

International exchange

Finland: world class primary care

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Global leadership

For three years the members of my research team have travelled round the globe examining modern primary care services and their new organisational developments. When they began they all seemed to be suffering from a common British malaise, particularly prevalent still in English primary care trusts (PCTs). All were apparently convinced that the NHS was in crisis and some, if they were honest, felt it was in terminal decline. The formal stated purpose of studying other health systems was ‘transferable learning’.¹ But the real need was tacitly understood to be at worst a remedy, or at best a cure.

In 2006 they each see the world differently. While the UK undoubtedly has its pressing problems, these seem to pale beside those of virtually every other country visited. Overall our health system appears to be just about the best; at least of the 24 countries in which we undertook our fieldwork. Of course elsewhere there are brilliant projects and spectacular innovations, but invariably in those countries where these exist they are the exception not the rule. The community health centres of Canada and Chile, for example, are outstanding; but in both countries human resource distribution problems are such that less than half the nation can directly access a general medical practitioner. As a package of clinical, economic, executive and community-oriented services, those commissioned and provided by NHS PCTs compare favourably with those delivered by any of their counterparts. In the States we selected for their post-2000 ‘modernising’ policy frameworks for health and social care, new collaborations and governance models for local resource utilisation abound. There are national exemplars of interprofessional practice that we have described elsewhere,² but it is the UK that stands apart in its conscious political attempt to harness together the energies arising from new constructs of both management and medicine.

Scandinavia seems to offer the only possible exception, although its countries too have their own financial and personnel struggles, with devolution to local authorities highlighting especially significant equity

issues for both resources and health status. Nevertheless, if I were to be asked ‘Where did you see the best organised primary care?’ I would give ‘Finland’ as the answer. It is the country in which I would feel most confident about the service arrangements offered to my family, my friends and for myself.

Context and culture

‘Even health economists never say a bad word about each other’, so we were advised, ever so slightly tongue in cheek, by a distinguished Professor of Health Policy in Helsinki. He had generously agreed to brief us on the 2002–2008 countrywide Modernising Health Project in Finland. In each country visited we augmented documentary reviews with expert witness interviews to prepare individual country profiles. ‘We are a family more than a nation’ commented the Kangasala Health Centre Medical Director a few days later. The language of the Finnish reform process with its ‘care chains’ and ‘service circles’ is one that reflects a deep cultural conditioning in consensual decision making and developments. Inevitably the last have long but lasting lead-in times. Management is a brokerage function between professions, politicians and the public. ‘Blowing on the coals’, another Finnish health policy professor called it at one of our workshop sessions. The role of central government, according to a civil servant responsible for the new primary care policies, is that of ‘guidance by information’, and civil servants are themselves termed ‘counsellors’. In their brokerage role, the currency is not so much money as ideas, with proposals for partnership and decentralisation representing an amalgam of five different political parties’ proposals. Each party is a constituent in the national government, each has elected municipal strongholds, and each is affiliated to one of Finland’s major university medical schools. In many ways Finland felt the most sophisticated of all the states we studied. The

comparative thematic analysis of over 150 semi-structured interviews with parallel policy makers and primary care leaders across our 24 countries indicated that, alongside the UK, Finland possessed the most profound strategies for overcoming professional elitism and institutional resistance to 'modernising' change.³

Certainly Finland's political environment and social context permitted the largest general practices we encountered between 2002 and 2005. The target norm nationally is a health centre with 20 general medical practitioners, each with a registered list of 1500–1600 local patients. This is four times the size of the English counterpart where, as PCT managers are still all too aware, partnership 'splits' and consequent organisational turnover remains an everyday angst. In the UK, placing 20 frontline doctors together would be a cultural anathema with almost certainly disastrous consequences. In Finland these new groupings into municipally based primary care organisations represent essential 'modernisation'. They are explicitly seen as the vehicles for maintaining popular 'trust' and 'respect', not only in the local health system but in Finland itself and all it stands for. The beautifully designed larger health centres are as conscientious a symbol of the country's commitment to social justice and popular wellbeing as its carefully crafted use of language.

Kangasala

When we visited the Kangasala Health Centre in the centre of the country, it actually had 28 general medical practitioners, with 82 rather than the usual 60 beds. Its catchment population similarly is a little over the standard 30 000 figure which is now being used to rationalise or reduce the number of health centres in Finland's 481 municipalities to about half that total. Under the auspices of 'decentralisation' the post-2002 Finnish reforms are resulting in mergers, especially in the more remote northern and eastern parts of the country, and the advent for the first time of multimunicipality regional councils. Historically the Finnish decentralisation has not been simply about localism and geographic sovereignty, but rather it has been concerned with the integration of communities and their legitimate representatives. Some of these, in terms of, for example, the private sector and higher education institutes, are relatively new to the national health system.

At Kangasala in central Finland all these elements are in evidence. Nominated as an exemplar of the extended general practice by both the municipally funded National Research and Development Institute (STAKES) and the Ministry of Health in Helsinki, the

Kangasala Health Centre has a management board comprising seven elected members from five municipal authorities (including three from the centre's host area), plus a lead nurse and dentist, with the GP Clinical Director and General Manager sharing chief executive responsibilities. Within the centre, the overall operational control of service provision is exercised by the general medical practitioners on the basis of their levels of both education and specialist skill. The former is based on a minimum 12-year period for general medicine with three of the first preregistration six years, for both doctors and nurses, being based in non-hospital community settings. In relation to the senior status afforded to the doctors at Kangasala their specialisms include, *inter alia*, minor casualty, orthopaedics, gastroscopy, paediatrics, psychiatry, obstetrics, rehabilitation, palliative care and, for the entire local population of catchment municipalities, occupational health.

