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Ideas of the Finnish Medical Association about marketization in the health care system

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Abstract

This article shall analyze the ideas represented by the Finnish Medical Association concerning marketization in the public health care system between the years 1970–2007. The main data consists of the documents. Data analysis aims to search for continuities by means of content analysis. The results are presented in two parts: 1) the 1970s and 1980s are described as the golden era of the public health care system and 2) the 1990s and 2000s as the period of the growth of marketization. The results suggest that the Finnish Medical Association has consistently advocated the importance of the private sector alongside the public sector. The means for achieving this goal is raising the levels of health insurance compensation, designing a more effective payroll system, emphasizing local solutions in service production and using different purchaser-provider models. The weight given to the different ideas by the Association has varied depending on the institutional situation in the welfare state. After the early 1990s, the Association's ideas became more concrete. Rather than promoting its own interests, the Association has made a strong reference in its argumentation to the "common good". However, the ideas are not in fact radical. The reason is that the welfare state institutions have created a system where the Association itself holds strong interests.

Keywords

Finland, physician, public health care system, ideas, institutions, interests, marketization

Introduction

Since the 1980s, health care systems in the developed world have faced economic concerns due to various factors, such as the ageing populations. In addition to structural problems, the demands for reform have been underpinned by altered mental models. Likewise, the ideas presented by different actors for developing

the system have changed. This change is manifested in the suggestion that health care efficiency, quality and freedom of choice should be promoted with the help of the market. A transformation of public services towards more market-based is one part of the new public management reforms (e.g. Berg 2006).

Traditionally, the public sector has been the most important producer of health care services in the Nordic countries. Still, the demand for marketization of the public service sector has also been justified in these parts of Northern Europe. Within the five Nordic countries, the marketization reform of the public health services has been implemented at different stages (van de Ven, 1996). Sweden, for example, has been a leading reformer. The marketization of the health care system began in the 1980s (Andersen et al., 2001).

Finland, however, has followed some years behind. Here, the marketization of the health care system began more visibly in the 1990s. Much of the ideas concerning marketization have been related in decentralization. The reform in Finland has emphasized the role of local solutions and incentives in terms of both service production and employment. Also, user charges have been the method for the marketization. However, the purchaser-provider models are still relatively rarely used in Finland. Instead of implementing new systems, the Finnish markets seem often to merely patch up problems arising in the public production. In general, the private sector has been employed when other alternatives have been exhausted. For example, private companies have produced services for some public health centres due to employee shortage in the public sector (Häkkinen, 2005). In other words, old structures are still dominating. Marketization has been strongest at the level of ideas even though the role of the private sector has become more central during the ten last years within public health service (see Stakes, 2007).

Various interest groups institutionalized within the welfare state have been thought to maintain the structure of the system (Pierson, 2001). An important interest group in terms of public health care are the professional physicians' organizations. Physicians are traditional and recognised occupational group (Freidson, 1970). They also have much power in different political issues concerning welfare state. This is the reason that why they can reproduce the welfare state system by manipulating public opinion. Physicians are also the leading occupational group in the health care.

This article shall analyze the ideas represented by the Finnish Medical Association (FMA) concerning marketization in the public health care system between the years 1970–2007. Numerous studies focusing on the construction of health care systems have shown contention in the interrelations of physicians and the welfare state (Immergut, 1992). In the earlier studies, it has been suggested that in this context, the most essential feature of the profession of physicians is the aim to retain autonomy in relation to the public sector (Immergut, 1992). Autonomy comprises several dimensions, but this article is concerned solely with the economic dimension of autonomy. Here, economic autonomy is essentially

related to the degree of control that the trade union has, regarding economic factors which are related to its members' work (Tousijn, 2002). Promoting economic interests is best realized when the provider has a leading position on the market and may thus set the price for the service.

