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Finnish solutions and experiences for integrated primary health care

Background: how Finland chose the health centre model for primary care

Finland is a Nordic country, a member of the European Union since 1995, with a population of about 5.3 million. Adhering to the Nordic tradition of a welfare society, Finland has maintained a strong local democracy, broad public responsibility for social and health services and education all based on tax funding.

Publicly run and funded local health services date back to the early decades of the 1900s. A system of municipally employed doctors and nurses, and a network of small local hospitals was the backbone of health care provision in the sparsely populated country, which had a strong agricultural and forestry based economy until the 1950–1960s. By the end of the 1960s, all municipalities under either legal obligations or voluntary choice begun to offer a variety of primary level health services, which were often scattered around as separate units under separate branches of the local administration.

At the same time, a Bismarck model inspired mandatory health insurance had been introduced in the 1960s. This system was built on reimbursement of costs incurred to the users of health services and on covering costs of prescription drugs. The new incentives moved staff and health services to newly established private practices in urban centres.

The health policy makers, who were actually a group of young doctors inspired by the political climate of the 1960s, were dissatisfied with the course of development. New epidemiological methods had just begun to show that Finland had an unusually high burden of cardiovascular disease. New promises of population level interventions, for example in cancer screening, had emerged.

Against this background, the concept of health centres was created. The health centres were to become, above all, an administrative roof under which all publicly run and funded primary health care services were to be placed. The law of 1972 obligated the municipalities to maintain health centres. The best comprehensive description

of the whole Finnish health care system is available in English in the latest Finland report Health Systems in Transformation series [1, 2]. The tasks were listed as presented in Table 1. Included are also later additions to the list through amendments to the law.

The list of tasks is broad. Consequently, the volumes of services, number of staff and the range of their professional backgrounds put Finland into the forefront of health centre development in the whole world. Similar health centres do exist in a number of countries, but only in a few industrialized countries they cover the entire country and most of the population. Two other Nordic countries, Sweden and Iceland seem to be closest to Finland in terms of coverage of health centres.

Perhaps the main feature that separates the Finnish primary care from other countries' solutions based on multi-professional work has been the local GP run hospital. These hospitals are inherited from the earlier decades when services had to be locally available in the time of poor roads and other means of communication. Many such hospitals had been active sites of surgical operations and obstetrics until the late 1960s.

During the first decade of health centres, a new concept of a local hospital was formed. These hospitals exist partly of long-term care units for the elderly, usually called nursing homes. The other half (in recent years about 60%) of the capacity is used for short-term care, either acute illnesses or for post-hospitalization care for patients recovering from stroke, major surgical operations or similar. These hospitals have attracted some international attention [2], but the model has not been widely copied.

In the 1970s, the country had about 470–480 municipalities in the early 1970s. The median size of the municipalities was around 5000 and the mean around 10,000. As the health centre was conceived to become a well-equipped health service unit with both special staffing and special items of medical technology—for example a dense network of laboratories and X-ray

facilities—the minimum population base was set to be 10,000 inhabitants for one health centre. The number of health centres settled for a lengthy period of time around 210. Small municipalities were made to maintain health centres jointly through a municipal federation.

Health centres enjoyed broad political support in the country. Only the medical doctors and dentists, who worked earlier as private entrepreneurs under a special local municipality contract, were dissatisfied with becoming salaried employees.

Developments during the past 40 years

The 1970–1980s were an era of economic growth and expansion of the welfare services along the Nordic model. Schools, social security and social services along with health services were built and new resources were channelled to these sectors. The whole country was gradually covered with health centres with newly built premises and young staff. For years, the best performance and the best satisfaction among both users and staff was commonly found in rural health centres. This was much due to the state subsidy formulae used at that time. The state funding covered up to two-thirds of the costs, which by rule are covered through a mix of local and national (state) taxes. The rural municipalities had the highest shares of state funding and thus also the best resources [3, 4].

Access to the GP remains a bottleneck

In the midst of expansion of many new types of services in the health centres, the basic illness-related physicians' services remained a bottleneck, especially in urban communities. The supply of services during the normal office hours turned out to be regularly insufficient, which led to long waiting times to get non-urgent appointments, up to 2–3 months. This, in turn, created the basis for a very odd culture of using out-of-hours services in large numbers by the population. Out of all face-to-face primary care physician contacts in some large cities, as much as 60% (at the highest) took place during evenings, nights and weekends. Such shortage also spurred the development of alternative service channels. Occupational health services, which by original intention were meant to be preventive services to combat occupational diseases and injuries, started to provide GP level generalists' services after a mechanism of joint funding by the employer and the national mandatory sickness insurance was set. The same sickness insurance refunds part of costs of using private doctors' services. These private doctors are usually specialists, who can be consulted directly without requirements for referral.

