

Putting Finland in the context

Assessing Finnish health care from the perspective of value-based health care

International comparisons in
health services research

Tampere University 23 Oct 2009

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Challenges in creating cost-effective
health services for the future

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Outline of the presentation

- about the past
 - 50 years of health care history in 5 minutes
- about the future
 - are past successes turning into a burden?
 - parallel funding channels
 - monopolies in service production
 - light national strategic stewardship
 - fundamental challenges to be met
 - how to measure health care outcomes?
 - how to pay for health care services?
 - how to put people on the driver's seat?

50 years of health care history in 5 minutes

- 1950's: heavy investment in hospitals
- 1960's: public health and health care crisis
 - life expectancy increase stagnating
 - cardiovascular mortality soaring
 - scarce resources tied to the hospitals
- broad public and political discussion
 - wide consensus on the need for a structural reform

50 years of health care history in 5 minutes

- key reforms
 - Health Insurance Act 1963
 - **Primary Health Care Act 1972**
 - Occupational Health Care Act 1978
 - Social Welfare Act 1982
- 1970/80's period of reform implementation and system expansion
- a "national project" where municipalities and state agreed on reform goals and financing
 - approval of regional plans by National Boards as a prerequisite for gov't transfers to municipalities
- a quantum leap from the crisis in the 1960's to the "WHO Primary Health Care Pioneer Country" in '80s

50 years of health care history in 5 minutes

- early 1990's: abolishment of the national planning system: era of "self-direction"
 - national boards dissolved
 - government transfers to municipalities based on risk-adjusted capitation
- present system has its pros...
 - lean administration
 - rewards cost-control
 - gives responsibility to the "front-line"
(N.B. experience in recession of the 1990's)
- ... and cons
 - weak support for promotion, prevention and primary services
 - few tools to balance resources throughout the system

Finnish Health Care in International Comparison

- structures and resources
 - the most decentralised health care system in developed countries(?)
 - more nurses, less physicians than in average in OECD countries
 - social expenditure close to European average
 - health care share of the national economy (GDP) for years among the lowest in W Europe
 - now close to average



Finnish Health Care in International Comparison

- outcomes
 - mortality amenable to health care somewhat lower than western European average
 - hospital productivity (technical efficiency) better than in other Nordic countries
 - citizen satisfaction among the best in EU
 - now deteriorating in elderly care and especially in GP services
 - one of the few OECD countries with pro-rich distribution of physician visits / admissions



Strategic challenges in the future

Present situation compared to the 1960's

- population health and wellbeing as well as the service system meets international standards
- age structure, chronic conditions, technology costs, and economic integration challenge sustainable development
- this time, increasing resources & expansion of the system **cannot** be the solution;
- more effective use of the resources through reforming structures and processes needed

What are the most pressing structural challenges?

Strategic challenges in the future

- are past successes turning into a burden?
 - parallel funding channels
 - monopolies in service production
 - light national strategic stewardship
- fundamental challenges to be met
 - how to measure health care outcomes?
 - how to pay for health care services?
 - how to put people on the driver's seat?

Parallel funding channels

- the most important channels are
 - municipal funding of health centres
 - municipal funding of hospitals
 - statutory medical care insurance
 - statutory earned income insurance
- parallel channels one of factors enabling rapid expansion in 1960's - 1980's
- now significant problems in terms of system performance (outcomes, costs)



”Big goals” in Finnish health care policy

- outcomes
 - cost-effectiveness
 - fair access (equity in use of services)
 - quality, client-centredness
- functions
 - prioritisation of health promotion, prevention and primary services
 - integration between primary and secondary services
- user groups with special emphasis
 - the elderly
 - people w/ mental health problems (/substance use)
 - people w/ chronic conditions

parallel funding hampers achieving key goals

Effects of parallel funding – few examples

- municipalities: weak incentives to ensure health centre access since they can shift costs to occupational health care
- municipalities have poor tools to control use of public hospitals since private / occupational health care physicians have no reason to limit use
- integration of primary – secondary services difficult since specialised ambulatory care confined to private practice or hospitals
- in elderly care, rules for funding home services vs. sheltered housing vs. nursing homes vs. bed wards are all different, encouraging cost-shifting
- unlike most OECD countries, distribution of physician services favours the rich (mainly due to OHC effects)
- significant problems in dental care, pharmaceuticals, rehabilitation, etc...

Monopolies in service production

- municipal responsibility for service provision a success story: has made the dense service network in the whole country possible
- simultaneously: geographically defined responsibilities together with funding-provision integration create provider monopolies
- weak incentives for renewal: why to change?
- more competition?
 - free economic competition does not work
 - there is a lot of "bad competition" (on wrong issues)
- what is needed is "**Good Competition**"
 - competition on cost-effective production of health
 - needed *inside* the public provision system

Light national strategic stewardship

- expansion of health care in 1970/80's through a joint "project" between the state and the municipalities
- the support structure of the "project" = national planning system abolished because of rigidity and poor incentives for cost control
- the new needs based state subsidy system probably one of key reasons to the survival of health services in the recession of early 1990's
- responsibility close to the frontline a good model for surviving a crisis - what about long term structural renewal?
- what are the future versions of "the joint project"?

