

CARE *for* CARE

administrative perspective



Design for Government, 2024

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Executive Summary

This report presents the findings and recommendations of a collaborative project conducted by Aalto University's Creative Sustainability Master's program, in partnership with Kela and the Ministry of Health and Social Affairs. The project addressed the critical issue of continuity of care in the Finnish primary healthcare system, with our group focusing on the administrative perspective. Continuity of care, defined as the ongoing involvement of patients and their physician-led teams in managing health care, is crucial for delivering high-quality, cost-effective medical care. This initiative aligns with the broader aim of designing sustainable, trustworthy healthcare systems that foster collaboration and meaningful care.

Our interdisciplinary team, as well as other teams from the course, analyzed the Finnish healthcare system through the lenses of patients, doctors, and administrators. We identified key barriers to continuity of care: inadequate support staff, high workloads and stress levels among healthcare professionals, excessive administrative burdens, fragmented communication, and the risk of doctors leaving their position. These challenges contribute to inefficiencies, reduced job satisfaction, and ultimately, altered quality of patient care.

Our research methodology included desk research, stakeholder interviews, workshops, and benchmarking against healthcare systems in other European countries. This approach allowed us to gather insights into the structural and operational factors affecting continuity of care. Key findings highlighted the need for better support systems, streamlined administrative processes, and enhanced collaboration within healthcare teams.

To address these issues, we propose a pilot project to test optimal team constellations within a health center. This involves experimenting with various team compositions—including doctors, nurses, secretaries, administrative staff, and/or AI—to identify configurations that maximize efficiency and job satisfaction. By redistributing administrative tasks to support staff and leveraging AI for routine functions, we aim to free up healthcare professionals to focus more on patient care.

The pilot will be conducted in Hanko, a location reflecting the demographic and healthcare service demands anticipated in Finland over the next decade. Feedback cycles and team training will ensure that the pilot dynamically evolves, refining team structures and workflows to optimize outcomes. This iterative process aims to identify the best practices for scaling the approach across different regions, considering the unique healthcare needs and demographic profiles of each area.

In the long term, our vision is to cultivate a healthcare system where continuity of care is the norm, supported by well-integrated teams working in harmony. We expect this approach to enhance job satisfaction, reduce burnout, and ultimately lead to better health outcomes. While the initial implementation will require significant resources, the anticipated benefits include long-term cost savings and a more resilient healthcare system capable of meeting future demands.

By fostering a collaborative, team-based approach and redistributing tasks to those specifically trained for it, this project lays the groundwork for a sustainable and effective healthcare model that prioritizes continuity of care and the well-being of both patients and healthcare providers.

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Introduction

Design for Government is a practice-based course offered by Aalto University's Creative Sustainability Master's program. Each year, student groups team up with a Finnish ministry to address a specific brief assigned by the ministry. This year, our team collaborated with Kela and the Ministry of Health and Social Affairs to tackle the brief "Towards a better healthcare system: Exploring Continuity of Care as a new Kela reimbursement model."

Our project addresses the critical issue of continuity of care within the Finnish healthcare system. Continuity of care, defined as the process by which the patient and their physician-led care team are cooperatively involved in ongoing healthcare management toward the shared goal of high-quality, cost-effective medical care. (AAFP, 2015) Given the complexity and scale of the Finnish healthcare system, this project presents a unique challenge that requires innovative solutions and multi-faceted approaches.

To thoroughly explore and address this challenge, three distinct groups were formed during this course project, each focusing on a different perspective within the healthcare system. One group examined the issue from the patient's point of view, another from the doctor's perspective, and our group focused on the administrative perspective. By analyzing continuity of care through these varied perspectives, we aim to develop comprehensive

and practical solutions that can enhance the overall performance and effectiveness of the healthcare system.

Our group's approach is rooted in the administrative perspective, considering the broader systemic aspects that influence continuity of care. This perspective is crucial for understanding the barriers and facilitators within the current healthcare infrastructure and for identifying leverage points that can drive positive change. By leveraging insights from our research and collaboration with key stakeholders, we have aimed to support the continuity of care and improve healthcare outcomes for all caregivers and caretakers.

