Health Economics, Policy and Law (2016), **11**, 303–319 © Cambridge University Press 2016
doi:10.1017/S1744133116000013

Health reform in Finland: current proposals and unresolved challenges

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Abstract: The Finnish health care system is widely respected for its pilot role in creating primary-care-led health systems. In the early 1990s, however, a severe economic downturn in Finland reduced public funding and weakened the Finnish system's deeply decentralized model of health care administration. Recent Bank of Finland projections forecasting several decades of slow economic growth, combined with the impact of an aging population, appear to make major reform of the existing public system inevitable. Over the last several years, political attention has focused mostly on administrative consolidation inside the public sector, particularly integration of health and social services. Current proposals call for a reformed health sector governance structure based on a new meso-level configuration of public administration. In addition, Finland's national government has proposed replacing the current multi-channel public funding structure (which includes health insurance subsidies for occupational health services) with a single-channel public funding structure. This commentary examines several key issues involved in reforming the delivery structure of the Finnish health care system. It also explores possible alternative strategies to reform current funding arrangements. The article concludes with a brief discussion of implications from this Finnish experience for the wider health reform debate.

Submitted 5 August 2015; revised 5 January 2016; accepted 11 January 2016; first published online 11 February 2016

Introduction

The Finnish health care system has an extensive history of leadership in international public health. The 1972 Primary Care Act harnessed central government planning to the introduction of new publicly operated and financed primary care centers which were built throughout the entire country. These primary health care centers, in turn, became an important model for the 1978 Alma Ata Declaration in

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which WHO called for primary care to be placed in the center of developed as well as developing country health systems (WHO, 1978). During this same time period, the North Karelia Project pushed prevention-based public health nutrition strategies into the health policy foreground globally. It demonstrated that concerted action by local health providers working with private food suppliers could transform unhealthy diets into a more heart-healthy approach with lower-fat foods accompanied by increased exercise (Puska *et al.*, 1985). One instructive public health example from this period was the shifting of some national agricultural subsidies from pork to fish farming, simultaneously raising the supply and reducing the cost of healthier sources of protein (WHO, 1991). Finland's substantial contribution to the global movement toward primary care and public health-based health systems has been quite remarkable coming as it did from a country of only five million whose land mass straddles the Arctic Circle in northernmost Europe.

From the early 1990s, however, Finland encountered a series of economic setbacks. The collapse of the Soviet Union in 1991, and with it the end of substantial Finnish trade with its largest neighbor, as well as a domestically created financial bubble, led to what Finns refer to as 'the Depression', in which GDP dropped by 16% and unemployment rose to 21% of the workforce. Helsinki had many storefronts boarded up, and there were long lines at food kitchens in the big cities (Kautto, 2000). Subsequently, while the emergence of Nokia as the premier global cellphone manufacturer helped restore economic growth later in the 1990s, Nokia's recent decline and, now, partial closing of its cellphone business after sale to Microsoft, coupled with the effects of (paperless) computer information technology on the Finnish forest products industry, has again left Finland in a difficult economic situation. The Finnish economy in 2014 was in recession for the third straight year, leaving its real output for that year 6% lower than it was in 2008 (Bank of Finland, 2014; Crouch, 2014). As of September 2015, the long-term forecast from the Bank of Finland projected that the growth rate of the Finnish economy will be only about 1% for the next 15 years (Bank of Finland, 2015).

Reflecting in part the lack of growth since 2008 in the country's overall economy, the health sector's share of GDP in Finland has grown from 8.0% in 2007 to 8.6% in 2013. Moreover, despite the economic slowdown, per capita expenditures have grown from $2905 in 2007 to $3442 in 2013, while out-of-pocket expenditures in 2013 fell by 2.5% (OECD, 2015).

As the per capita statistics imply, at the same time that economic growth has stalled over the past six years, demand for higher standard and more accessible health care services has simultaneously grown considerably. Finland's accession to the European Union in 1995, coupled with a rapid expansion of the technology sector of its economy in the 1990s, has produced a generation of relatively well-off middle class Finns who expect their services – including their health services – to be at the same high European standard as those available in other European countries such as Germany or France. Finnish national health policy has thus

found itself whipsawed between the expectations of many citizens for high quality care, as well as formal policy targets tied to expanded primary care and population-based public health, on the one hand, yet growing financial stringency in public sector revenues and, increasingly, in the publicly operated health care system, on the other hand.

