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Finnish care integrated?

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Abstract

The public Finnish social and health care system has been challenged by the economic crisis, administrative reforms and increased demands. Better integration as a solution includes many examples, which have been taken to use. The most important are the rewritten national and municipals strategies and quality recommendations, where the different sectors and the levels of care are seen as one entity. Many reorganisations have taken place, both nationally and locally, and welfare clusters have been established. The best examples of integrated care are the forms of teamwork, care management, emphasis on non-institutional care and the information technology.

Keywords

municipality, strategy, care management, information technology

Background

The Finnish social and health care system is, for the most part, financed by the public budget and covers the whole population. The Finnish system is decentralised, about 450 autonomous municipalities are responsible for most services [1–3]. In the WHO's Observatory report the number of working nurses in Finland [4] is striking when compared to the other European countries. On the other hand, there is a shortage of physicians, especially in the health centres of remote and small municipalities. The salaries in the welfare sector are low by international standards. The specialised level of health care is carried out in the health care districts. The municipalities will annually receive grants from the state to cover the expenses for the social services and for both the primary and the specialised health services. In addition to the public services, there is a private alternative to some health and social services. The costs of the use of private services are partly covered by the Social Insurance Institution [5]. There are a large number of third sector organisations, which work for the benefit of special patient groups. The voluntary sector is financially partly supported by the Slot Machine Association [6].

Most of the population is happy with the health care system, and in the international comparison the Finnish national economy, citizens' social and health welfare and the public services' output indicators compete well [7–12, 43, 44]. The system has been challenged mainly due to the public financing crisis of the 1990s and the continuing high level of unemployment. An equity problem arises from the rising proportion of health funding from out-of-pocket payments. That these have risen is more likely to be a function of economic constraints imposed by the past recession than a consequence of recent changes in the social or health care system. In table 1 (latest statistics available 1995–2002) Finland is compared with three Beveridge-type countries, and with the Bismarck-types, Germany and the Netherlands. Finnish public health care system is relatively efficient, since it is financed with relatively little public money and run by underpaid but competent nurses.

The normative and bureaucratic role of the central government was radically diminished in the beginning of the 1990s. Due to the decentralisation and deregulation and the growing demands of efficiency, integration has become an important topic. Finnish strategies, law and national recommendations encourage integration.

Concepts

Integrated care includes the methods and strategies for linking and co-ordinating the various aspects of care delivered by different care levels, of primary and secondary care. In Finland, the concept of integration applies also to the social services, since especially

Table 1

	FIN	SWE	DK	UK	GER	NL
Rank of Country's Human Development Index	10	4	15	14	17	8
Rank of Country's Technology Achievement Index	1	3	–	7	11	6
GDP per head (Index EU-15 = 100)	101	102	118	102	108	113
Unemployment rate as %	10.2%	7.2%	5.2%	6.1%	8.8%	3.3%
Expenditure on Social Protection (excluding Health) as % of GDP	20.3%	24.9%	21.7%	19.8%	18.8%	19.9%
Expenditure on Health as % of GDP	6.9%	8.4%	8.3%	7.0%	10.5%	8.6%
Health Care Expenditure from Public Sources as %	76.3%	83.8%	81.3%	84.2%	75.3%	70.4%
Physicians and Nurses per 1000 Population	3.1/21.7	3.1/8.2	3.4/7.2	1.6/5.0	3.5/9.5	2.5/9.0
Hospital Beds per 1000 Population	2.5	2.5	3.4	2.4	7.0	3.4
Average Length of Stay in Acute Hospitals in Days	4.5	5.1	5.7	5.0	11.0	8.3
People Satisfied with the Health System as %	74%	59%	76%	56%	50%	73%

patients of long time care need support, which is a duty of the social sector as well.

The scope of integration in this article covers the non-institutional and institutional echelons, also municipal and national levels. The perspective of this article is related to the management reforms, and organisation redesigning. General systems theory, social exchange theory, and co-operation theory [13] are behind the forms of integration, but practical forms of integrated care have apparently evolved without a grand theory.