In this project report, we will outline the supergroup vision, our research methods, including desk research, stakeholder interviews, and benchmarking. Key findings on administrative burdens, fragmented communication, inadequate support staff, and demographic challenges will be summarized. We will analyze perspectives from patients, doctors, and administrators, and present our comprehensive proposal for improvement, focusing on streamlining tasks, promoting collaboration, and pilot testing team configurations. Finally, we will discuss the implementation plan, anticipated benefits, and long-term impacts, concluding with our final thoughts on enhancing continuity of care in the Finnish healthcare system.

Vision

All three groups –also called “Supergroup” during this project– collaborated to develop a unified vision to guide our efforts towards a common goal. This vision serves as a guiding light for our work. Each group examined the Finnish healthcare system and continuity of care through different lenses–patients, doctors, and administration–and decided to pursue distinct methods or ‘entry points’ to achieve this vision.

Our vision addresses key enablers of continuity of care in the Finnish healthcare system, identified through secondary research and a roundtable discussion with our partners: Kela, the Ministry of Health and Social Affairs, and members of the Suomen Lääkäriliiton (Finnish Medical Association). The crucial points we decided to address are:

Trust:

Currently, there is a lack of trust both from patients towards the healthcare system and from doctors towards the working conditions within the system. Indeed, as a poll conducted by Taloustutkimus revealed, only “Half of people in Finland said they believe public health services will care for their needs” (Yle News, 2024).

Sustainability:

We aim to create a system that can endure over time and handle periods of high medical demand, such as pandemics, without overburdening medical staff or depleting public funds. Our research indeed revealed that the Finnish healthcare system has gone through multiple structural changes throughout Finnish history. This was in part due to national needs –such as wars or the recession– which forced the healthcare system to adapt to the different demands and demographics of the country (Kokko, 2009). These facts we also confirmed and supported during our roundtable discussion with our partners (Design for Government, 2024). However, this also created confusion and disillusion during these adaptation periods –which were not always as smooth as expected– of the population/ patients towards their healthcare system.

Collaboration:

We need to enhance collaboration between patients and medical staff, and among medical staff members themselves. Today, medical staff often work in fragmented and isolated environments (Design for Government, 2024), which negatively impacts efficiency and job satisfaction. Our research showed that teamwork improves efficiency, job satisfaction, and even reduces burnouts (Taranu et al., 2022).

The Feeling of Being Cared For and Doing Something Meaningful:

The current lack of human contact, collaboration, and trust hinders the overall experience for patients, doctors, and medical staff.

We believe these points are the necessary ingredients to bake a Finnish healthcare system that excels in continuity of care. Taking them into account, the vision we developed as the “Supergroup”:

“We provide a trustworthy and sustainable healthcare system that fosters collaborative and meaningful care for patients and staff in a society where everyone feels cared for.”



By achieving this vision, we will create a Finnish healthcare system that embodies trust, sustainability, collaboration, and a sense of meaningful care. Considering our group approach to administration, this will bridge the gap between patients and healthcare providers, ensuring that medical professionals can focus on their core responsibilities without unnecessary administrative burdens.

As a result, patient care will become more consistent and efficient, enhancing overall satisfaction and reducing the workload among healthcare staff. Ultimately, this transformation will foster a healthcare environment where continuity of care is the norm, leading to better health outcomes and a more resilient healthcare system for future generations.

Research & Methods

In our research process, we used a variety of methods to ensure that we had a holistic understanding of the Finnish healthcare system.

Desk Research

First, we turned to desk research to get a broad overview of how the primary healthcare system operates and functions. To do this, we read several studies, including material provided to us by our partners. Our priority was in understanding Finnish healthcare in the context of continuity of care as well as the new health reform and the *omalääkäri* model. In addition, we conducted benchmarking to compare the Finnish healthcare system with that of other countries, focusing on Türkiye, France, Norway, and Germany.

Roundtable Discussion

Simultaneously with our desk research, we had the first roundtable discussion with our partners. This was not only to get to know our partners but also to get a better overview of the brief and to ask fundamental questions about Finnish healthcare. Previously we had agreed on a structure within the supergroup and selected questions that we summarized under the topics of continuity of care, general questions about the brief, and finances.



Picture 1: The first meeting with our partners: The roundtable discussion



Fig. 1: Timeline of our research process throughout the project.

