

FINLAND

Political and demographical description

Finland is situated in northern Europe. It has a population of 5.2 million with 15 inhabitants per square kilometre. Finland has an 80-year old history of independence and Western democracy. Finland is a parliamentary republic with a multiparty political system. It has been a member of the European Union since 1995.

The Finnish administration system consists of three levels: state, province and municipality. However, the provinces are actually regional representatives of the central state government. Their administrators are appointed by the central government; they do not have any democratically elected organs. Finland is divided into five administrative provinces and the Åland Islands which have an autonomous status.

Power in Finland is vested in the people who are represented by deputies assembled in Parliament. Legislative power is exercised by Parliament, the President of the Republic having a minor role. The highest level of government of the state is the Council of State (Government) which consists of a Prime Minister and a requisite number of Ministers.

The head of the state is the President of the Republic who is elected for a period of six years. In practice, the President's power in political areas other than foreign policy is limited; but the power to accept laws and to appoint senior civil servants does incorporate the potential for acts of political significance.

The Parliament has a single chamber of 200 representatives, elected for a four-year term. Parliament has three main functions through which it represents the people and makes basic decisions on Finnish policy. It passes laws, it debates and approves the national budget and it supervises the way the country is governed.

Closest to the people are the self-governing municipalities which are all governed according to uniform national legislation. Many responsibilities, including primary education and the social and health services, are devolved at the level of the 432 municipalities. Municipalities levy a local income tax which is decided independently by each municipality. Municipalities also receive other tax revenues, subsidies paid by the state, and other revenues.

The National Health System

In its institutional structure, financing, and goals, the Finnish health care system is closest to those of other Nordic countries and the UK, in that it covers the whole population and its services are mainly produced by the public sector and financed through general taxation. The Finnish health care system can be described as one of the most decentralised in the world. Even the smallest of the municipalities are responsible for arranging and taking financial responsibility for a whole range of "municipal health services". From an international perspective, another unique characteristic of the system is the existence of another public finance scheme (the National Health Insurance-NHI-scheme) that partly reimburses the same services as the first, but also services which are provided by the private sector. In addition to subsidising the use of specific private health services, the NHI scheme also finances occupational and student health services and outpatient medicines.

Municipally provided services include primary and specialist health care. Primary health care is mainly provided at health centres that are owned by municipalities or federations of municipalities. Preventive care for communicable and non-communicable diseases, ambulatory, medical and dental care, an increasing number of outpatient specialised services, and various public health programs (e.g. maternity and school health care) are provided by the health centres. They also provide occupational health services and services for specific patient groups, e.g. clinics for diabetes and hypertension clinics. Included with health centres are inpatient departments. The majority of patients in these departments are elderly and chronically ill, but in some municipalities health centres also provide short-term acute curative inpatient services. In addition to the inpatient departments of health centres, long-term care is provided at homes for the elderly that administratively come under municipal social services.

The local authorities are also responsible for organizing specialized medical care for residents of the municipality. To this end, the country is divided into 20 hospital districts (in addition, Åland forms its own hospital district). The largest hospital district in terms of population base has over 1.4 million inhabitants while the smallest has over 65,000. Each municipality must belong to one hospital district. The number of members in a hospital district varies from six to 58.

Each hospital district has a central hospital and other units. Five of these are university hospitals offering more demanding forms of specialized medical care. Hospital districts provide specialised outpatient and inpatient care. Patients need a referral from their health centre doctor or any other licensed physician in order to get access to the outpatient or inpatient department in a specialized care hospital. In general, patients cannot choose the hospital where they will be treated. In practice, travelling distance limits the choice. Moreover, health centres have guidelines on where patients with certain symptoms and diagnoses should be sent. In hospitals, the possibilities for patients to choose their doctor depends on, for example, the organization of departments and the number of specialists.

The second public financing scheme, the NHI, covers its members (i.e., all Finnish residents including people who are not working) in the following fields: sickness allowances, maternity allowances, special care allowances, student health services, rehabilitation services, and medical expenses (drugs prescribed by a doctor, private-sector examinations and treatments performed or prescribed by a doctor or dentist, and transportation services). In addition, it partly reimburses employers for the costs of occupational health services.