Further, Finland will likely have to increase its military spending. In the summer of 2014, Russian warplanes started flying into Finnish airspace, seeking to test Finland's air responses (Finland is not a part of NATO) as well as to send a worrying message as Russia puts increasing military pressure on Estonia only 90 miles away across the Gulf of Finland. These provocations have raised the stakes for Finland's own self-defense capacities and may require Finland to increase the proportion of its non-growing public tax revenue that it spends on military preparedness, in turn further reducing the availability of public revenues for health services and providers.

An additional concern is that the current demographic shift in Finland is among the strongest in developed countries. The main reason for the diminishing size of the working age population is that the post-World War Two baby boom was substantial but only lasted until the end of the 1940s. This large cohort has mostly retired and, in a decade or two, will substantially increase the demand for both medical and social care (YLE, 2015).

Given the fundamental disconnect in the Finnish health sector between expanding demand and strained public supply, Finland's central policymaking challenge has become to define a strategy that, while reflecting the reality of reduced public revenues, nonetheless does not drive down quality in essential/core public sector provision; does not worsen social inequality or harm vulnerable populations; and that is stable, replicable and accountable as part of explicit public policy and planning.

This article explores several key issues that Finnish policymakers face on the provider and the funding sides of the health care system, and reviews some of the proposals and strategies that have been considered as possible solutions. After a brief review of Finland's health system structure, the article discusses two basic issues in the internal Finnish debate: (1) consolidating the formal governance arrangements for publicly operated hospitals and primary care centers; and (2) re-allocating financial costs among the existing 'multi-channel' public funding system. The article concludes with a short section exploring some of the implications of the present Finnish reform process for likely future reform efforts elsewhere in Europe and beyond.

Existing institutional framework

Finland has a complicated health system structure, characterized by operational decentralization of the publicly run system to local governments combined with a parallel private system of hospitals (of which there are just a few) and physicians

that receives fixed volume-tied public subsidies (Vuorenkoski *et al.*, 2008). Reflecting strong historical pressures, operational decision-making and a substantial degree of financing for the public system is fused to municipalities, either alone or in federation (Saltman, 1988). The main instrument for this decentralized control has been the municipal social services and health committee (Vuorenkoski *et al.*, 2008). Until now, this has meant that Finland's 317 municipal governments-more than half of which are smaller than 6000 inhabitants – were the health system's main steering agent. Numerous studies suggested that this radically decentralized model, in an era of rapid technical and clinical change, leads to substantial variation between hospital districts in costs, productivity and effectiveness (National Institute for Health and Welfare, 2015a, 2015b). Moreover, some analysts believe this municipal structure of governance has been associated with what are felt to be unnecessarily high levels of social and geographical variation of service provision and quality (Tarkiainen *et al.*, 2012). A one year pilot study in Oulu found that 81% of health and social sector resources are consumed by only 10% of the population (Leskelä *et al.*, 2013) – a distribution similar to that found in other developed countries – however, difficulties at the municipal level in providing well-coordinated and integrated services are believed to further increase costs and reduce the quality of outcomes. Finland also has a small number of private hospitals, although recently a large banking and insurance conglomerate (OP-Pohjola) opened a new private hospital in Helsinki and announced its intentions to build several other private hospitals elsewhere in the country.

There also have been some practical difficulties with municipal management of the public primary care centers. Some rural municipalities cannot hire enough primary care physicians to meet their needs, in part because working conditions in under-staffed organizations are often seen to be inadequate. In October 2014, 15% of public health center patients – including chronically ill elderly – had to wait >30 days for a non-urgent appointment with a doctor (National Institute for Health and Welfare, 2015b), and a 2014 study showed patient satisfaction with publicly run primary health centers falling noticeably (Raivio *et al.*, 2014). New private personnel companies have sprung up to supply temporary doctors, costing municipalities substantially more than regularly hired doctors. Further, several municipalities have contracted out management of their public primary care centers to private companies, in an effort to make them more cost-effective and to ensure an adequate workforce.