The most interesting case for "physician study" has traditionally been the U.S. health care system (see Brown and Eagan, 2004). Studies which have focused on the aforementioned relationship usually come from countries where the health care system based on insurance. The reason why Finland is so interesting and unique case is that the health care system is mainly tax-funded but it also includes a national health insurance system (see Häkkinen, 2005). This also means that the institutional context of the interrelationships between physicians and marketization is unique. Finnish physicians are highly organized; the union encompasses 95 per cent of all physicians (FMA, 2006). An important lobby method of the union is to render the statements of the boards and committees to state authorities (FMA, 2005b, p. 32–36). Furthermore, the union has actively organized seminars on the theme of public health service for different interest groups (FMA, 1987; 1994; 1998; 2002; 2007b).

Ideas and institutions

According to recent studies, the profession of physicians has been seen as a monopoly which operates primarily to promote its own interests (Hafferty and Light, 1995, p. 135). It is clear that explaining the physician's profession through the interests is a simplification. However, it is fruitful to examine the Medical Association on the macro level with the help of interests because in the Medical Association the actors have joined together to promote their interests.

Essentially, institutions are created by various actors engaged in a political struggle (Immergut, 1992). The ideas and the actors' interests have been formed through establishing institutions (Campbell, 1998). The main theoretical starting point of this article is that there are always formal and informal institutions behind ideas. Institutions, then, include both formal and informal establishments. Whereas the health insurance system is an example of a formal institution, the Nordic welfare culture and the related normative values, such as the equality demand, are examples of informal institutions (Pfau-Effinger, 2005). This article discusses both types of institutions. Basically, idea types can be divided into four categories: ideas as paradigms, ideas as frames, ideas as general ideas and ideas as programmes (Campbell, 1998). In this article, ideas are understood primarily as programmes.

Welfare state institutions may generate path dependence, which basically means that the solutions of the past strongly affect current decisions (Mahoney, 2000). An external change, such as an economic depression, can serve as a break in the path. This means that the interest groups see and seize the opportunity to

push through their ideas more strongly than before in a political system. (Torfing, 2001, p. 288–291.)

The public discussion is a struggle wherein the power resources of an actor are even more important than the content of ideas (Chard, 2004; Béland, 2005). The strength of the medical profession is that it has both technical skills regarding health care and related political expertise (Filc, 2006, p. 273). During the era of recalibrating welfare states, the interrelation of physicians and health policy has not been examined in a country with a wide public sector such as Finland.

The Finnish health care system in international comparison

The health care systems of developed countries can roughly be divided into two types: an insurance-funded model and a tax-funded national health service model. In the insurance-funded model, the private producers traditionally have a more significant position than in the tax-funded model. In a tax financed model, the costs of the services are covered mostly by taxes, as in the Nordic countries. (Freeman, 1999; van de Ven, 1996.)

There are much similarities between Nordic countries when we look at the historical role of medical profession, for example a majority of the physicians have been public employees (Riska, 1993). Many studies present an argument that marketization challenges the medical profession (see Tousijn, 2002). Due to the differing health care systems, health care marketization is manifested in different ways within the medical profession. This is an aspect ignored by most studies. The profession has been strongly regulated in countries with a wide public service sector, and therefore marketization can supposedly provide the doctors an opportunity to regain some autonomy. Controversially, in liberal countries, the increase in competition may lead to tightened terms of agreement and therefore weaken the autonomy of the medical profession (Filc, 2006; Tousijn, 2002).

Despite the fact that physicians in Finland have been employed by the public sector since the 1800's, the interrelation of medical doctors and municipalities was finally cemented with the 1964 national health insurance system. In 1972, Finland implemented a new primary health care Act. The new Act focused on reforming the administration, finance and design systems. The new reforms were organized in the municipal health care centres. (Häkkinen and Lehto, 2005.) Since the reforms of 1972, physicians were transformed into tightly controlled civil servants for primary health care.

One special feature of Finnish health care is the use of services acquired from the private sector with the help of the compulsory health insurance system. The national health insurance reimbursements do not affect the amount of the state subsidies of the municipalities (Järvelin, 2002, p. 31). In this sense, Finland is an interesting mixture of two models (Häkkinen and Lehto, 2005). The national health insurance scheme is run by the Social Insurance Institution. Fees for private physicians are reimbursed by the NHI up to 60 per cent of the established basic

tariff. (Järvelin, 2002, p. 35.) From the point of view of medical doctors, this means that they often work part-time in the private sector in addition to their public full-time job. In 2006, as much as 22.5 per cent of physicians worked full-time in the private sector. At the same time, 30 per cent of all physicians worked part-time in private establishments. (FMA, 2006.)

