

## POLICY AND PRACTICE

# Integrating health and social services in Finland: regional and local initiatives to coordinate care

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## ABSTRACT

In comparison with other countries, health and social care in Finland is already relatively integrated, with local governments (municipalities) organizing most primary care and social services, and running, together with other municipalities, hospital districts for specialized services. However, the services are highly decentralized, with a small median size of the municipalities, devolved decision-making and weak central-government steering. The ageing Finnish population and rural–urban migration are creating challenges to the structure of the Finnish health and social care system. Recently, the Finnish government has proposed policies for both the administrative and the operative integration of health and social care, to create larger authorities for organizing services and to strengthen the coordination of primary and specialized care, and social services. Nationally,

the new policies have led to legislative initiatives attempting to reform the service system and to support integration; At the local level, municipal collaboration has been launched to establish novel types of municipal care organizations and to create regional joint health and social care authorities to boost administrative integration and to facilitate the implementation of innovative forms of integrated care. This article describes three examples of these novel integrated-care initiatives: two of these – one of which provides integrated health and welfare centres, with the other providing children's and young people's services – are run by regional joint authorities; the third is an urban health and welfare centre based on an alliance model of public-, private- and third-sector partnership.

**Keywords:** INTEGRATED CARE, PRIMARY HEALTH CARE, SOCIAL SERVICES, FINLAND

## INTRODUCTION

Compared to the case in most other countries, health care and social care in Finland are already relatively integrated, with local governments, termed “municipalities” [kunta], organizing most primary care and social services and running, together with other municipalities, hospital districts [sairaanhoitopiiri],<sup>1</sup> which organize public specialized care services (1). The Finnish system is usually considered to be both effective and efficient (2). However, at the national level, the system is often evaluated less favourably, and several issues in terms of access to and quality and efficiency of the services have been identified (3, 4).

As the Finnish health and social care system is highly decentralized, with strongly devolved decision-making powers and weak central-government steering mechanisms, the provision of health and social care in Finland has become fragmented. This fragmentation has been intensified by the impact of private-sector sources of health and social services, particularly with respect to occupational health services and ambulatory specialized care (5, 6). Consequently, the national health and social care system has not been able to adequately meet the changing needs of the population, leading to poor and inequitable access to services and undermining the performance of primary health care, at least in some regions (7).

In addition, factors such as differing sectoral legislation and disparate professional identities related to education and training contribute to different conceptions of what the objectives of the health and social care system should be and what clients need from health and social services (8, 9). For

<sup>1</sup> A hospital district is an administrative unit that is a federation of municipalities; it is responsible for the provision of specialized medical care in the region governed by the municipalities in the federation.

example, the fragmentation of the Finnish health and social care system has resulted in an imbalance in the resource development of primary and specialized care as, for the last 20 years, the larger part of the health care resources has been allocated to secondary care, due to a lack of coordination and steering mechanisms. For primary health care, this has resulted in poor access to physician services particularly and inequities in access to care more generally, although well-to-do groups, such as those with steady employment status, continue to be able to enjoy access to services provided by occupational and private health care (10).

In addition, unfavourable demographic and economic trends have challenged the capacity of the public health and social services. Two main factors have changed the profile on care demand and undermined the sustainability of the current health and social care system:

- repeated waves of rural–urban migration have significantly diminished the ability of small rural municipalities to offer adequate services for their populations; and
- ageing of the population, together with associated multimorbidity and related social challenges, has led to an increasing demand on health and social services.

Thus, while health and social services in Finland are more closely integrated than those in many other countries in Europe, an integrated-care approach at the levels of practice and multidisciplinary care is seen as a solution for many of the issues arising in the health and social care system. Moreover, there are several patient groups, such as patients with mental health problems or substance abuse and social problems, who would benefit from improved care integration (11, 12).

