

PARLIAMENT OF FINLAND  
Committee for the Future

## **The Future of Health Care**

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### **The Position of the Committee for the Future on Health Care in the Year 2015**

## **1. Introduction**

In a couple of generations, the life expectancy of a newborn baby has risen by about 15 years in Finland. Health care has played a significant role in this increase. Medical science has relegated many catastrophic epidemic diseases to history. The rise in the number of healthy years of life is not however based solely on health services. From the standpoint of health, better living and working conditions, as well as better lifestyles, have made a decisive contribution - one greater than that of health care, even - to this favourable trend.

In most OECD countries, the share of gross domestic product devoted to health care expenditures has grown in the last couple of decades. In the United States the portion is approaching 16 per cent, while in Finland health care's share is still below 8 per cent. According to a recent OECD study, aging explains a third of health care's growth in GDP share in the OECD countries between 1980 and 2002. New therapeutic procedures and medications explain two thirds (Martins et al. 2006).

This position paper includes a discussion initiative on the national organization of health care. That initiative strives to address the challenge of aging. In addition, it takes account of four other subjects that receive special consideration in this paper -

- Health promotion through prevention, and through support for the citizens' own responsibility for promoting their health
- Utilization of information and communication technology (ICT) in seeking and deciding about care
- Controlling the rapidly increasing costs of medications and hospital care

- An ethically sustainable way to protect the right to care in the last years of life.

If in the next decade an aging Finland follows the average trend prevailing in other OECD countries in recent decades, health care's share of GDP will grow about 1 to 2 per cent by 2015. On the basis of the *Futures of Finnish Health Care* assessment, it appears that GDP share may even grow fundamentally faster than that. Limiting growth in GDP share from 2006's 8 per cent to 2015's 10 per cent could be established as a goal. This evidently can only be achieved by reforming operational practices.

Finland cannot assume that its health care system, which currently functions at very little cost in international comparative terms, will remain in 2015 as it is now. An aging Finland will need more and more health services. We will be able to alleviate key endemic diseases and lengthen the citizen's lifetime with new medicines and modes of care. Therapies based on new technologies are however extremely expensive. Health care personnel have justified hopes of improving their level of earnings.

According to the Committee for the Future's view, we shall however be able to answer all the aforementioned challenges at reasonable expense through purposeful action. The 2004 *Government Report on the Future* predicted that economic growth would average about 2 per cent annually over the 2005-2015 period. With this assumption, there is good reason to attempt to keep health care expenditures, currently about € 11 billion, from growing in real terms to more than € 17 billion, or over 10 per cent of 2015's GDP.

*The Committee for the Future takes the position that, by purposeful action, health care's share of GDP can be kept below 10 per cent up until 2015, while improving public health.*

## **2. Personal responsibility in the advancement of health**

Health, its advancement, and the control of health threats are constitutionally protected human rights in Finland. The protection of equal opportunities in access to services, regardless of age, gender, language, ethnic background, geographic region, or economic status enjoys broad support throughout the society.

One key task of long-term futures policy is to question the assumptions that shackle thought. The notion that the advancement of health and the augmentation of resources for health care - that is, for health services themselves - are clearly linked to each other can be considered such an assumption. The notion is erroneous. Per capita, the United States currently devotes to health care about three times the resources that Finland does. Life expectancy there is however slightly shorter, on average, than in Finland.

Success in the promotion of health can be evaluated in terms of functional ability, perceived health, or a lack of health problems, in addition to longer life. Health care - that is, the production of health services - represents just one of the ways to advance health.

*In the future, the promotion of health will call for more responsibility on the part of each citizen for his or her own health, and his or her family's. In Finland, health care must be organized so that, utilizing technological possibilities effectively, it supports the citizens' own responsibility for their health. The maintenance of health is not the business of the field's professionals alone: it is everyone's business.*

Personal responsibility means the prevention of health problems and intervention in such problems on the basis of their early symptoms. Personal responsibility also encompasses both responsibility for one's immediate relatives and activity that promotes health within various communities. The support that communities provide has been found to explain many of the health differentials between residents of western and eastern Finland. In addition to the family, important communities include workplaces, schools, associations and meeting-places for all ages established in city neighbourhoods. The importance of stimulating activity on the part of pensioners' organizations will grow as the population ages. Internet peer-to-peer networks offer a new possibility for a sense of community. The increasingly important task of professional care-givers is to serve as supporters and advocates for citizens with poor prerequisites for advancing their own health either independently or with the support of their families and communities. In the future, the key task of health care - and particularly health counselling by occupational health care, school health care, and new health clinics intended for the adult and elderly population - will be to support citizens and their communities in their independent health maintenance. In this sense, too, occupational health care must reach everyone who works.

*Health promotion must be made a more effective element of the health care system. Low-threshold counselling must be increased. Here the most important development tasks include both the reshaping of children's health clinics as family centres that support parenting, and the establishment of health clinics intended for adults outside of occupational health care, and especially for the elderly population. At the new health promotion clinics, the nurse will furnish guidance and counsel patients to seek out a physician or other expert, if the need for such exists. Regular yearly examinations could also be a health clinic task.*

*Everyone who is working should be within the sphere of preventive occupational health care that promotes health and maintains working ability. Inclusion in the health care system of persons holding atypical employment, individual entrepreneurs, and small businesses with fewer than five employees continues to be limited. A worker-specific occupational health care monitoring system, inclusion in which is easy to verify, has to be created. With its aid, occupational health care is to be integrated with health promotion based on a personal, electronic patient or health report.*

Only someone who is adequately functional and active enjoys the possibility of independence. This challenge is encountered especially in care of the elderly. Housing arrangements that support the mobility of elderly people must be promoted. From the standpoint of barrier-free movement, lifts are especially important. From the perspective of maintaining functional capability, the generous use of tranquilizers and the placement of elderly individuals in institutional beds are very problematical. Studies indicate that the latter leads to a rapid decline in the elderly individual's condition.

New ICT offers excellent prerequisites for promoting health. Finnish care personnel have already learned to use electronic services. Finnish physicians use electronic care recommendations more than physicians anywhere else in the world. By 2015, it will also be possible to create good informational prerequisites for citizens to take personal responsibility for their own health. Possibilities are offered by both the electronic patient or health report and databases that relate genetic information, bar code based databases concerning the composition of the nourishment used, and databases that relate the impact of therapies. These among other things can be attached to the personal health report. New biotechnological innovations also furnish enhanced possibilities for self-help health care.

Information from a patient or health report can wind up in the wrong hands. The citizen must be able to choose how his or her health report can be used, and who can use it. As a basic premise, the health report must be openable at all of Finland's care-providing institutions. This sort of health report constitutes a key prerequisite for the efficient, seamless organization of future health care.

Citizens must have the right to stipulate what part of the health report and its attached files will be available for their use by means of a health card, an ID number, or possibly a biometric ID. The citizen must also be able to decide what parts of the health report his or her confidants, such as the members of his or her care team (see below) may use confidentially, and what persons possibly authorized in turn by them may utilize those parts of the report confidentially.

