

# General practitioner beds in Finland — lessons for the UK?

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**SUMMARY.** *The Finnish Primary Health Care Act of 1972 aimed to provide comprehensive health care to the population. One consequence was an increase in the number of beds for the use of general practitioners, so that there are now 2.2 general practitioner beds per thousand population. Use of these beds varies with the location of the health station in which they are situated, but in rural areas approximates to that of general practitioner hospitals in the United Kingdom. Despite integration of general practitioner beds into overall planning, some potential benefits of these facilities have not been realized. For the UK, with traditions of personal general practice and continuity of care, the Finnish system offers one model of community care which may have medical and economic advantages.*

## Introduction

GENERAL practitioner hospitals — hospitals where general practitioners may admit and care for their patients — have enjoyed mixed fortunes in the UK. Department of Health and Social Security consultation papers<sup>1,2</sup> have stressed their importance, a working party of the Royal College of General Practitioners has endorsed their valuable contribution<sup>3</sup> and at least one regional health authority has formalized its support for their development.<sup>4</sup> Yet these small hospitals remain vulnerable to closure or change of use,<sup>5</sup> often becoming long-term geriatric units, despite having an important part to play in other forms of medical care.<sup>6,7</sup> They have been neglected in the planning strategies for both primary and secondary care.

The integration of general practitioner hospitals into overall planning is a feature of the health services of some other European countries, notably Norway and Finland and rural areas of France.<sup>8</sup> This paper reports a visit to Finland, made to study the contribution that inpatient facilities for general practitioners make to health care.

## Background

Finland is medically distinguished by a high death rate from coronary heart disease and one of the lowest perinatal mortality rates in the world.<sup>9</sup> Its population is approximately 4.7 million, with a population density of 15 per km (compared with 229 per km in the UK). The population is growing slowly and the age structure is typical of an industrialized country, with 11.4% of the population aged over 65 years. Local self-government is an important feature of the country's constitution; policy is decided centrally but is implemented by the elected councils of the 461 local communes, which have the power to levy taxes. Health policy is decided by the Cabinet, formulated by the National Board of Health in Helsinki and implemented by the commune to suit the needs of the local community. Primary care services are the direct responsibility of the communes.

In the 1960s, like most other Western countries, Finland

devoted most of its health resources to specialized hospital services, with only 10% going to primary health care. Despite this 'the hospital-centred approach was simply incapable of meeting the challenge posed by the high adult mortality and chronic morbidity'.<sup>10</sup> The political basis for the new philosophy of 'primary care first' was the Primary Health Care Act of 1972; its aim was to provide comprehensive, free health care to the population. One of its consequences was the creation of a salaried general practice service. Another was the establishment of administrative areas called (confusingly) 'health centres', usually with 10–15 000 inhabitants, which are sometimes co-terminous with communes or federations of communes, although in larger urban communes such as Helsinki, there may be several health centres. The health centre administrative area is responsible for organizing adequate health education and preventive services, primary medical care, dental care, ambulance services, maternity and child care, and school and occupational health care. Each year every area draws up a five-year plan, concordant with the more general national plan. The financing of primary and secondary care is shared by the state and the communes so that the poorest communes are responsible for one-third of the expenses whereas richer communes pay up to two-thirds. National expenditure on health over the past 10 years has been between 6.5 and 7.5% of the gross national product, although the proportions spent on primary and secondary care have changed dramatically as a result of the 1972 Act (Figure 1).

## Primary care in Finland

Primary health care in Finland is based on 'health stations' which are comprehensive in concept and execution. Each health centre administrative area has a health station. Most of the health stations have been built in the last 10–15 years; some are

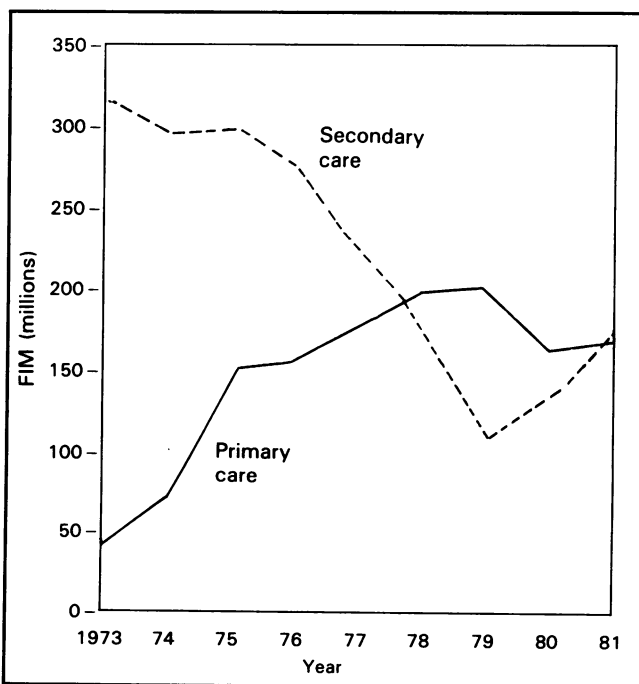


Figure 1. Expenditure on primary and secondary care in Finland in 1973–81 in millions of Finmarks at 1973 prices.