In this article, we describe three novel integrated-care initiatives in Finland and review their preliminary experiences in improving the integration of primary and specialized care and social services. Two of these initiatives, one providing children's and young people's services and the other providing combined health and welfare centres, were organized by regional-scale joint authorities; the third is a local, urban-area health and welfare centre whose organization is based on an alliance model involving public-sector, private-sector and third-sector partnerships.

## THE HEALTH AND SOCIAL CARE SYSTEM IN FINLAND

The Finnish health and social care system has been described in detail elsewhere (1). In addition, the development of the primary care system in Finland, as well as the challenges facing it, has been reviewed in previous publications (13, 14). However, in order to provide a context for the integrated-care initiatives described in this article, a short description of the Finnish health and social care system and its current trends is given here.

The Finnish health and social care system has developed gradually over the decades. Unlike the case in many other European countries, in Finland, municipalities have always played a central role in health and social care, including elderly care and other welfare services, as in public services such as schools, children's day care, libraries and waste management (1). For primary health care, a network of municipal health centres with a broad remit covering general practice, maternity and child care and school health services, often with local hospital wards led by a general practitioner, was established in 1972; this made Finnish primary health care more health centre oriented than is the case for primary care in most other countries. Finnish primary care is also exceptional in terms of the numbers of staff and of different professions it employs (14).

In terms of hospital care in Finland, although prior to 1990 most public hospitals were already being run by federations of municipalities, in the early 1990s all specialized care administration was brought under the control of 20 municipal federations, the "hospital districts". In 1993 the role of the municipalities in health and social care was further strengthened by the dismantling of central-government planning and steering mechanisms; in addition, whereas, previously, central government subsidies to the municipalities had been based on realized costs, they became based on estimated costs and annual block grants.<sup>2</sup>

The current Finnish health and social care system is claimed to be the most decentralized in Europe, if not in the world. The main responsibility for organizing both health and social services lies with the 297 municipalities. For organizing

<sup>2</sup> Read more in Cylus J, Williams G, Karanikolos M, Figueras J. Using risk-adjusted capitation for financial resource allocation and purchasing primary health care and social services. A rapid review of international experiences and lessons for Finland. Brussels: European Observatory on Health Systems and Policies; 2018 ([https://thl.fi/documents/2616650/2646346/Finland\\_RiskAdjustmentBrief\\_12may.pdf/41a46c24-5c58-47f8-b65a-bbad0995c298](https://thl.fi/documents/2616650/2646346/Finland_RiskAdjustmentBrief_12may.pdf/41a46c24-5c58-47f8-b65a-bbad0995c298), accessed 5 December 2018).

primary and social care services, smaller municipalities have established joint authorities [kuntayhtymä], which make the actual number of the entities responsible for health and social service organization around 170. As mentioned above, hospital and specialized care is under the control of 20 municipal federations termed “hospital districts”. In addition, 16 joint authorities organize services for people with developmental disabilities.

However, recent developments in the health and social care system have increased the heterogeneity in services provided. For example, in some regions, municipalities have merged the functions of primary and social care in joint authorities and hospital districts and formed integrated authorities for all health and social services. In others, municipalities have outsourced all or part of health and social services to private or public-private companies.

One important feature of the Finnish health system is the large role of the private sector in the provision of health care, owing to the fact that the national health insurance system has historically reimbursed the use of private health services. However, the reimbursement currently provided is only around 15% of the cost, a situation which – together with recent problems in obtaining access to municipal services – has created a relatively large private health insurance market in Finland (15). Another, related aspect is the occupational health service organized by employers for their employees, as a large part of the working-age population gets their ambulatory health services through this channel. The extensive use of private-sector and occupational health services, together with the decentralization of the public health and social care system, further contributes to the fragmented nature of the Finnish health and social care system.