Strategic challenges in the future

- are past successes turning into a burden?
 - parallel funding channels
 - monopolies in service production
 - light national strategic stewardship
- **fundamental challenges to be met**
 - how to measure health care outcomes?
 - how to pay for health care services?
 - how to put people on the driver's seat?

How to measure health care outcomes?

- in vast majority of services, numbers and costs of individual outputs are the primary parameters surveyed
- in many services, measures on quality and effectiveness exist...
- ... but they lack a link to strategic steering and incentives
- present situation problematic because
 - the number of outputs often has a weak correlation with health gain
 - you get what you measure: volume and old outputs
 - you don't get what you want: new processes with better cost-effectiveness
 - leads to rigid norms on processes and resources

Can cost-effectiveness be measured?

- conceptual, technical and data source challenges
- many health professionals have serious doubts

AND YET,

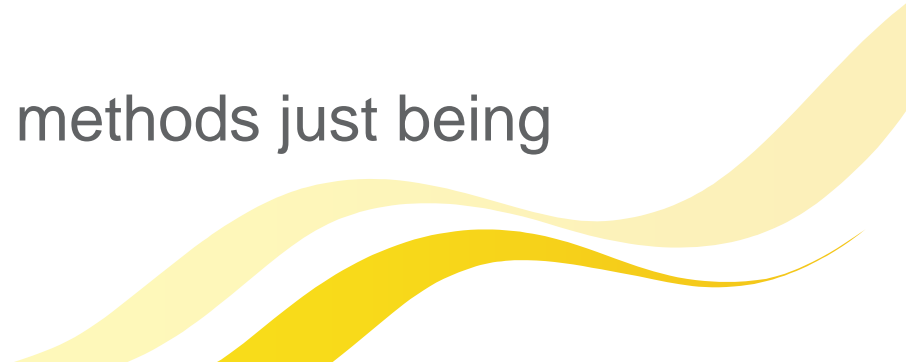
- many measurement models exist today
- Case PERFECT (prof. Unto Häkkinen & Co)
 - methodologically sound data on variation in productivity since the 1990's
 - now evidence on significant variation in cost-effectiveness
 - hospitals: typically 30% variation in costs, 50% variation in effectiveness
 - this evidence seems to have no effect on hospitals(!!)
- not only development and use of measurements need to be developed: linkage to steering and incentives vital

How to pay for health services?

- Two basic approaches:
 - fee-for-service (FFS): each individual intervention is paid for separately (Finnish hospitals)
 - global budgeting (GB): units operate within pre-fixed budgets (Finnish health centres)
- FFS rewards technical productivity, encourages maximum amount of interventions irrespective of true health gain
- GB rewards cost-control, encourages cost-shifting
- Now, "a third way" is being looked for
 - condition specific capitation = "bundled pricing"
 - pilots ongoing in the U.S., Germany, Canada, Sweden

Bundled pricing

- one prefixed sum depending on health problem and risk factors
 - does not depend on individual interventions
 - covers the whole process of treating a condition
 - has to be coupled with health outcome measurement
- advantages:
 - rewards effective production of health gain
 - removes incentives for over-production and rationing
 - encourages totally new approaches
 - forces focus on health outcomes
- disadvantage:
 - somewhat complicated - methods just being developed



How to put people on the driver's seat?

- patient-centredness, client-centredness etc. in strategy documents and ceremonious proclamations
- not too much true progress – anywhere(?)
- WHY change from people as objects to people as core actors is necessary
 - general motivations
 - human rights; services dealing with life and death
 - rights as taxpayers
 - motivations directly linked with value creation

WHY a change to people as core actors is necessary

Motivations directly linked with value creation

- primary prevention fails without people's own decisions
- care for chronic conditions (secondary prevention) fails without people's own decisions
- individual preferences a key determinant of cost-effectiveness in many major conditions with several treatment options
- well-informed people do **not** want excessive care
- active people can push service providers to compete in terms of better processes and outcomes

making people core actors necessitates

- *change in processes, roles, communication, attitudes*
- *redefinition of the health care concept as a whole*

In conclusion:

- a "joint national project" in the 1970's/1980's
 - ... enabling a quantum leap to a higher level of services
- now new challenges
 - ... which cannot be solved through further expansion
- the heritage of the past decades has to be reviewed critically...
 - ...to create a common(!) vision on structural changes
- measuring outcomes (value) and connecting this to steering structures is difficult...
 - ...and, simultaneously, a necessity
- "putting people in the drivers seat" sounds empty talk...
 - ...but if we fail in joining people as partners, the most crucial resource is left untapped