses as the only professionals present throughout the working week. More and more tasks were delegated to nurses, and this took place first through nurses' reception and in the context of telephone advice, a number of channels of communication, both mobile phones, and the electronic mail systems. Soon the nurses were getting formal training to both assessment of new health problems, acute infections and small trauma. They also expanded their skills in prevention and care of chronic illnesses, for example in the reduction of risks (smoking, obesity, low level of exercise) and in care of persons with chronic illnesses, often with multiple chronic illnesses. New initiatives were tested in pilot projects. The results and outcomes of the pilot will be used in preparing national recommendations, developing the training for health professionals and in other preparatory work associated with development of the division of labour between doctors and nurses/ public health nurses. In primary health care, the visits to nurses' on-call reception constituted, at their highest 30 per cent of all emergency visits and the visits to nurses' reception almost 50 - 60 per cent of the total visits to physicians' and nurses' reception.

The service provision by nurses is becoming a new institutional feature in how services are accessed. In comparison to the 1970-80's, the usual pathway now is to contact the practice nurse, who will assess the needs, the urgency of next steps. The nurse can manage a large share of problems on his/her own, but can also make prearrangements before the patient sees the doctor. Plans for giving a limited right to prescribe certain medicines according to clear algorithms of guidelines are proceeding in the Ministry. The government will introduce a proposal for legislative change to the Parliament in June 2009.

So far, the experiences are good and encouraging. The expanded role of nurses is not limited to rural areas only, but the importance of nurses' work is highest in remote areas.

### **Being connected through remote technology**

Finland is known to be a pioneer country in mobile information technology. We might want to be proud to present an impressive array of both technology and arrangements of how information is passed in the electronic form. So far, the achievements seem to be similar to many other countries, and this includes a number of disappointments and warning lessons to others, too.

The most encouraging examples come from well-planned applications of diagnostics. Digital x-rays are taken, passed immediately to whichever site needs them and stored in archives, which will help to reduce taking new x-rays just to have them available. Similar results of laboratory

tests appear immediately on the computers of the referring health centers as soon as the tests are processed. The samples do need to be (still) transported to the laboratories. Ordinary communication through web camera are useful in a broad range of settings, beginning from mental health services to diabetes care. Similarly, digital photographs and short videos can be transmitted for consultation. Electronic consultations between health professionals are commonly possible as soon as protected networks are available. The bottleneck seems to be the variable interest and readiness of medical doctors to use such means of communication.

Conversion of health records from paper to electronic has been a somewhat frustrating experience. Primary health care is almost 100 % operating electronic, but the systems are clumsy conversions of paper text into the electronic format. The systems do not have appropriate data base features to aggregate information. The 5-6 main software solutions do not communicate with each other without installation of expensive conversion modules. Patients and users of services can not use e-mail services to connect with their services, since ordinary e-mail is not regarded as reliable enough, and the protected systems are in their first steps of development.

Until these days, almost all rural municipality centers have kept their health centre buildings and they have several staff available. Connecting through tele communication means is available in pre-planned meetings only, although needs to be connected without previous plans are high. There is also resistance in these remote communities to developing tele communications, since there is a fear that the mere availability of this technology will be used as an excuse to cut or reduce personal services. However, the course of development seems to be towards an expanding use. The government is ready to give full support to this course.

### **Caring for the growing numbers of older people**

Finland has developed in the Nordic welfare state tradition. This has meant being ready to cover through taxes a broad responsibility for care and nursing at both ends of the life span. The same pattern has also allowed women to build careers outside the home and also gain financial independence and security through own income and earned social security benefits. Caring for frail older people is perhaps the most demanding expression of the principles of the welfare state. As traditional farm based homes have been disappearing and the younger generations have moved to places they find work, demand for nursing type care has been growing, as it is in most European countries.

In Finland, caring has meant for several decades around 1970-90's being ready to offer care in an institution, for example a long term care hospital or a nursing home. Alternatives to these expensive forms of care remained for too long underdeveloped and they offered only light support to living at home. Since the 1990's, speeded by a national project of restructurization, alternative care to institutions has been actively sought for older people, for persons with long-term psychiatric illnesses or with learning disabilities. Much structural change has been seen to take place, but the resources of true home based care are not at the level needed. Old style nursing homes are being converted into more modern homes of assisted living. However, there is too seldom a home based choice for persons with significant dementia, if they do not have carers available in the family.