Currently, in Finland there is a wide consensus on the need for health and social care reform which would consolidate the fragmented administrative and financial structure of Finnish health and social care. In response, the Finnish government has recently proposed a broad reform of the regional government structure, to create a new administrative layer consisting of 18 counties. These counties would be responsible for organizing and financing health and social services, as well as providing a number of other tasks and services previously supplied either by the municipalities themselves or by the central government (10, 16). At the national level, the new government policies have led to a series of legislative initiatives to reform the health and social services system; at the local and regional levels, the policies have been implemented through

municipal collaboration to create regional-scale joint health and social care authorities, to boost integration and facilitate the implementation of innovative forms of care (17).

As health care policies in Finland have long emphasized the strengthening of primary care services and the integration of care, particularly in terms of coordinating primary health care and social services (1), health and social services in most municipalities currently operate under a unified administration. However, with the exception of local pilots, vertical integration has not developed at the same pace, and primary care services and specialist and hospital services are organized and provided by separate organizations. In addition, at the municipal and the joint authority levels, the administration of health and social care has varied. Over the years, most municipal authorities have adopted a model with a joint municipal board and office managing health and social care. Due to many factors, practical services are, however, still running in silos in many municipalities. Moreover, issues such as differing sectoral legislation and professional identities related to education and training, are contributing to different conceptions of the objectives of the service system and clients’ needs in professionals in health and social services (8, 9). Thus, many aspects of care would benefit from enhanced administrative and operational integration.

## REGIONAL AND LOCAL INTEGRATED-CARE INITIATIVES

In the following, three initiatives to improve the integration of primary health care and social services in Finland are described, and some preliminary experiences from them reviewed (see Table 1). As the initiatives are all more or less recent, there is as yet no systematic evaluation of them, but they show quite well the direction in which integrated Finnish primary health care is currently developing. The first two initiatives described, the Eksote children’s and young people’s house and the Siun sote health and welfare centres,<sup>3</sup> are managed by regional-scale joint health and social care authorities; the first initiative provides an example of how to organize integrated, multiprofessional children’s and young people’s services, and the second shows how coordination of multidisciplinary health and social care can be strengthened at the health centre level. The descriptions

<sup>3</sup> “Eksote” is the abbreviation for *Etelä-Karjalan sosiaali- ja terveystieteiden* (translated as “South Karelia Social and Health Care District”), which is the joint authority that runs the facility.

TABLE 1. MAIN FEATURES OF THREE NOVEL INTEGRATED-CARE INITIATIVES

	Eksote children's and young people's house	Siun sote health and welfare centres	Tesoma Wellbeing Centre
Organizer(s) of the services	Joint authority of the nine municipalities in South Karelia (130 000 inhabitants).	Joint authority of the 14 municipalities in North Karelia (169 000 inhabitants).	The City of Tampere (approx. 230 000 inhabitants) and the district of Tesoma (approx. 20 000 inhabitants).
Provider(s) of the services	Joint authority of the municipalities in South Karelia.	Joint authority of the municipalities in North Karelia.	An alliance between the City of Tampere, a private provider and a third-sector provider.
Principles for integrated care	In order to integrate all health and social care under the same management, services for children and young people have been placed in a joint organization. Children and young people can have practically all their services from one organizational unit and location. The families do not have to know which services they need, but a multiprofessional team of professionals is gathered based on their situation.	In order to integrate all health and social care under the same management, mental health and substance abuse services and related social services have been located to health centres providing integrated primary and social care services. Professionals from various fields work under their own management but in the same facilities. A shared front-line manager supervises daily work and care processes.	The alliance aims to combine the services in a way where the boundaries of services, organizations and professions are dissolved for the benefit of the clients. The collaboration is based on multiprofessional teamwork conducted in a framework where the client is the centre about which the professionals move. Early prevention, self-care and digital services are emphasized as key elements in this service concept.
Integrated services provided	The house provides primary care services, children's and young peoples' mental health services (primary and secondary care), maternity and child health clinics, school health and welfare services, child protection and social work. Services in urban areas are organized in a specific children's and young people's houses operating on a walk-in principle. In addition, services are provided at schools and rural areas.	The centres provide outpatient primary care by physicians and registered nurses as well as care by nurses specialized for mental health and substance abuse services, and social services professionals.	The centre provides primary health care services, dental care for adults and supported living services for the elderly and persons with disabilities; services for families and young people (such as maternity and child clinic, family work, home care, dental care for children and young people); guidance, advice and case-management services; employment and library services; and a community coffee shop and other third-sector activities, such as organizing peer-group meetings.
Outcomes	Positive assessment based on administrative information systems: the amount of substitute care of child protection needed in institutions decreased, the amount of psychiatric hospital care for young people (<17 years) under the national average. Scientific evaluation not yet available.	Positive assessment based on personnel interviews (unpublished): care paths more efficient, shortened waiting times, decreased number of formal referrals, consulting other professionals easier. Scientific evaluation not yet available.	Not available yet.