Service organization has been divided into 20 hospital districts which are responsible for specialized health care. It should be noted that the districts are administrative federations of the municipalities. Over 200 municipal health centres are responsible for primary health care. Health care centres are owned by municipalities or joint municipal boards. The average size of the population cluster for which public health services are thus organized and financed is small internationally, even compared to other Nordic countries (Häkkinen, 2005; Häkkinen and Lehto, 2005; OECD, 2005). The state subsidies that go to municipal health care services are intended to ensure equality between different regions (Rissanen and Häkkinen, 1999).

Research design

The ideas of physician association's towards public health care system marketization have been not studied in countries with large social security systems. It is important to study physicians' ideas because system will be structured on them. The study questions are:

1) what kind of ideas the Finnish Medical Association has fostered regarding the marketization of the public health care system?
2) how and why the Medical Association has become institutionalized as a part of the Finnish public health care system.

The time period for the article is 1970–2007. The reason for choosing this particular period is that in the year 1972, a new law concerning health care centres came into force. At the same time, the health care system adopted the universalistic principle, as primary health care became free of charge.

Data is gathered from a) the issues of the Finnish Medical Journal, b) the internet site of the Finnish Medical Association and c) the archive of the Finnish Medical Association. The main data consists of the public statements of the Medical Association. Other documents, such as proceedings of the association's executive committee, are also analyzed. Data analysis aims to search for continuities by means of content analysis (Mahoney, 2000). In this article we don't analyse the political process that how different sub-groups of the Finnish Medical Association (example private vs. public sector physicians) conclude to shared statements. The point is to analyze documents – not the political battle how those statements have made.

The results are presented in two parts: The golden era of public services (1970s-1980s) and the period of the growing marketization (1990s-2007). The justification for this division is that during the 1990s the Finnish public health care system came under mounting pressure in the public discussion with increasing calls for a greater role of market forces.

The golden era of the public health care system

During the golden era of the public health care system, the Finnish Medical Association methodically emphasized the significance of the private sector (FMA, 1971; 1971a; 1975; 1978; 1978a; 1980; 1982; 1985; 1987a). It was believed that the private sector was more suitable for producing some of the health services than the public sector (FMA, 1982). Between 1970 and 1990, the association attempted to improve the position of the private sector in three essential ways: by increasing health insurance compensation payments, by increasing decentralization and by creating more effective payroll systems.

Enhancing the role of the private sector through raising national health insurance compensation levels

In order to expand the private sector, the union suggested raising the compensation levels for national health insurance (FMA, 1975a; 1981; 1989; 1991; 2001a; 2002e; 2004b; 2005; 2007). The Ministry of Social Affairs and Health decides the amount of the basic tariff. The fees for doctor's appointments exceed the basic tariff. Thus, the compensation is in practice much lower than the original fixed percentage. (Häkkinen, 2005.) Compensation charges had fallen due to inflation (FMA, 1987a; 1989a).

On the other hand, through demanding raised health insurance tariff levels, the Medical Association resisted the politics which sought to remove user charges in primary health care centres (FMA, 1987b). The reason for this resistance was that seemingly free service could increase the unnecessary use of resources. Therefore, one might promote the efficient use of services with the help of payments (FMA, 1983). Behind this thought was also the assumption that this situation would be followed by the growing importance of the private sector. Raising health insurance compensation while receiving health care centre fees would bring the real prices of the public and private sector closer to one another.

Emphasizing a less centralised health care system

As early as in the 1970s, the Finnish Medical Association pointed out that the production of services should emphasize the opportunities taking local conditions into consideration (FMA, 1976). Transferring decision-making power to the municipalities instead of a central government would enable improved local

solutions. In the 1980s, it was also noticed that in the basically well operating and carefully built health care system there were certain problems, such as the constant growth of demand for primary health care services (Tsupari and Lappi, 1987, p. 23). The idea of decentralizing the administration and simultaneously expanding the role of the private sector was carefully brought forward as an answer to these problems.