Integrated strategies

The most important integrated nation-wide strategy of social and health care is the government's political programme [14], which articulates the political social and health targets for the years the coalition is in charge. The coalitions have been quite stable and they have been able to carry out their intended policies.

The Ministry of Social Affairs and Health has the responsibility to publish general outlines for the overall development of the sector. The most important current integrated strategies are:

- Strategies for Social Protection 2010 [15] integrates both the social and the health sectors
- Government Resolution on the Health 2015 Public Health Programme [16] is the national version of the WHO's Health 21 [17]
- Goal and Action Programme for Social Welfare and Health Care 2000–2003 lists both the social and the health care targets

One form of soft law, quality recommendations, sets targets for integrated care as well:

- The quality management strategy for social and health sectors
- The quality framework for the care of elderly people
- The national framework for mental health services
- The medical associations' [18] evidence based medicine recommendations
- The health care technology assessment unit's (FinOHTA) [19] recommendations
- The social care evaluation project's (FinSoc) [20] reports

These various quality tools make the clients aware of the expectations of good care. Recently published reports have suggested that standards should be set

for maximum waiting time and care guarantee for health services as well.

Most of the ministries were reorganised in the beginning of the 1990s [21]. In the Ministry of Social Affairs and Health [24] two separate agencies were amalgamated into the National Research and Development Centre for Welfare and Health (the STAKES) [22]. It now carries out research, development and evaluation of both social welfare and health. The institutional integration of both the social care and the health care research was not easy, since both sectors have different fields of interest, scientific paradigms, research methods, and traditions [23]. Further integration of social and health care administration have been suggested.

Municipal reforms

The municipalities have the key role in welfare services. The radical [25] Law of Social and Health Care Planning and State Subsidy (1992) changed the state grants from a piecemeal detailed ex-post system that covered the expenses into a system based on the ex-ante calculation of needs with a particular mathematical formula. The municipalities also have the right to use the subsidies as efficiently as they wish; the government will not monitor how the money is spent. Another major reform, the new Local Government Act [26] of 1995 allowed the municipalities to reform their own administration. The municipal legal obligations to arrange social, health and other welfare services have not diminished, but the steering systems have become less normative.

There is growing criticism about the increased autonomy of municipalities. Equal access for all citizens to public social and health services has been the key value of the Finnish welfare state, so many were worried about a too radical administrative reform. The resulting varying quality of institutional care, especially the care for the elderly, was a sensitive topic in the 1990s. The effects of the changed subsidy system and other administrative reforms were unfortunately mixed with the effects of the deep economic recession of the early 1990s [27].

Primary care's municipal associations jointly maintain health centres with neighbouring small municipalities. Many of them had been financially inefficient, since the economics of scale did not work here. Some of these primary care associations were dismantled in the 1990s and the member municipalities took over the tasks.

There are also the larger municipal associations for specialised health care, the health care districts. Previously these municipal associations also got their financing directly from the state. The municipal associations were quite independent from the municipalities until 1992. After the change in the grant system, the associations became subordinated to the municipalities, since the municipalities received the state grants instead. The health care districts now have to get the majority of their money by selling the specialised health services to the member municipalities. The internal special health care quasi-markets were evolved in the 1990s.

The autonomous municipalities have the right to plan and implement their social and health service activities as they see fit. There are so many social and health development projects that not all of the municipalities have been able to carry them all out. The general problem with such programmes is that they are rather dispersed and uncoordinated. Therefore, there is an official suggestion that says each municipality ought to integrate the projects and programmes into a single municipal welfare policy portfolio.

The municipalities have integrated their political health care and social care boards and other public service boards into fewer, but larger, boards. In many municipalities, the social and health boards have been integrated with each other and/or with the board of primary education, or with the board of sports, or with the board that deals with the temperance work. The integrations aimed at reducing bureaucracy and streamlining the administrative processes. It is clear that democracy and the citizens' participation element in municipal administration are the losers. Management has more degrees of freedom but at the expense of democracy, which is an important value. There are fewer people making decisions on local social and health policy than before.