*Every Finn is to have a personal electronic health report which he or she, or his or her representative, can open, at least anywhere in Finland. The electronic health report is a key point of departure for the effective use of ICT in health care. Development of the electronic health report is to be continued, in the direction of a genuinely smart system.*

*The part of the health report used by the person him- or herself must be easy to use, for example with a health card, an ID number, or possibly a biometric ID. In addition to information on treatments and their effectiveness, the health report is to contain monitoring data on the person's health and factors that affect it. So that information does not get into the wrong hands, a part of the health report, in accordance with the individual's wishes, may be openable only together with a person belonging to his or her care team. The improper use of confidential health information must be punished.*

The introduction of new therapies and medicines is linked to major financial interests. This furthers medicalization, the translation of social and life problems into medical terms. In medicalization, problems of day-to-day life are transformed into medical problems; minor symptoms are perceived as serious, and risks as diseases. The prevalence of problems is exaggerated. Advertising and the economically motivated misuse of authority by care personnel feed both a consciousness of disease and pointless visits to the doctor.

Medicalization must be vigorously opposed by enhancing the level of knowledge among persons receiving care, in addition to developing the care system. Finns spend more than €250 million yearly just to bring their blood pressure and cholesterol under control. Some of the added use of medicines is justified, but a significant portion of the medicines' expense and deleterious side-effects could be avoided by more sensible choices of medicine and lifestyle.

In the future, citizens will presumably express more opinions about their treatment - whether that is accepted as the point of departure for Finland's health care or not. The patients' knowledge and their desire to take part in decision-making that bears on their own care will grow. Independent of the care system, the internet will furnish a diversity of opportunities to evaluate treatments that have been offered or are possible. It will become more and more important to contribute to the ability of citizens to choose, from the available information, what is valid and fundamental from the standpoint of their health. As WHO and patients' organizations have emphasized in their recent position statements, the patient is in any event moving more and more towards an active role as the person directing his or her care. It has been predicted that, in 2015, patients or their immediate relatives will in Finland initiate many times the number of legal and administrative processes that they do today. Those actions will concern malpractice, care that did not correspond to therapeutic recommendations, or the possibilities offered by new treatments.

### **3. How to Control the Growing Costs of Hospital and Medical Care?**

The new biotechnology is revolutionizing health care technologies. In particular, gene technology and the use of stem cells are opening up great possibilities. Therapeutic practices and diagnostic methods are evolving so fast that, depending on the field of specialization, they can be said to be revising themselves completely in five to ten years (Linden 2006). In medication, development is especially swift. At Turku University Central Hospital, for example, only 3 of the 20 most-used medicine products (measured in terms of costs) in 1998 and 2003 were the same.

The most dramatic developments are anticipated to lie in the care of cancers. The progress is however expected to be expensive. Experts have predicted that in 2015, cancer therapies will cost some two to three times what they cost now. Above all, new

medications are involved here. According to compensation statistics from the Social Insurance Institution (in Finnish, Kela), the institution's medicine costs rose from € 677 million to € 1015 million between 2000 and 2004; that is, yearly growth was about 12 per cent. Symptomatically, among the major disease groups, the costs of cancer medications rose fastest - from € 54 million to € 128 million, meaning a yearly growth rate of about 25 per cent. The rise in Kela's medication costs was slightly faster than growth in the world medicine market. The latter grew about 10 per cent a year between 2000 and 2004; that is, from \$357 billion to \$552 billion. In practical situations of care, the relationship between expensive medications and their effectiveness is emerging as an increasingly thorny ethical question.

It is becoming more and more important to control the use of medicines better. The trend in cholesterol medications in recent years provides an excellent indication of how Finnish physicians are very quick to introduce the newest and most costly medicines. Very controversial information is circulating in respect of the effectiveness of the most expensive cholesterol medicines, compared to inexpensive drugs that have already lost their patent protection.

The introduction of new and genuinely effective treatments is justified almost regardless of the price. It is however very important to develop a method to prevent the use, at public expense, of therapies that are either ineffective or expensive and only marginally more effective than previous therapies. Disease-specific indicators have been developed to assess the effectiveness of therapies. Various indicators allow for monitoring the internal effectiveness of a certain procedure or specialization. Even greater promise has been seen in quality-of-life indicators related to health. They allow for comparison between specializations in terms of QALY (quality-adjusted life years gained). In Finland, 15D is a tool already in very wide use. It has been generally - but by no means unanimously - viewed as being suitable as Finland's national yardstick of effectiveness.

Although all solutions used in actual therapies should be shown to be cost-effective, this should not hinder the search for new solutions through research. Experimental creativity and innovativeness must not disappear from Finnish health care. Testing new medicines and other new health care solutions is associated with the possibility of success in the field's international market. Without the government's active contribution, new health care innovations will hardly get to develop in the framework of the Finnish care system.

Recently an attempt has been made to influence development by excluding expensive medicines that are only marginally better than inexpensive medicines in terms of effect from Kela's list of medicines that qualify for reimbursement. Managing development by today's procedures clearly will not suffice to answer the challenges of the time, however. We cannot proceed from the assumption that growing expenditures for medications and hospital care will be left to the municipalities alone to manage. Even the large municipalities lack real prerequisites for exerting much impact on the trend in those expenditures. When one takes into account, further, the municipalities' future major differences in terms of aging, leaving things to the sole responsibility of the

municipalities would lead to growing differentials, both geographic and among social groups, in health and the use of health services.

Both the information on medicines and the supplementary training that physicians receive are mostly the responsibility of the pharmaceutical industry's marketing operations. This circumstance promotes the use of expensive new medicines. For physicians to be able to better compare the effectiveness, deleterious side-effects, and costs of treatments offered, health service providers should attend better to the availability of impartial, research-based continuing and supplemental education.

In the extreme case, failure to control the costs of medications and hospital care may lead to an uncontrollable rise in health care's GDP share, in the fashion of the United States. It may also lead to a partial collapse of the health care system, for example so that care provided in emergency rooms soaks up most of the resources.

*In the national organization of health care, the main challenge is to control the costs of medications and hospital care while improving public health - and without compromising the quality of care. A method by which only cost-effective treatments are underwritten with public funds must constitute a central element of the organization of health care in 2015. It must however be possible to develop new, innovative treatments with the help of research activity.*

## **4. In promoting health, prevention is essential**

The prevention of health problems through lifestyles and living environments that promote health - exercise, working conditions that promote mental health, healthful food, avoidance of smoking, and control of the use of alcohol - represents health care that is more effective than the increasing use of medicines.

