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EDITORIAL

Towards fragmentation of general practice and primary healthcare in Finland?

Studying national solutions and arrangements for primary healthcare in Europe shows that general practice comes in packages of various shapes and sizes. Task profiles of the various professionals vary. At one end of the scale there is still the single-handed doctor and at the other a health centre with a wide range of duties and a large number of employees.

Finland is known to be one of the few countries in the world with a health centre as the fundamental structure of public primary healthcare. Health centres were established in the 1970s under strict steering of the government. Although the picture of health centres around the end of the establishment period of the 1970–1980s became colourful, there were – and still are – certain uniform features in the composition and operation of the centres. Every health centre is by law expected to provide services specified by a list of 14 items, ranging from health promotion to more narrow obligations of providing specific services to listed target populations.

A look to the future only a few years ahead will give a forecast of changes. Some changes are clearly planned and part of the national policy of restructuring municipal services. Some are unplanned but results of innovative initiatives, whilst some unintended changes occur due to sharp decreases in the interest of young professionals in going into primary care, especially in rural and remote areas.

Roots of the changes date back to earlier years. By the end of the 1990s about 40% of the local municipalities had merged social services with primary healthcare, first administratively, then also at the functional level. Soon there were about 10 to15 mergers of local or small specialist level hospitals with primary healthcare. These somewhat unexpected "marriages" led to colourful developments ranging from national success stories to sour battles over survival and resources. Now the government is implementing a restructuring policy, which is actually a compromise arising from disagreement on how to merge local municipalities. The tasks and structures of the health centres will be reformatted to cater for populations of 20 000 inhabitants as a minimum. This does not mean the introduction of a longer journey to see the doctor or the nurse. Local services will be held as priorities. A Finnish version of the Swedish word "närservice" (service nearby) has become popular among local politicians. Services should remain as near as possible, but the overall operation should be based on units larger than now. This could also be expressed as a reduction in the number of independent health centres from around 250 to about 60. Experiences from the preparatory phase during 2006–2007 show that the whole process will be difficult. The aim is to rationalize the service network, to make savings and also to ensure reasonable access and quality to all Finns irrespective of place of residence.

As to the unplanned changes, there was a planned reduction in the intake of students to medical and dental schools in the 1990s. There has also been planned expansion in the capacity for and recruitment of medical manpower in the specialist hospitals. The actual number of medical doctors working in primary healthcare has decreased only slightly, but many young doctors are behaving in a non-committal way. Instead of entering long-term full-time employment, working for workforce temp agencies and working part time have grown in popularity. This has led to polarizations: the older and experienced GPs are having increasingly heavy workloads. Many have left the public sector due to experiences of exhaustion and frustration. The work settings and climates for the young trainees are not attractive enough or, at least, too few see a career in general practice.

One of the paradoxes is in the pattern of what is transferred to the GPs or what the GPs are expected to do more of or better than now. A mixture of voices expressing demand and criticism is heard. One common denominator is the challenging of *generalism* in general practice. This criticism, usually well known to emanate from the spokesmen of specialized medicine, is now coming from positions nearer to primary care. GPs are criticized for not being interested in prevention and health promotion and thus not acquiring the necessary skills. Similarly, GPs who in a country like Finland deal very much with elderly patients, and are shown to provide poor care and inappropriate medications to geriatric

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patients. Many specialties would like to see mini-specialties established – formally or informally – among GPs, for example for children, for diabetics, or for psychiatric problems such as depression.

Some larger cities have grown tired of the problems of recruitment. About 10 cities and at least a similar number of small municipalities have contracted out parts of their primary care either as comprehensive transfers of all duties or as fragments of duties. The new actors come from the same background as the workforce temp agencies, which earlier mediated for young doctors for out-of-hours work or locum positions. Some cities have moved into a new lifespan-based structure for their social and health services. There can now be administrative units for services for children or for families with children, as well as for the elderly. General practitioners stay somewhere in the middle ground, but might end up seeing new types of specialists or "mini-specialists" step in at the two ends of the lifespan. The private sector has already offered walk-in-clinic-type services for decades, but those could become part of the municipal services too. There are strong pressures to release the lock between services based on residence around the largest cities.

What will happen to the general practice known to offer continuity, comprehensive services, and coordinated care as its special strengths? Perhaps there will be no immediate dramatic changes. The segments of the population expecting and demanding a breakaway from the earlier structures are currently already free shoppers for services. However, the next wave or age cohort could make a difference, which could even harm primary care and general practice.

The GPs are puzzled and tired of having been subject to changes and promises. The latest policy demand has been to enable both the patient to choose the doctor and the doctor to determine the size and perhaps composition of the list. There would be adjustment problems and friction if a totally new model was introduced on top of all the frequent changes. Building on choice would still be valuable for the best features and properties of true general practice.

The vision of increasing fragmentation raises concerns. Similar concerns were expressed at the recent 15th Nordic Congress of General Practice in Iceland over British developments during the 2000s. A growing proportion of GPs are now working under the new umbrella of Personal Medical Services, as against General Medical Services, which has been the traditional practice framework and contractual basis. Currently, one of the problems in Finland seems to be that many actors and stakeholders outside general practice are defining what primary medical care should be. Should this be interpreted as a weakness of our Finnish professional body of general practitioners? Should the GPs and their organizations go deeper into the essence or the specialty and find strength and common vision from there? Or should we go along with the voices that point to times changing?

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