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Designing publicly funded healthcare markets – Note by Finland

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More documents related to this discussion can be found at

http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm

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Finland

1. Designing Publicly Funded Healthcare Markets – Finland

1. The issue of designing publicly funded healthcare markets is highly topical in Finland. The reform process has been going on for more than a decade now. While outlining this memo the law drafting continues in the Finnish Parliament and the legislative process is presumed to be over late in the autumn term 2018 or early 2019.

2. In the following, the reform will be referred as *health and social services reform* (also HSS reform) as both healthcare and social services are to be partly integrated. The reform under preparation covers also the reorganization of the regional government[1].

3. This paper will briefly illustrate the present structure of providing healthcare services in Finland, the main characteristics of the reform and also shortly describe the ongoing debate as well as the steps in the long process. Also the contributions of the Finnish Competition and Consumer Authority (FCCA) during the preparation process will be discussed.

4. The FCCA would like to underline the fact that the legislative process is proceeding in the Parliament while processing this paper and the final outcome of it is still to be seen.

2. The Finnish Healthcare System – The Present Model[2]

5. Finland spends 9.5 % of its GDP on healthcare, close to the average in OECD (9.0 %) but somewhat less than its Nordic neighbours (Denmark 10.4 %, Norway 10.5 %, Sweden 11.0 %). In 2016, the healthcare expenditure totalled EUR 20.5 billion, the per capita figure was EUR 3 738. Primary healthcare (EUR 3.3 billion) and special healthcare (EUR 7.2 billion) covered around half of the total expenditure.[3]

6. The Finnish healthcare system is characterized by a universal right to healthcare services as defined in the Constitution of Finland "The public authorities shall guarantee

[1] The reform, called "The Health, Social services and Regional Government Reform" is one of the largest reform packages dealing with administrative structures and practices ever undertaken in Finland. The aim is to transfer the organising of health and social services and other regional services (e.g. rescue services, environmental healthcare and regional planning) from the municipalities to the 18 new counties as of 1 January 2021. The regions would be managed by elected councils. The reform would also have an impact on the financing, management and taxation of health and social services. Financing of the counties would come entirely from the central government, the counties would not be entitled to levy taxes. More information on the reform can be obtained: https://alueuudistus.fi/en/frontpage

[2] More information on the present Finnish healthcare system in English, see eg. Health care in Finland (2013) and https://www.choosehealthcare.fi/healthcare-in-finland

[3] In SHA 2011 statistics system healthcare expenditure covers apart from primary and special healthcare also medicines, long term care of elderly and disabled etc.

for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population".[4] The responsibility for organising publicly funded healthcare services lies on the municipalities.

7. Besides publicly funded services, special and primary healthcare services are delivered to the population through two other systems: occupational healthcare and entirely private healthcare. Of these three ways of providing the services public healthcare services amount of 83 %, occupational healthcare services around 6 % and private services about 11 %. The three systems differ in financing, organizing and provision of the services and there is some overlap as citizens are always entitled to the publicly funded services.

8. The present healthcare system is characterised by multisource financing. The financial resources are assembled from various sources and these are then channelled to the services via different financial resource providers like central and local government, households and employers. Financial resources for healthcare are collected through taxation, obligatory insurance contributions, voluntary insurance premiums, employer's contributions and fees charged from clients and deductibles paid by clients. In 2016, the share of public funding was 73.8 % and that of private funding 26.2 %.

2.1. Public Healthcare

9. A municipality can organise services by providing them itself or in collaboration with another municipality. A municipality can also procure services from a private enterprise or from a non-governmental organisation. The services can also be delivered through vouchers if a municipality so decides. The use of vouchers has not, however, been very common, although some increase has been seen during the past few years.

10. Today about 190 authorities are responsible for public social and health care services (healthcare services: around 150). Municipalities form hospital districts that are responsible for the provision of specialised healthcare; every municipality must belong to one of the 20 hospital districts.

11. The state supports municipal service provision by means of central government transfers to local government. The amount of the transfer depends on the municipality's population, population structure and morbidity, among other things.

12. Municipalities are able to decide on the client fees but the Government sets the maximum level. In international comparision client fees' share of financing healthcare services is high in Finland. The share varies, however, a lot between different type of services.