Adult-onset diabetes is based on a hereditary disposition. Lifestyles have a decisive impact on the onset of the disease, whose occurrence has increased rapidly in our country. Diabetes is shifting to younger and younger age groups, even to children. The portion of children aged 12 to 18 who are seriously overweight increased between 1977 and 2003 from 6 per cent to about 16 per cent (Rimpelä et al. 2004). Overweight individuals are 10 to 20 times more likely to get diabetes (Hakala 2005).

The total costs that diabetes places on the health care system are difficult to evaluate because most of them consist of complications. Type 2 diabetes, which afflicts an estimated 190 000 or more people in Finland ([www.diabetes.fi](http://www.diabetes.fi)), typically constitutes part of a so-called metabolic syndrome that includes elevated blood pressure, aberrant blood lipid values, an increased tendency toward blood clots, and excessive weight in the central trunk, as well as elevated blood sugar levels. Diabetes is the most important cause of kidney diseases and visual impairment. It leads to amputations and increases



the risk of heart disease. It has been estimated that direct costs for diabetes will surpass 10 per cent of total expenditures for health care in Finland (Eerola et al. 2001). Expenditures for diabetes may thus approach as much as €2 billion in 2015.

Exercise and nutrition play key roles in controlling diabetes. ICT is already being used for support systems in diabetes treatment (Eerola et al. 2001). ICT should also be utilized effectively in preventing the disease.

*Citizens should be encouraged to exercise from the time they are children. Physical activity in schools should be increased, for example through recess exercise and campaigns conducted in cooperation with NGOs. The objective should be established of making fitness exercise a way of life for as many as possible - and especially for those with a hereditary disposition towards obesity and/or diabetes. In particular, forms of exercise that prevent this group from becoming ill should receive financial support.*

Mental health problems are emerging as one central challenge facing the health care system. Today, 700 000 Finns are using any of a variety of psychiatric medicines. For example, 5 to 6 per cent of Finns (260 000-310 000 persons) suffer from serious depression, and bipolar personality disorder occurs in 1 to 2 per cent (50 000-100 000 persons). In 2004, 25 per cent of sickness benefits stemmed from mental health causes and 43 per cent of disability pension recipients had been pensioned for reasons of mental health.

Mental health problems are often social as well as medical. Psychiatry alone does not suffice as therapy: it must also be possible to affect the life situation. According to a study by the National Research and Development Centre for Welfare and Health (in Finnish, Stakes), mental health problems generate by far the greatest total costs for the society.

As the population ages, geriatric psychiatry and the special expertise it requires are coming to represent an increasingly crucial challenge. For example, the new psychiatric medicines' suitability and dosing for the elderly are not always known. Often it is purely loneliness that lies behind old-age depression. Drug abusers who suffer from psychiatric problems constitute another group demanding increasing attention.

*Mental health work, both preventive and therapeutic, must be raised to a level commensurate with the economic and human significance of psychiatric diseases. We need a more comprehensive approach to the treatment of mental health problems - an approach in which medical science and other measures related to the life situation support each other. Particular attention must be focused on the initial phase of care, when the preservation of working ability and quality of life will best succeed.*

Increased smoking by young people, especially girls, is a problem. In 2005, according to a survey on the health habits of young people, 22 per cent of boys aged 14 to 18 and 23 per cent of girls the same age smoked daily. Smoking among 14- to 18-year-olds decreased momentarily in the late 1970s, particularly after a legislative reform aimed at

reducing smoking among young people. In recent years, however, smoking among young people has again become more common though daily smoking has stabilized in the period 2001-2005 (Rimpelä et al. 2005).

*In recent years, meaningful progress has occurred in the reduction of smoking, especially by reducing the number of places where one may smoke. The impacts have been visible in tobacco-smoking by adults. By contrast, the measures have not had an adequate impact on young people, girls in particular. New means should be found that will make it possible to influence girls especially. To make it easier to quit smoking, products that facilitate quitting should be made eligible for full reimbursement.*

Alcohol-related deaths account for as much as almost one fourth of lost years of life. Although tobacco causes more deaths than alcohol, the latter clearly accounts for more lost years of life than tobacco does. This stems from the fact that alcohol-related deaths, compared to deaths from other causes, occur on average at a much younger age. The elimination of quotas in the importation of alcohol from Estonia and the drop in alcohol prices by an average of 33 per cent in early 2004 contributed to the fact that alcohol consumption in Finland rose 10 per cent in a year. It has been estimated that deaths caused by alcohol rose about 15 per cent (Stakes bulletin, 8 February 2006).

*The attention of heavy drinkers must be directed to their health-endangering consumption before serious health problems appear. In this sense, solutions that reduce alcohol consumption aimed at drunkenness should be introduced without prejudice. The Finnish culture of alcohol use should be changed so as to be more positive from the standpoint of health.*

## **5. Palliative care must be improved**

With health care improving constantly, it is possible to increase life expectancy further. On the other hand, infectious diseases that may grow into pandemics, and lifestyle diseases - diabetes above all - may mean a downturn in life expectancy.

The reality of death and confronting one's own death are becoming increasingly important themes in health care's ethical discussion, and in the development of patient care. The patient's right to decide about his or her own care represents an important principle. The patient's statutory status in Finland is strong in comparative international terms. According to the Act on the Status and Rights of Patients, patients are to be cared for through a mutual understanding with them, and patients always have the right to refuse treatment, in which case they are to be cared for in another medically acceptable way. On the other hand, a patient who has earlier stated his or her wishes respecting treatment firmly and competently, for example in the form of a written advance care will, may not be given care that runs counter to those wishes.

Thus far, very few Finns have advance care wills. With such a will, the patient can state under what circumstances he or she wishes to be shifted from care aimed at remedying the disease or lengthening of his or her life span, to palliative care. Palliative care avoids needless treatment that strains the patient; it concentrates instead on treatments that alleviate symptoms effectively. A professional definition of the principles of palliative care is to be formulated by professional care-givers, as in other fields of care. Since, among citizens, notions of both the strenuousness of treatment and quality of life after falling ill accompany the drafting of an advance care will and the refusal of treatment, the will should always be drafted in cooperation with professionals in the field.

The advance care will must also make it possible to specify a consenting person as an attorney-in-fact or agent who has the right to speak on the patient's behalf at that stage of illness when the patient is no longer able to formulate or express his or her own will. The attorney-in-fact may be a close relative of the patient, a friend, or a health care professional, whose judgment the patient trusts in the difficult situations of care-related decision-making that may arise. The naming of an attorney-in-fact also prevents possible controversies related to care choices among relatives with differing opinions. The position of the attorney-in-fact is to be defined in the Act on the Status and Rights of Patients.

A good death has great community meaning: good palliative care for dying patients is valuable from the standpoint of the entire community, as well as the patient. Sickness, disability or infirmity does not diminish anyone's human dignity, and this ethical principle must be manifest in the care of patients.