Given difficulties with queues and, sometimes, the quality of public primary care, many patients often go private. Beginning with the 1991–1993 economic crisis, a large and increasing number now turn to Finland's system of occupational health services, which is heavily subsidized by Social Insurance Institution of Finland or 'Kela' (60% for prevention; 50% for clinical services), has no patient co-payments, and which currently provides up to 40% of all primary care visits in some urban areas (Voipio-Pulkki, 2014). Alternatively, in small towns, 'going

Table 1. Sources of health care funding in Finland

1. National/municipal taxes (for public hospital, public primary health center and public social care)
2. Social insurance institution (Kela)
   a. Medical care insurance (for private doctor services – 23% reimbursement)
   b. Earned income insurance (for occupational health services for both private and public employees; 60% reimbursement for preventive services, 50% reimbursement for clinical services)
3. Employer paid insurance (some private employers)
4. Individual citizen purchased private insurance for their children
5. Out-of-pocket payments for health care services made by individual patients

Source: authors.

private' typically has meant that the patient sees the same physician who works in the public hospital or primary health center, however, in the afternoon when that physician works privately. Patients who make these private physician visits receive a reimbursement for a small part of the visit cost from Kela.

Many middle class Finns also carry a separate privately written health insurance policy for their children, to ensure that their child will not have to wait in a long queue when ill. Figures from June 2015 show over 400,000 children had a separate health insurance policy (Federation of Finnish Financial Services, 2015). For the same year, almost 400,000 private individual policies for adults were written, and nearly 200,000 individuals were covered by employer paid private insurance (Federation of Finnish Financial Services, 2015).

Funding for both public and private health care services in Finland currently runs through a complex system of both public and private payers (Table 1).

Overall, when all funding channels are taken together, tax-based funding covers three quarters of health sector expenditure in Finland, while private households provide about three quarters of the remaining one-quarter that makes up private sector expenditures (Table 2).

Two key reform proposals

Consolidating public provider governance

There has been a long-running debate in Finland about the management capabilities of the municipal-government-driven operating structure for public health care providers (Vuorenkoski *et al.*, 2008). Having municipalities form federations that then run hospital districts – there currently are 20 hospital

Table 2. Health expenditures in Finland 2013

Funding allocation (2013)	
Public	75%
State	24%
Municipalities	38%
Kela	13%
Private	25%
Households	18%
Private insurance	2%
Employers	4%
Others	1%

Source: National Institute for Health and Welfare (2015a).

districts across Finland – reflect, as do many decentralized systems (Saltman and Bankauskaite, 2006), the country's commitment to local democracy and decentralized authority, but also the potential for fragmented hospital management and strategic development. A widely acknowledged drawback of the existing model has been its inherent economic inefficiencies. In a period of prolonged austerity with constrained public revenues, proponents of consolidating administrative units argue that fewer hospital districts would reduce unnecessary duplication of clinical facilities and thereby free up scarce tax-based revenues to support more and/or higher quality services.

A similar argument has been made about the service delivery consequences of the separate administrative systems that municipalities use to manage hospitals, primary care and social care. Policy analysts have contended that these three separate systems should be combined in a single administrative structure that can prioritize the type of integrated and well-coordinated services which can produce a higher standard of care at a lower total cost to public resources. This same argument has recently been made by a senior policy analyst about the type of reform necessary in the similarly tax-funded English National Health Service (Timmans, 2015). Evidence from an ongoing trial of integrated arrangements in the South Karelia district of Finland has been largely positive, seeming to point toward reduced costs and, possibly, increased access (Erhola *et al.*, 2014).

A further factor in the current Finnish debate has been the movement in neighboring countries around Finland toward a stronger role for the national government vis-à-vis meso and local level government bodies (Saltman, 2008; Jakobowski and Saltman, 2013). The driving force in this Nordic re-centralization has been pressure for higher quality and more timely clinical care, particularly in sensitive medical specialties like cancer services. There also has been a desire on the part of these other Nordic politicians to pre-empt the 'blame factor', e.g. when dissatisfied citizens seek to hold national policymakers accountable for inadequate locally determined services (Magnussen *et al.*, 2009). To achieve better outcomes,

policymakers have sought to re-design decision-levers so that national bodies would have a substantially stronger role in the making (and in some cases, the funding) of health policy. Governments also have sought more administrative capacity and competence at the meso governmental level by consolidating that level into fewer, larger units (Jakobowski and Saltman, 2013). Elsewhere in the Nordic Region, Norway in 2002 combined 19 fylke (counties) into five now four health care regions, with boards appointed by and – crucially – funded entirely by the national government (Ringard *et al.*, 2013). Similarly, Denmark in 2007 combined 14 county councils into five elected districts, which also became dependent on national policymaking directives and on entirely national funding (Olejaz *et al.*, 2012). In Sweden, although a proposal put forward in 2007 by a government commission to create six to eight regional governments that would replace the 21 existing county councils has not been adopted, voluntary mergers in three parts of the country have created larger regional governments (Vastra Gotaland, Skane and Stockholm County) to operate the hospital and primary care system (Anell *et al.*, 2012). In this Nordic environment of greater centralization of policymaking as well as mergers of regional level governments, the Finnish model of decentralization to municipal control has appeared to be somewhat anachronistic.

