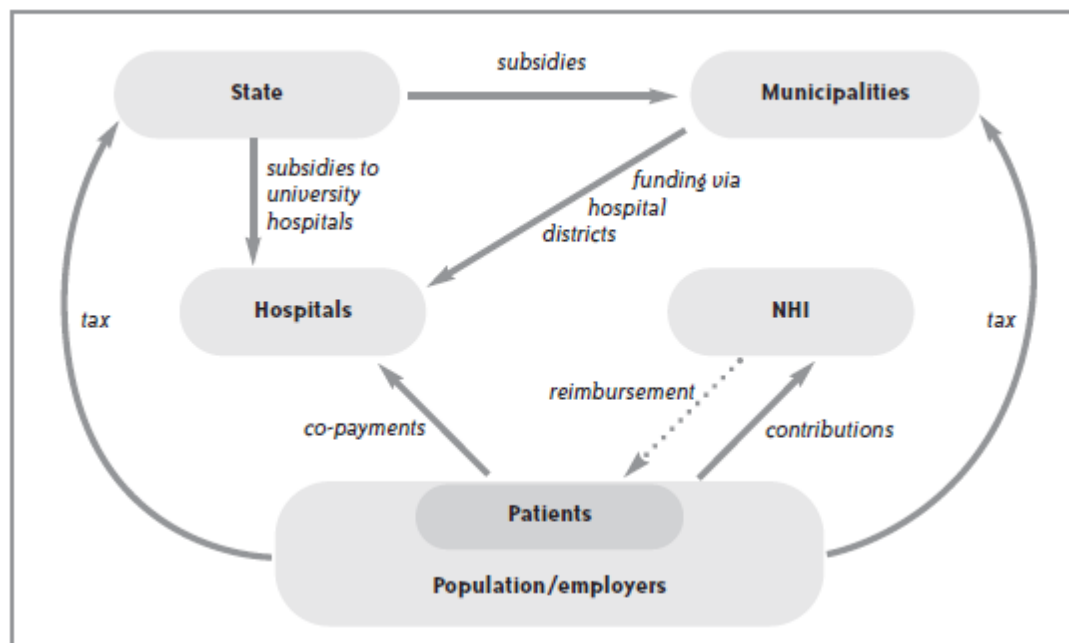


Financing of hospital care in Finland

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In its institutional structure, financing and goals, the Finnish health care system is closest to those of other Nordic countries and the United Kingdom in that it covers the whole population and its services are mainly produced by the public sector and financed through general taxation. However, compared to the other Nordic countries the Finnish system is more decentralized; in fact, it can be described as one the most decentralized in the world. Even the smallest of the 342 municipalities (local government authorities) are responsible for arranging and taking financial responsibility for a whole range of 'municipal health services'. Another unique characteristic of the system is the existence of a secondary public finance scheme (the National Health Insurance scheme, NHI), which partly reimburses the same services as the tax based system, but also services which are provided by the private sector. NHI also partly reimburses the use of private hospital care. Specialized care (psychiatric and acute non-psychiatric) is provided by hospital districts which correspond to the federations of municipalities. Each municipality is obliged to be a member of a hospital district. In addition to services provided through health centres and hospital districts, municipalities may purchase services from a private provider. In 2008 specialized care comprised 33% of total health care expenditure. There are 21 hospital districts in the country. Each hospital district has a central hospital and in some districts care is supplemented by small local hospitals. There are 15 local hospitals in the country. Tertiary care is given in five university hospitals, which also act as central hospitals for their hospital district. Hospital districts are managed and funded by the member municipalities. Funding is mainly based on municipal payments to hospital districts according to the services used. In 2008, 4.2% of funding came from user charges.¹ In addition, governments subsidize hospitals' teaching and research activities, which are mainly undertaken in university hospitals. The funding of Finnish hospitals is illustrated in Figure 1. As purchasers, municipalities negotiate annually the provision of services with their hospital district. There are different

Figure 1 Hospital funding flows in Finland



contractual or negotiation mechanisms between hospital districts and municipalities for agreeing target volumes and payments which comprise elements of purchaser and provider separation. Both the volumes and costs are planned based on the previous year. In many cases views on the right size of the resource allocations differ between the municipalities and the hospital districts. There is a tendency for budgets to be too low and agreements are therefore sometimes revised during the year according to the actual amount and type of services provided by hospital districts. Usually, there are no explicit sanctions if there is

deviation from agreed plans and targets, and municipalities cover any deficits and retain any savings in their accounts. The negotiation mechanisms are under continuous change and development. The budget of each hospital district is based on these negotiations and is formally decided by a Council, whose members are appointed by each municipality. The council also approves the financial statements (such as payment methods and levels of payments (prices)) and makes decisions about major investments. If the budget is exceeded, the municipalities must cover the deficit from their own revenues, usually by paying higher prices for services. In the case of budgetary surplus, the prices paid by municipalities can be lowered. Thus, the major purpose of hospital pricing systems has been to cover the costs of production and to allocate hospital costs fairly between the municipalities financing the provision of services within a hospital district. Thus, in the absence of nationally set regulations or even guidelines, each hospital district determines the payment methods used to reimburse its hospitals. Because payment methods are district based, they may vary from district to district. The pricing trend has been consistently moving away from the bed-per-day price towards case-based prices. Presently, 13 out of 21 districts use DRG-based pricing. The principles and rules for DRG usage vary greatly between hospital districts because there are no national guidelines. There is now increasing evidence that Finnish hospitals are more efficient than hospitals in other Nordic countries. According to a recent study, Finnish hospitals were somewhat more efficient than Danish ones, about 10% more efficient than Norwegian hospitals and almost 20% more efficient than Swedish hospitals.² The reason for these differences have not been fully analysed, but one explanation may be that cost control by municipalities (financed mainly by local taxes) is much more effective than that of counties or national governments.