Designing the adjustment of the state subsidy act was commenced at the end of the 1970s. It was possible to detect attempts to increase the decisive power of the municipalities and the role of the private sector. A law regarding the planning and state subsidy of social welfare and public health service was connected to the reform. It may be considered in a local government as the first law which refers to marketization. So the features which the union had promoted were connected to the reform (FMA, 1978). On the other hand it was a question of only a careful aim for giving more responsibility to the private sector. The union suggested how certain limitations in the outsourcing services of the municipalities might be removed (FMA, 1982; 1982a).

The following significant step towards a less centralized system was “the free municipality trial” which was started in 1989. The purpose of this was to reduce norms in the chosen experiment municipalities. The association reacted positively to the experiments and considered the fact that the self-government of municipalities was strengthened as a step in the right direction. On the other hand, it emphasized that in connection with “the free municipality trials” attention should also be drawn to the production of services. (FMA, 1987b.)

Designing a more effective payroll system

The aim of the Finnish Medical Association as the representative of a strong profession has been to reach local agreements. Local payroll agreements have been seen as having an efficiency-generating effect throughout service production. (FMA, 1987b.) The Medical Association has underlined the significance of the new payroll system possibilities since the 1970s (FMA, 1980; 1989b; 1990b; 1998a). The physicians suffered from a decrease in their income in the 1970s following the era’s solidary income policy. Dissatisfaction regarding this policy led to a physicians’ strike in 1984. Consequently, an experiment involving a more attractive payroll system was begun within the public sector in the public primary health care in many municipalities (Häkkinen, 2005). In the new family doctor system, the basic salary was only one part of the total salary. Altogether one significant background factor for the new payroll system was increasing the effectiveness of service production (FMA, 2000b; 2003).

Later in the end of the 1990s the system was developed more towards so-called population responsibility. In this system the physicians are responsible for the health care of a geographically specified area. Only part of the Finnish general practitioners are in this system. (Järvelin, 2002, p. 77.) This turn of events took

place partly on account of the association that initially drew attention to the incentive payroll systems. Later, the union took up the significance of the new payroll system also in hospitals (FMA, 1997c).

Growing marketization

In the 1980s, certain preparations were made for a public sector reform (Häkkinen and Lehto, 2005). However, it was a only a question of fine tuning. During the early 1990s, the health care system experienced mounting pressures regarding its involvement in the market. Actually, now it had become a widespread belief that the efficiency in health care services delivery is enhanced by delegating responsibility to local level. This would also be a good incentive for municipalities to create market based solutions in health care provision.

The most essential reform was the State Subsidy System act of 1993. In the same year, Finland was faced with the reality of an exceptionally deep economic recession. The reform was significant because it included the decentralization of the central administration control system. In the new system, state subsidies are not even earmarked. The key issue of the reform was that on top of increasing local freedom in service production, it also increased deregulation and improved efficiency (Järvelin, 2002, p. 14–15). This was "a big bang" in the quite socialized health care system. The Finnish Medical Association considered the developing of the State Subsidy System act as a good deal for them. The reform increased the independent decision power of the municipalities in the service production. (FMA, 1989c; 1990; 1992; 1992c.)

The reform was a beginning for implementing the politics which the Finnish Medical Association had been advocating since the 1970s (FMA, 1978a; 1992a). The state subsidy reform together with the depression served as the break needed for changing the ideas of the health care system. The municipalities were given a new freedom to purchase services from private providers (Järvelin, 2002, p. 24). At the same time, the ideas of the association became even more concrete and more courageous. It was no more enough for the association that the municipalities were given the freedom to use private service producers in the public health service (FMA, 1996a). Now the physicians began to present how the size of the organizer of services, in other words of the main financier, should be increased.

Declining public health expenditures

With the economic depression, other changes also took place in the public health care service system. In the legislation, the municipalities were given the right to implement user charges in the primary health care centres (Committee report, 1993). The doctors supported the introduction of charges (FMA, 1992a). The explanation for this was old: totally free health care can increase the unnecessary

use of resources (FMA, 1991a; 1992c; 2005b). At the time when the payments were brought into use, the association already introduced the idea of later considering the raising of customer payments (FMA, 2003).