In 2013, reform proposals in a government draft bill focused on establishing larger public provider districts called SOTE (social services and health), which would combine municipal level social and primary care services into an unspecified number of public regions (MOH memorandum, 2013). Subsequently in March 2014, Finland's parliamentary parties agreed a compromise structural reform that would organize health and social care into five regions, which – much like both the Norwegian and Danish reforms – would be built around existing university hospital catchment areas. Moreover, these regions would have administrative responsibility for primary and social care as well as hospital services, combining all three levels of care within the same administrative unit. These five SOTE regions, serving as administrative bodies, were meant to then contract for actual services from a maximum of 19 service production units, which would have consisted of existing public hospital, primary care and social care facilities organized into one authority within a discrete geographical area. These 19 proposed service production units would probably have followed closely the lines of Finland's current 20 hospital federations, and would likely have the ability to contract out some services to private providers. In theory, each of the five SOTE could then decide which of the 19 care production units to contract with for specific services, creating the possibility of contestability between these provider organizations.

In March 2015, the soon-to-retire government abandoned its proposal based on five SOTE regions, officially due to constitutional problems. The new coalition government formed in May 2015 continues to express strong interest in provider-side reform. According to the most recent reform proposal, 18 SOTE regions

will be created which will combine within themselves both administrative and service production responsibilities. These meso-level administrative districts are to have governing bodies directly elected by the area population (previous hospital districts had governing boards made up of representatives chosen by the member municipalities), and will make both strategic policy decisions as well as owning public provider facilities and contracting out for private services as necessary.

In an innovative effort to simultaneously consolidate service areas while still maintaining a traditional distribution of local control, the current proposal calls for only 12 of the 18 SOTE to be full-service 24/7 providers, while three of the SOTE will have to rely on the 12 for full services, and the final three SOTE will not be allowed to provide services themselves but will be required to do so in cooperation with one or more of the other 15 regions. In the initial phase, at least, the SOTE regions will not levy their own taxes, but rather will get their funding directly from the state. At present there continues to be pressure from one of the governing coalition's members (Center Party) to allow these new administrative districts to incorporate other regional level functions in addition to health and social care. Another unresolved issue concerns whether patients will be allowed to take public funding with them if they see private providers. Substantial new legislation will be required to implement this ambitious new plan, with these and other specifics about the re-structuring process yet to be finalized.

In practice, the proposed health care reform would be essentially a public administration reform. However, the effort to re-structure existing hospital districts into SOTE regions, and, further, to remove governance and financial links from local municipalities, will be both complicated and controversial. Further, as has recently been proposed in England (King's Fund, 2014), the reform would unify hospital, primary and social care services under one administrative roof. The expectation is that, by so doing, better coordinated, better integrated services can be provided more efficiently and more effectively, especially to the growing numbers of multiply chronically ill elderly. To the extent that the new reform would eliminate the authority of municipalities to run public health and social care providers, however, it could be seen as a breach of municipal authority in Finland, jettisoning the traditional core of health and social sector governance in Finland.

As an administrative re-organization inside the public sector, the SOTE region reform will not introduce any new or extensive market mechanisms into the proposed arrangements. Hospitals will remain directly administered units of government and there will likely be little or no open competition between public hospitals either with each other or with private hospitals for public patients or funds, even in the more populous urban areas. It remains unclear whether current patient rights to choose another hospital – which thus far have rarely been exercised – might alter the relatively fixed service environment. This is notable given the movement in a number of European tax-funded countries to create semi-autonomous management and contract bidding among providers inside the

public sector, coupled with patient choice of hospital, in an effort to generate market-style incentives to improve the quality, efficiency and effectiveness of delivered services (Saltman *et al.*, 2011).