of the initiatives are partly derived from data gathered for an ongoing research project on the changing competencies of the health and social care workforce and are based both on themed interviews of managers at different levels and on the documents from the service providers (18). The initiatives were chosen because they demonstrate options for organizational integration and cooperation between organizational units: specifically, the Eksote children's and young people's house is a pioneer initiative which has provided an example for several other regions to follow when developing integrated-care solutions, while the Siun sote initiative is an example of how professionals from different sectors can be brought to primary health care centres to work together. The third initiative we describe is a recently launched

local initiative consisting of an urban-community well-being centre created via a novel public procurement process aiming at forming an alliance between public-sector, private-sector and third-sector actors in order to provide integrated care.

## THE EKSOTE CHILDREN'S AND YOUNG PEOPLE'S HOUSE

The first example of a novel integrated-care initiative in Finland is the multiprofessional children's and young people's care facility or "house" run by the South Karelia Social and Health Care District [*Etelä-Karjalan sosiaali- ja terveystieteiden*] (abbreviated as "Eksote"). As mentioned above, the municipalities have responsibility for organizing health and

social services in Finland. However, as the municipalities are, in general, rather small, they have established joint authorities for arranging health and social services. Further, while the municipalities have responsibility for hospital care, the hospital care is actually provided by the hospital districts, which are joint authorities owned by the municipalities. This means that primary care and social services are run by organizations that are different from those that run the hospitals, and so are under separate management. However, in the past few years, the municipalities in some regions have formed regional-scale joint authorities covering whole counties. These authorities, such as Eksote, finance and organize virtually all the health and social services in the region and provide most of the services (some services are purchased from private- and third-sector organizations). This arrangement means that all of the services in these municipalities are under the control of the same management and so can be organized in novel ways.

Eksote is responsible for organizing services for 130 000 inhabitants in nine municipalities. Compared to regular health and social care authorities, Eksote is considerably different with respect to its organization as well as its work and care processes. One example of this is the creation of a special facility for children and young people, the Eksote children's and young people's house [*Lasten ja nuorten talo*], which provides multiprofessional somatic and psychiatric services for its target population. In this facility, services and professionals are gathered into one organizational entity, with common management and resources from primary care, social services, the specialist hospital and the municipal school authorities. Although professionals from maternity and child health clinics, from school health and welfare (earlier managed by the school organization) and from child protection, mental health services for children and young people, and other areas of social care work in separate units within the facility, they operate as a multiprofessional team.

The children's and young people's house operates on the walk-in principle and does not require referrals. In addition, it is possible just to walk in without knowing exactly which professional services are needed. When a person seeking advice or support arrives at the facility, a team of professionals assesses his/her needs and then gathers a dedicated team for her/him. While the aim is to provide services in a flexible way, the composition of the team organized and the volume of services provided depend on the client's needs.

The service model aims to provide services based on early intervention and tailored according to the needs of the client. Investing timely and appropriate services is expected to increase

efficiency and result in savings, even if services may be more intensive in the beginning. In addition, at the Eksote house, health and social services at the primary and secondary levels are all under the same management. The manager's role is to facilitate an innovative working model of care based on seamless service processes, in contrast with traditional patient pathways which must go through organizational boundaries. In the beginning, the manager of the house was a medical specialist, but later on the manager was from social care services.