During and after the depression, the patients' portions of payment have considerably increased (Häkkinen, 2005). A conservative estimate can be made that in the beginning of the 1990s, the universalistic model of the public health service weakened significantly in Finland. Actually, the health care system became a little bit more regressive (Häkkinen, 2005). There were inequities in health care in Finland already in the 1980s. However, the changes in the early 1990s have meant that the health care expenditures have been relatively higher for the persons with low income, who are also sick more often than the average population (Keskimäki et al, 2002, p. 284–285).

Because of the economic depression, the economic resources of the public health services at the municipality level weakened and the number of the public outsourcing services decreased (Häkkinen, 2005). The association stated that the country had evaded its responsibility by reducing the financing of the municipalities (FMA, 1993). The option of intensifying the public services from the inside had been exhausted because it had lead to the "burn-out" of workers of the public sector (FMA, 1995a). In addition to the internal intensifying, the effects should be investigated with help from the private sector.

Purchaser and provider should be separated

The economic depression served as a trigger for change in the welfare culture, in which marketization was the new slogan. This change of mental models appeared to be positive from the physicians' point of view (FMA, 1990a; 1993a). The Medical Association began to present increasingly concrete ideas in a new institutional environment. Emphasizing the significance of the quasi markets was the "new big thing".

The new concrete ideas of the Medical Association were published in 1992 under the title "Basic security and freedom of choice in the public health service" and in 1993 publication entitled "Financing and services". As a theoretical base of its new sharpened role, the association formed "The theses of the public health service" in 1995. The paper emphasizes citizens' equal possibilities, freedom of choice, quality, the purchaser's and the provider's differentiation and the significance of the user charges (FMA, 1995). After this concrete step was a proposal from 1995, establishing "The operation and financing of the public health service" team which left its report at the beginning of the year 1997 (FMA, 1997; 1997a).

The promotion of the new concrete financing model continued: "The developing of the financing of the public health service and promotion" was presented in 1999. In this model, financing and of the last resort arranging of services would be organized by the regional combinations of several

municipalities. The public health care units of the area would be accountable units equal with private producers. The customers would pay part of the fee themselves and they would get the rest as a voucher. This model would be better for guaranteeing freedom of choice, effectiveness and quality. (FMA, 1999a.) These principles were emphasized also in "the 10 steps to the better public health service" which was designed for the local elections of 2000 (FMA, 2002e).

The system is fine-tuned but the construct of service production remains the same

Since the 1990s more and more attention was paid to the problems of the Finnish public health care service in the media. This fulfilled the wishes of the union. At the same time, an attempt was made to increase economic resources. "The National Project on Safeguarding the Future of Health Care Services" was made, which partly involved the system "access to services" (OECD, 2005, p. 73). The aim of this treatment guarantee system is to improve the availability of non-acute care within a reasonable timeframe. If the health care centre or hospital is not able to provide treatment in a certain timeframe, it must arrange the same treatment either in private sector or in another municipality. The union had already stated in the early 1990s how the position of the public health service should be strengthened with the help of the laws and the guarantee system. The justification entailed not only increasing equality but also improved effectiveness. (FMA, 1994; 1995; 1999.) However the Medical Association still though that the problem was that the structures have not further been changed in practice (FMA, 2002a; 2002c). The double role of the municipalities as a purchaser and a provider is still strong (FMA, 2000b; 2002a). Another problem is that Finnish health policy has not paid attention to patients' freedom of choice (FMA, 2002c; 2004; 2006b; 2006d; 2007a).

The significant public sector reform in Finland has been the so called "project to restructure municipalities and services" which started in the spring of 2005. The objective of the project is to restructure the municipalities and services financially and provide a structural basis for bigger units in the future. The Finnish Medical Association viewed this project very positively. According to the Medical Association, the problem in the reform is that it is not sufficient from the point of view of the stability of financing, because of a minimum population of 20000 inhabitants. From the point of view of the organizer of services, this population is still far too small for pooling risks. Also, the problem is that developing financing channels is not very innovative in the reform, which means that old structures are sustained. (FMA, 2005a; 2006a; 2006c.)