A second, under-emphasized element in this Finnish debate over re-structuring the publicly operated provider side of the health care system has been the potential role of additional non-public providers. Finland currently has some private for-profit activity at the level of municipally run primary health centers, mostly in the form of contracted out management of some public primary care centers. Similarly, contracted companies also provide a portion of elderly care services. However, there has been little recent consideration of whether private non-profit as well as private for-profit providers could add to the existing service capacity in the Finnish health system, or whether new private providers could add innovative, higher quality and/or less expensive service delivery strategies to the overall delivery system. Thus far, the debate over health reform continues to concentrate on re-centralization strategies for existing publicly operated providers. In this context, it is interesting to note that there are now over 100 not-for-profit primary and social care providers operating in England, made possible by extensive government efforts to establish the necessary legal, financial and operating conditions for such non-profit actors (Mutuals Taskforce, 2014).

Consolidating and diversifying funding sources

A second health system topic that has been debated in Finland is how to fund existing and future health care services in a more sustainable manner (Reports of the Ministry of Social Affairs and Health, 2015). This discussion reflects the economic pressure that public tax revenues in Finland are now facing, especially when combined with higher citizen expectations for better quality and more timely curative care.

A central focus of the debate has been whether to combine the national social insurance (Kela) funds currently used to partly subsidize private and occupationally provided services with existing state-provided tax-based funds, creating a larger pool of public health sector funds. A possible related question is whether to continue to send state funds for health care to municipal governments, and to continue the existing model of a single state block grant for social, health, education and culture services established (at municipal demand) in 1992. The alternative would be to send state tax funds for the health sector directly to whatever new regional bodies will be responsible for providing public hospital and primary health care services. Both funding questions are controversial.

The issue of folding Kela's existing health sector expenditures into direct state funding of public health services has been discussed for >20 years. The debate has focused on the value of keeping the Kela social insurance-based funding for occupational and private health services separate from the public tax-based funding pool. Proponents of ending this tripartite public sector structure have

argued that using public funding to pay private providers (both private medical providers and corporate occupational care) was socially unfair, in that the oldest and other poorer and/or vulnerable citizens often did not have access to these services. These proponents of consolidation also argue that private doctors often referred their private-pay patients to public hospitals more frequently than did publicly employed doctors in primary health centers, in part to impress and keep those private patients, and thus private doctors were also obligating a disproportionate amount of tax-based public funds for their private patients. In the view of those who have opposed keeping Kela funding part of private practice in Finland, Kela's funds could be put to more equitable use through a central 'coordinating body' linking the existing network of both publicly and privately operated primary health centers and hospitals.

While those who made these arguments started doing so before the Finnish economy's difficulties began in the early 1990s, they have recently renewed efforts to capture this additional revenue stream for publicly operated providers. In response to this suggestion, opponents of the proposal to 'end the multi-channel system of financing' (as it is termed) typically refer back to the original logic presented by Tapani Purola, one of the designers of Kela's role in subsidizing privately delivered services. Purola contended that this supplemental funding structure would serve as a 'steam valve' to allow lower as well as middle income patients who were not satisfied with publicly operated providers to receive care from the private providers (Haro and Purola, 1972). A more recent argument in favor of keeping the Kela subsidies is that cutting subsidies to private production would inevitably increase the number of public patients, further increasing waiting times in public health centers that are already unacceptably long. It is worth noting that both employers' and employee's labor market organizations have traditionally been strong proponents of the autonomous occupational care service development with a separated funding arrangement.

This debate about the future role of existing public funding channels takes on additional significance in the current context of prolonged public revenue austerity that has also appeared elsewhere in Europe (Pavolini and Guillen, 2013; Thomson *et al.*, 2014; Maresso *et al.*, 2015). In Finland, the biggest relative growth has been the increase in employer funding, but it is still just 3.5% of total health care costs (these statistics are for 2013). The present problem, however, is not the absolute lack of resources, but rather that expenditure levels reflect opposite incentives in the public as against the private delivery sectors: public health centers have a global budget and, therefore, any visit directed to other providers is just saving money, while private providers, including occupational care, make money from each new visit since they are paid on a fee-for-service basis.