*Encountering death is a matter of one world's view, and profoundly so. The increase in diseases of long life - dementia, for example - challenges The Finnish health care system to invest in the humane, respectful, and individualized palliative care of dying patients. Through the advance care will, the citizen should enjoy a better opportunity to influence the question of what circumstances palliative care will be initiated under. The person who composes the will should have the right to name a person who interprets the former's care-related wishes if he or she is not personally able to express those wishes. The sensible care of dying patients must however be accessible to all - including those who have not written an advance care will as such. Expertise in palliative care must be made part of the basic training of physicians and other health care personnel.*

## **6. A comprehensive solution to the national organization of health care in 2015**

### **6.1. General concepts and points of departure**

In this section of this discussion initiative, we shall present and briefly justify a basic solution for the national organization of health care. From among the models examined in the course of a three-year evaluation process, the model to be presented will appear to be the most functional long term, regardless of what reforms are decided upon in the years immediately ahead respecting the structure of municipalities.

The goal of the basic solution is a good, comprehensive, functional public health care system that the citizenry will trust. In implementing the solution, particular care must be taken in respect of equality. Democratic decision-making, direction and oversight constitute the firm foundation of Finnish administration, health care included. Municipal autonomy and municipal democracy that is close to the people form the basis of the model presented in this initiative.

In addition to municipal democracy and opportunities for influence on the part of those receiving care, the central points of departure for the solution proposed include the seamlessness of care chains; the aging trend, which affects different parts of the country in different ways; the availability of care personnel and their motivation for their tasks; and the cost-effective procurement of the medicines and equipment used in the care. Increasingly intensive hospital care, which will give rise to substantial cost pressures in the near future and especially in the years further ahead, has been identified as a special challenge. In answering these challenges, particular attention must be given to the appropriate division of labour between public and private health care.

*Democratic decision-making and opportunities for citizens to affect their care must represent points of departure for the provision of health care. The Committee for the Future takes the position that the municipalities must bear responsibility for the provision of services and the planning of care in 2015, too. Private social and health services and the activities of organizations will complement municipal services and create alternatives to them.*

The primary concepts used in depicting the organizational solution include the following:

**Health service area (HSA):** A regional area, typically based on an employment region of daily pendeling. Within the framework of an HSA it will be natural to organize at least care for the elderly, primary medical care provided during the daytime, and the bulk of care based on the repeated medication of chronic diseases. The HSA will be part of a health district (HD) or will in itself form an HD. In the latter case the area must be large enough in terms of population base and must have enough basic expertise to purchase hospital care from the welfare district, for example through a regional hospital situated within the HSA.

**Health district (HD):** A district formed by its territory's municipalities and able to assume a portion of the district's hospital care and hospital emergency services. The HD's own production will give it the qualifications, in terms of knowledge, to purchase hospital care from the welfare district. In practice, the current regional hospital or

hospital district's central hospital will for the most part take charge of the basic specialist care produced by the district itself. The HD will encompass one or more HSAs.

**Basic specialist care:** That portion of specialist care that the HD can take charge of as its own production. This portion will vary from HD to HD, depending on what special expertise the HD's regional or central hospital possesses. The rest will be purchased by negotiating through the welfare district. Through sanctions and joint agreements among all the welfare district's HDs, the welfare district will be able to forestall solutions, such as duplicative equipment acquisitions, that are inappropriate from the standpoint of the welfare district.

**Welfare district:** An entity that will be owned by its territory's municipalities, and organize and purchase specialist care, primarily, for HSAs and HDs. After a transitional period, however, the welfare district will not produce services. It will contain a university central hospital or other unit capable of producing the most demanding care and high-quality medical research. One welfare district will be assigned responsibility for Swedish-language specialist care of this level of exactingness. The welfare district will be given planning responsibility for the equitable advancement of the district's welfare, and especially its health. The district will attend to this task in cooperation with HDs and a national Health Care Council. The state will provide the welfare district with partial funding for its operations related to especially demanding specialist care and campaigns connected with the levelling out of health differentials within the district.

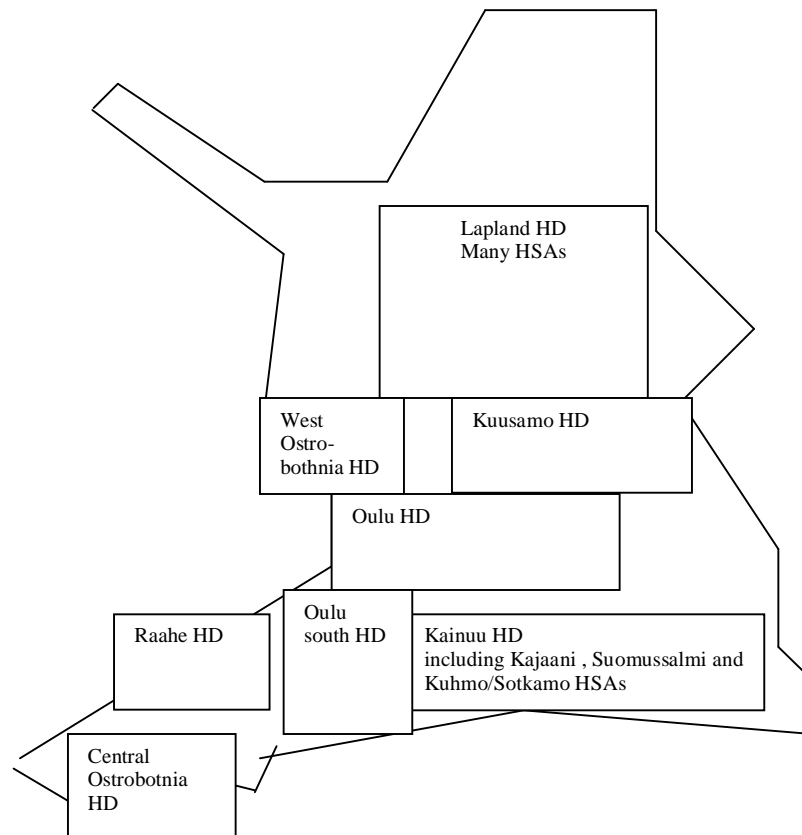
## Current hospital districts functioning in various tasks:

This discussion initiative's model does not include hospital districts of the current type. In their main features, the changing tasks of today's hospital districts can be characterized in the following table.