Interviews and workshops

Due to the complexity of the issue, it was important for us to gain insights from different perspectives. To do this, we contacted and interviewed various stakeholders. These consisted of distinct medical staff members, including doctors, nurses and secretaries, administrative staff as well as medical personnel from different countries.

The interviews were semi-structured and were conducted either alone or within a group. In addition to the interviews, we also held two workshops with some of the stakeholders. It was important for us to work with the interviewees in a solution-oriented way, to develop a concept together with them, and to listen to their ideas and objections. To this end, we first held a workshop with a person working in the administrative field, and later we held a workshop with a general practitioner, two nurses, and a secretary, all working in the public sector. The variety of the group allowed us many different insights and points of view.

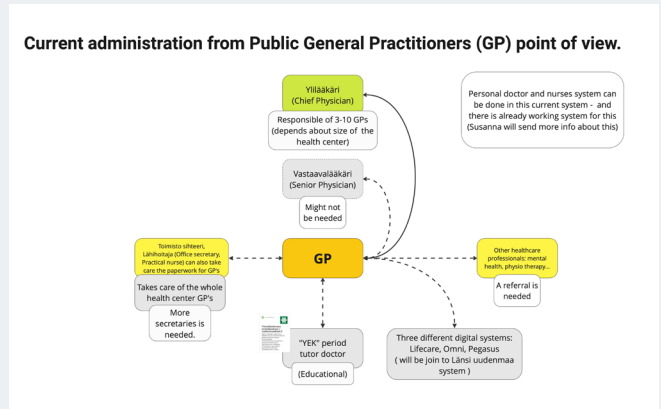


Fig. 2: Workshop 1: participants: 1 administrative officer, goal: understanding the current administration in public health care

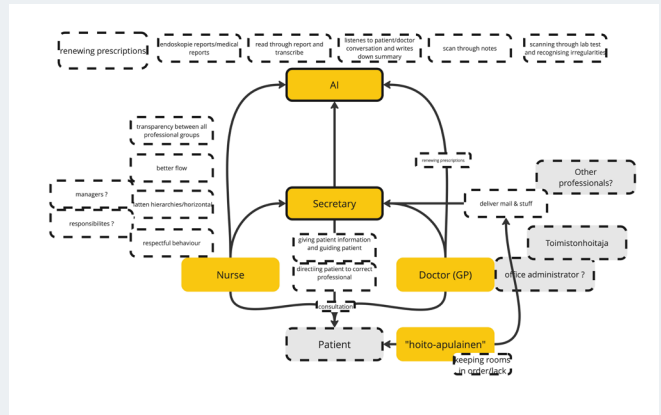


Fig. 3: Workshop 2: participants: 1 doctor, 2 nurses, 1 secretary, all working in public primary healthcare. goal: understanding healthcare team tasks and dynamics

Our Interviewees:

- 2x General Practitioners working in the public sector
- 1x Specialist working in the public sector
- 1x Specialist working abroad
- 1x General practitioner working in the private sector
- 3x Nurses working in the public sector
- 2x Secretaries working in the public sector
- 4x Administrative staff members
- 1 Medical student

Field trip to Nummela

Since many of us are international students and therefore not as acquainted with primary health care in Finland, it was particularly important for us to visit a health center to make sure that we understand and can imagine the physical environment in which we operate. To this end, we made a field trip to the Nummela Health Center, where we interviewed the Senior consultant physician, (Valtteri Kiuru), and were given a tour of the health center. Previously we had sent a research request to LUVN and were referred to the Nummela health center.



Picture 2: Tray of the emergency room in the Nummela healthcenter



Picture 3: Hallway of the Healthcenter



Picture 4: Examination room in the Nummela healthcenter

Affinity Mapping

In preparation for the Midterm presentation, we made use of an affiliation diagram, to further narrow down our research. Therefore we gathered all the insights we had gained so far and grouped them into topics. In a follow-up step, we determined which points were most important to our topic, especially the administrative perspective, and have thus narrowed down the topic better in order to work in a more targeted manner.

Midterm Presentation

In the mid-term presentation, the previous findings as well as “opportunity areas” were presented to our partners, who were then able to give their feedback in a supergroup context. This gave us further valuable insights and food for thought, as well as an insight into whether our concepts are conclusive.