These extensions to general practice attract additional 'buy-ins' from both other professions and the public. Going it alone is not a viable option, either clinically or commercially. As a result the primary healthcare team stretches well beyond the physical premises through, for example, attached Red Cross ambulances, research and educational programmes with the local University of Tampere, and shared care protocols with, in 2004, the new (German) privately financed and trade union supported diagnostic and treatment centre. At Kangasala, the other professionals include four psychologists, eight physiotherapists and eight laboratory technicians, 16 dentists, two mental health workers and a small group of generic social workers, plus a whole range of public health, community and acute care nurses. Although, by law, the individual can choose and access directly clinical specialists, in reality the extended general practice is in a local gatekeeper role for secondary and social care. Both are combined at the commissioning level of elected municipal management. It is the municipality too that owns and majority funds (~70%) the health centre. These funds are augmented at Kangasala with a 20% contribution to local service developments from patients themselves, through, for example, registration and modest weekend and night-time call-out fees; plus payments from those who opt to contribute 1% of their income on a designated national charity tax; and employers' occupational health contracts.

The services themselves are both comprehensive and to a high standard. The 1972 Primary Health Care Act in Finland was a global forerunner in terms of locating community health and development responsibilities with primary care. Kangasala Health Centre itself hosts no fewer than 36 public health nurses and six environmental health and animal welfare officers, while, in terms of inpatient care, GPs lead teams dedicated to rapid recovery and maximum bed utilisation

through intensive rehabilitation and domiciliary support programmes (e.g. for hip replacement patients). Accordingly, while a length of stay may be six months, two to three nights is the norm, and such preventive measures as biannual mammograms after the age of 50, five-yearly health checks for women, and mandatory examinations for men from 19 years onwards, mean many admissions are planned and proactive. Remarkably, when we visited the extended general practice at Kangasala, it had a total of 293 full- and part-time staff, and the doctors themselves are, of course, salaried and public service employees. At Kangasala there are certainly echoes at least of the PCT, and 100 new community hospital combinations mooted in the UK government's last general election manifesto and 2006 White Paper, and its proposals for hitching practice-based commissioning to innovations in integrated care.⁴

From a global perspective, Kangasala stands out because it offers the complete primary care package without compromising the fundamental relationship values of primary care. Notwithstanding the complexities that arise from being an emergent network organisation with an array of stakeholders, its primary care is personal, and pastoral through services that span the life cycle, promote appropriate lifestyles and respond to both the needs and demands of the whole locality. And, in contemporary terms, Kangasala is also effective and efficient.

Of course, on individual items, other primary care organisations may well be ahead of Kangasala. For surgical procedures the equipment and expertise of the Anogia Health Centre in Crete, for example, would be hard to beat; while for levels of community volunteering the T-shirted health agents tackling issues from domestic violence to diabetes at the Chiclayo MaxSalud Clinic in central Peru were without parallel.⁵ Alongside the Viseu Health Centre in central Portugal with its tripartite GP–nurse–social work leadership; the Clinic CIES (Centro de Investigación y Educación en Salud) in El Alto, Bolivia with its continuous daily offerings of parentcraft, day care and youth work; and the Lange township triple-trained nurses of the Bundeheuwal Community Health Centre in the South African Western Cape; Anogia and Chiclayo would make up my personal short list of the top six modern primary care organisations for international transferable learning.⁶ The sixth name on this list is, of course, Kangasala and, interestingly, with the exception of remote and rural Anogia each now serves a population of around 30 000. As some UK politicians have begun to realise this does seem to be the demographic unit at which public health and healthcare commissioning can be legitimately common-sensibilities for the environment, education, security and, of course, social care.

European leadership

Ten years ago, however, many in the UK were still operating under the illusion that its NHS model of general (medical) practice was synonymous with primary care. Politically, British governments had taken the lead in pressing for sovereign controls over national health systems through the principle of subsidiarity and the promotion of a new regionalism. This pressure led, for example, to such clauses as the following in the European Union's 1999 Amsterdam Treaty:⁷

Action in the field of public health shall fully respect the responsibilities of the member states for the organisation and delivery of health services and medical care.

With the licence this provided, the continuous experimentation in the organisation and delivery of primary care services in England in recent years has proceeded, for better or worse, at a relentless pace, without external oversight or international benchmarking. The next wave of proposed PCT mergers in 2006–2007 is a further example and a consequence of this continuing approach. The contrast, with the parallel development of new community health agencies under the auspices of the Pan American Health Organization across Latin America is striking.

Ten years ago Finland had already adopted a somewhat different relational style and set of values. Already regarded as 'a pioneer' public administration in its intersectoral policies for public health through the state's adoption of a modern 'stewardship' role, it used new agreements at the level of the World Health Organization (WHO) and European Union (EU) to foster and harness international goodwill and expertise. Its points of reference included, for example, the following Article (152) in the 1993 Maastricht Treaty:

Community and Member States shall foster cooperation with third countries and the competent organisations in the sphere of public health.

With the impetus this provided, Finland has led the way in both helping to define and then deliver, through its primary care developments, the 38 WHO Health for All targets identified specifically for Europe.⁸ It has pioneered with its new Baltic partners in Estonia and Lithuania, a new generation of community nurse practitioners and their educational curricula. Kangasala is an excellent example and a consequence of the Finnish approach.

Accordingly while, reassuringly, our NHS may stand overall comparison with other health systems, on the particulars of primary care development Finland may still be felt to compare favourably. For our primary care organisations in the UK, the lessons of its development are those of attitude and values expressed not

so much in the formulation of modernising policies – which are often remarkably similar – but in their implementation. Time, space, tolerance and, above all, transferable learning are of the essence.

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CONFLICTS OF INTEREST

None.

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