Some new forms of patients' and citizens' participation have been taken into use. The municipal joint boards of the elderly and the municipal joint boards of the handicapped people hold meetings with the third sector associations and the municipal authorities as well as with the private sectors' representatives. The status of the joint boards of the physically challenged is mentioned in the law. The task of the joint boards is to guide the municipal authorities to ensure that the local services are also fitted to the needs of the elderly or the physically challenged. The joint boards are established to make the weakest peoples' voices heard, so that the municipal services and also the private sector's services could be better suited to them.

''Teamwork'' is one of the most intensely repeated words in the Finnish social and health sector at the

grassroots' level. Unfortunately, the usual problem has been that the home care workers and the home-nursing professionals have carried out their work without knowing of each other's doings, even though they have had the same patient/client. Autonomous teams have been the theoretical ideals of many management doctrines. The integrated teams of social sector's homecare and health sector's home nursing are more common. A team can have members from different professional backgrounds. The members organise the tasks so that the people from the social care and health care can work jointly and in co-operation with the patients.

The service circle is one version of the teamwork. For example, a sick child can have supporters from primary care, specialised health care, social care, and from the voluntary sector. Every part of the circle is aware of the sick patient's needs and the other partners' roles in the collaboration.

The leading group is a way to integrate strategic management between different welfare sectors. Managers who represent different divisions or sectors can organise their collaboration in official or unofficial meetings. Leading groups are a common way to integrate the work of different result units or, for example, of the social and health sectors within a single municipality. The leading groups can include meetings with private and voluntary sectors. Leading groups can have an unofficial or official role and they can be called by different names. The idea of the leading groups is to transfer knowledge and information and is apparently quite a widely used phenomenon in the public sector.

One particular version of the leading groups is the SAS-group (See the client's problem, Assess the service needed, Suitable placing). The SAS-group of the municipal social and health authorities meets regularly to organise the integrated care for the new long time patients/clients. The systems vary in every municipality.

The law of the public authorities' collaboration in rehabilitation says that the municipalities must establish a leading group, called the local co-ordination group of rehabilitation services, for the collaboration of the state's local authorities with the local representatives of the Social Insurance Institution. The task of the group is to arrange the necessary services for people in need of various forms of rehabilitation. Rehabilitation consists of different duties and the process is particularly bureaucratic and exhausting for a patient who is weak. The same law established the regional co-ordination boards for the rehabilitation services as well. A nation-wide body of rehabilitation was also established to co-ordinate the rehabilitation processes at the macro-level.

Welfare clusters and centres

Welfare clusters, or wellness clusters, technology centres, and centres of excellence have been built up during the 1990s according to Porter's [28] ideas. Wellness cluster means that the social care and/or the health care know-how are developed into marketable wellness products and services. Clusters consist of local partners (universities, polytechnics, hospitals, private companies, and third sector associations, municipalities), who aim at new innovations in the fields of social care, health care, biotechnology or information technology. The innovations, products and the scientific work that they hopefully will produce in the future are eventually meant to benefit all the partners and even in some cases, to become profitable export businesses. There are clusters and centres of various scales in the cities of Oulu, Turku, Kuopio, and in smaller scales in some other cities. They call themselves by different names and their profiles vary. These clusters/centres concentrate mostly on the hard sciences: medicine, biotechnology, economics and ICT engineering. Unfortunately the social care has a smaller role in these centres.

Examples of care management

Seamless care means that collaboration between the primary health care level and secondary specialised health care should work as smoothly as possible. The primary health care takes place in municipal health centres, also in private clinics, working places, schools, and defence forces. All these organisations have their own budget and their own patients and they are administered separately. If the patient needs further investigations and care, he or she will be guided to the next level of care, to the special health care. In further cases, the patient will be sent to a university hospital. After he or she returns home, very often some kind of social service is needed, which the municipality provides. The social sector is also responsible for the same patient/client. In addition to that, the patient's employer's primary health services, Social Insurance Institution, insurance companies, and third sector associations can have a role in the service chain. The patient/client should be taken care of in the most appropriate and cost-efficient place. Since the patient/client usually prefers living at home, all the alternatives should be planned so that he or she would not need to stay away from home and from normal life more than necessary. That is also cost-efficient, since the patient's bed in specialised health

care is the most expensive place for care. Integration and better co-ordination are not new demands; they have been hot topics for decades.