Ideation Session

The ideation session was used to present the current state of our concept as well as to discuss it with our partners in a solution-oriented approach. Each group presented three selected entry points, which we further developed with the help of our partners and were able to clarify any questions.

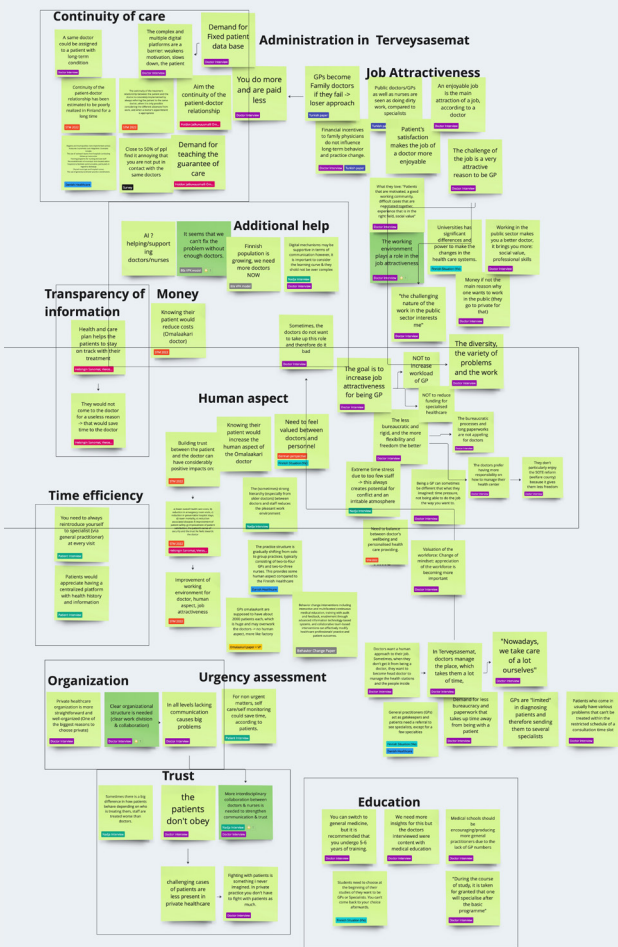
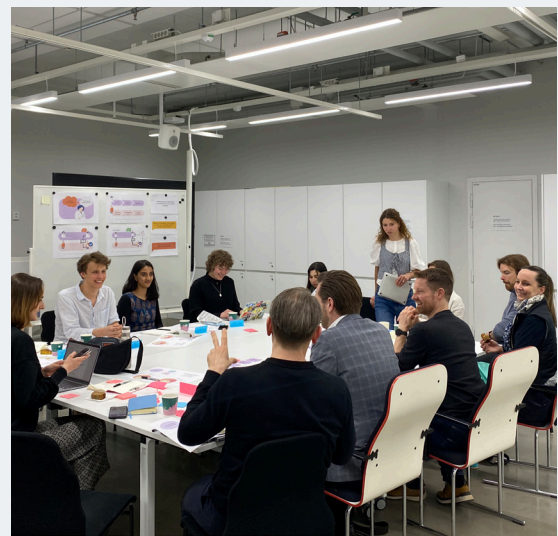


Fig. 4: Our Affinity Map in preparation of the midterm presentation



Picture 5: At the ideation session we present our progress to our partners and collectively discuss our entrypoints.

Findings

Through a comprehensive analysis of our desk research and engagement with key stakeholders, we have identified several critical findings that highlight the current challenges and opportunities for improving continuity of care from an administrative perspective.

Key Findings

1. Inadequate Support Staff:

The reduction of support staff due to budget constraints has increased the workload on medical professionals. Tasks such as scheduling, documentation, and organizing, which could be handled by support staff, are instead performed by doctors and nurses, further exacerbating the workload.

2. Workload and Stress:

The high workload and constant feeling of rush among healthcare professionals negatively impact their job satisfaction and the quality of care they provide. Reducing non-medical tasks and improving work conditions can alleviate stress and enhance the overall work environment.

3. Fragmented Communication:

Effective communication within the healthcare system is lacking. The current setup involves multiple, non-integrated digital systems that complicate the workflow and lead to errors. Improved communication channels and integrated systems are essential to streamline processes and enhance care continuity.