13. From the beginning of 2014, a public healthcare client has been able to choose any public health centre in Finland. Clients can also choose – together with their doctor - a specialised medical care unit located in Finland. Medical care can even be seeked abroad according to the rules based on the EU Directive on Patient Rights in Cross-Border Healthcare.

[4] Constitution, Section 19 – The right to social security

2.2. Occupational and Private Healthcare

14. Employers have an obligation to provide *occupational healthcare* (OH) to their employees. The primary aim of occupational healthcare is to maintain and improve work ability. A third of the population (1.8 million of 5,5 million) and almost 90 % of wage earners have access to occupational healthcare and almost 90 % of clients who have access to OH services have a medical care contract too. The scope of services provided, however, varies a lot between employers based on the agreement between the employer and the service provider. There are no client fees on OH services. Employers can claim reimbursement for the cost of providing occupational healthcare. The Social Insurance Institution of Finland pays the reimbursement from employers' and employees' earned income insurance contributions. The reimbursement varies from 0 to 60 percent depending on the service concerned.

15. Health services are also provided by *private* companies, independent professional practitioners and organisations. The Social Insurance Institution of Finland reimburses a proportion of the costs of private healthcare. The proportion reimbursed has decreased significantly during the past few years. For example less than 20 % of a GP visit is reimbursed today. Several special healthcare services – e.g. gynecologist and ophthalmologist services - are today largely provided by private professionals.

16. At present, 1.2 million citizens – more than every fifth - have a private health insurance. The popularity of insurances has increased in the past few years especially among families with children. The motivation to buy an insurance is the preference to have faster access to services, the ability to choose the doctor and have a say in the time and place of service.

The number of private companies providing doctor and dentist services is around 6 300 in Finland. A vast majority of them are, however, micro companies (e.g. doctors that work as private practitioners in the premises of large service providers). There are four big companies that are able to provide large scale of services nationwide. Some consolidation and integration have been seen in recent years as insurance companies have established their own service provision. The number of mergers and acquisitions has been significant as the big national players have acquired smaller local providers. Few mergers have, however, fallen under the jurisdiction of the FCCA merger control[5]. All acquisitions notified to the FCCA have been approved by the authority as such or after conditions have been attached.[6]

2.3. Evaluation of the Present System

17. In international comparison, the Finnish healthcare system has performed quite well. The quality of care (e.g. mortality rate in certain conditions) and health status (e.g. life expectancy) indicators seem to be close or somewhat above the OECD average. [7]

[5] According to the Competition Act, the FCCA must be notified of the transaction if the combined turnover of the parties to the corporate transaction exceeds 350 million euros and the turnover from Finland of at least two of the parties exceeds a combined total of 20 million euros.

[6] At present, the FCCA is investigating a transaction whereby Terveystalo Healthcare Oy acquires Attendo Terveyspalvelut Oy. Both companies are among the five biggest private healthcare service providers in Finland. The final decision is due by mid December.

[7] OECD (2017), Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris

18. Although the quality of services is good, there are problems with the availability of the services and long waiting lists especially in the primary care. Thus, the equality between citizens has been deteriorating in the recent years. The specialist care has dominated the increase in costs in the past years. The ageing of population will set a major challenge to the financing of the system. The size of the municipalities varies a lot and the municipality-based system of organizing the services is very fragmented and thus week to meet the cost restraints.

19. Although citizens are according to the surveys reasonably satisfied with the healthcare system and the quality and safety of the services, the problem still is that part of the population does not get the primary care needed or they have unreasonable waiting time which stimulates inequalities in the system. In a comparison of 15 OECD countries, only Estonia and the United States showed greater inequality than Finland in access to doctors.

20. Also the continuity of healthcare services is low in Finland compared to many other countries. In a comparison between 16 European countries, Finland was the last when the possibility of having an own GP was compared. In Norway and Estonia the figure was 99 %, in Finland 70 %. The continuity in primary care is critical when considering the quality and cost control of healthcare.

21. Both OECD[8] and the EU Commission[9] have recommended Finland to take action to ensure the adoption and implementation of the administrative reform to improve cost-effectiveness and equal access to social and healthcare services.