The world of home care is in change and perhaps also turmoil. There are many contradictory pressures to home care. On one hand older people insist on staying in their original homes much

longer than earlier. On the other hand, organising intensive care night and day throughout the week needs resources, and the public sector is diving deep into funding difficulties with the recent economic development. Organising flexible care at home (instead an institution) would require taking certain degrees of risk, but there are too many warning examples of how individual carers themselves can be a risk or even how individual municipalities can offer services which do not meet the requirements for adequate and safe care.

An efficient model to support home care was developed in a project launched by the Central Union for the Welfare of the Aged. The model is based on an intervention study and the effectiveness, incl. cost-effectiveness, of the intervention has been shown. The main pillars of the model are as follows:

- Focus on the family instead of separate individuals;
- Focus on the everyday life of the family;
- Focus on the strengths and resources instead of the deficits and problems;
- Be culturally sensitive;
- Collaborate and respect the family autonomy;
- Be flexibility in all actions.

Home care of persons who need long term care consists in the Finnish tradition of home nursing by professionals with training in health-related nursing and home help with carers with a more general and shorter training. Finland has undergone a lengthy period of trying to integrate these two traditions into integrated home care. This has been far from easy in many communities, but changes are visible and hopefully irreversible. Professional home nursing is now actively developing new working patterns in short term home nursing for patients recently discharged from hospitals or in many cases acute active care which substitutes hospitalization. This is the front of development which is advancing at the highest speed at the moment. Modern information technology is being used to pass information between the carers at home (both professionals and family member carers) and the medical doctors and other specific professionals. This approach is often combined with modern assistive technology, which aims at securing safe living and care at home.

In order to ensure adequate and timely support as well as high-quality services for older people, policy and practice guidelines have been launched. The national old age policy is expressed in the National Framework for high-quality and services for older people (<http://www.stm.fi/julkaisut/julkaisu-sarja/nayta/julkaisu/1063089#en>) outlines strategies for raising the quality of services for older people. The strategies have three dimensions: 1) promoting health and welfare and the related service structure, 2) staffing and management, 3) living and care environments. The service system is strongly recommended to be developed with the main emphasis on services that help older people to live permanently at home.

The equity of older people in their access to services is being improved by developing a more extensive and harmonised assessment of service needs. Since January 2009, all people over 75 years of age and those receiving a special care allowance from Social Insurance Institution of Finland may have an assessment of their non-emergency service needs if they so require by seventh working day from the day of contact. In urgent situations, the need for all services must be assessed at once, regardless of age.

## Conclusions

The Finnish system of social and health care is complex and it is based on units that are internationally considered to be inappropriately small – the Finnish municipalities (median size has been around 6000 until recently and the mean around 12000). Small size could at its best mean intimacy and mutual knowing and caring in settings of care. The official policy is now towards larger unit size in organising care in order to preserve financing sustainability. There are concerns that this all will lead into less personal contact, longer distances to get help and gradually erosion of the support infrastructures of the rural communities. Some even fear that active introduction of modern communication technology may speed this development.

There does not seem to be any serious possibility for turning back in the social and economic development. Finland has taken an active course in the three developments addressed in professor Maynard's paper and in this paper: increasing non doctor inputs in primary care, introduction of advanced communicative technology and developing new ways to take care of older people in their homes. The authors believe this is the right course to take. All health systems are products of their development histories. Therefore broader scope solutions can't be copied from one system to another, which is very much true in how the role of nurses is seen and developed in national systems.

Good home care for older persons is proactive. It is based on a comprehensive assessment of the client's and his/her family caregivers' functional capacity, coping strategies and other resources, and reacts rapidly to changes in their health and capabilities. Good home care promotes rehabilitation and responds to the client's physical, cognitive, mental and social rehabilitation needs. A 'rehabilitative approach' means encouraging and helping clients to use their remaining personal resources in their everyday life. Rehabilitation helping the older persons to live at home emphasizes community and outpatient services such as forms of rehabilitation that can be given at home.