The special health care partnership agreement is a Finnish version of the purchaser-provider split, which aims at improved integration between primary and secondary care. The municipalities buy the services for the citizens from the health care districts, and pay for the services. Since 2001, most services in all the health care districts have been priced according to the Diagnosis Related Groups (NordDRG) [29]. The purchaser can be a group of smaller municipalities, or alternatively, a single larger municipality. Collaborating small municipalities agree how they split the costs between themselves. The provider is the health care district. The written agreement says how many services will be purchased during the period of 1–3 years and for what price. In case more or fewer services than expected would be purchased, another price will be set according to precisely agreed criteria. The meaning of the agreement is to plan a better balance of the future variations of needs and costs and the general rise of expenses. The market-oriented models have not always been successful [30, 31], so the Finnish models are rather cautious. The Pirkanmaa Health Care District has the longest experience of a partnership agreement since the end of the 1990s. The central problem at the moment is that the municipalities own the municipal associations, which run the hospitals. The municipalities are, at the same time, the buyers and the sellers of health services, and their interest is not to use alternative, maybe more efficient or cheaper private services, since in any case they have to cover the expenses of their own institutions. From the administrative point of view the situation is not quite clear.

One recent care management example concentrated on the information flow between primary and secondary care in Helsinki. The manual system of referral-epicrisis since the 1950s did not work well enough. The Helsinki University Hospital's solution is the mutual case management agreement, which is also known as the regional care plan. The literal agreement/plan mentions the division of responsibility of a single patient's care. The written agreement will be sent from the primary health centre to a specialised care hospital, to a day care institution, to a maternity clinic, or other relevant partners in the single patient's service chain. The paper will be signed and returned to the physician who takes the overall responsibility of the patient's care. The agreement states the details of how the partners will exchange information and how they will collaborate in order to make the care most useful for the patient.

Some primary health centres have ensured that the patients are treated by the same staff. The responsibility can be personalised in the family doctor system. Municipal primary health care's population responsibility means that the responsibility of the care is divided between teams of the health centre. There are also list systems in some forms of social care, and in maternity care. Some of the biggest municipalities have divided their population into several local integrated social and health service stations, which are responsible for the local listed citizens' primary social and health services. The units have their ''own'' listed patients/clients, and every citizen should know his/her ''own'' physician, if appointed, or at least should know the particular social and health station where he/she should go to if necessary.

There are various case managers of social and health services. The case managers' task is to supervise and help the clients/patients through the care processes or ''care bureaucracy'', so that a single individual patient/client actually gets the required services in every phase. The case managers can also receive complaints from the patient/client and/or give information about the different alternatives of social or health service.

The rehabilitation case manager is working in the hospital and he/she is responsible for the management of the patient's rehabilitative care. The rehabilitation case manager arranges, for example, postoperative rehabilitation for the heart or lung patient, and also visits the patient's home to make sure that the services are actually carried out, which is conducive to recovery. The rehabilitation case manager can be a nurse, physiotherapist or a social worker i.e. the professional background can be different. The dementia case managers are responsible for the supervision and arrangement of integration of the care for single demented patients in different phases in the social and health system. They are employed by the health care districts, or jointly with third sector associations. In some hospitals the appointed SAS-nurses are responsible for patients' flow, for example in surgical procedures. In most hospitals the nurses who are responsible for single patients are called the own nurses. It means that one nurse is responsible for the individual patient's welfare during the care process. The patient knows for whom to ask, or whom to tell, if there are some problems. Since there are many departments and many people who carry out different parts of the whole care, the own nurse can inform the patient about the steps of the care and follow the patient's care process.

In the city of Pori's Makropilotti-project, every client/patient was supposed to have a personal advisor. The

advisors' role was to make sure that the patients and clients are aware of the services and of the different possibilities to get the right kind of care in the right place.

The patient ombudsmen are nominated in every hospital and municipal health centre. The ombudsmen work part-time, in most cases. A physician, nurse, or one of the administrative personnel is nominated for that job. The patient ombudsman is responsible for giving information and supervising all the patients who want to know more about their rights or to complain about the health services. The ombudsman is responsible for the guidance and supervision of the patients, so that the patient can get more information or make a complaint.

