Conclusions and recommendations of the National Audit Office

Centralization of health services - Implementation of division of work in specialized medical care and of joint emergency services

Amendments to the Health Care Act (1516/2016) as well as the Decree on Division of Work in Specialist Medical Care and the Centralising of Certain Tasks (582/2017) and the Decree on the Grounds for Urgent Care and the Requirements for 24-hour Services by Specialty (583/2017) applicable to them entered into force at the beginning of 2018. On the basis of these statutes, surgical procedures requiring general anaesthesia were no longer performed in small hospitals, certain surgical procedures were centralized to university hospitals, and the hospitals that must have either a unit providing extensive 24-hour services or a unit providing primary and specialized 24-hour health services in connection with their central hospitals were identified. The centralization and 24-hour service reforms were estimated to bring cost savings of EUR 350 million for the local government sector by 2020. Due to the wellbeing services county reform, the potential economic gains from the centralization of health services will benefit central government finances directly.

The audit examined the national and regional implementation of the centralization and 24-hour service reforms, achievement of the key objectives set for these reforms, and their consequences for different types of hospitals, units providing extensive 24-hour services and units providing 24-hour joint emergency services. The timing of the audit is appropriate as a government proposal on the reorganization of the hospital and 24-hour service network is currently under preparation.

Rigid regulation and decision-making based on agreements have slowed down the implementation of the centralization decree

Complex medical treatment set-ups cannot always be successfully steered by means of rigid regulation. Hospitals have interpreted steering based on procedure numbers differently regarding which procedures should be centralized and which should not. In some cases, physicians have questioned the workability of the statutes, which has contributed to slowing down the smooth implementation of the centralization decree. In addition, rigid regulation does not address adequately interdependencies between different specialities at the hospital level, hospitals' existing areas of expertise and effectiveness of treatment chains.

The implementation of the centralization decree has progressed to varying degrees in different areas. In particular, the special catchment areas' possibilities and capabilities to make decisions have been limited. A purely collaborative management model has not always worked smoothly. In the special catchment areas, no one has had the decision-making power, and different hospital districts

have striven to promote their own interests and maintain their existing functions. Agreements on the organization of specialized medical care have been nothing more than general cooperation documents, and their binding nature and impact on the division of labour between the areas has been realized to variable degrees.

Measures aiming for the centralization of specialized medical care are currently being taken in the wellbeing services counties and their collaborative areas. According to the audit findings, the collaborative areas are afflicted by the same decision-making power-related problems that hindered the development of activities in the special catchment areas.

Specific information on the achievement of objectives set for centralization is not available

When passing the legislative amendments related to the centralization of services, Parliament required that the operational and financial changes ensuing from health service centralization be closely monitored. The audit found that monitoring has not been carried out as originally intended. The available financial and statistical data have not provided sufficiently specific information at the level of tasks, procedures and operating units to enable focused monitoring. It has not been possible to tell the impacts of centralization from other factors affecting the operation and costs of specialized medical care.

A cross-administrative coordination group led by the Ministry of Social Affairs and Health was set up to monitor the implementation of the centralization and 24-hour service decrees, mainly based on the targets set for procedure numbers. In-depth information has not been obtained on how the centralization measures have affected uniform criteria for access to treatment in different regions or the costs of providing services, let alone the macroeconomic impacts of centralization. Neither has any information been available on how expertise or patient safety have developed. The impacts of centralization on the costs, quality and patient safety of services are also not known accurately at the regional level.

Providing primary and specialized 24-hour health services in the same unit has increased the costs of specialized medical care

As the 24-hour service reform was being prepared, no separate assessment was conducted of the reform's impacts on the operation of units providing primary and specialized 24-hour health services. The audit found that the reform has affected the operation of 24-hour joint emergency services and increased the costs of 24-hour services. The large range of examination and testing options available in units providing 24-hour emergency services are increasingly also used to diagnose primary healthcare level patients. Increased patient numbers have also made it necessary to hire more healthcare personnel for the 24-hour services. Additionally, providing primary and specialized 24-hour health services in a single unit has not made it easier to find on-call general medicine physicians, and resorting to agency physicians continues to be necessary to organize 24-hour primary healthcare services. In the future, more attention should be paid to the reform's impacts on authorities when drafting legislation on plans to provide

health and social services or primary healthcare and specialized medical care services in a single unit.