For decades, organizing and reorganizing the physicians' services has been the central issue in the Finnish primary care, at least in the eyes of the public and of the local decision makers, who are in charge of



running the health centres and of allocating resources. Already in the 1970s, a common perception was that small rural health centres seemed to perform better than the large impersonal hospital-like urban clinics. In the small centres, the staff learned to know the users of services. The overarching principles of continuity, comprehensiveness and coordination of care became transformed into daily practice in the rural centres, but not in the urban municipalities, where the majority of the population lived.

Solving problems of access

Learning and even copying from rural experiences led to new experiments in physicians' services. The aim was to move away from large impersonal service units, which could cater for the needs of the whole city, towards practice settings of smaller scale. List-based personal doctor models saw their advent at late 1980s [5, 6]. For a while, there were two alternative directions in parallel or even in competition. One was to organize the service by the patient lists of individual GPs. The other was to create somewhat larger team-based units, where 2–4 GPs, nurses and other staff shared the responsibility for a defined catchment population of 4000–8000. The list model organized around one GP became the dominant solution as it was soon supported by a national payment scheme. At its highest peak, in the 1990s, about 70% of the population was served by such a model, and half of the rest lived in small communities with a framework for personal care without formal listing [7, 8].

This was a time of discussions and debates on how the services should be configured. The debates went on both inside and outside the health centre teams. A leading theme and dividing line was to choose between 'generalism' and specialization among the staff, both physicians and nurses. Physicians had the international model and example of General Practice [9] available for a guiding principle. General Practice had been established as a medical specialty comparable to other clinical specialties already in the 1970s, but the professional and academic solidification took place in the 1980–1990s. This also raised the esteem and self-consciousness of the general practitioners.

Nurses had, since 1972, been divided into fractions by the type of service, even within the health centres. Public health nurses were trained to provide preventive services, such as antenatal care, well baby clinics and other child care, school health and occupational health services. Soon each type of service had its specific skills requirements for public health nurses. Clinical nurses—working in the assessment and care of illnesses and other common health problems—were first uncommon. However, their numbers gradually increased in home nursing, in clinical settings at the receptions. They first assisted the doctor in medical and surgical procedures. Soon there were nurses with special training in the care of diabetes, rheumatoid arthritis, asthma and other chronic diseases. In the 1990s psychiatric outpatient services were moved under the administrative roof of health centres in about 60% of the country. This brought in new professionals, psychiatric nurses and clinical psychologists to health centres, which

had from their early years employed psychologists for preventive work. Simultaneously, team work with new lines of divisions of tasks was expanded and strengthened in dental services, rehabilitation and in home nursing.

Paradoxically, around the middle of the 1990s, when the country and its public sector economy were still in the middle of recovering from the recession of the first half of that decade — which was exceptionally deep in Finland as a consequence of an unseen bank crisis and of the collapse of the trade with the former Soviet Union, the health centres were showing their best performance in their history. All posts were filled with staff motivated to stay in their jobs and develop their work and careers [8].

Obscuring of the strategic aims from the late 1990s on

In order to solve the problems of access to primary medical care, a conviction grew that small size was the right direction to go towards. Small rural municipalities seemed to have the best health centre services. Therefore, larger cities began to break their services into smaller units with catchment populations of the same size as the small rural municipalities. Many believed that this would bring out the true advantages of integrated care by a multi-professional team, but still in a scale that kept services personal and helped to build on both continuity and also on familiarity with the local population. This climate helped in finding new ways for the primary health and social services to collaborate and even integrate services. In this spirit, in the middle of the 1990s, about 60 new small independent health centres were created through breakdowns of health centre federations. This brought the total number to 275 at its highest.