### Changing tasks of current hospital districts up to 2015

	Operations based on elected municipal officials	Operations in the form of municipally owned production companies (nonprofit public commercial enterprises or for-profit limited companies)
University hospital districts	Functioning as the welfare district's core purchasing organization using the expertise of its expert production company, representation from its welfare district's municipalities/HDs, and experts on purchasing  Organizer and possible producer of basic specialist care for its HDs, at least in connection with the central hospital's HD	A production company that functions as an expert organization for specialist care, medical research, and training. Its special expertise is respected both nationally and internationally.  Works in close cooperation, sharing work on the basis of expertise, with production organizations in other welfare districts.
Hospital districts that are divided into multiple HDs	Organizer and possible producer of basic specialist care for its HDs, at least in connection with the central hospital's HD	Functioning as a limited company or public commercial enterprise that offers services primarily for its district, but also for parties outside the district  Alternatively, integration as part of a university hospital district's production operations
Hospital district transformed to HD	Functioning as the organizer and producer of its district's basic specialist care	Sale of those services that can be economically produced for parties outside the district

**National Health Care Council** is prestigious body appointed by the Council of State. Government ministers for the sector, managerial civil servants, representatives of the municipal sector and welfare districts, and representatives of the sector's professionals will belong to the council. The council's key task will be the national organization and coordination of health care, particularly specialist care. In cooperation with the welfare districts, the council will assist in the division of labour among university hospitals in the provision of especially demanding care. The Department for Specialist Care, which will have the highest authority in the approval of new therapies and the evaluation of therapies already in use, will be the council's main preparatory organ. The council could also have a Department for the Financial Evaluation of Health Care.



To exemplify how a geographic configuration that conforms to the proposal might take shape, we depict the Northern Welfare District in 2015. This is only an illustration, from which the actual arrangement might differ a great deal.

The Northern Welfare District will be formed from the ERVA that encompasses the present hospital districts of Lapland, Länsi-Pohja, Kainuu, North Ostrobothnia and Central Ostrobothnia. An ERVA (its Finnish acronym) is the geographic area for which a provider of especially demanding specialist care bears responsibility. At the beginning of 2005, 725 000 persons lived within the ERVA in question.

The ERVA's municipalities will own the welfare district either directly or through the HDs. Each of the welfare district's municipalities will belong to one of its eight HDs. Operationally, the welfare district will be based on a central or regional hospital that provides specialist care.

- Lapland HD: Lapland Central Hospital
- Länsi-Pohja HD: Länsi-Pohja Central Hospital
- Kuusamo HD: Kuusamo Hospital
- Oulu HD: Oulu University Central Hospital
- Oulu South HD: Oulaskangas Regional Hospital
- Raahede HD: Raahede Regional Hospital
- Kainuu HD: Kainuu Central Hospital
- Central Ostrobothnia HD: Central Ostrobothnia Central Hospital

It is impossible to predict what sort of HSAs with a population base of approximately 15 000 to 40 000 would be formed in the aforementioned HDs. The Oulu HD would in any case represent a special case. Only in the case of Kainuu can we state that the HSAs will be Kajaani (current population base 44 000), Suomussalmi (17 000), and Kuhmo/Sotkamo (22 000). In Lapland it would in all likelihood be necessary to accept HSAs with far fewer than 15 000 inhabitants. One major significance of the welfare district would be the ability thus to transcend the partially artificial current boundaries of hospital districts in forming HDs. As referred to below, this would make sense in the case of Kemijärvi, for example.

## **6.2. Background of the organizational solution**

On 11 April 2002 the Council of State took a decision in principle to protect the future of health care. The decision defined points of departure for the regional development of the health care system. The decision found, for example, that "primary medical care will be provided in the form of functional regional entities. The recommended population base is 20 000 to 30 000, and 12 to 18 physicians would work in the units thus constructed. In forming the entities, however, attention must be given to regional circumstances. Particularly in the formation of a network of operating locations, it must be taken into account that distances should not become an obstacle to the use of the services. . . . The functional cooperation and division of labour in specialist care will be implemented through specialist-care responsibility areas. The hospital districts are to conclude cooperative agreements, merge, or form health districts. The regional hospitals will form health service areas with their regions' primary medical care units or operate as part of the central hospital for their region."

The main point of departure for the Council of State's decision in principle was the construction of seamless care chains connecting primary medical care, care for the elderly, and specialist care. Research results and expert evaluations assembled in the assessment project supported the position that this sort of consolidation will be sensible to effect, given the future's challenges, in the form of units - HSAs - responsible for 15 000 to 40 000 persons. According to a 2003 Government Institute for Economic Research survey on health centres headed by general practitioners (Aaltonen et al. 2005), the median population base of the most efficient tenth of all health centres was about 16 000, while the median population base for all health centres headed by general practitioners was slightly less than 10 000.

To be able to consolidate basic specialist care with care for the elderly and primary medical care, it has on the other hand been considered advantageous that a number of HSAs seek to cooperate by grouping themselves around a central hospital or regional hospital responsible for more continuous emergency care; that is, that they form an HD. The population base of the largest unit - that is, the unit primarily responsible for basic specialist care in this sort of arrangement - should be at least 20 000. As such, this solution apparently is not suitable for large population centres or their immediate environs, however. An estimated 60 to 80 per cent of the region's care chains for care for the elderly, primary medical care, and specialist care could be handled in this sort of



HD, i.e., one with a population base of 50 000 to 150 000. In 2003, hospital districts maintained 5 university hospitals, 16 central hospitals and 33 other, municipal hospitals. About 40 of these could perhaps serve as points of departure for the development of HSA of the aforementioned sort.

Good examples already exist of solutions of the aforementioned type - i.e., those founded on a population base of 20 000 to 150 000. In addition to Raahe, whose population base is 36 000, and which has already been referred to as an HD, many other urban regions have developed similar solutions. The Forssa Region Municipal Joint Union (MJU) for Health Care was formed on the basis of a regional hospital. The MJU's population base is 36 000. The organization takes responsibility for all the health services of its five member municipalities by purchasing them or producing them itself. Since 2001, all the municipalities' health care costs have gone through the MJU (Puro 2005). The municipalities have belonged to the Kanta-Häme Hospital District, but the MJU has been able to purchase services as it wishes from the appropriate organization. On the basis of an examination in accordance with the MJU's budgeting, the proportion of self-produced services has been about 60 per cent, and that of purchased services about 40 per cent. On the basis of Forssa's experiences we can conclude that even a unit functioning with a population base of under 40 000 can produce more than half of all health care and elderly care services. Solutions along the lines of Forssa's and Raahe's have in recent years been created by Jämsä (population base 24 000), Imatra (30 000), Kemijärvi (10 000), Pieksämäki (25 000), Mänttä (13 000), and Rauma (33 000).

Except for Mänttä and Kemijärvi, these projects meet the condition of a population base of 20 000. From the standpoint of future solutions, grounds exists to examine at least Kemijärvi more as an HSA than an HD. In 2003 Kemijärvi took an initiative to organize joint emergency physicians' services in the eastern Lapland municipalities of Kemijärvi, Pelkosenniemi, Posio, Salla, and Savukoski, and the Koillismaa region municipalities of Kuusamo and Taivalkoski. This would fit in extremely well with Kemijärvi's serving as a part of the previously outlined Kuusamo HD, whose population base would thus be about 45 000. Further, in terms of specialist care, the region in question is oriented clearly more towards the welfare district - that is, Oulu - than towards Rovaniemi.