Altogether, the Finnish Medical Association's view on a central administration versus local autonomy has been somewhat conflicted. The Association wants more solutions which generally observe the local conditions. On the other hand, the Association wants more control of central administration in some areas because this guarantees the equality of citizens in health care (FMA,

2002b). The union balances within the significant dilemma of the Finnish welfare state: what is the suitable balance between geographical equity and local autonomy (see Kröger, 1997).

Conclusion

Since the period of the growth of the public sector, the Medical Association has suggested health political solutions that have spread the ideas of the expanding role of the private sector. A key point in the ideas put forward by the Association is that the health care system should be improved with a view to greater efficiency and people's freedom of choice. Among the means proposed by the Association for the achievement of this goal are raising levels of health insurance compensation, using different purchaser-provider models and the wider introduction of incentive-based wage schemes.

The weight given to the different ideas put forward by the Association has varied depending on the institutional situation of the Finnish welfare state. In the wake of recession in the early 1990s, marketization gathered momentum and the Association's ideas became more concrete. The Finnish Medical Association was indeed able to bring out its ideas better than before because of the change of formal and especially informal institutions. Since the 1990s, more and more attention has been paid to the private sector (FMA, 1998a). Furthermore, the slides in the salaries have increased in the 2000's (Vänskä, 2006). This is just one part of the story. Traditionally patients do not have much choice in the Finnish health care system, either of hospital or physician (Järvelin, 2002, p. 85). Freedom of choice has not been especially taken into consideration (FMA, 2002a). Also, the compensation levels of the health insurance have remained low because the tariffs have not been raised after the year 1989 (FMA, 2005). Furthermore, the role of the private sector as the producer of public services has become more prominent, but purchaser-provider models are utilized to a small extent.

In the earlier studies it has been pointed out that the interference with the providers' prices has been seen as a threat to the professional autonomy (Immergut, 1992). This is the situation in Finland. The main focus of the Association's ideas about marketization are mainly on the demand side; they do not separately take a stance on the view that it also makes sense to regulate the provider's prices when an quasi market is being created (see FMA, 1996a; 2002b). The Association does not take a stand regarding the fact that in the private production of services, the providers market often dominates. Hence, we can argue that The Association wanted marketization as long as the provider's position was not too much threatened.

The minor interest in the provider's prices expresses economic interests behind the ideas. The Finnish Medical Association does not take seriously the problems caused by the two-tier finance system. The system in which the same doctor often acts in both public and the private sector does not create a

competition between the producers actively and causes inequality both regionally and between groups of people. The problem is also that public funding from the health insurance system does not affect the state subsidies given to municipalities (Rissanen and Häkkinen, 1999). The two-tier system will be an obstacle for the comprehensive developing of municipal services and encourages the transfer of the responsibility to the private sector from a public one to avoid costs (Häkkinen, 2005; Häkkinen and Lehto, 2005; OECD, 2005).

One's own interests can best be entitled by "washing away" these interests so that they appear to be invisible (Béland, 2005). The Finnish Medical Association has also used this strategy. Rather than advocating its own interests, The Association makes strong reference in its argumentation to the "common good". One example is provided by the Association's argument that the present funding structure is not conducive to equality because private health care is far more expensive and there is a real risk of polarization in the population (FMA, 1992b; 1996; 2002; 2002b; 2002c; 2005a). It is not noted, that when the providers market dominates, also the doctor's economic autonomy is better.

However, it is significant that Finnish Medical Association has also strongly supported the most essential basic feature of the Nordic health care model which is tax-based financing (FMA, 1996a). Welfare state institutions have accomplished a system where there are strong interests concerning The Association. That is the reason why the presented ideas are not very radical. The Finnish two-tier financing system has provided the opportunity for the doctors to be at the same time public sector wage earners and private practitioners in the market sector. If the doctors would be mostly market actors, the support for a universal health care system would also be weaker.

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