“13.7% of doctors experienced a lot of work pressure and little control over their work in 2021, compared to 6.5% in 2015, meaning that the number of doctors suffering from work stress has more than doubled during the observation period.”

Eskola et al., 2022, STM's Omalääkäri 2.0 Paper

4. Administrative Burden:

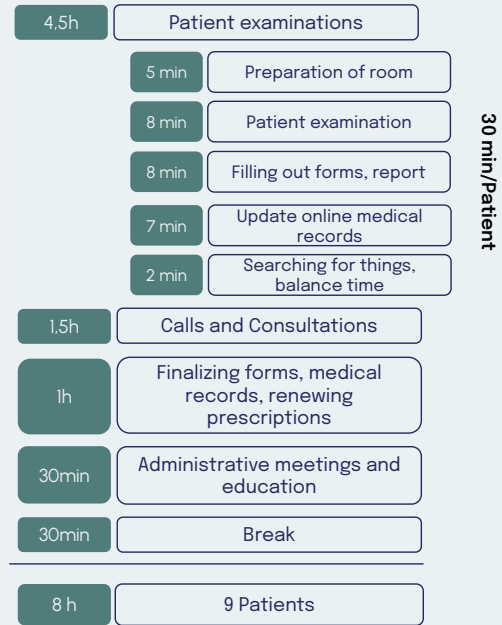
Doctors and nurses are significantly burdened with administrative tasks that detract from their primary role of patient care. During the office day, physicians spend 27.0% of their total time on direct clinical face time with patients and 49.2%. (Bud, 2023)

This administrative overload leads to inefficiencies and impacts the quality of care provided. The accompanying schedule illustrates how doctors and nurses spend a substantial portion of their workday on non-clinical tasks, highlighting the need for better support systems.

“During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR [electronic health records] and desk work”

(Bud, 2023)

Doctor - Workday (8-16)



Nurse - Workday (8-16)

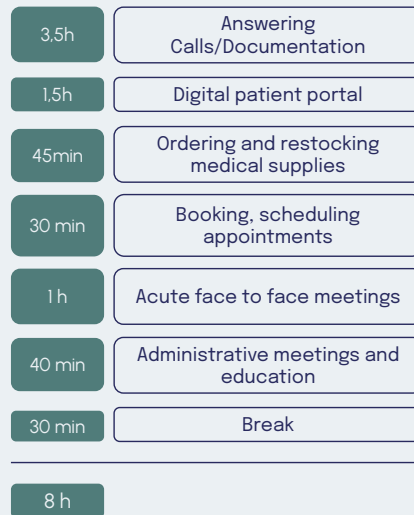


Fig. 5: Visualization of a doctor’s and a nurse’s daily schedule

5. Physical and Digital Work Environment:

Healthcare professionals face challenges both within their physical and digital work environments. Non-optimized workspaces and fragmented digital systems contribute to inefficiency and stress. Addressing these issues through better infrastructure and cohesive digital tools can significantly improve workflow and job satisfaction.

6. Changing Demographics lead to increasing demand:

Finland is experiencing significant demographic shifts, with an aging population that will increase the demand for healthcare services. This demographic change will place additional strain on the healthcare system, making it necessary to develop sustainable models of care that can accommodate the growing needs of an older population with more chronic illnesses.

7. Threat of Discontinuity & Unmet Demand:

Despite recent increases in the number of doctors due to reforms, there is still an unmet demand in Finnish healthcare. Long patient queues are common, and the challenge lies deeper in the system’s value and workload issues, not merely in the number of doctors.

“Patients face long waiting times, 17% wait for more than 1 month for access to a physician in primary healthcare” (Lääkäriliitto, 2016)

8. Doctor Attrition:

The demanding nature of the job has been driving doctors away from the public sector or reducing their working hours, exacerbating the workload for those who remain and perpetuating a cycle of burnout and attrition.