The municipal social care ombudsmen are responsible for the supervision of social services for all citizens in the municipality. The ombudsmen can work full-time or part-time. The social care system is a particularly complicated system, where the clients, in most cases, are not aware of all the possibilities they are entitled to. The patient ombudsmen and the social care ombudsmen are not judges; their role is to inform the patient what to do next and what he/she is entitled to.

Emphasis on non-institutional care

The emphasis on non-institutional care or community care rather than institutional care will continue to be given priority and the service structure will be adjusted further, accordingly. Day surgery means that some surgical patients do not have to stay overnight or longer in the hospitals, but they are sent home after the operation. That is possible with some smaller operations due to technical developments. A patient hotel is a place where the patient can rest after the operation if he or she is not capable or willing to go home right after a surgery. Some long time patients can stay there for longer periods of time, in case some service from the hospital is needed. It saves resources and it is less expensive for both the patient and the municipality. There are residential homes for the elderly or for the physically challenged in which they can live as normal a life as possible, but can get help if needed. There are also various forms of retirement or nursing homes, which represent alternatives for people who need more or less assistance. Financial support for the relative's care at home is one way to shift the responsibility of the care of the patient from the authorities to the immediate family or to relatives. A spouse or other relative can receive a small salary for taking care of the patient at home. Children's day-care can also be done at home, and the mother receives a small salary, called the home day-care support.

Home help or domiciliary care is an important public social service. There are home help professionals who regularly visit the patient/client/families and do part of the housework, so that the patient/client/mother can manage better at home. The home hospital is a new type of activity and it means specialists' and nurses' visits to the patients' homes. The physicians' house call is actually a reinvention, since abroad the physicians' house calls have been common. Since the 1970s, the municipal primary care's services have been provided only at municipal centres, mainly due to the large area of the country and due to the shortage of physicians. Today, in some municipalities, physicians can visit patients at their homes again, but the arrangements vary in every municipality.

The private alternative of health care has always remained quite a significant part of the Finnish health care system. Non-profit organisations primarily produce social welfare services, while private enterprises concentrate on health services [32]. Physicians can work in a private clinic full-time or part-time, and there are dentists, physiotherapists, home care aiders, and children's day carers who work privately, but get their money for the most part from public sources i.e. from the municipality or from the Social Insurance Institution. The social insurance system was constructed so that an alternative private system exists if the patient prefers it. Even though the Social Insurance Institution later reimburses the private sector's bills for the client for the most part, it is cheaper for the patient to choose the public services.

Another form of integration or mixture of public and private is that specialists can treat his/her ''private patients'' in a public hospital. The patient pays a higher fee for the care in the hospital and the specialist is expected to pay more attention to the private patient. This integrated or mixed system was motivated due to a shortage of specialists so that their capacities could be used in the most efficient way in order to benefit as many patients as possible. Secondly, the expensive equipment in public hospitals could also be used in the most cost-efficient way. Thirdly, there are patients who demand more care and are willing to pay for it.

Better integration of care through information technology

Telematics or information and communication technology has a promising role in Finnish social and

health integration. Due to the relatively small costs of ICT-devices compared to institutional care, the various ICT-based systems will be a more common sight. There are the experiments of personal alarm systems for the physically challenged. There are GSM phones attached to the GPS-satellite system, which tell the public nurses where the patient is in case he/she has problems. The city of Helsinki's home nursing workers' portable computers are combined with GSM cell phones, with which they update the laboratory data of the patients and other care files. The professionals can spend more time with the patients and do the actual work. Most health care districts have taken into use live on-line video conferencing. The Internet has proven to be a good medium for the digital transfer of X-ray shots and other laboratory tests. There are experiments of tele-psychiatry and of Internet wellness clinics, which advise people who want to ask questions about health.