3. The Reform of Publicly Funded Healthcare Services

3.1. The Proposed Reform in Brief

22. The ongoing reform is a combination of reorganizing the regional government as well as the structure of the publicly funded health and social services system in Finland. [10] Its objective is "to reduce inequalities in health and wellbeing, improve the equality of services and the access to services as well as to curb the costs". The reform aims at bridging a large part of the sustainability gap in Government finances. The Government aims to save EUR 10 billion, and the health and social services reform is expected to cover approximately EUR 3 billion of this sum.

23. The core of the reform is to transfer the responsibility for organising health and social services from 190 local authorities and joint municipal authorities to the 18 counties on 1 January 2021. Horizontal and vertical integration are among the targets of the reform, too. Healthcare and social welfare services would be under the management of a single structure, the county. The target is also to make the multisource financing of healthcare and social welfare simpler.

[8] OECD Economic Surveys: Finland 2018 https://read.oecd-ilibrary.org/economics/oecd-economic-surveys-finland-2018_eco_surveys-fin-2018-en

[9] COM(2018) 425 final. 23.5.2018 https://ec.europa.eu/info/sites/info/files/file_import/2018-european-semester-country-specific-recommendation-commission-recommendation-finland-en.pdf

[10] Further information on the reform: https://alueuudistus.fi/en/frontpage

24. Besides structural and financial reforms, the steering and operating models in healthcare and social welfare would be thoroughly changed. More Government steering would be introduced as the funding of the services would come entirely from the Government. The reform also includes the aim to increase the digital services as well as make the information flow more smoothly between service providers.

25. More freedom of choice to citizens is on the agenda, too and that is meant to be a key method to improve the availability of primary services. An Act on Clients' Freedom of Choice in Healthcare and Social Welfare (Freedom of Choice Act) would be enacted for this purpose. Freedom of choice would be gradually expanded.

26. The freedom of choice would cover so called direct-choice services provided in health centres. Direct-choice services mainly include primary healthcare services and certain types of consultations with medical specialists as well as guidance and advice on social services. Basic-level services given by dental clinics are also direct-choice services (In the following "health centres" cover also dental clinics). At their discretion, health centres could also provide additional paid services in addition to the services funded by the county. These services would be paid by the client in their entirety.

27. Health and social services would be organised by a county and provided by public, private or NGO actors. Counties would receive their funding from central government but make autonomous decisions on using the funds. The counties would not have the right to levy taxes themselves – an issue that has been debated during the reform process.

28. The organisation and provision of services would be separated in the counties. The county would provide services itself or in cooperation with other counties, or outsource them under a contract to some other service provider. Services provided by a county should be structured as an unincorporated county enterprise.[11] If preferred, a county could also set up enterprises.

29. If the service supply in some areas remained insufficient, the unincorporated county enterprise would have to provide the services itself or subject them to competitive tendering and outsource them. An unincorporated county enterprise would also provide those services that are not available in health centres (e.g. most social services, demanding specialised healthcare and extensive emergency care services). The unincorporated county enterprises would also make official decisions and exercise public power like granting social benefits.

30. A system of HSS vouchers and a personal budget would also be introduced as part of the reform. They would be granted by the county's service unit and the client could be provided with e.g. an operation or physiotherapy. The provider should be approved by the county.

31. According to the legislative proposal, the counties would have an obligation to inform residents about their rights and benefits and assist and advise them in using health and social services and exercising their freedom of choice. The county would be responsible for ensuring that the residents have access to sufficient information, enabling them to choose their health and social services.

[11] The Constitution Law Committee found earlier that a previous draft bill with statutory corporatization of services provided by a county would be problematic from the Constitution point of view as adequate services as set in the Constitution could not be guaranteed.

32. The counties and a national supervision authority would monitor the service providers' activities. The supervision of competition neutrality between public and private providers would be dedicated to the FCCA by adding relevant sections in the neutrality rules of the Competition Act.[12]

3.2. Compensation of the Providers

33. According to the Government bill, decisions on the compensation paid to service providers would be made by a county. Counties would pay to service providers a monthly amount, which is a periodic fixed payment per client for the health and social services provided (capitation). The compensation would be grounded on national needs-based factors, such as the age, gender, employment and socio-economic situation of the county residents. It is stated in the bill that the capitation should account for at least two thirds of the compensation paid to the service providers.[13] Calculating the correct amount of compensation will require a calculation model, or weighting coefficients that are currently prepared by the National Institute for Health and Welfare.