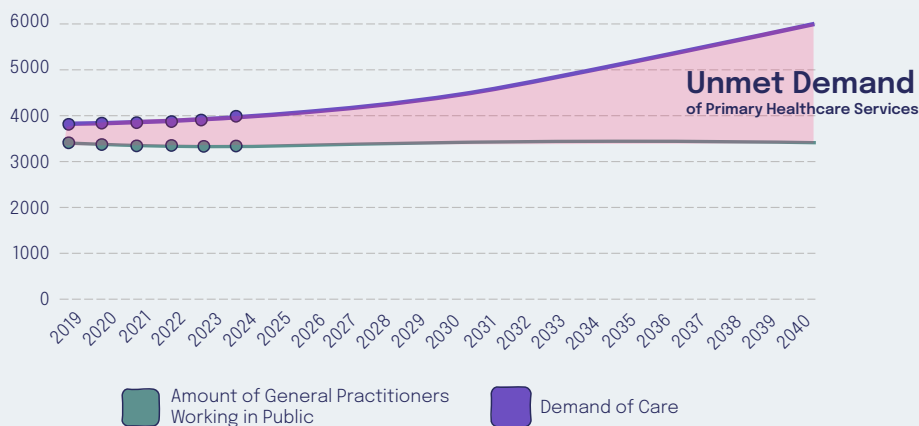


Fig. 6: Graph showing the thread of discontinuity of care

By addressing these findings through improved administrative practices, we have aimed to enhance the continuity of care and overall healthcare outcomes in Finland. Our proposals are informed by successful models from other countries, stakeholder feedback, and a deep understanding of the current challenges within the Finnish healthcare system

Narrative for Change:

With these findings, we understood that the time to act was now.

Medical staff in the public sector are overworked, frustrated, and stressed. This is in part due to the fact that in their workday they are forced to do things that are not their expertise or their area of responsibility. This prevents them from properly executing their work as a doctor or a nurse, meaning the number of patients they can see decreases. Public health centers are already overburdened, but this trend will increase as more and more medical staff leave the public sector due to poor working conditions.

At the same time, the demand for care will increase in the coming years. On the one hand, Finland, like many other countries, has a

changing demographic, meaning more elderly people in the near future who will need more nursing and medical care. Simultaneously, the demand for care in general will increase (more pandemics, etc.). The current primary healthcare system cannot cope with this demand. There is a gap showing the unmet demand that will continue to grow in the future if the way healthcare is delivered is not changed.

A common misconception is that more doctors will provide more continuity of care and will close the gap.

Although there is a shortage of doctors (8% meaning about 300 doctors), the main reason for this gap is the way the medical staff works. Even if more doctors were employed and more medical students were admitted, the vicious circle would be repeated. Medical staff would continue to be overworked, would continue to do things that are not their responsibility, would become frustrated and stressed, and would decide to go into the private sector or work part-time. The key to improving continuity of care is not to increase the number of physicians but to increase the amount of time physicians spend with patients. To achieve this, physicians and medical staff must have more time in their daily routines to care for patients.

Opportunity Areas:

Based on these insights, we have identified three main areas that have influence on continuity of care:

The Work Environment: this includes the physical environment that the medical staff is operating in as well as legal frames and restrictions.

The team: This includes social interaction and the psychological demands placed on medical staff.

Work distribution: This refers to the distribution of tasks and the allocation of time.