The belief in small being optimal vanished in a short time. It is hard to analyze why the health centres started closing their branch offices in suburbs and why arguments of there being too many health centres in the country began to gain popularity. In 2001, a national tour of consultative regional meetings was arranged by a senior director of the Ministry of Health. His message in short was: Finland has a sound and solid health care system, which must get ready for the difficult times ahead. Therefore, in order to make structural efficiency gains, the number of health centres must be reduced and — over time—primary health care and the specialist level should be merged. The two separate legislations should be replaced by one law on health services [10].

This initiative — together with a national project of health care reforms that was launched in 2003 [11] — set in motion a sequel of multi-faceted structural changes, which are currently being implemented. However, many analysts believe that the current changes are only a beginning of even more fundamental reforms. This chapter will be an attempt to give an account of the changes that have occurred or are about to occur—some planned, some unplanned. The developments have been grouped under the headings of agendas that have been identified to be at play.

(1) Agenda of the Ministry of Health in response to criticism of structural inefficiency

The whole Finnish health care system, together a number of other municipal services, have been criticized

of being inefficient. One line of criticism argues that merely the large number of municipalities and the fact that the majority of the municipalities are small with <10,000 residents, lead to inefficiency. Inefficiency results from excessive numbers of units, health centres, hospitals, diagnostic services and the density of administrative units in the system. Therefore, merging services would improve efficiency. A parallel line argues that the municipal services lack market and entrepreneurial dynamics, since they are budget steered and because local politicians, who tend to be conservative and maintain the status quo.

The response of the Ministry of Health was to launch a national health systems development project, which had a number of developmental objectives, but the core was expected to be a deal between the state and the local municipalities. The municipalities agree to take a number of steps towards consolidation of the services, and the state promised a raise in the level of the state subsidies to the municipalities. One important element of this package was the implementation of legal guarantees of access to care. Primary health centres were given a target of (voluntarily) reorganizing based on catchment populations of 30,000 inhabitants at the minimum. The government provided special earmarked project funding to development projects that would facilitate progress toward this target [11].

(2) Political agenda of merging primary care with the regional specialist care districts

One political vision of the future of public administration in Finland is to allow continued existence of a large number or independent municipalities, but combating inefficiency through extensive co-operative structures. The 360 municipalities maintain 21 municipal federations for specialist care. In the future, primary health care services and social services either entirely or selectively could go under the same administrative roofs. In health services, this would lead to disappearance of the clear dividing line between primary and secondary or higher levels of care. The main frontier of integration would thus be inside the health services.

This vision has much support in one of the three largest political parties.

(3) Political agenda of creating larger and stronger municipalities with new service structures

Two out of three main political parties are more or less in support of a vision of a sharp reduction of the number of municipalities, perhaps to the level of 50–100. These municipalities would become a new framework for improved efficiency in public services. Primary health care would be one fundamental element in the services, but it would be integrated with those specialist level services which are deemed to be appropriate to be placed into these organizations. A close partner in a deepening process of integration would be the local social services, but in many visions also education, employment, housing and even planning of the physical environment should go together.

Although the policy of strong reduction of the number of municipalities would have a political majority in the Parliament, municipalities cannot be coerced to merge, since interference with the right of municipalities to

exist would require changing the constitution with 5/6 majority.

But, in spite of these constraints, much is happening inside the 20–30 largest cities in the country, where the majority of the population live. One common denominator is that these changes are based on beliefs of the advantages of integration in new and innovative ways. Another, much more problematic common denominator at least in the eyes of an analyst coming from the world of Primary Health Care is that they all seem to disintegrate the Finnish health centre, or at least lead to a clear risk of losing the identity of Primary Health Care.

The health centre model is being challenged by a recent trend of dividing the merged social and health services by the age group of the users of services. About 40 Finnish municipalities are implementing some version of this administrative model according to the unpublished figures from a recent survey in March 2009. Typically, these municipalities would have services for children or adolescents, or 'children and their families', and in all cases separate services for older people, ranging from chronic outpatient care to intensive nursing services either at home or in a nursing home or chronic stay hospital. Some have drafted models that go beyond dividing by the age group by bundling services according to the types of 'processes' or situations in life, which lead to needs of services. Thus, a municipal organization could be created to individuals in vulnerable positions in life be it in terms of health, vulnerability on the labour market or, for example, homelessness.

Many larger cities are also introducing purchaser-provider models to create desired dynamics also inside municipal operations. The municipal boards and their headquarters act as purchasers and service units streamline themselves into dynamic and efficient service providers, which are or will be competitive in the near future when private enterprises will be competing for contracts of clients/patients.