Kainuu, Eastern Savo and Päijät-Häme furnish examples of broader regional cooperation. We referred to Kainuu earlier. It may be considered a model of how an HD can in practice be divided into HSAs. Plans call for launching an Eastern Savo HD, to function with a population base of somewhat more than 60 000, on 1 January 2007. The councils of the member municipalities decided to launch this undertaking in the spring of 2006. The HD project got its start on the basis of a study by Stakes (Pekurinen et al. 2003). The fundamental principle in the Eastern Savo undertaking has been "bringing the entire care chain under control". The intention is to organize primary medical care within the same organization as the municipalities' social services - elderly services especially. Plans call for reorganizing services, after the Kainuu model, as service entities for the elderly, working-age people, and children and families with children.

The Päijät-Häme HD differs much from Kainuu and Eastern Savo in its substantially larger population base (about 210 000). In creating the district, more problems have emerged than in the Kainuu and Eastern Savo regions. According to a spring 2006 position statement by the Regional Council of Päijät-Häme, it will not be possible with the district model alone to resolve the service production problems of the decades ahead, although Päijät-Häme is committed to trying the model. In Päijät-Häme, questions related to the owner-control solution, such as the problem of unowned money, have been seen as a risk in implementing the district model. According to the regional council's statement, the weaknesses, in principle, of the district model and a public monopoly include a rise in cost level. The council has taken a position favouring the establishment of a municipality covering the entire region. The commitment of the region's municipalities to such a broad consolidation of functions has however been uneven.

A large population base cannot in itself be a barrier to the formation of an HD. The crucial thing is for local democracy to function well in the region. Large centres of population and good internal transport services within the HD justify operations with population bases substantially greater than the 150 000 established as a guideline for HDs. While welfare districts that direct operations vigorously are taken as the point of departure, there is no justification for pressuring municipalities into functioning as HDs larger than what they are ready for, taking local conditions and the demands of local democracy into account. In particular, the idea that the boundaries of future HDs will follow the current boundaries of hospital districts should as a general principle be rejected. HDs that operate with large population bases raise questions, especially in the areas of elderly care and the appropriate provision of housing for the elderly. The consolidation of elderly housing with health care and elderly care requires flexible, people near solutions. If decision-making and the provision of care are closer, the voice of the elderly themselves will be better heard in the decision-making.

As regards the control of the costs of medicine and especially demanding specialist care, a population base of 200 000 evidently will not suffice to meet the challenges of the future. For that, a unit functioning with a markedly larger population base will be necessary. Only when a population base of about 600 000 is reached can we expect the unit responsible for the population to have the size- and expertise-based prerequisites to exert a tangible impact on the costs of especially demanding specialist care and the future's increasingly expensive medications - and then only if those units cooperate closely nationwide. The same applies to the full utilization of the possibilities offered by information technology and laboratory automation.

The idea of HDs operating with a population base of about 200 000 brings to mind Sweden's current solution, in which the 21 county councils take charge of organizing health care. Sweden's parliamentary Ansvarskommitten, established in the summer of 2004, is studying a reorganization of the regional administration of health care. The committee's chair, provincial governor Mats Svegfors, has predicted publicly, and in his introductory remarks to the Committee for the Future when it visited Sweden on 21 February 2006, that responsibility for health care in Sweden will be transferred to six university hospital areas or "superprovincial councils" (analogous to Finland's ERVAs). As justifications he cited both experiences gained with superprovincial councils tested in

Scania (population 1.1 million) and West Götaland (population 1.6 million), and the need to answer health care's future challenges. The future challenges identified were fundamentally similar to the challenges identified in the assessment performed under the direction of the Committee for the Future.

**Tähän saakka tarkastettu**

### **6.3. Tasks of the welfare district in 2015**

What tasks might welfare districts have that would each function with a population base of at least about 600 000 and typically serve HDs of 20 000 to 150 000 persons? Experiences already exist from the ERVAs of the University Hospital of Tampere (in Finnish, TAYS; population base 1.2 million) and the Oulu University Hospital (OYS; population base 725 000), which have inaugurated operations of this kind. In these areas, there has already been activity in the following sectors:

- 1) *Making the recruitment of physicians, at least for municipally owned care units, competitive.* The competitive recruitment of physicians which was organized by TAYS has led to significant savings in the ERVA's municipalities.
- 2) *Procurement.* TAYS has made the procurement of diabetes therapy devices competitive, achieving fundamental savings within its hospital district.
- 3) *Organizing the division of labour in tasks that demand special expertise.* In OYS's ERVA, heart- surgery care is being concentrated at OYS. In this ERVA, a division of labour is being formulated in the areas of intensive care, treatment of apnoea, and psychiatric care, too.
- 4) *Establishment of prioritization and valid-treatment guidelines.* The welfare district could be given a special appropriation for research, as regards, for example, an experimental therapy that is controversial in terms of cost-effectiveness and is not approved for trial use in a national assessment.
- 5) *Promoting seamless care chains and equivalence of service in all the ERVA's municipalities.* In OYS's ERVA, emergency services, transport, and the queue register, among other things, have been objects of scrutiny.
- 6) *Prevention.* In OYS's ERVA, the targets have been type 2 diabetes and a smoke-free hospital.
- 7) *Applications of information technology.* Construction of nationally compatible information systems; a contact-centre service based on telephones and e-mail and covering the entire ERVA or a part thereof; establishment of an uniform electronic patient report; compatible referral, feedback, and consultation systems; establishment of DRG billing; electronic archiving of images and improvement of related imaging.

- 8) *Other possible tasks* that have been considered in OYS's ERVA: provision of continuing education, a manpower bank, organization of job rotation, preparedness planning, international cooperation.

In their spring 2006 statements, many of our country's provinces and municipalities expressed hope for the transfer of at least the most demanding specialist care to state control. This cannot be considered appropriate in a system already suffering noticeably from the complexities engendered by separate funding from municipalities, Kela, and the Slot Machine Association. In the summer of 2004, the MPs serving in the assessment project's steering group named complexity as the health care system's biggest problem. Giving the task to welfare districts, with state funding, is a more sensible solution than a state takeover.

In addition to the care institution's procurement of medicines, the welfare districts could take on an active role in other aspects of their districts' management of medicines. It has been predicted that the monopolistic position of Finnish pharmacies in supplying drugs will be dismantled in stages by 2015. It will become possible, in controlled fashion, for households to use internet pharmacies, to which it will also be possible to send prescriptions in electronic form (cf. service vouchers, discussed below). Because of the intensifying competition among internet pharmacies, it can be anticipated that Finnish pharmacies will assume an active role in tutoring citizens in self-care, in cooperation with the public health care system. In 2015, numerous health tutors trained in pharmacology may be working in Finland. Through agreements with municipalities, they could function as support people, especially for those suffering from chronic diseases. This sort of trend is very natural, since with many chronic ailments the significance of medication is growing, and it is important that someone take charge of the individual's use of medicines as a whole. The medication of many elderly people for various diseases has already got out of control.

In addition to the aforementioned, additional tasks appropriate to the welfare districts would include coordinating laboratory services in their districts and managing the quotas of care institutions.

