

## 2009 November report from Finland

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### **The Economy and the Health Care**

The economical recession and the growing number of unemployed people have strongly influenced the tax flow to the municipalities. Because these are responsible for organising health care to the inhabitants, the situation has led to diminished budgets in health centres. Year 2010 will be very tough for the primary care in the country.

At the same time several governmental programmes promote development in health care. The government forces small health centres to unite. Each health centre should serve a population of at least 20 000 inhabitants. This has caused turbulence in small health centres. GPs have left for this reason many well functioning centres that are too small to qualify for the new legislation. 8 % of the GP positions are now vacant.

It has become very popular for the young physicians to work in private companies, where they can dictate their own working conditions. The companies then hire physicians to health centres. The young physicians stay often a very short time in each centre, which again causes more turbulence.

### **Combining the resources of R&D units**

The ministry of health and welfare united the human resources of Stakes and National Public Health Institute from the beginning of 2009 to a new administrative unit, THL – the National Institute of Health and Welfare.

Rohto, which is a governmental programme that promotes rational use of medicine is under governance of THL since the beginning of 2009. The programme takes place in many health centres and involves now about one fourth of GPs in the country. Rohto uses the working method of workshops. They are of high quality and they promote process building. In 2009 Rohto has started a break through project (IHI method) with 15 health centres in developing the updating of medicine lists.

### **Patient Security and Harm Reduction**

The ministry of health and welfare started a new programme in 2009 on patient security and harm reduction. The programme is very much quality based. It has a strong support from the specialised care, which now seems to find its aspect in QI – adverse event reduction. Most of the cases concern mistakes in ordering and delivering medicines.

Nurses have been very active in this new programme. Time will show if the doctors use the possibilities of harm reduction in larger scale.

So far the programme has very limited connections to ambulatory care and there is a concern that this programme can put a side the positive development in chronic disease management and quality development in primary care.

### **Current Care Guidelines and Evidence Based Handbook**

96 national evidence based guidelines are available. An English summary of 63 of them can be read on [www.kaypahoito.fi](http://www.kaypahoito.fi).

Many of the guidelines have already been rewritten with the new evidence included. Maximum time before rewriting is three years. Implementation of the guidelines is the tough part of development. There is no organised way of doing that so far. Some research

is done on implementation, mainly on guidelines of hypertension. The Finnish Quality Network (FQN) is doing that so some part and Rohto to some part.

The evidence based hand book that is used in electronic form by most physicians in Finland is now been translated several other countries like Germany, Switzerland and Portugal.

### **Indicator development**

Several bodies have shown their interest to develop indicators. The Guideline office intends to develop indicators to follow up how the guidelines are implemented. At the same time there is a goal to get indicators to support process development on health centre and hospital level.

Rohto people have also started indicator development. Their first intention is to get indicators for good ordering praxis for prescriptions and maintenance of medicine lists for chronically ill.

THL has also shown interest for indicator development. Instead of having only national indicators for performance there is now a goal to get indicators for hospitals and health centres.

The Finnish Quality Networks have developed indicators mainly for primary care, but to some extend also to specialised care. The latest development work has been on dementia care indicators.

### **The Finnish Quality Networks**

There are four quality networks in function: the Quality Network of Prevention of Cardiovascular Diseases, the Quality Network of Reducing Risk Use of Alcohol, the Quality Network of Osteoporosis and Fracture Prevention Network and the Quality Network of Memory Dysfunction. Conmedic is running the networks. The networks have in total over 70 health centres joining. These cover more than 60 % of all GPs in Finland.

The activities of networks are yearly measurement of quality and intermediate outcomes, network meetings and campaigns for good care. Local quality meetings in health centres are organised 1-3 times a year. In these meetings the results are analysed, processes developed and quality thinking is taught. Health centres get the bench marking results from Conmedic in power point presentations which are easy to use in local quality meetings. The GPs at the health centres have also the possibility to get help from the quality facilitators, if they so wish. More information is available on [www.conmedic.fi](http://www.conmedic.fi).

The networks are developing material that is available for all members from the data ware house. The data ware house on the web site of Conmedic possess bench marked models of good clinical care, examples of good instructions for different working models and patient leaflets. Examples of quality indicators and bench marking analysis are easily available.

Conmedic has developed a web audit instrument for quality measurement. It is easy and fast to use and secures high quality of data collection in quality measurements.