(4) Temporary law on reforming municipal service structures

Since the developmental objectives of the agendas two and three were logically incompatible, and very few structural changes were taking place voluntarily, the government reached, after a laborious negotiation process, a political compromise. This became a temporary law with the possibilities for legal reinforcement. The essence of the law was that (1) the state encourages and actually offers significant incentives for mergers between municipalities, but (2) those smaller municipalities who decide to remain independent must form a formal co-operative organization that creates a minimum catchment population of 20,000 for primary health care services and 'those social services that are closely linked to it'. The government refused to specify what these social services are, but according to the legal interpretation, some social services must be included.

This law, which is supported by project activities [12] is being implemented between 2009 and 2013. The number of health centres (or similar organizations the name health centre may disappear from legislation) will drop to 115–120. Some have found the new partners they needed without problems, some municipalities are

ambivalent and dissatisfied with the position they are put into. About 10 municipalities have announced that they will defy the governments demand and they are ready to see the process to its 'constitutional end' in their pursuit of continuing the independent provision of services.

Before the ongoing reforms, about one half (53%) of the Finnish population lived in a municipality, with social and health services under the same administrative roof. In many cases, this has also meant functional integration of key services. In the future, the proportion of the population with integrated services will rise to 70% and another 20% will have some social services integrated. Only two municipalities, among them the City of Helsinki, with about 10% of the total population, will have separate boards for social and health. The law does not oblige large cities to merge the two administrations.

What does merging or integration of health and social services then mean? Would there be lessons for other countries with structures that keep these two services apart? In the light of Finnish experiences dating back to the 1980s, integration can mean a range of arrangements. In some communities, the local democratic decision-making bodies and the upper management may be fully merged, even up to the names of administrative units and the terminology used to describe positions of employees in upper management, but still the way that operative grass-root work is run is far from integration. Conversely, there are examples of very advanced practical integration of services, for example in nursing care at home or in special housing units, but still the social and health decision-making and leadership are apart. Still, on a longer run, merging the administrations and service provision units seems to lead to new, rational and even innovative ways of service provision.

The most important advances seen in the integration between health and social services have been seen in the care of the elderly. Home nursing by trained nurses and home help, which was originally oriented to giving practical help with everyday living (cleaning, shopping, cooking, and helping with daily routines) have merged into 'care at home'. The home help staff has received tailored training in health related tasks, such as medication, care of wounds or diabetes care.

The next major development in integration will result from children's health services and social services to children or families with children—practical help to families with small babies, child protection etc.—coming together. The result is often locally called 'the family centre', which may come in variable compositions of health and social sector professionals. A new normative ruling is about to be added to the legislation on preventive services to children. This ruling defines the services to be for the whole family of the child, including the father.

(5) A number of health centres combine primary and secondary care

In international comparison, the dividing line between primary and secondary care runs somewhat different from most other countries. Finnish primary care can 'penetrate' into areas or services usually thought to belong to the secondary or upper echelons of care. In the beginning, this was a carry-over from the times

before 1972. Local rural hospitals were active providers of surgical and obstetric care. With the advancement of medical technology, it was not a surprise to see all health centres be equipped with X-ray and laboratory facilities, later followed by newer diagnostic technology, such as endoscopies and ultrasound.

When the local municipalities were put in charge of all secondary and tertiary care costs from 1993 on, being active in providing services usually seen in secondary care, became lucrative financially. For some time, there were signs of competition in equipping and acquisition of special skills on both sides between primary and secondary care.

Recently, crossing the border through integration has become popular. This can mean running joint services for example in out-of-hours services, in non-operative hospital care, joint outpatient clinics or use of specialists in selected tasks in primary care. There are also early signs of primary care representatives entering the specialist hospitals to ensure successful discharges and seamless linkage. There are high expectations in the national discussions and debates of the benefits that vertical integration could lead to. Above all, it is expected that structural efficiency will be improved, but there are also promises to the users of service of a good mix of primary and secondary services perhaps from the same facilities without the usual process of being referred.

In the future, about 20–25 of the health centres will be organizations that combine primary and secondary care in several key specialty areas. Integration and creation of a new culture of working together has not been easy for some. For specialists, for instance, being employed by a joint organization of primary and secondary care means that they are no longer able to work in a large teaching hospital with numerous narrow specialties. This has led into problems with the recruitment of specialists. However, some of the pioneers of vertical integration have become national success stories with lessons to learn for all.