The Eksote children's and young people's house has also proven to be efficient in financial terms. In addition, the high costs incurred by expensive child protection services, such as substitute care in institutions, have decreased (19). Moreover, in the region covered by Eksote, the number of days spent by young people (<17 years old) in psychiatric hospital care (52 days) is much less than the average in Finland (103 days) (20).

## SIUN SOTE HEALTH AND WELFARE CENTRES

The second care-integration initiative described in this article is an example where professionals from different parts of a health and social care organization have been relocated into joint health and welfare centres. Siun sote is a regional-scale joint authority comprising 14 municipalities. It is responsible for arranging all the health and social services in the region, as well as mostly providing them for the 169 000 inhabitants of North Karelia in eastern Finland. In administrative terms, Siun sote is similar to Eksote.

Finnish health centres normally provide primary health care for all the inhabitants in a particular area. Unlike the case in general practitioner systems in many European countries, the health centres in Finland have multidisciplinary personnel, including physicians, registered nurses, physiotherapists, psychologists and nutritionists. In addition, the health centres provide maternity and child health clinic and dental care services, as well as arranging physicians' consultations for home care under elderly care services.

However, despite there being strong administrative integration in the health centres, care processes between individual professionals in the health centres are not commonly highly coordinated. In addition, although mental health, substance abuse and social services professionals work in the same municipal organizations as primary care professionals, they are usually under separate management. Consequently, primary care professionals find the coordination of care with them difficult. In response, the Siun sote authority has established integrated health and welfare centres in which



health care professionals work together with professionals from mental health and substance abuse services (usually nurses specializing in mental health and substance abuse care) and other types of social work.

The different health professionals at the centre still have their own managers, but they all work in the same facilities, thus broadening the scope of primary care to meet the complex needs of patients with multiple conditions. However, having common premises is not always sufficient to establish multiprofessional work practices; common management is required in order to take care of common care processes and cooperation practices and to ensure smooth work processes between professionals. Therefore, while each professional group has their own manager, a common front-line manager supervises daily work and care processes.

Bringing different health professionals under same roof enables the provision of timely services and allows clients to be directed straight to the right professional, without the need for formal referrals, resulting in shortened waiting times for patients. In practical terms, working in the same facilities allows professionals with different backgrounds and training to get to know each other's working practices and ways of thinking. In addition, consulting other professionals is easier when you know them and they happen to be next door. Moreover, integrating social work into the centres gives patients better access to social services.

## TESOMA WELLBEING CENTRE

The third integrated-care initiative described in this article is the Tesoma Wellbeing Centre. Tesoma is a district in Tampere, which is an inland city with approximately 230 000 inhabitants; Tesoma lies about eight kilometres to the southwest of the city centre, with approximately 20 000 inhabitants. On average, social problems are more prevalent in Tesoma than in the other districts in Tampere.

The Tesoma Wellbeing Centre is an example of a new kind of a welfare centre model which is based on a partnership between public-sector, private-sector and third-sector actors, to provide and integrate health, social and welfare services in a joint organization (21, 22). The centre was developed through an innovative, outcome-based public procurement process in 2015–2017. During the process, rather than there being a pre-existing definition of the way the centre's services would be produced, the outcomes and effects of the centre were co-defined by the different actors involved in the procurement process. The concept of the centre was co-designed in partnership with Tampere, private companies and third-sector

organizations in a participatory process which included also the inhabitants of the Tesoma district, and health and social welfare professionals from Tampere. The competitive tendering for the alliance was then carried out according to the negotiated procedure with the participating private providers.