The most important pilot of integrated care was the Makropilotti-project [33]. The project's idea was to integrate, with ICT, the patient records from primary health care, from the specialised health care, from the municipal social services, and from the Social Insurance Institution. The patient/client had a credit card-sized identification card, which is a key for the physician or social worker to gather the patient's other data from the network. The data network combined the patient's different periods into one history, so that the specialist could have on-line, updated, reliable data on which expert has done what and when to the patient. This exchange of data is important, since the core problem of the integrated care has been the lack of updated information. The patient was supposed to control the systems, since he/she could monitor who has read his/her data and when. The aim of the experiment was better care and cost control by information exchange. The strict rules on the delivery of patients data were only possible due to special legislation [34]. Unfortunately, the technical problems were only partly solved during the pilot when it ended in 2001. Despite the disappointments of this particular, maybe a bit over-ambitious pilot, there are numerous other smaller scale pilots, which aim at the same thing.

Better pilot management

Typical for Finland are numerous experimental projects, pilots. There are projects for mental health, social inclusion, urban programmes, asthma care, diabetes etc. Internet portals are a practical source of information, when information on special experiments is needed. The experiences of the projects could not be distributed efficiently through research reports or evaluation reports. These portals are either already in use or soon forthcoming:

- VerkkoTATO lists the social and health care development programmes
- TietoVEP lists the social care experiment projects
- SOSIAALIHUOLLON E-KONSULTAATIO is a portal for professional social workers' information exchange
- HARE lists all the ministries' projects
- SOTEVERTTI contains municipal benchmarking statistics of the social and health care
- SOTKA database lists comparative health care output and financial statistics
- SOSTERNET lists activities of third sector organisations

So far, the portals are not functioning sufficiently well; there is more potential on the Internet than has been used yet.

Integrated education

There are many education programmes, which have integrated social and health sectors horizontally, or theory with practise vertically.

At the basic level, a new three and half years integrated vocational study programme has been established to educate multi-professional practical nurses. Practical nurses are capable of doing some basic medical work; home help and some tasks of social care also belong to their fields of competence. Some criticism has been presented about their actual capability to handle both medical and social tasks in practice, but development of this vocational programme continues.

There are complementary management courses in the polytechnics, which add nurses' competencies to become ward sisters. Due to the growing complexity of management especially the nurses have felt that they need further education of administrative tasks. The same management studies fit also for the social workers, whose previous management studies have been rather little. The contents of the complementary courses vary in different polytechnics of the country, but one of their core themes is the integration of services. For those people who already work in social or health care management, there are additional academic courses. Professional Development programmes consist of management studies. It usually takes 2–3 years to complete the studies alongside with the normal work. The PD-programmes are also somewhat different from each other. In academic education, there are departments dealing with health management in several universities [35–38]. Masters

of Public Health can major in health management, or health economics. There are also academic disciplines of the social and health administration [40], the social care administration [41], and the social and health policy [42]. Better integration of services is one of their important topics.

One problem in the health sector is the lack of competent physicians in remote municipalities and some bigger cities. One solution to the lack of doctors is the decentralised education of physicians at the specialising phase of studies. Some hospitals, other than university hospitals, are now entitled to give lectures and supervision to the students. This decentralisation is expected to encourage students to carry out more work in the regional hospitals after they have finished their studies. This form is to suit the education better to the needs of working life.

Summary

This article gives a short introduction to the integration of the Finnish social and health care from the administrative point of view. Integration can take place vertically between different levels, or horizontally between different sectors.

Politically and strategically, there is good general awareness of the benefits, but how that should take place in practice, is another thing. The municipalities are free to integrate activities according to the strategies that the ministries provide for them but there are also examples of disintegrative actions. Integration of organisations does not automatically result in integration of professions or multi-professionalism at the operational level.

Leading groups and teamwork are ways to combine horizontally the management of different parts of the social and welfare sectors. There are also different kinds of case managers, whose tasks are to guide the client/patient through the welfare sectors. This task is more important, since the social and health bureaucracy is rather complex for ordinary people. Vertical integration is also possible. Integrating the education of physicians vertically with the local hospitals combines the capacities of the universities and the needs of working life. Some forms of integration are horizontal and vertical at the same time. Recently established welfare clusters and centres of excellence are expected to benefit the universities, polytechnics, municipalities, companies, regions, exports industry, and the patient/client also. These various new forms of integration seem to be quite interesting, since the partners are looking for a win-win relationship. They have joined to collaborate with their own capacities, and to benefit from them. Information and communication technology across the boundaries of the social and health sectors is also a very promising way to integrate the social care and the health care services.