**Table 1.** Primary health care statistics for Finland: expansion of numbers of personnel, patient contacts and investigations between 1972 and 1982.

	1972	1982
<i>Personnel</i>		
Physicians	943	2632
Nurses	1203	5250
Public health nurses	2787	4096
<i>Patient contact (000s)</i>		
Physicians:		
Surgery	5048	8239
Home	56	34
Nurses:		
Home	966	2162
<i>Laboratory investigations (000 000s)</i>		
Primary care	6.1	14.9
Total	9.0	17.9

architecturally distinguished and possess facilities which can only be described as lavish by UK standards. They contain consulting rooms for doctors, public health nurses and often psychologists, emergency treatment rooms, X-ray and laboratory facilities, large physiotherapy departments and dental departments — Finland has the highest ratio of dentists to population in Europe. All but 25 of the 214 health stations have inpatient facilities. The number of doctors, nurses and public health nurses (analogous to health visitors in this country) are shown in Table 1, with other details of primary care activities. The increase in primary care staffing over the last decade is apparent and has taken place against a background of a relatively low annual patient consultation rate of approximately 2.3. However, it should be noted that in Finland about one quarter of all patient contacts are with physicians working in the private sector.

Finnish general practitioners are salaried and work a 37 hour week, with further payment for extra duty and on-call work; their financial rewards seem comparable with those of British general practitioners. There is no personal registration or list system, although patients develop allegiances to doctors in the same way as in some large group practices in this country. Consultations are relatively leisurely, taking place at 15 to 20 minute intervals. The consulting rooms seem clinical and impersonal, similar to some hospital outpatient accommodation in the UK.

All Finnish doctors spend one of their two postgraduate years in secondary care at the large central hospitals or the smaller hospitals in the health centre area and one year in primary care at health stations. They may, at present, begin work in primary care immediately after this period or may undertake further specialist training in general practice. There are plans to make this second option compulsory. Undergraduate training in primary care is evolving steadily, with Chairs of general practice in two of the country's five medical schools, Helsinki and

Tampere. Postgraduate education in primary care is poorly developed.

### General practitioner beds

Some statistics for the inpatient facilities in Finnish health stations are given in Table 2, with figures reported by Cavenagh<sup>6</sup> on general practitioner hospitals in the UK for comparison. The number of general practitioner beds in Finnish health stations has risen in the last decade, so that they now account for about 20% of all hospital beds. A considerable proportion of this increase in provision of beds for primary care is more apparent than real, because of transfer of old peoples' wards from the under-funded social services to better-supported primary health care. There has, however, been a real increase of over 2000 beds for the use of general practitioners.

How are these beds used? The 1972 Primary Health Care Act planned that 30% of them should be used for acute, general medical cases and 70% for chronic or geriatric patients. In fact, the proportions vary. In Lapland, remote from central hospitals, half of the beds are used for acute medicine and these health station hospitals also provide surgical and maternity facilities. In health stations nearer to large hospitals as many as 90% of the beds are used for long stay patients. Some insight into the use of beds is afforded by an interesting study<sup>11</sup> which examined all patients occupying health service beds on a single day in March 1981. There were 3689 acute and 6844 chronic patients in general practitioner beds, suggesting that the 30:70 ratio proposed in 1972 was appropriate, but the study confirmed the wide variation in use between rural and urban practices. Over 80% of patients in general practitioner beds were over 65 years and over half were over 75 years of age. More than one third of the patients in general practitioner beds have been resident for over a year. Almost half of the permanent residents were bedridden.

It is often difficult to assign a single admission diagnosis to an elderly or chronically ill patient and for this reason direct comparison of clinical data about reasons for admission may also be difficult. Although cardiovascular diseases are major admission diagnoses both in the UK and in Finland and account for about 40% of all acute admissions in Finland, some major differences emerge. Cerebrovascular accidents, which account for over 10% of acute admissions to a number of general practitioner hospitals in the UK,<sup>12,13</sup> are under-represented in Finland (4.5%) whereas diabetes and its complications (18%), renal tract infection (14%) and senile dementia (13%) are apparently more important there. Chest infections and asthma also account for about 10% of acute admissions to general practitioner beds in the UK, whereas chronic bronchitis and asthma together represent less than 5% of admissions in Finland. Malignant disease is also a less common admission diagnosis in Finnish health station hospitals. The overall impression from the statistics is that the Finnish hospitals are oriented towards an older, more chronic group of patients with predominantly degenerative diseases. Despite this, only 9% of all deaths occur in general practitioner beds.