An alliance agreement for providing the centre's services was made between one of the participating private providers and the City of Tampere. The alliance has a common contract, common goals and a common organization, as well as a shared budget and common earning logic. The partners share the risks, profits and losses that are expected to drive intensive integration, collaboration and continuous development. The activities of the alliance are based on person-centred service, confidence, effective performance and continuous improvement. For the private provider, the alliance has an incentive system with bonuses and sanctions. For example, according to the alliance contract, when the costs of the alliance are under the budget criteria, the share of the private partner is 47% of the savings. When the cost criteria are exceeded, the private partner must pay 50% of the overspend.

All of the services provided by the centre are considered to be public services provided by Tampere, but the alliance is jointly accountable for integrating horizontally primary health care, social care and welfare services within the centre. The centre provides two types of services: (i) health and social care services and (ii) services to strengthen the community and facilitate interactions between its inhabitants. The City of Tampere is responsible for providing the centre's services for families and young people (such as maternity and child clinics, family social care, home care, dental care for children and young people), and guidance, advice and case-management services, as well as employment and library services. The private provider is responsible for primary health care and reception services, dental care for adults, and supported living services for the elderly and persons with disabilities. The third actor, a local nongovernmental organization, is responsible for the community coffee shop and other third-sector activities. The coffee shop is meant to be both the living room for the centre and a meeting point for the Tesoma community. In addition to providing information on health and social welfare services, the nongovernmental organization is responsible for planning and organizing events and theme activities supporting the community, as well as running peer-group meetings for local people with similar support needs. Thus, the centre constitutes a service network and interfaces with other health and social services of Tampere; in addition, professionals from centralized services provided by Tampere also operate at the

centre. Moreover, the centre attempts to provide a focal point for culture and leisure-time services in the district.

The alliance behind the centre aims to combine the services in a new way in which the boundaries of services, organizations and professions are dissolved for the benefit of the clients. The collaboration is based on multiprofessional teamwork operating in a framework in which the client is the centre around which the professionals move. The core services of the centre include low-threshold advice, guidance and case management. Early prevention, self-care and digital services are emphasized as key elements in the service concept. Clients are segmented according to the need profiles: children, young people and families, working-age adults and the elderly. Under these main segments, client profiles have been defined by means of service design for developing the services.

The success of the alliance will be evaluated on the basis of outcomes and effectiveness. The goals for effectiveness defined for the services are, for example, increased health, decreased dental diseases, decreased sickness among children and young people, increased interaction between the inhabitants, decreased unemployment and increased skills in searching for and utilizing information. The outcomes defined for the centre are, for example, cost-effective running of services, renewing and developing practices, remaining under the predefined budget limits during the 10-year contract, continuous and open development of services, high user satisfaction with the services of the centre, and increasing the number of users during the contract period.

Although the Tesoma Wellbeing Centre opened in April 2018, its performance and outcomes have not yet been evaluated. However, the key question from the point of view of the centre's clients is how their care can best be integrated to ensure seamless and timely services within the centre and across other public services.

## DISCUSSION

In general, the Finnish health care system fares well in international comparisons and usually is rated high in terms of quality and efficiency. However, fragmentation of the health care system has undermined the performance of primary health care, at least in some regions (13). In addition, unfavourable demographic and economic trends due to the ageing population and rural–urban migration, with many rural municipalities withering, have challenged the capacity

of the public health and social services. In Finland, there is a wide consensus on the need for health and social care reform which would consolidate the fragmented administrative and financial structure of health and social care and create larger authorities to organize the services. In addition to this financial and administrative integration, an integrated-care approach is seen as a possible way to address the increasing and changing demands on the health and social care system.

Administrative and financial consolidation and integrated care also form the starting-point in the government's reform proposal, which is currently being debated in the Finnish parliament (16). If the government bills on reform legislation are accepted in the parliament, the legal responsibility for organizing social and health care would be transferred from the municipalities to 18 new counties. In line with the Eksote and Siun sote pilots, the new administrative structure would support health and social care organizations to implement novel integrated-care models. However, the government's proposal also includes features which may be controversial in terms of improved integration of services. These are related to proposals for the introduction of a market-based provider-choice model for primary and elderly care provision, where public and private providers would operate and provide services on equal terms. Depending on the extent to which these proposals are implemented, the reform may, in fact, impede the possibility of counties introducing services based on integrated-care principles. However, as the government's proposal, particularly the parts leading to the privatization of health and social services, has been criticized heavily, it is unclear whether it will pass the parliament or even be voted on.

