The evolution of Primary Health Care in Finland

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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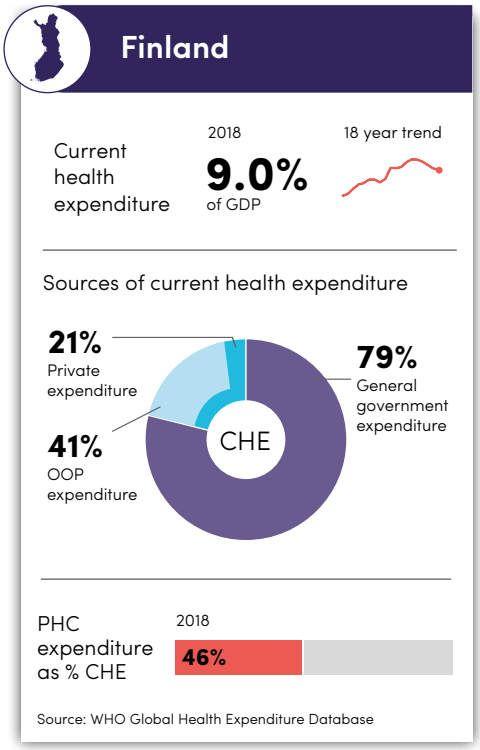
The provision of primary health care in sparsely populated, rural areas has been an ongoing challenge in Finland since its initial primary health care policy in the 1960s. Over the past 50 years, the country has undertaken a series of incremental reforms to establish a universal and comprehensive primary health care system. These reforms have led to changes in how primary health care is planned and financed, with municipalities having overall responsibility for the provision of services. Municipalities now face the growing challenge of a shortage of primary health care physicians at a time when demand from an aging population with chronic and multiple health needs is growing.

This paper provides a detailed description of Finland's PHC reforms from the 1960s to the present day, focusing on the challenges that the country experienced in establishing a universal primary health care system and the changes that reforms have brought in terms of planning and financing arrangements.



1960S & 1970S: PRIMARY HEALTH CARE REFORMS TO ACHIEVE UNIVERSAL HEALTH COVERAGE

A National Health Insurance Scheme was first introduced in Finland in 1964, aiming to provide universal health coverage to all residents through a series of reimbursements for consultation fees, medicines, loss of earnings, travel expenses and maternity care. At the same time, the government sought to increase the supply of health workers by establishing new medical schools and training programmes. After the reform, the use of outpatient services increased in urban areas especially amongst low-income groups. However, challenges remained in ensuring an adequate supply of physicians and health services in rural areas, resulting in a lack of access to services and poor health outcomes.

To solve these challenges, the government launched the 1972 Primary Health Care Act, which involved a series of supply-side reforms relating to administration, financing and health care planning, placing responsibility on municipalities to organise health services. All primary care activities were organised and integrated into networks of health centres, often operating over several facilities. At the same time, funding for General Practitioners changed from fee for services, paid directly by patients, to salaries paid by municipalities. Municipalities received reimbursements from the state government to cover the running costs of health facilities, with the level of funding varying according to their financial status.

1990S: ECONOMIC CRISIS AND REFORMS TO INCREASE THE ROLE OF MUNICIPALITIES

The health care system experienced several major changes in the early 1990s caused, in part, by a severe economic recession. Between 1991 and 1994, health care expenditure reduced by 12% and the state government cut transfers to municipalities significantly. Households experienced an increase in direct payments for health with the reintroduction of user fees for facility visits, reductions in health insurance reimbursement rates, and the abolition of tax breaks for personal health expenses.

In 1993, reforms granted municipalities greater freedom to organise health services for their inhabitants, limiting the power of the central government to influence primary health care spending decisions. Following from the economic crisis, reforms also aimed to contain costs and the retrospective cost-based state subsidy system was

replaced by capitation-based resource allocation, with adjustments based on six criteria: population size, age structure, density, morbidity, land area, and financial status. Despite efforts to reduce inequalities, differences in financial capacity to invest in health services emerged between municipalities, and there were growing regional differences in the availability of health care as younger populations moved to urban areas.

2000 TO THE PRESENT DAY: THE NEED FOR AN INTEGRATED APPROACH TO PRIMARY HEALTH CARE

Compared to other health specialities, primary health care has not been prioritised by regions and municipalities in Finland. Between 2000–2019, public primary health care expenditure increased by just 17% compared to 71% for specialist care, and the number of doctors in primary health care stagnated. During this time, there was also a rapid expansion of the private health sector resulting in parallel public, private and occupational health systems, further enhancing competition for doctors. The rise of the private sector heightened inequalities in access to health care with relatively wealthy and employed populations having better access to services despite having less need.

The provision of adequate services to aging populations with multiple morbidities remains a key challenge. Current reforms aim to consolidate and increase the role regional authorities in organising and funding health care and to better integrate primary and specialised care with social services. In 2021, the Finnish Parliament passed a legislative package which establishes a new regional administrative layer and reforms 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.

In several regions, municipalities have already voluntarily made changes and formed joint health and social care authorities, running innovative service units which integrate multi-professional primary health care and preventive approaches with rehabilitative services, home care for the elderly and family services. In the Finnish context, with an aging population and depopulation of rural communities on one side, and threat of social segregation in urban areas on the other, these types of integrated services look to be the most promising way to develop primary care.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

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