There are only a few private hospitals that provide less than 5% of the hospital days in the country. Patients do not need any referral for these hospitals, and National Health Insurance reimburses part of the expenses to the patient. In addition, some municipalities and hospital districts purchase some specific services from private hospitals. However, this is not very common at the moment. There are also doctors' own private practices which provide specialized outpatient care.

Both primary health care physicians and hospital specialists may work in the private sector in addition to their work in the public sector. About one-third of all doctors (both general practitioners and specialists) have some kind of part-time private practice. In addition, about 10% of doctors work full time in private practice. In the private sector, patients are free to choose any private general practitioner or private specialist. Doctors in private practice can refer patients to public hospitals as doctors in health centres can.

Health data collection

The responsibility for national social welfare and health care statistics is divided in Finland between Statistics Finland and National Research and Development Centre for Welfare and Health (STAKES), both of which are official statistical authorities in this field. Statistics Finland collects and publishes the economic and manpower statistics and mortality records. STAKES's field of activity is the service structure of social welfare and health care: birth statistics, day care statistics, hospital statistics, income support and child allowances, etc. Most of this information comes from nation-wide client-patient registers based on individual personal identification numbers (PIN). This makes it possible to link different in-patient episodes and even different registers together.

STAKES collects data from the social welfare and health care institutions. Providers of health care services include hospital districts, primary health care institutions and 50 private care institutions. In the social services, service producers total about 1,800. It includes services for the elderly, services directed at alcohol and drug problems, services for disabled people, etc. There is also a large private sector that especially produces so-called half-open services, largely various kinds of service homes.

Discharge reports (Hilmo) are sent yearly to STAKES from care institutions. Before sending, they are scrutinised for technical errors at the institution. At STAKES, the data is analysed, checked and corrected both manually and with a computer program. A personal identifier is encrypted and the data is included into the relational database. This is used for reporting and research purposes.

The collection process has many phases and it depends on the capabilities of the data providers. At one end of the process, everything is done by filling in paper forms while at the other end of the process everything is done by information technology. The data collection technology may be integrated into commercial information systems. For smaller organizations, there is a product for collecting data. About 700

producers use this free product. This product includes classifications, definitions, rules, etc. and it also includes a reporting system. STAKES also collects individual data of special health conditions: births, congenital anomalies, abortions, sterilizations, cancer, and sight disabilities. Regarding social welfare, there is a special collection process for income support and child welfare.

One idea of data collection is to give automatic and quick feedback information (reports on paper) to the service producers and information senders. New information technology has made it possible to create intelligent and safe database access systems. As examples, there is SOTKANet information bank and hospital benchmarking data base which are available on the web.

The SOTKANet Indicator Bank is a new STAKES information service that offers key population welfare and health data from 1990 onwards on all Finnish municipalities, based on the current administrative division into municipalities. For instance, it allows the user to search for indicator data concerning different geographical areas in absolute numbers and percentages. Indicator descriptions provide information on data content, interpretations, data sources, years covered, and possible restrictions. The Current News section on the front page will offer summaries prepared by experts on interesting topics.

The hospital benchmarking project is a collaboration between STAKES and hospitals. It uses a patient level national register of discharges (for all somatic inpatient and outpatient admissions) and costs data. To measure output, a new measurement unit was developed. It is called the 'care episode'. An episode consists of all the admissions and outpatient visits for a patient due to one and the same illness. The indicators that are used to measure productivity can be viewed from two different viewpoints and at different levels: from the provider's viewpoint at the hospital level, speciality and patient group (DRG level), and from the regional viewpoint at hospital-district and municipality levels. This permits, for example, the comparison of productivity in different hospitals and disaggregated specialities to the comparison of episodes on each DRG group using indicators such as hospital admissions per episode, outpatient visits per episode, bed days per episode, and cost per episode.