34. Besides the fixed payment, a county might pay performance-based remuneration, incentive-based remuneration (based, for instance, on the quality and effectiveness of care) and other remuneration (based, for instance, on a remote location).

3.3. The Reform from a Patient Point of View

35. A client would be able to choose his/her preferred HSS centre among public and private providers. A change of the provider would be possible six months after the previous choice.

36. As in the present system, employed persons would continue to have access to their occupational healthcare unit. Similarly, clients would still be able to get private health services at their own expense, for example, by using private health insurance. Costs for private health services outside the scope of freedom of choice would not any

[12] The FCCA has the authority to intervene – with legally mandated requirements and restrictions – in the provision of goods and services in public sector business activities, if the **operating models** used (such as pricing below cost) or operating **structures** (such as undertakings controlled by the public sector) prevent or distort competition on the market. https://www.kkv.fi/en/facts-and-advice/competition-affairs/competition-neutrality/

[13] At the invitation of the Finnish Ministry of Social Affairs and Health, the European Observatory on Health Systems and Policies has undertaken a review of risk-adjusted capitation formula usage internationally and provided an expert opinion of the general approach in the Finnish reform proposals, *Using risk-adjusted capitation for financial resource allocation and purchasing primary health care and social services, A rapid review of international experiences and lessons for Finland, May 2018*. The aim of the exercise was to consider how common risk-adjustment is in health systems internationally, some of the approaches and data used for risk-adjustment internationally, and provide reflections on what international experience portends for the Finnish reforms in this regard. The report supported the proposed use of risk-adjusted capitation both to allocate financial resources to the counties and purchase primary healthcare and social care services on behalf of clients. https://alueuudistus.fi/documents/1477425/4278701/Finland+Risk+Adjustment+Brief+European+Observatory+12.52018.pdf/6c5ac7ad-675a-4e5e-a2d9-f1d7b20f7ea0/Finland+Risk+Adjustment+Brief+European+Observatory+12.52018.pdf.pdf

longer be eligible for reimbursement by the Social Insurance Institution of Finland after a transition period.

37. If a client does not sign up with the HSS centre, he or she would at first stage be listed to the public provider according to his or her address. A client would be informed about the right to change a provider. If a client had not made a choice by the end of 2022, a county would be obliged to list her/him with a public or private HSS centre which is best achievable.

3.4. The Reform from a Provider Point of View

38. All actors meeting the legislative criteria and conditions set by the county who are entered in the national register of service providers might become listed as service providers. In addition, a county would conclude a contract with the providers of direct-choice services. Counties would also supervise the service providers.

39. HSS centres would be obliged to accept all new clients who register with them and provide up-to-date information online about their services and actual waiting times. The providers would have to issue annual reports on revenue, taxes paid and place of taxation, profit and loss, management salaries and bonuses as well as on corporate social responsibility, among others.

40. Additional paid services could also be provided by HSS centres in addition to the services funded by the county. These services would be paid by the client in their entirety.

41. The Freedom of Choice Act would contain provisions on competition neutrality, too. All service providers should be treated equally by the county. The Act would also contain provisions on keeping separate accounts between direct-choice and other services in order to improve neutrality between public and private providers. According to the Government bill, supervisory role of the FCCA would be of importance.

42. Supervision of the legality of marketing of direct choice services would fall under the scope of the Consumer Act and, thus, come under the jurisdiction of the FCCA.

4. Competition Related and Other Concerns

43. Several competition as well as other concerns and risks have been recognized by the Government and indicated by many stakeholders and experts, too, concerning the reform.

44. In direct choice services the main risk would probably be linked with the compensation model based mainly on the capitation. The capitation based model drives to cost efficiency which in turn might stimulate under-treatment as well as cost transfers to other providers. Also risk of adverse selection and cream skimming based on choices of clients with different needs has been pointed out.

45. The Government has stated that the fact that providers would have to accept all the listed clients, would prevent them from influencing their client base by limiting the maximum number of clients. Although the requirement might have an impact of increasing the capacity, the limiting of maximum number of clients would, thus, not be appropriate. The Government also refers to the report of the international group of experts stating that the risk-adjusted compensation model is suitable for the future Finnish model (see footnote 13). Also the fact that the compensation includes besides capitation also

other elements, decreases the detrimental incentives as the elements complete and balance each other.