Given the ongoing structural weakness of tax-based funding – and the associated economic reality that public taxes are unable to rise without further damaging macroeconomic growth, job creation and national income – a central

funding question going forward would seem to become quite different from whether to collapse Kela's private and occupational funds into the existing state tax-based funding pool. Rather, it may well be that sustainable future funding can be more readily achieved by better and more fully harnessing the existing advantage of having social insurance and private dimensions to the present health care funding structure. From this rather different perspective, the reform challenge to the public sector becomes one of better coordinating costs and services with social insurance and, simultaneously, the two different types of private sector payment mechanisms: e.g. out-of-pocket payment for medical services by individuals and households, and two types of non-state collective payment mechanisms – e.g. employer-paid employee and parent-purchased children's private insurances.

In the past, proponents of a wholly public tax-based system have rejected as inequitable any form of private insurance, arguing it is dependent on premiums that differ by different demographic (age, sex) or health status category, and that have dramatically different marginal costs for low-income as against high-income individuals and families. This argument, however, has more or less lost its validity in Finland: almost all European insurance-based systems provide physician visits more equitably than the Finnish system (van Doorslaer *et al.*, 2004).

Yet in a financial environment where some form of private sector funding needs to expand, the appropriate policy question may well become not whether private insurance is bad *per se*, but whether private insurance can provide a collective risk-sharing mechanism if properly regulated. A key question may therefore become whether national policymakers could write socially responsible legislation that could supplement existing public sector provision for expensive acute inpatient services with collective but non-state operated payment mechanisms supplied by several alternative forms of private voluntary insurance. This may not be the preferred choice of Finnish policymakers, however, it would appear to be strengthening the part of the existing funding system that would itself seem to be at least somewhat collectively based and thus more socially responsible than individual self-payment. It may be worth noting here that, in a variety of universal-access-based, developed country health care systems (The Netherlands, France, Belgium, Switzerland, Israel), such forms of supplemental privately purchased insurance have long played an important role in financing a portion of the overall supply of health care services (Thomson *et al.*, 2014). In addition worth remarking on is that the large private insurer mentioned earlier (OP-Pohjola) bases its compensation scheme on capitation rather than fee-for-service – in effect mimicking to some degree the public system's form of payment to providers.

A second dimension of preparing for a health system future in which tax-based public funding will play a smaller role is to consider developing a variety of new, publicly structured and supervised funding mechanisms with publicly created and regulated incentives that seek to stimulate more private individual funding for

health care expenses. One potential approach to supplementing funding for clinical services may be to partially re-establish the former role of non-profit private collectives that existed before the post-World War Two growth of the European welfare state (Saltman and du Bois, 2004). Evolved from workers associations and labor unions, these funders sought to provide members with protection against the cost of disease and death. In today's world, they hold out the potential to generate financial protection against the costs of illness via collective contributions. Existing social health insurance funds in countries like Germany and Austria continue to function as forms of this non-profit collective model tied to membership (not citizenship or shareholdership) (Saltman *et al.*, 2004). One could argue today these non-profit private collective arrangements exist in a quite different funding structure than the tax dominated arrangements that characterize Nordic countries like Finland (Magnussen *et al.*, 2009). These re-created mechanisms should not be dependent on (permanent) employment, however, given that present day demographics and working life dynamics are less likely to support the traditional non-profit approach. A further concern would be to adapt these non-profit organizations to fit into a diverse funding arrangement as one of several simultaneous methods of paying for health services.

These two additional funding options, which would stimulate more private sector collective funding mechanisms, are themselves internally compatible each with the others, and also with continued public sector provision. However, this approach to health sector funding would carry a range of implications as to how best to structure future funding for health care services in Finland overall. Given anticipated further weakness in tax revenues for public providers, one question is whether it makes sense politically or clinically to take away the Kela subsidy from use of private sector providers? How likely is it that public tax funding would in fact go down if Kela monies were incorporated into a single publicly sourced funding system, on the argument that health care will have become relatively better off compared to other important public sector obligations? Might it not make political sense to take advantage of the existing multi-channel funding structure, to harness its diversity of sources and funding capacities, as a way to ensure that Finns retain a range of different access routes to needed health care, and to preclude additional service burdens on an already overburdened public delivery system?

One further dimension of the funding debate is that while legislation and regulation can change-or abolish-the two different components of the public sector funding mix (e.g. state grants and Kela national insurance), the behavior in the existing private insurance sector reflects decisions made separately by the private citizenry. To be sure, national policy can influence these decisions at the margin, especially through tax policy. However, the overall mix between public as against privately funded services in Finnish health care is not exclusively a government decision, but rather a balance between public and private initiative. If public sector funding continues to falter, Finland's private funding channels will most likely expand to meet some of the underserved demand.