## **6.4. A service voucher scheme administered by the welfare district**

A possible task that could be given to the welfare district is to establish the use of service vouchers in the district. The service voucher system could perhaps offer a more cost-effective way to produce services for which Kela provides reimbursement. Compared to present practice, the system depicted below would not mean a greater public funding share for private producers of health services. Enough information does not yet exist on the scheme's possible problems. Only on the basis of trials shall we be able to consider its introduction.

The service voucher system would have four objectives:

- 1) To be able to use private service production better in complementing public service production. For example, if an area had too few public-sector ophthalmologists, it would be possible to obtain additional services with service vouchers.
- 2) To guarantee a reasonable price level. The purchasing organization would subject service producers to competition and certify them. It would be exceptional for a service producer not to be certified.
- 3) To guarantee the quality of operations. For example, a valid-treatment recommendation and, in the most demanding treatments, the monitoring of the care's effectiveness and quality would be required.
- 4) With the aid of the service voucher scheme, to restrain competition between the public and private sectors for health care manpower.

The service voucher system would exert a significant impact on the way occupational health care is provided. Occupational health care's current way of operating contributes a great deal to the fact that fairness is not being realized in Finland's health care system (Teperi 2005). According to an OECD comparative survey of 21 countries, published in 2004, significant problems exist in the social fairness of the Finnish health care system as regards visits to the doctor: once the need for service was observed, total doctor's visits broke down in the favour of high-income individuals most in the United States, Portugal, and Finland. The occupational health care system's share as a generator of visits to the doctor for primary medical care has grown steadily. At present the service user's only means of getting to a physician free of charge - which is at once the best means in terms of availability - is realized in occupational health services. Comprehensiveness of services is worst in atypical employment situations. Workers who have permanent jobs with major employers and often earn good salaries enjoy the most comprehensive occupational health care.

Medical services are being incorporated into occupational health care more than before. The importance of the occupational health care system as a producer of non-institutional medical services appears to be continuing its growth. Incorporating medical care as part of occupational health care is voluntary on the employer's part.

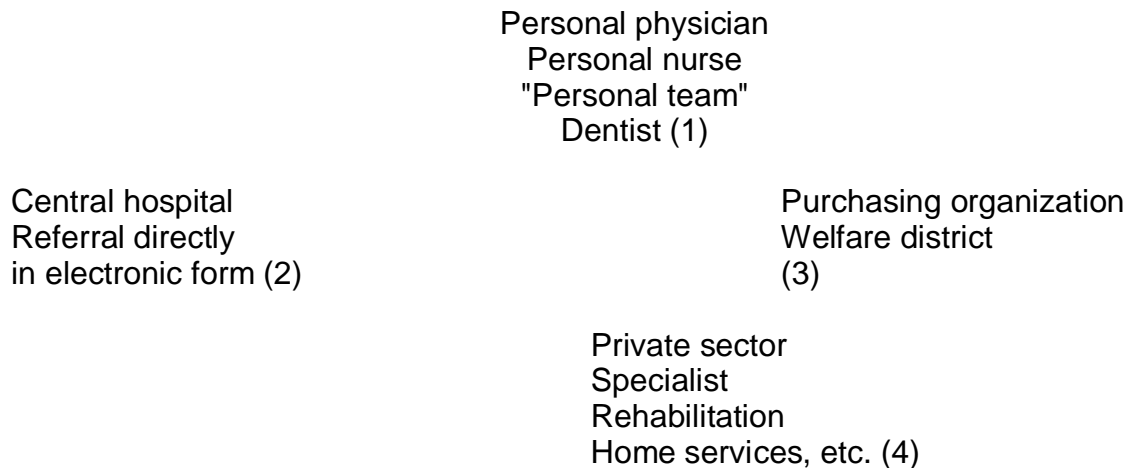
Kela reimburses 50 per cent of the expenses of medical care provided by the occupational health care system. The remaining costs are tax-deductible for the employer. The state thus compensates most of the cost of the medical care that occupational health care services provide. Employers purchase a great portion of these services from private health clinics.

Sixty per cent of a private physician's fee is reimbursed, but that percentage is computed on the basis of a rate approved by Kela. In practice the actual compensations for private-physician costs are significantly smaller. This stems from the fact that the rates on whose basis Kela calculates its reimbursements are much lower than the actual physician's fees. In 2004 the average actual reimbursement was 30.3 per cent of the physician's fee. Kela paid out €65 million in compensations. In occupational health care, reimbursements paid in 2003 under the Sickness Insurance Act, for occupational

health care provided at private clinics (€ 68 million) were more than twice those paid for health centre treatment (€ 30 million).

The service voucher system would rely primarily on the electronic health report, which would be openable anywhere in Finland, and on files attached to that report. If the system proves functional in trials, Finnish health care could in 2015 be primarily public or funded with service vouchers in terms of service production, and entirely public or funded with service vouchers in terms of its funding base for cost-effective care. From the standpoint of its practicality, it is crucial that the system allow the citizens a possibility at least comparable to the current Kela reimbursement scheme to choose care providers on their own. The scheme should be flexible enough to be adapted to situations that call for urgent care, too. The system would perhaps be best suited to treatments for chronic diseases.

A service voucher administered by the welfare district might for example work in the trial area as follows:



- 1) In 2015, each citizen will have his or her own physician or "team," which will consist of more than one physician and a nurse and may function either at a health centre or in the private sector, for example in association with occupational health care. The personal team will include a personal nurse, who will direct the individual onward within the team. Contact with the team or physician will generally occur by phone or e-mail, via the contact centre. The personal nurse or physician will either handle the patient's case entirely him- or herself, or send the patient onward. The physician or nurse will be able to use either a patient transfer (if the health centre and central hospital are part of the same organization), a referral (if the central hospital is part of a separate organization), or a service voucher application (if the patient so desires or it is otherwise appropriate to use private services). All forms of referral will be electronic. Provided with instructions, a team member other than a physician will also be able to send out a service voucher application.

- 2) The referral or patient transfer information will go electronically to the central hospital, which will care for the patient more or less as it would now.
- 3) The service voucher application will go in electronic form to the purchasing organization, which, adhering to clear principles, will evaluate the need for the voucher. As a point of departure, the voucher will be issued only for services which the public sector cannot provide itself, or which the private sector can provide in a fundamentally more economical manner. In care for which the patient can use a service voucher, the excess (deductible) portions will vary from a nominal share up to 70 per cent, for example. The individual will of course be able to select care that the government does not subsidize at all. In general the voucher will be awarded automatically, in which case it will get to the person needing the service immediately - within a few seconds - in electronic form, and he or she will then have the right to use the private physician's services in accordance with the voucher. The welfare district will however monitor closely the total number of vouchers awarded by each team.
- 4) Private service producers will be certified by the purchasing organization. The private service producer will receive the certification when his or her professional skill has been demonstrated (for example by completing a degree in a medical specialization); when a commitment exists to the agreed-upon payments to be collected from the patient and to the observance of accepted therapeutic practices; when electronic data transfer is in use; and, in the case of the most demanding units (private parties that perform surgery, for example), when they have committed themselves to a quality system and the monitoring of patients. The purchasing organization - the welfare district - will issue the certifications. It will be possible as necessary to subject private service producers to competition. The service voucher will only enable the purchase of services from certified producers. The producer will be at risk of losing the certification if the ground rules are broken. In practice, it is to be anticipated that all current individual service producers will receive the certification.