(6) A large number of health centres have been sliding into difficulties with key manpower

As the national economy improved and its growth accelerated to unseen levels, alternative sources of care received injections of new resources. Lucrative employment was offered to doctors and dentists. This, together with the sharp reductions of numbers of training of doctors and dentists in the recession years from 1992 on, led into shortages of staff with highest training [13]. The shortage of dentists is currently perhaps the deepest problem and it calls for urgent measures, including international recruitment. Specialist level care has absorbed large number of medical graduates. During the 10 past years new companies offering temporary physician labour for rent have appeared. They have been very successful in recruiting young doctors with flexible terms and perks. Table 2 gives an overview of the shortages of primary care doctors [13]. At the moment, there are signs of incipient shortage of nurses in large cities, but the largest gaps are expected around 2015–2020 when the large generations (born after World War II) are at their retirement ages [14].

At present, about 15–20% of the work of the physicians is organized through rental arrangements and a large share through temporary employment by young graduates at an early stage in their career. Some health centres, both urban and rural, are very severely hit by these shortages [13].

As a consequence, or at least much speeded up by this development, expansion of nurses' tasks and also of numbers of nurses in clinical practice has taken place. Even though there still is no formal basic training that would aim at giving the mix of skills needed, large numbers of nurses have acquired new skills through extended additional training and local learning at work. The new skills cover both assessment and examination of patients with new acute problems and care of patients with chronic and/or multiple diseases. New models of how services are provided are emerging. Some health centres operate on the principle of tight two-person teams of doctor and nurse, usually coupled with a defined list of patients. Other health centres profile the nurses, or at least portions of their working time into acute and chronic care. Chronic care is actually a too narrow notion of the scope of work, which ranges from giving preventive advice to rather independent management of patients with chronic illnesses. National pilot projects were launched by the Ministry of Social Affairs and Health in the early 2000s [15]. There are plans to mainstream and legally recognize the expanded roles of nurses in the whole country in the near future [16].

Discussion

From a systems point of view, the description of the Finnish primary care and its multi-dimensional integration in the health centres may sound efficient and like the right thing any health system should copy. However, there are many stakeholders at play, and the end result can easily be far from harmonious agreement on how health care should be organized.

Many analysts would state that during the past 3–4 years, the Finnish health centres are either in a state of crisis or at least on a path that may lead into crisis if they now fail to attract enough young doctors and dentists and will later have severe difficulties in recruitment of nurses. The true picture is, of course, much more colourful. There are health centres that continue to offer good service and were able to avoid major problems of recruitment.

But why would a primary care system, which has been often admired internationally, drift into the difficulties that have been described here? Finland launched its health centre based primary care with rather idealistic goals at a time, when the country was much centrally steered. The government held the power through the instrument of tailoring the state subsidies to the local municipalities and thus also to the health centres. When the national policy called for adding resources to health promotion, rehabilitation, mental health or similar lines of services, the local level complied, since the funding received in return was significant. When the pendulum took its rapid swing from central steering to extreme decentralization, the course of development changed within a few years. Services that could be characterized

as being less attractive or appealing to the middle-aged and often middle-class local decision-makers, suffered. Substance abuse services, long-term care, rehabilitation and similar were easiest among those sectors that experienced cuts.

This means that one main lesson from the Finnish experience could be that decentralization can lead to loss of coherent health policy making. The local scenes are occupied by stakeholders who defend the local interests, fight for local jobs and behave in unsustainable ways if they see ways to make savings.

How could the government have prevented the unwanted effects of decentralization, which is usually thought of to be a positive development when supported by local democratic decision-making? For years, the government has believed in 'information steering'—steering through guidance, bench-marking comparisons, publishing of good examples and good practices. Dissatisfaction with the level of compliance with guidance, the government has explored ways to move into more binding ways to steer or reinforce. Care guarantees of access to services appeared in the health service legislation in 2005. They speeded up entry to elective surgical and diagnostic procedures and they also may lead to longer-term increases in the volumes of these procedures. The current cabinet is stating in its social and health policy programme that legal reinforcement will be introduced to secure the recommended levels of key preventive activities [16].