According to the most recent proposal put forward in November 2015, the multi-channel funding will be dismantled and a single channel model will be introduced instead. Interestingly, the proposal states this will be done taking into account the role of occupational health care. At the moment, this reference to occupational care seems to be interpreted in quite different ways by the different political parties inside the government coalition. Specific propositions will have to be hammered out before it is possible to assess the true implications of this funding reform.

One additional initiative that might be considered/moving towards service production reform

Most of the Finnish health care reform discussion and initiatives have recently concentrated on the re-structuring of local government and public sector funding for health care. However, the financial sustainability of the system is largely decided in the service production system. One additional policy area which Finnish national policymakers could consider more closely is involving the individual patient/client and his/her family as a part of the service delivery and care apparatus. Well planned new co-production-based service models could improve health care outcomes and at the same time help reduce overall health care costs.

Finland already provides home care patients with vouchers (which can be topped up) to enable them to select providers and a desired mix of home care services, similar to programs in The Netherlands and England (Carr and Robbins, 2009). Also, modest caregiver allowances are in place for individuals (typically family members) who care at home for an elderly patient who otherwise would require formal home care services or nursing home placement. Beyond these measures, a range of self-care and self-monitoring mechanisms utilized by providers for example in The Netherlands and the United States could be considered to encourage individuals (in addition to the elderly) to help increase the effectiveness and lower the cost of their day-to-day care.

Concluding observations

In the longer perspective, current Finnish policy developments reflect a complex set of health policy processes. The rapid development of Finnish health care in the 1970s and 1980s occurred in part because it was based on separate, parallel and largely non-coordinated reforms. This resource intensive strategy was possible during an historical period of strong economic growth and welfare state expansion. Many Finnish health experts now see the legacy structures of these parallel reforms as the essential root cause of the health system's current problems. However, while it may be natural to now seek to introduce administrative

consolidation, that slowly proceeding process may be a too incremental a strategy to meet the new challenges of prolonged austerity and demographic change.

Reflecting that structural conundrum, this paper has sought to raise possible alternatives to the prevailing policy logic. Potentially interesting questions include (a) why not convert the malfunctioning of the multi-channel funding system into the positive asset of a wider funding base and (b) why not re-direct the national impetus toward health sector change into a new policy emphasis on reforming service processes and provision models, instead of only changing public administrative arrangements. One further topic could be how to encourage greater diversity of funding and provision while at the same time pursuing effective administrative consolidation.

Viewed from this broader perspective, Finnish policymakers are grappling with issues that are in many ways similar to the structural dilemmas that other developed country health policymakers face. Concerns about the best way to configure the meso level of governance for publicly operated health systems have been a part of various national European debates for the last decade or more (among other countries Ireland, Norway, Denmark, Sweden and also inside England). Worries about how to re-structure funding for health services have been part of health policy in many countries for several decades, but has become increasingly acute since the onset of the 2008 economic crisis (Thomson *et al.*, 2014). Alternative strategies similar to those currently under discussion in Finland are in the forefront of the present discussion across Europe. Many European countries have mixed public-private funding arrangements for health care, whether in the format of predominantly tax-based or social-health insurance-based financial arrangements (Mossialos and Thomson, 2004). How these mixed arrangements have shifted since 2008 between different public and private modes of payment, and, more importantly, how sustainable current payment configurations will be as populations age and the cost of high quality clinical services continues to rise, remains to be seen. As one example, the King's Fund in London has issued a high-level report entitled 'A New Settlement for Health and Social Care' that calls for a combination of increased patient co-payments and individual taxes to eliminate the expected 30 billion pound shortfall of the NHS in 2015 (King's Fund, 2014).

The proposed reforms in Finland are complicated, involve extensive legislative changes, and will eventually require a clearer agreement among the governing coalition parties. Nonetheless, Finland's long experience with basing major health policy initiatives around preventive as well as curative measures will draw considerable attention to its reforms from other country's policymakers. Overall, a central question will be whether those reforms can achieve a stable and sustainable settlement that satisfies Finnish citizens' expectations for timely, high quality services while also accommodating traditional Finnish political concerns about promoting local democratic control and equitable outcomes. How Finland resolves its health care dilemma will be of continuing interest among policymakers across Europe and beyond.

Acknowledgment

The authors thank the Journal's external reviewers for helpful comments and suggestions.

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