46. The capitation system would be risk-adjusted taking into consideration e.g. age, sex and morbidity. Further development of the details of the coefficients is, however, needed. At the moment, a large part of the population most probably burden public primary healthcare only lightly. This is because of occupational healthcare system, use of private insurance and use of private services without insurance. Some people require little services because of good health. This means that capitation compensation for those who do not use or use only rarely public primary healthcare should be very low and high for those who use it frequently.

47. The Finnish extensive occupational healthcare system causes some overlapping insuring as most employees are entitled both to public healthcare and occupational healthcare. The Government has recognized that the compensation on these clients should be smaller to avoid overcompensation. The Ministry of Health and Social Services has launched a survey on how the more detailed register data could be obtained to illustrate the use of occupational healthcare. There will be challenges as the scope of OH services varies between employers.

48. It has also been argued that the private providers in providing OH services have access to client register that they can make use of in their marketing and thus have predominance in the market by having "easy" clients. The private providers have database of the clients which at the moment use their services by paying themselves, or with private insurance or occupational healthcare services. These people are likely to use public healthcare services only a little also in the future and may therefore be very profitable unless the capitation compensation for them is minimal. The correct compensation model will be of importance to have the right incentives and make all clients equally profitable to the providers.

49. If the private company does not find providing services profitable enough, it can exit the market in 6 months. If the withdrawal results in the lack of services in an area where the withdrawing company is the only provider, the county has the obligation to step in and provide the primary healthcare services.

50. The problem of possible *cost transfers* from private primary care service providers to public providers of specialized services has also been pointed out. A direct-service provider could e.g. send expensive clients to public hospital "too easily" to reduce its own costs. The gate keeping role of county hospitals would therefore be important when accepting the referrals.

51. The effective competition requires that there are *entry possibilities* to new providers as well. It is, however, possible that the capitation model requires a large customerbase in order to compensate between profitable and unprofitable customers. Therefore the scope of services that a provider has to be able to provide is essential – the wider the scope is, the fewer is the number of providers that are capable of being on the market. The proposed set of services in health centres is large covering most primary healthcare services. Therefore e.g. small and medium sized providers would not probably be able to provide services by themselves but by organizing e.g. a consortium. There is a risk that in many areas there may be only one private company offering services in addition to the public primary healthcare.

52. The counties would be able to set *additional conditions* to the providers. The FCCA among others has emphasized that the setting needs careful consideration by the

counties so that the conditions would not create extra burden on the providers, especially the small ones.

53. The *level playing field* for public and private providers is necessary to achieve the desired efficiencies. It will have to be kept in mind, however, that the public providers have obligations that the private providers do not have like the ultimate responsibility to guarantee healthcare and social services in all circumstances and all over the country including e.g. the sparsely populated areas.

54. Public providers have been obliged to follow the rules of statutes like the Act on the Openness of Government Activities and the Administrative Procedure Act. In the reform the obligations would apply also private providers to guarantee transparency and neutrality.

5. About the Reform Process - A Long and Winding Road

55. The reform process has been underway for more or less a decade as the ongoing reform has been on the agenda of several successive Governments as well as Parliaments. Several different legislative proposals have been under scrutinity.

56. Consensus seems to prevail on the need to reduce the number of authorities organizing the services. Municipalities, of which many are very small, are financially weak to carry the increasing cost burden due to the ageing population. Unanimity also seems to prevail on the need to put more resources on the primary care.

57. The debate between political parties as well as between experts has concerned e.g. the *role of private companies* in providing publicly funded services as well as *incentives* in the new system. Different views have been presented concerning the role of public and private providers.

58. The role of *the Constitutional Law Committee of the Parliament*[14] has been critical when the reforms have been under scrutiny in Parliament in the past few years.[15] The present Government again started drafting a new model in 2015 and a package of bills have been issued. The latest version of the Government proposal on the Act on Freedom of Choice was submitted in March 2018. It has, however, been again partly

[14] In Finland, there is no Constitutional Court but the Constitutional Law Committee. The Committee members are members of Parliament and the composition of each committee reflects the relative strengths of the parliamentary groups. The Committee issues statements on bills/legislative proposals sent to it for consideration and points out from the constitution point of view problematic elements. If there seems to be problematic elements in the bill/proposal, a simple majority of votes is not enough but a more complicated procedure must be followed to enact a bill.