But the government has not been able to prevent the turning of primary health care into a battleground on which the future of the Finnish municipal structures and also of the ways that municipal services operate will be settled. In the name of integration, or creation of structural efficiency or building of networks or getting rid of disturbing borders, Finland now sees changes that are seriously threatening to dissolve the whole identity of primary health care as it has been known in the country for almost 40 years.

Would this be a sad end to the story of Finnish health centres or a sequence of steps in the inevitable development towards an innovative development of primary services on a broad front of health, social and other related services? Opinions and visions of the future are divided. The leadership of primary health care seems to be on the defence with feelings of a hostile takeover. During a consultative tour of the author's small team through 27 regional meetings of chief doctors, nurses and administrators, many voiced self-criticism of having let the core principles and objectives become obscure. Many said that the Finnish health centres should have remained more faithful to the original ideals of prevention and health promotion instead of becoming very obsessed with securing access to patients with acute respiratory illnesses. Similarly, the quality and results of chronic care leave room for improvement [17].

Therefore, one of the main lessons from Finland could be that integrated primary health care cannot rest on its historical foundations or achievements. Its basic principles and ways to operate must be continuously renewed. In a country, where local democratic decision-making has a

strong position in health services, the whole system can easily end-up into a moral dilemma: should primary health care remain loyal to its fundamental principles of prevention, health promotion and provision of equitable services, which would mean a special emphasis on those who are disadvantaged? Or should primary health care seek to please the general public and the decision-makers by offering whatever is in demand? It would be unwise to forget either side, but self-analysis is much needed.

The field of primary health care is feverishly trying to invent and develop ways to improve both the

performance and attractiveness of health centres. The Ministry of Health is launching its action programme aimed at turning many of the conceivable control knobs in the system.

The action that should turn the course must now be taken at a time, when the public funding is being reduced due to the effects of the global economic crisis. The short history of Finnish primary health care shows a wave-like development where enthusiasm is followed by pessimistic visions. Unfortunately, it seems that many difficult years may now be ahead.

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Background: Finland has since 1972 had a primary health care system based on health centres run and funded by the local public authorities called 'municipalities'. On the world map of primary health care systems, the Finnish solution claims to be the most health centre oriented and also the widest, both in terms of the numbers of staff and also of different professions employed. Offering integrated care through multi-professional health centres has been overshadowed by exceptional difficulties in guaranteeing a reasonable access to the population at times when they need primary medical or dental services. Solutions to the problems of access have been found, but they do not seem durable.

Description of policy practice: During the past 10 years, the health centres have become a ground of active development structural change, for which no end is in sight. Broader issues of municipal and public administration structures are being solved through rearranging primary health services. In these rearrangements, integration with specialist services and with social services together with mergers of health centres and municipalities are occurring at an accelerated pace. This leads into fundamental questions of the benefits of integration, especially if extensive integration leads into the threat of the loss of identity for primary health care.

Discussion: This article ends with some lessons to be learned from the situation in Finland for other countries.

Key Words: primary health care system, social services, Finnish solution.

Решения и опыт Финляндии в организации интегрированной первичной помощи

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В Финляндии с 1972 года система первичной медицинской помощи, базирующаяся на основе медицинских центров, работает и финансируется органами местного публичного управления под названием «муниципалитеты». Среди систем первичной медицинской помощи, её организация в Финляндии является наиболее ориентированной на центры здоровья, а также самой многочисленной, как с точки зрения численности персонала, так и по количеству вовлечённых различных профессий. Осуществление комплексной помощи через мультипрофессиональные медицинские центры было омрачено существенными трудностями в обеспечении гарантированного доступа к населению, нуждающегося в первичных медицинских или стоматологических услугах. Решения проблемы доступа были предложены, но они не являются устойчивыми.

В течение последних 10 лет, медицинские центры стали основой для активного развития структурных изменений, для которых не видно окончания. Более широкие вопросы муниципальных и общественных структур управления решаются путем перераспределения первичных медицинских услуг. В рамках этой перестройки, интеграция со специализированными службами и социальными службами совместно со слиянием медицинских центров и муниципальных образований происходят в ускоренном темпе. Это приводит к возникновению фундаментальных вопросов о преимуществе интеграции, особенно когда обширная интеграция ведёт к угрозе потери идентичности для первичной медицинской помощи.

В представленной статье обсуждаются некоторые уроки, которые можно извлечь из ситуации в Финляндии для других стран.

Ключевые слова: первичная медицинская помощь, социальные услуги, финские решения.

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