In the examples we present here of integrated care, the two regional-scale joint authorities responsible for health and social services, Eksote and Siun Sote, operate much like the proposed counties would. These examples show that, if decision-making and management of the whole service structure are coordinated, it is possible to change the current organization-based service provision to enable seamless service chains. The walls between social services and health care, as well as between primary care and specialized care, can thus be torn down.

On the other hand, organizations are not the only key to new service models. It is possible to build integrated services over the organizational barriers. Bringing services under same roof may help in this process, but working together requires planned procedures and coordination of daily work. It also requires learning about each other's work and getting to know professionals individually.

The alliance model provided by the Tesoma Wellbeing Centre has been piloted as a way to provide health and social care via collaboration by multiple service providers from both public and private sectors. Many national and local experts considered the Tesoma model promising and potentially modifiable for the proposed new Finnish social and health care system. Its core idea of alliance is straightforward and easily adaptable to the different local contexts present in Finland. Broadly similar centres with multiple service providers have been developed elsewhere in Finland but, unlike the Tesoma Wellbeing Centre, these are not based on an alliance model.

In conclusion, the integrated-care pilots implemented in Finland have been proven to be feasible, and many of the preliminary experiences from these pilots have been mainly positive for the health and social care providers as well as the clients. As the utilization of health and social care in Finland is strongly skewed – 10% of the population incurs 80% of the service use and costs – is it essential to provide health care services which are able to respond to patients' complex needs of care both effectively and efficiently.

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## REFERENCES<sup>4</sup>

1. Vuorenkoski L, author, Mladovsky P, Mossialos E, editors. Finland: health system review. *Health Syst Transit* 2008;10:1–168.
2. GBD 2016 Healthcare Access and Quality Collaborators. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. *Lancet* 2018;391:2236–71. doi: 10.1016/S0140-6736(18)30994-2.
3. Ministry of Social Affairs and Health. Sosiaali- ja terveydenhuollon järjestämistä, kehittämistä ja valvontaa koskevan lainsäädännön uudistaminen. Peruslinjauksia valmistelevan työryhmän loppuraportti [Reforming the legislation on organising, developing and supervising health and social care. The final report of the working group preparing the principles]. Reports and Memorandums of the Ministry of Social Affairs and Health 2011:7. Helsinki: Ministry of Social Affairs and Health; 2011 (<https://stm.fi/documents/1271139/10139132/Yleisperustelut.pdf/4a8b42ec-289b-4a22-b1bd-147122b18a9e/Yleisperustelut.pdf.pdf>).
4. OECD/European Observatory on Health Systems and Policies. Finland: Country Health Profile 2017. State of Health in the EU. Paris: OECD Publishing/Brussels: European Observatory on Health Systems and Policies; 2017.
5. Saltman BR, Teperi J. Health reform in Finland: current proposals and unresolved challenges. *Health Econ Policy Law* 2016;11: 303–19. doi: 10.1017/S1744133116000013.
6. Vuorenkoski L. Restructuring municipalities and municipal health services in Finland. *Eurohealth* 2007;13:8–10.
7. Raivio R, Jääskeläinen J, Holmberg-Mattila D, Mattila KJ. Decreasing trends in patient satisfaction, accessibility and continuity of care in Finnish primary health care: a 14-year follow-up questionnaire study. *BMC Fam Pract* 2014;15:98. doi:10.1186/1471-2296-15-98.
8. Liberati EG, Gorli M, Scaratti G. Invisible walls within multidisciplinary teams: Disciplinary boundaries and their effects on integrated care. *Soc Sci Med* 2016;150:31–9. doi: 10.1016/j.socscimed.2015.12.002.
9. Maslin-Prothero SE, Bennion AE. Integrated team working: a literature review. *Int J Integr Care* 2010;10:e043.
10. Couffinhal A, Cylus J, Elovainio R, Figueras J, Jeurissen P, McKee M et al. International expert panel pre-review of health and social care reform in Finland. Reports and Memorandums of the Ministry of Social Affairs and Health 2016:66. Helsinki: Ministry of Social Affairs and Health; 2016 ([https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/79070/RAP\\_2016\\_66.pdf?sequence=1&isAllowed=y](https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/79070/RAP_2016_66.pdf?sequence=1&isAllowed=y)).
11. Sinervo T, Tynkkynen L-K, Vehko T. Mitä kuuluu perusterveydenhuolto? Valinnanvapaus ja integraatio palveluiden kehittämisen polttopisteessä [How are you, Finnish health centre? Freedom of choice and care integration as central targets of development]. Report 16/2016. Helsinki: National Institute for Health and Welfare; 2016.
12. Jolanki O, Tynkkynen L-K, Sinervo T. Professionals' views on integrated care. *J Integr Care* 2017;25:247–55. <https://doi.org/10.1108/JICA-06-2017-0018>.
13. Kokko S. Towards fragmentation of general practice and primary healthcare in Finland? *Scand J Prim Health Care* 2007;25:131–2. doi: 10.1080/02813430701576482.