Integration must mean better know-how, better organisations, and better management. Integration means transformations of power-relationship and professional boundaries. These issues are sensitive and difficult. The municipalities want to be more autonomous, the institutions want to be bigger, the strong professions want to be stronger, etc. Integration means something that is sharing, reforming, transforming, negotiating, revolutionising, collaborating, exchanging, etc. If the patients'/clients' benefit is the target, the obstacles should be overcome.

In the comparative perspective, Finland follows international examples and experiences. The problems and also the solutions are rather similar in all the EU countries. Our national social and health system is decentralised but the citizens are mostly happy with the system. However, better quality, better cost control and better accessibly of care are continuous demands. The labour-intensive nursing will face labour shortage within ten years; therefore new (perhaps integrative) efforts have to be invented in order to manage that forthcoming problem.

After a decade of decentralisation, and deregulation, ideas have come up that it would again be time to centralise, or institutionally integrate, the Finnish health care system. In 2001, the Minister of Social Affairs and Health suggested that the health care is too scattered into too many small units, therefore, they should be amalgamated with each other and with the health care districts. Some health care districts should also be integrated with each other. The proposed ''regional health care districts'' should be made responsible for both the primary and specialised health care, and possibly for some social care services as well. A big health care reorganising project was initiated in 2001, and a green paper with detailed propositions was published in April 2002. The propositions resemble partly the UK reforms, and partly the Swedish reforms. These are the two countries from which we have traditionally copied the new ideas. The dispute about integration continues.

Vitae

Jouni Niskanen works in the faculty of social sciences. His main research interests are the market-oriented modes of operation, ethics and values, and the quality management in the public social and health care.