**Table 2.** Inpatient facilities for the use of general practitioners in Finland and in England and Wales

	Finland		Comparable figures for England and Wales	1983
	1972	1982		
Number of health stations with inpatient facilities	202	189	Number of GP hospitals	350
Number of health station beds	5745	16 862	Number of GP hospital beds	8729
Number of GP beds/1000 population	—	2.2	Number of GP beds/1000 population	0.25
Number of patients admitted	113 931	197 299	Number of patients admitted	195 202
Mean length of stay (days)	16.4	30.6	Mean length of stay (days)	20.1

What are these health station hospitals like? Just as it is difficult to identify 'typical' general practitioner hospitals in this country, for example those approximating to the model originally proposed for community hospitals in 1972 by Rue,<sup>14</sup> so it is difficult to describe a 'typical' Finnish health station hospital. I visited several health stations in central and southern Finland, but not in the more remote northern areas.

To take one example, the health station at Kouvola, in central Finland serves a population of 32 100 and is 30 km from the nearest large hospital at Kuusankoski. Eighteen general practitioners work at the health station, which contains 160 beds on two floors. The aim of this inpatient facility was to take care of the chronically ill who did not need specialized care and those with minor illness. In 1983, 711 patients were admitted, 592 were discharged and 88 died; the mean age of these patients was just over 75 years, the average inpatient stay was 64.8 days, with a bed occupancy of 103%. Medical cover for the wards was provided by general practitioners who did no other work in the health station; although there were excellent physiotherapy facilities for outpatients, occupational therapy was not provided for these chronically ill, elderly patients.

The health station at Nilsia, on the other hand, is situated about 80 km from the nearest large hospital, in Kuopio. It serves a population of about 15 000 people and is staffed by eight general practitioners. As well as the usual consulting facilities there are 35 general practitioner beds on the same ground-floor level. This hospital accepts acute admissions, so that 15% of its patients were aged under 65 years. Cerebral and myocardial infarction accounted for about one third of acute admissions, malignancy, chest infection and diabetes together about 18% and alcohol and psychiatric problems a further 5%. There were approximately 360 admissions in 1983.

### Comment

The Finnish health system has been watched with considerable interest over the last few years because of its commitment to primary health care. Its theoretical framework for providing comprehensive health care is impressive and in many respects appears to be effective in practice. The importance given to general practitioner beds in this system is innovative and exciting. Doubts remain, however, about the extent to which the potential benefits of these beds are being realized. The uncertainty stems from problems of continuity of care. Because Finnish general practitioners are salaried and because there is no personal registration system, consultations in Finnish health stations have more in common with visits to outpatient departments in the UK. This problem is more important when considering the use of beds by general practitioners. Although the aim that patients should be kept in or near their own community when they are ill is achieved by providing beds in health stations, another perceived advantage of this form of care — that these patients will be looked after by general practitioners and nursing staff with whom they have become familiar over a period of years — is not realized. The first British general practitioner hospitals were literally cottages, distinguished only by their levels of cleanliness and hygiene. The tradition in this country has been to regard general practitioner hospitals as extensions of the home, in which levels of nursing care and technological support are appropriate to this notion. The reverse appears to be true in Finland, where the health station hospitals are extensions of the large hospital, with their own 'hospital' doctors, large ward plans and a disease-oriented rather than a person-oriented approach to care. However, there is evidence from Finland that the provision of increasing numbers of health station general practitioner beds results in a reduction in the requirement for central hospital beds and bed occupancy, suggesting that their contribution is cost-effective.<sup>15</sup> A recent study from the UK has provided evidence of a similar inverse relationship.<sup>16</sup>

This rather disappointing situation is probably commoner in more populous areas of the country and is exemplified by the inpatient statistics at Kouvola. When the health station is more remote from the central hospital, then the amount of acute medical work that it has to undertake increases, as is the case in Nilsia. In remote regions of the country such as Lapland, the health station hospitals have to provide facilities for operative surgery and interventive obstetrics.

What can we learn from the health station hospitals in Finland that can be applied to the NHS? The most heartening lesson is that it is possible to integrate access to beds for general practitioners into overall planning for primary health care. It is not adequate, however, merely to provide beds; outpatient facilities are also required so that the advice of visiting specialists may be obtained and adequate occupational therapy and rehabilitative facilities are vital. There are virtually no day hospitals in Finland and this is yet another dimension of care in the community which can often be located appropriately in general practitioner hospitals. The lack of continuity between ambulant consultations and care in the hospital is a major weakness of the present arrangements in Finland. Continuity of care remains a controversial issue in general practice but it is an important ingredient in the success of the existing general practitioner hospitals in the UK. Payments to British general practitioners for looking after their patients in general practice hospitals are little short of derisory but the job satisfaction derived from doing so seems compensation enough.

Finland offers a tantalizing glimpse of new opportunities for primary care which, paradoxically, could be more effective in this country with its tradition of personal general practice.

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### Acknowledgements

I would like to thank the Royal College of General Practitioners for supporting this visit, all the friends that I made in Finland for their hospitality and in particular Dr Matti Rimpela for helping to plan the trip.

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