<sup>4</sup> All references were accessed on 8 December 2018.



14. Kokko S. Integrated primary health care: Finnish solutions and experiences. *Int J Integr Care* 2009;9:e86.
15. Tynkkynen L-K, Alexandersen N, Kaarboe O, Anell A, Lehto J, Vrangbaek K. Development of voluntary private health insurance in Nordic countries: an exploratory study on country-specific contextual factors. *Health Policy* 2018;122:485–92. doi: 10.1016/j.healthpol.2018.03.008.
16. Tynkkynen L-K, Keskimäki I. Finland: Health Policy Updates: Health and social service reform draft goes back to the Parliament. In: *The Health Systems and Policy Monitor* [website]. Brussels: European Observatory on Health Systems and Policies; 2017 (<https://www.hspm.org/countries/finland21082013/countrypage.aspx>).
17. Keskimäki I, Heponiemi T, Sinervo T. Striving for integrated care and efficiency in Finland: country-wide and local skill-mix innovations. In: Glinos I, Sagan A, Wismar M, eds. *Skill-mix innovations in primary and chronic care: mobilising patients, peers, professionals*. Observatory Studies Series. Brussels: European Observatory on Health Systems and Policies (in press).
18. COPE. COPE: Competent workforce for the future [website]. Helsinki: COPE; 2018 (<https://www.stncope.fi>).
19. Miettinen V. Lasten ja nuorten talo näyttää suuntaa [Children's and young people's house shows the direction]. *Kuntalehti* 2017;25: 46–9.
20. Sotkanet.fi: statistical information on welfare and health in Finland. Helsinki: National Institute for Health and Welfare; 2018 (<https://sotkanet.fi/sotkanet/en/index>).
21. City of Tampere. Tesoman Hyvinvointikeskuksen palvelut: allianssikumppanusmalli. [Service of the Tesoma Wellbeing Centre: an alliance partnership model]. Tampere: Tampereen kaupunki; 2016 (<https://www.innokyla.fi/documents/1906667/e12810ec-5055-44bb-b8e7-9fda3b9bc428>).
22. City of Tampere. Tesoman hyvinvointikeskus [Tesoma Wellbeing Centre]. In City of Tampere [website]. Tampere: Tampereen kaupunki; 2018 (<https://www.tampere.fi/tampereen-kaupunki/yhteystiedot-ja-asiointi/alueelliset-palvelut/tesoman-hyvinvointikeskus.html>). ■