*The Committee for the Future proposes that a state-financed development and utilization trial for a service voucher of the sort described above be launched in one of the existing ERVAs.*

## **6.5. Summary of the organization of health care in 2015**

The following summarizes the decision-making levels and decision-makers in the model for the organization of health care in 2015.

The **Health Care Council**, which the Council of State will establish, and which will comprehensively represent the entire health care field and all of its central players. Members: ministers of social affairs and health; representatives of the welfare districts; management of the Ministry of Social Affairs and Health, Stakes, and the Commercial Employers' Association; representative(s) of the Association of Finnish Local and Regional Authorities; representation from the private and organizational sectors; health care personnel (for example, the Duodecim Society and care personnel' organizations); and a representative of patients' organizations.

The **Department for Specialist Care**, which will function as chief presenter to the Health Care Council. The department's special tasks would be the approval of new therapies and medications for trial use, and the issuance of recommendations for the discontinuation of therapies previously in use. The department could include representation from health care professionals from all welfare districts/university hospitals, rotating representation from non-university HDs, specialization associations, and the major cities; and representatives of medical faculties, the Finnish Office for Health Technology Assessment, Stakes, the Commercial Employers' Association, and the Association of Finnish Local and Regional Authorities. Experts on health promotion would be involved, too.

The **Department for the Financial Evaluation of Health Care**, whose special task would be to monitor and report to the council on the financially effective and equitable implementation of health care services. Experts on health care finance would serve as members.

The **welfare districts** will be formed from the five present ERVAs, which are based on university hospitals. We must however be ready for the possibility of a separate welfare district being formed for example from the eastern part of the Hospital District of Helsinki and Uusimaa's responsibility area; that part of the hospital district comprises southern Karelia and the Kymi Valley and has a total population base of about 310 000. One welfare district will be given nationwide responsibility for the provision of Swedish-language care. Each welfare district will have a university or other research unit that provides education in the sector. The governing body will include professionals in health service purchasing, experts on health promotion, representation from all of the welfare district's HDs/municipalities, and a representative of the Ministry of Social Affairs and Health. It is particularly important that the management understand specialist care, but also defend primary medical care and other municipal services effectively.

The **health districts (HDs)**, of which there could be 40 to 50 nationwide. Their management would include physicians in charge of the HD's different sectors (health care for adults, the elderly, and families with children, for example), or other health care professionals; officials responsible for care for the elderly; and key municipal decision-makers.

**Health service areas (HSAs)**. Their management would include both professionals responsible primarily for the HSA's care and health promotion, and local political decision-makers.



An important policy associated with the solution presented is the organization of health care services primarily as the municipalities' or HSAs' own activity, typically in areas having 20 000 to 150 000 inhabitants. Purchaser-producer relationships could emerge at this level, too, but only in functions especially suited to this sort of arrangement. The service voucher scheme administered by the welfare district will complement the system at this basic level.

After a transitional period, the welfare district will clearly function only as a purchaser - not in any way as a producer. This proposal proceeds from the assumption that financial transparency based on a well-controlled purchaser-producer relationship, the directability of the activity, the possibility of increasing production autonomy, and market competition that takes into account the special features of health care will function best at the welfare district level (cf. Lillrank et al. 2005). At this level we can expect that the purchaser-producer relationship will lead to an improvement in the services' quality as well as better control of costs. It is especially important for there to be adequate resources for primary medical care, care of the elderly, and other municipal services, as the costs of specialist care increase constantly. If this is taken care of, it will be possible to base the purchaser's relationship with producers of specialist care on long-term agreements and ongoing joint learning (a partnership relationship).

Since the abolition of the National Board of Health, there has been no administrative organ that would be able to take effective decisions on what methods are acceptable in health care. Today, new methods are introduced very haphazardly, for example as a result of conference travel by chief physicians. Research based on experimental care is typically driven by product manufacturers, and no information about the actual effectiveness of the method exists. The new method is often "5 per cent more effective and three times more expensive than the former one."

It is important to find a solution which, on one hand, restrains the growth in costs for medication and specialist care, but also allows for the innovative development of new solutions. An administrative solution for the introduction of new therapies could be founded on the following principles. First, experimental care will be made subject to a license. Second, the party proposing to provide the trial care will address an application to the Health Care Council's Department for Specialist Care, which will render its decision on the approval of the treatment within a specified time. The effectiveness and costs of the therapies will constitute the criteria. Special ethical reasons may also affect the decision. Third, if the trial care is not allowed, it can still be funded from the welfare district's research budget. Fourth, the recipient of a license for trial care will be obliged to produce monitoring information. As the data accumulates, the care can be approved as experimental.

Justification exists for directing part of the state support for municipalities directly to the welfare district, which, with this funding, will take charge for example of especially demanding specialist care services ordered by the municipalities through a capitation calculation (the same payment per resident of the municipality, regardless of the number of those receiving the care). The district is to have a fairly large research budget. It will also receive state funding, for example for projects that enhance equality and promote health in the district. All the municipalities in the welfare district's hospital

districts will in this fashion join the owners of the "health care wholesaler" thus formed. The connection to producers of specialist care will be fixed - a partnership - but the municipalities' needs, other than specialist care and medications, will be taken into consideration equitably in the implementation of the care.

**Concisely presented, the 2015 model for the national organization of health care could be as follows:**

- **Health districts (HDs) and health service areas (HSAs), which - taking local needs into consideration - will combine primary medical care, basic specialist care and care for the elderly especially, and will act as strong representatives of municipal democracy. They will represent the municipalities' other services, too, in relationship to the growing costs of specialist care.**
- **Welfare districts, of which there will be five to seven. They will be owned by the municipalities/HDs. They will operate as purchasers of health services (as purchasing pools) for their districts' HDs; in addition they will bear overall responsibility for the health trend and health differentials in their districts. They will receive state funding for providing the most demanding specialist care and for promoting equality in matters of health within their districts.**
- **The Health Care Council will coordinate care nationally. Members will include, among others, government ministers, the welfare districts, the municipal sector, and care personnel. The Department for Specialist Care, which will exercise great authority, and the Department for the Financial Evaluation of Health Care will act as presenters.**

*The Committee for the Future proposes that the Finnish health care system be developed so that it will operate in 2015 in conformity with the principles presented in this discussion initiative.*

Helsinki, 7 April 2006