Problems with follow-up treatment cause congestion in primary and specialized 24-hour joint emergency services and increase the costs of specialized medical care

Problems associated with follow-up treatment are also reflected on primary and specialized 24-hour health services. Patients cannot be transferred to follow-up treatment, as sufficient places are not available. As a result, primary and specialized 24-hour health services treat patients who need care rather than treatment. On the other hand, some patients in primary and specialized 24-hour services are waiting for a bed in the hospital's inpatient wards, as patients cannot be transferred from the wards to follow-up care. Consequently, primary and specialized 24-hour health services also treat patients who require hospitalization. In the worst case, patients in 24-hour services may have to wait several days for access to follow-up treatment.

The wellbeing services counties are now seeking savings by such means as closing down health centres or reducing their activities, centralising 24-hour services, reducing the number of 24-hour care places for older persons, and imposing stricter criteria for access to assisted living and home care. This may mean that more patients will end up in the 24-hour joint emergency services, pushing up the costs of specialized medical care.

To secure the availability of labour, specialists' fields of expertise should not be narrowed further

When drafting the centralization decree, no consideration whatsoever was given to the significance of the level of care required by patients for personnel resources. The audit found that the centralization of expertise has meant in practice that patients requiring the highest level of care are now treated at university hospitals. While university hospitals have developed special measures to secure the availability of personnel, this has not been sufficient.

The audit showed that the competence requirements in 24-hour care have increased, as the healthcare personnel must have expertise in both primary healthcare and specialized medical care. While the decree on 24-hour services requires units providing extensive 24-hour services to have physicians in a number of specialities on call, the training of specialists has tended to focus on narrower fields. The narrow scope of the specialities increases the number of on-call physicians needed in 24-hour services. To ensure the availability of physicians, their areas of expertise should consequently not become any narrower.

Centralization of healthcare services affects their accessibility, increasing patients' costs and Kela reimbursements

When preparing the hospital and 24-hour service network reform, travel costs and savings were estimated to be equal. The travel distance was only expected to be significant in urgent cases. However, the audit found that the distance travelled is also significant in treatment requiring several visits. Repeated visits to examinations and treatments increase the patient's travel costs and the reimbursements paid by Kela. When reforming the healthcare and social welfare service network, the overall costs incurred from the accessibility of services should also be assessed (all means of transport, travel times and Kela reimbursements).

'Hospital' may no longer be an apt term for small hospitals

The objective of centralising surgical procedures requiring general anaesthesia to central hospitals was to achieve savings by discontinuing these procedures in small hospitals. The audit found that the activities of small hospitals have expanded, however, and their specialized medical care expenses have increased. Hospitals offer quite a wide range of outpatient surgical procedures, surgical procedures requiring general anaesthesia have been replaced by those performed under local anaesthesia, and inpatient wards for specialized medical care patients have been partly replaced with primary healthcare inpatient wards and partly adapted for social welfare use. Regarding inpatient care, small hospitals' operating profile has changed in line with the objectives and promoted the integration of healthcare and social welfare services. The hybrid structure of these units no longer resembles that of a traditional hospital, however.

Recommendations of the National Audit Office

Based on the audit, the National Audit Office recommends that

1. if content-related or financial targets are set for the centralization of healthcare services, indicators on the basis of which target achievement can be monitored should be defined by the steering ministries. The responsible authorities are the Ministry of Social Affairs and Health and the Ministry of Finance.
2. when reforming the hospital and 24-hour service network, well-functioning reception services for urgent cases must be secured in primary healthcare to avoid patients unnecessarily ending up in costly specialized medical care. The responsible authorities are the Ministry of Social Affairs and Health, the wellbeing services counties, the City of Helsinki and the HUS Group.
3. decision-making and commitment to decisions in the collaborative areas should be strengthened by resolving any ambiguities related to competence. The responsible authorities are the Ministry of Social Affairs and Health, the Ministry of Finance, the Ministry of the Interior, the wellbeing services counties, the City of Helsinki and the HUS Group.