[15] There is public debate on the role of the Constitution in drafting legislation on social reforms. E.g. the former chairman of the Constitutional Law Committee, Mr Sasi has suggested repeal of Section 124 of Constitution. The section concerns delegation of administrative tasks to others than the authorities ("*A public administrative task may be delegated to others than public authorities only by an Act or by virtue of an Act, if this is necessary for the appropriate performance of the task and if basic rights and liberties, legal remedies and other requirements of good governance are not endangered. However, a task involving significant exercise of public powers can only be delegated to public authorities*." According to Mr Sasi the concept of *public administrative task* is interpreted too widely and corresponding regulation does not exist in western countries.

rewritten and completed due to the remarks of the Constitutional Law Committee in early June.

59. The Committee considered that the timetable for the reform coming into force was too tight to meet the constitutional right to have adequate health and social services; the coming into force of the reform will thus have to be phased. Also more attention should be paid to the counties' ability to provide the services themselves and finance the services especially in exceptional circumstances. The relationship between the proposed reform to the EU state aid rules should also be reconsidered e.g. by notifing the model to the Commission.

60. The Parliament is supposed to vote on the reform in late 2018 or early 2019 after the publication of the memorandum of the Social Affairs and Health Committee. The memorandum, however, has to pass once more the Constitutional Law Committee's assessment prior to the final vote.

6. Activities of the Finnish Competition and Consumer Authority

61. In the past few years, as the HSS reform has been going on, the FCCA has contributed the process e.g. by submitting reports and statements.

6.1. Reports

62. The FCCA has issued reports both on its own initiative and also by assignment from the Government.

63. The first in the series of the FCCA reports was *The Patient's Freedom of Choice, The Swedish Model and the Finnish Reform – The Perspective of the Functioning of the Market and Economic Impact*.[16] In 2015, the Government had made the decision that more freedom of choice would be introduced in the reform and the FCCA wanted to contribute to the preparation by describing the corresponding Swedish reform dating a few years back. The report stated that according to the Swedish evidence and international studies competitive mechanisms will in the short run contribute to better availability and client orientation of the services.

64. According to the report the freedom of choice as a single measure does not, however, automatically guarantee the curbing of cost increase which has been one of the key drivers in the Finnish reform. Attention should be paid to licencing the providers as well as competition neutrality aspects. The amount, quality and comprehensibility of information on services and providers for patients is also of importance. Also provider reimbursement needs careful assessment to avoid potential incentive problems. The FCCA assessed that the final results of the reform will depend a lot on how the future counties will implement it. Opening up the market is not enough to achieve cost savings; new technology and new procedures are urgently needed, too. On the other hand, they could be best achieved in a competitive environment.

[16] The FCCA Reports 5/2015, in Finnish only

65. In 2016, the Government assigned the FCCA to perform a study *The Possibilities and Preconditions for Competition in Healthcare and Social Services*.[17] Special attention was to be paid to cost control and the efficiency of the system.

66. The FCCA established that competition can exist both on the procurement market and the consumer market. To achieve positive results through competition it will be essential to prevent the concentration of the future HSS market. The need to branch specific competition rules should also be assessed. Quality supervision and licencing are of importance, too. Constant learning and renewal of all stakeholders are preconditions for the new system to bring about positive outcome. The FCCA also suggested the launching of a Healthwatch[18] type of organization to taking into consideration the clients' view and advising them.

67. In its report *The Freedom of Choice in Publicly Funded Healthcare, part 1: the Regulatory Framework in the National and Cross Boarder Healthcare*[19] the FCCA studied how the freedom of choice materialized in the present publicly funded system. Although the law guarantees the freedom of choice, it has materialized poorly in practice. Common procedures have not been developed and medical report transfers seem to be difficult, among other things.

68. In the second part of the study *The Freedom of Choice in Publicly Funded Healthcare, part 2: Providing Information to Support the Freedom of Choice*[20] the FCCA investigated the quantity and quality of the information provided to citizens nationally. Some comparison was also made between information provided in Finland to that provided in Sweden and Estonia on freedom of choice in cross boarder services.