References

1. The Social Protection in Europe 2001. Available from: URL:http://europa.eu.int/comm/employment_social/missoc2001/index_en.htm
2. The Nordic Social-Statistical Committee NOSOSCO. Available from: URL:http://www.nom-nos.dk/nososco.htm
3. The Nordic Medico-Statistical Committee NOMESCO. Available from: URL:http://www.nom-nos.dk/nomesco.htm
4. Health care systems in transition, Finland 2001. European Observatory on Health Care Systems. Copenhagen: WHO; 2002 Vol. 4, No. 1. Available from: URL:http://www.who.dk/document/e74071.pdf
5. The Social Insurance Institution of Finland. Available from: URL:http://193.209.217.5/in/internet/english.nsf
6. RAY in brief. Available from: URL:http://www.ray.fi/english/ray/index.htm
7. The Social Situation in the European Union 2001. European Commission.
8. World Health Report 2000 – Health Systems: Improving Performance. Copenhagen: WHO; 2000. Available from: URL:http://www.who.int/whr/2000/en/report.htm
9. Häkkinen U, Ollila E, editors. The World Health Report 2000: What Does It Tell Us About Health Systems? – Analyses by Finnish Experts. Themes 7/2000. Helsinki: Stakes; 2000. Available from: URL:http://www.STAKES.fi/verkkojulk/pdf/Themes7-2000.pdf
10. McKee M. Measuring the efficiency of health systems. The World Health Report sets the agenda, but there's still a long way to go. British Medical Journal 2001;323:295–6.
11. Heikkilä M, Hvinden B, Kautto M, Marklund S, Ploug N. Conclusion: the Nordic model stands stable but on shaky ground. In: Nordic Social Policy, Changing Welfare States. London, New York: Routledge; 1999. p. 262–73.
12. Trends in Social Protection in Finland 2000–2001. Helsinki: Ministry of Social Affairs and Health; 2001. Available from: URL:http://www.vn.fi/stm/english/publicat/publications_fset.htm
13. Loxley A. Collaboration in Health and Welfare. Working with Difference. London: Jessica Kingsley Publishers; 1997.
14. Programme of Prime Minister Paavo Lipponen's Second Government. Available from: URL:http://www.government.fi/vn/liston/base.lsp?r=696&k=en&old=385
15. Strategies for social protection 2010 – Towards a socially and economically sustainable society. Ministry of Social Affairs and Health; 2001. Available from: URL:http://www.vn.fi/stm/english/tao/publicat/strategies2010/strategia2010eng.pdf
16. Government Resolution on the Health 2015 Public Health Programme. Publications 2001: 6. Helsinki: Ministry of Social Affairs and Health; 2001. Available from: URL:http://www.vn.fi/stm/english/eho/publicat/health2015/health2015.pdf
17. Health 21. Copenhagen: WHO;1999. Available from: URL:http://www.who.dk/document/EHFA5-E.pdf
18. Current Care. Available from: URL:http://www.duodecim.fi/english/
19. FinOHTA. Available from: URL:http://www.STAKES.fi/finOHTA/e/
20. FinSoc. Available from: URL:http://www.STAKES.fi/palvelut/finsoc/finsoc_news.htm
21. World's best public sector? Final report. Helsinki: Ministry of Finance; 1993.
22. National Research and Development Centre for Welfare and Health (STAKES). Available from: URL:http://www.STAKES.fi/english/index.html
23. International Evaluation of the National Research and Development Centre for Welfare and Health. Ministry of Social Affairs and Health Publications 1999:12. Helsinki: Edita; 1999.
24. Ministry of Social Affairs and Health and Related Authorities. Available from: URL:http://www.vn.fi/stm/english/organ/organisation_fset.htm
25. Martikainen T, Uusikylä P. Reforming health policy in Finland – a critical assessment. Helsinki: Ministry of Social Welfare and Health; 1997.
26. The Finnish Local Government Act (1995). Available from: URL:http://www.kuntaliitto.fi/english/indexeng.htm
27. Lehto J, Blomster P. Impact of the economic crisis on the social welfare and health care systems. Kunnallistieteellinen aikakauskirja; 2000;1:44–60.
28. Porter M. The Competitive Advantage of Nations. London: Macmillan; 1990.
29. NordDRG user's manual. Available from: URL:http://norddrg.kuntaliitto.fi/
30. King's Fund. Learning from the NHS Internal Market. In Le Grand J, Mays N, Mulligan J-A, editors. London: King's Fund; 1998.
31. The Impact of Market Forces on Health Systems. Final Report. Dublin: European Health Management Association; 2000.
32. Trends in Social Protection in Finland 1999–2000. Publications 2000:9. Helsinki: Ministry of Social Affairs and Health; 2000.
33. Satakunta Macro Pilot. Available from: URL:http://www.makropilotti.fi/english/
34. Act on experiments with seamless service chains in social welfare and health care services and with a social security card (2000). Available from: URL:http://www.vn.fi/stm/english/tao/publicat/taocontents51.htm
35. University of Kuopio, Department of Health Policy and Management. Available from: URL:http://www.uku.fi/laitokset/tht/

36. University of Oulu, Departmnent of Nursing and Health Administration. Available from: URL:http://www.oulu.fi/hoitotiede/
37. University of Helsinki, Department of Public Health. Available from: URL:http://www.kttl.helsinki.fi/
38. University of Turku, Department of Nursing Science. Available from: URL:http://www.utu.fi/med/hoito/hoieng.html
39. Åbo Academy, Department of Caring Science. Available from: URL:http://www.vasa.abo.fi/svf/vi/
40. University of Vaasa, Faculty of Social Sciences. Available from: URL:http://www.uwasa.fi/ytt/english.html
41. University of Kuopio, Department of Social Sciences. Available from: URL:http://www.uku.fi/wwwdata/pulu/Departments/26.shtml
42. University of Tampere, Tampere School of Public Health. Available from: URL:http://www.uta.fi/laitokset/tsph/indexeng.htm
43. Human Development Report 2001. United Nations Development Programme 2002. Available from: URL:http://hdr.undp.org/reports/global/2001/en/default.cfm
44. World Competitiveness Yearbook, Rankings 2002. International Institute of Management Development 2002.