Current issues

Government involvement and monitoring

Under current legislation the power of the Ministry of Social Affairs and Health is very weak, and it does not have effective means to affect decisions made at the local level. However, in recent years the government's involvement in providing health care has increased. In 2005 the government implemented two reforms. The first was the introduction of clinical guidelines for a wide range of treatments, aimed partly at bringing about some convergence across Finland in rates of elective surgical procedures and setting thresholds for admission to waiting lists for procedures. The second was the introduction of a set of maximum waiting-time targets for non-urgent examinations and treatments at health centres and hospitals. The hospital districts must pay a fine if they do not meet waiting-time targets. *Scale and scope* There is a clear trend towards increasing the size of the hospital providers as well as purchasers, which has happened on a voluntary basis following government recommendations. One example is the merging of three hospitals (Helsinki University, Jorvi and Peijas hospitals) in 2007 into one big unit, which produces about 25% of all acute somatic care in the country. The new unit is organized under medical specialities so that the same specialties in the former three hospitals were merged. A current initiative from the Ministry will centralize the care of diseases requiring highly demanding treatment to five special responsibility hospital districts (government legislation 2010; implementation 2011). On the purchasing side, in 2009 the number of municipalities decreased from 415 to 342. *Vertical integration* During the last ten years several local reforms have integrated service provision to a single organization. The purpose of these reforms is to enhance cooperation between primary and secondary health care and social welfare services. The reforms include merging of health centres and regional hospitals into one organization, creating a new regional, self-regulating administrative body for all municipal services (including health care, social services, upper secondary schools and vocational services) with regional councils and hospital districts also taking responsibility for primary health care. In 2008 about 10% of the Finnish population lived in areas where most primary and secondary care is provided by the same organization. Another current initiative from the ministry includes greater integration of care between health centres and nonuniversity hospital districts throughout the country (government legislation in 2010; implementation expected in 2011). *Patient choice* In the municipal health care system, patients are not free to choose between hospitals. A current government proposal involves the idea that patients can choose (public) hospitals from their own special responsibility hospital districts (government legislation presented to parliament in 2010; implementation is expected in 2011). However, so far, it has not been decided (or indeed proposed) how municipalities would pay hospitals under such a framework. *Hospital benchmarking* In 1996, the National Research and Development Centre for Health and Welfare (STAKES) launched a project, called the Hospital Benchmarking project, in co-operation with the hospital districts. The main purpose was to provide hospital managers with

benchmarking data to improve and direct hospital activities. The project designed and implemented an internet-based information system that supports continuous data gathering and processing, as well as displays benchmark measures at the desired level of aggregation. The project has taken advantage of the existing information systems in hospitals (the patient administration systems, cost accounting and pricing/reimbursement data and cost administration) to collect patient-level data on produced services and their costs. Nowadays, annual data is collected routinely. Productivity and efficiency calculations are made with traditional activity measures, such as DRG admissions and outpatient visits, and with a more advanced DRGweighted episode of care measure. The quality as well as efficiency of specialized care has been evaluated in a PERFECT project (PERFORMANCE, Effectiveness and Cost of Treatment episodes, (www.thl.fi/fi_FI/web/fi/tutkimus/hankkeet/perfect) since 2004. In this project, protocols for eight diseases/health problems (acute myocardial infarction (AMI), revascular procedures (percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass grafting (CABG)), hip fracture, breast cancer, hip and knee joint replacements, very low birth weight infants, schizophrenia, and stroke) have been developed. The development has been undertaken in seven separate expert groups, whose members (approximately 50 experts) are leading clinical experts in the disease areas. DRGs are used for calculating the costs of diseases. At present, register-based indicators (both at the regional and hospital levels) on the content of care, costs and outcomes between 1998 and 2007 are available for seven health problems. The indicators are freely available on the internet, and they will be routinely updated using more recent information. They have been widely used in local decision-making and also have been discussed in the media. The Ministry of Social Affairs and Health uses the information in its strategic planning: the indicators developed in the project will be used to evaluate the development of regional differences in the effectiveness of specialized care. The ministry also has used the information in its recommendation concerning the centralization of certain services (such as care of low birth infants) to university hospitals with adequate resources.

Conclusion

Internationally, the Finnish decentralized hospital system seems to be rather effective in producing services, but we do not yet have information on its performance in terms of outcomes. There exist great regional and hospital-level differences in efficiency, cost and outcomes which indicate great potential to improve performance. New government initiatives (such as introducing patient choice) have been proposed without considering how financing will be arranged. On the other hand, benchmarking of hospital efficiency and outcomes is well developed. Originally, this activity was initiated by researchers and later implemented, together with producers (hospitals districts) using financial support from research funds. The information has been increasingly used in local and national decision making

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