69. The problem was not the quantity of information, a lot of information was available e.g. on web pages, but it was quite difficult to find the relevant information and it was fragmented. The information between providers also lacked comparability which is a crucial element to make an enlightened choice. A clear need for more client friendly provision of information was found out.

70. In early 2018, the FCCA submitted a report The Regulatory Framework on the Marketing of Healthcare Services and the Challenges on Marketing Emerging through the Healthcare and Social Services Reform[21]. The marketing of healthcare services has impact both on the clients' freedom of choice and competition between the service producers. In the report the authority stated that it is essential that marketing is not restricted too widely. Competition neutrality should also be observed when regulating and monitoring the marketing by public, private and non-governmental organisations.

71. At present only marketing by private operators is regulated and supervised through rules in the Consumer Act. The present legislative proposal on the Act on Freedom of Choice, however, includes a provision on marketing by all providers. Thus, the provisions on marketing in the Consumer Act would apply to public providers, too.

[17] The FCCA Reports 5/2016, in Finnish only

[18] see https://www.healthwatch.co.uk/

[19] The FCCA Reports 3/2015, in Finnish only

[20] The FCCA Reports 3/2016, in Finnish only

[21] The FCCA Reports 1/2018, in Finnish only

6.2. Statements

72. During the reform process, the FCCA among other relevant private and public stakeholders has been consulted on the draft regulation at several stages of the process. The authority has also been invited to hearings of Parliamentary Committees to give its view on the reform.

73. When commenting the first drafts of the reform the FCCA criticised the multi-target character of the reform. The targets were not only numerous but also partly contradictory. In the short run, it would e.g. be very demanding to curb the cost increase and improve the availability of the services simultaneously.

74. The authority has stated that the details of the system design will be essential to make the potential entry of new providers as smooth as possible. On the whole, the possibilities of new entry will be essential from the point of view of functioning of the competition. The set of services required from a provider licenced into the system, for example, may either facilitate or hamper the entry of small and medium sized providers. If the starting point is a wide set of services, entry costs will be high and only bigger providers might be able to meet the conditions. Also additional conditions which regional authorities could set on the service providers could have a negative impact on the potential entry.

75. Also the importance of competition neutrality issues have been emphasized by the FCCA. The statutory corporatization of the public service provision was on the agenda at the first phase of the reform. The corporatization was seen essential to have the level playing field for public and private providers and to avoid the conflict with the EU state aid rules.

76. The Constitutional Law Committee, however, assessed that such a provision would violate the constitution. If the public provider went bankrupt that could endanger the provision of basic healthcare and social services which would in turn violate section 19 of the constitution, the right to social security.

77. The county reimburses the producers. The higher the capitation part of the reimbursement, the bigger is the risk to under-treatment. If the reimbursement is largely based on the performance, the bigger is the risk of over-treatment. A bigger capitation based part of the reimbursement favours larger producers. According to the FCCA assessment it is also essential that the counties would be able pay incentive based reimbursement or reimburse on regional factors.

78. The aim of the reimbursement model should be that all clients should be equally profitable to the providers. The question of how the new model would reimburse providers for those clients that have access to occupational healthcare services is still somewhat open. Anyway, it is obvious that the reimbursement model will have to be reviewed after some experience have been obtained.

79. The authority has emphasized that within HSS there are many different services which differ from each other, which has an impact on how and to what extent the market mechanism can be applied. Asymmetry of information e.g. can result in over- or under-provision of services. Thus, the right incentives and restrictions are in a key possession to steer the service provision that meets the targets of both the society and citizens. Besides the market failure, also government failure has to be kept in mind when assessing the pros and cons of different systems of organizing the healthcare service production.

80. The high level of concentration in the healthcare market and the likelihood that many areas will be dominated by only few providers is a concern. The FCCA will work together with counties so that they foster the cooperation between small and medium sized entities which could not provide primary healthcare services by themselves. As to competition neutrality between public and private healthcare providers, understanding well the services and costs incurred only by the public operator is essential.

81. At the moment, the FCCA is waiting for the Parliament to decide on the reform. After the framework for the reform has been decided, the FCCA has announced that it will take a role in bringing together independent experts to help counties in designing the compensation mechanism so as to maximize the incentives of private operators to offer good quality services to all patients. It is important that there is nationwide support for counties and sufficient means of gathering information on the costs caused by patients in order to create a functional compensation system.