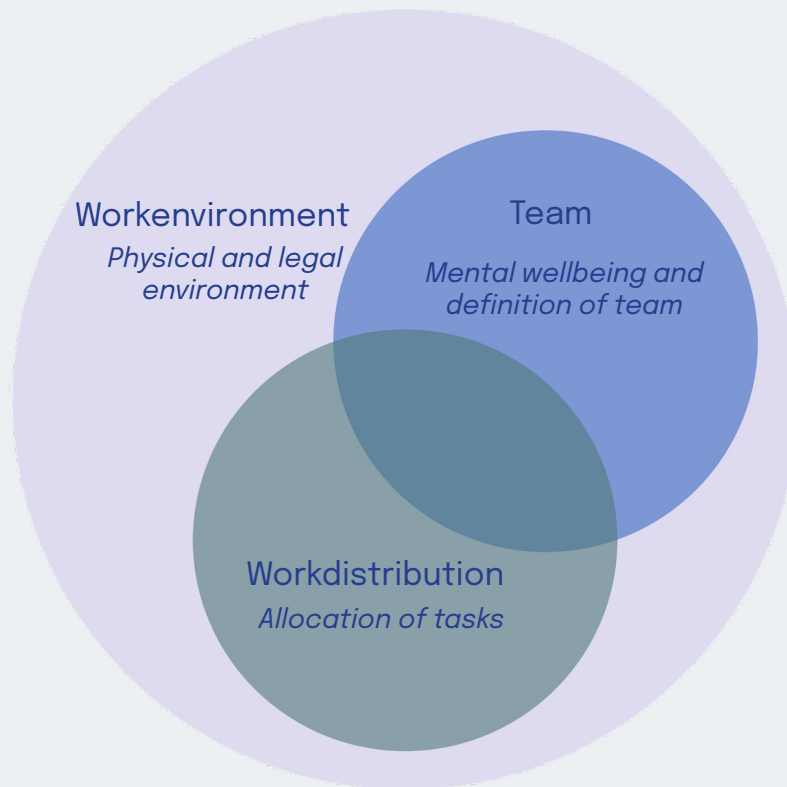


Fig. 7: Our identified opportunity areas

Definitions

Entrypoint:

An entry point is an effective place within a system where work to improve it might begin. It is a focused enough opportunity to be actionable, yet strategic enough to help unlock new opportunities towards broader goals (Steinberg, 2024)

Opportunity Area:

An opportunity area in design thinking is a specific domain or aspect within a problem space that has potential for innovation and improvement. It is identified through research and insights as a promising focus for generating impactful and user-centered solutions.

Entrypoints:

We have created entrypoints in our team to help intervene in this problem. out of the previous 8, we decided on three that seemed most effective for addressing this vicious circle with simple means.

1. Pilot test of optimal team constellations:

Within one or several health centers create a variety of constellations of teams.

Example:

- Doctor - Nurse- Secretary;
- Doctor- nurse - Medical office administrator
- Doctor- Doctor- Nurse- Secretary- AI Specialist.

And by that ascertain the „starforce“ that works best.

2. Streamlining Administrative Tasks:

Implementing efficient administrative systems or utilizing AI to automate routine tasks, to reduce doctors' workload and free up more time for patient care. This could involve developing user-friendly interfaces for electronic health records systems, optimizing appointment scheduling processes, or employing virtual assistants to handle administrative requests.

3. Promoting Collaborative Training:

Investing in professional development opportunities that unite medical teams through collaborative training programs, workshops, and seminars, enhancing teamwork and improving care delivery.



Proposal:

After agreeing on the most efficient entry points to proceed with, namely a pilot, testing optimal team constellations our group began working on the concrete proposal.

Freeing up time for patient care

We discovered through our interviews and workshops that many tasks currently handled by nurses and doctors could be delegated to non-medical workers. This would free up doctors and nurses to focus more of their time on patient care and other medical-related tasks.

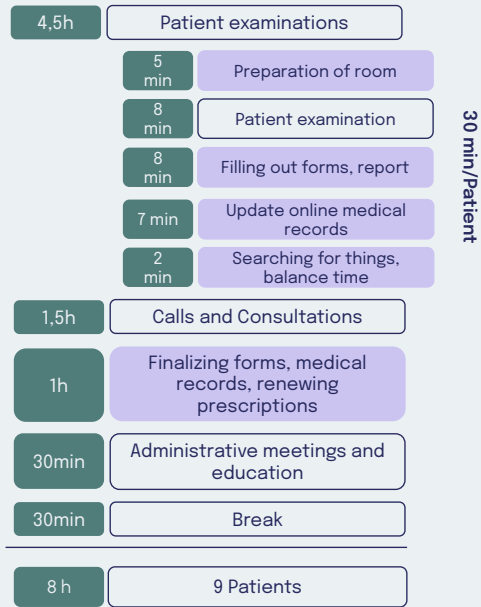
A proposal detailing the average working day for a primary health care doctor and nurse is provided in figure 8.

By delegating non-medical tasks to other staff, doctors and nurses could focus a lot more time on patient care. In this visualization (figure 9), the doctors time with the patient increases from 8 to 15 minutes. The amount of patients the doctor can see in one day almost doubles going from 9 to 15 patients per day. Furthermore, nurses could have 3 hours in their schedule dedicated to patient care resulting in about 10 min

per patient. This can be used for example to do a pre-examination or guide the patient through their treatment. This extra time with the patient is extremely valuable when building a more trustful and continuous relationship between patients and the medical staff.



Doctor - Workday (8-16)

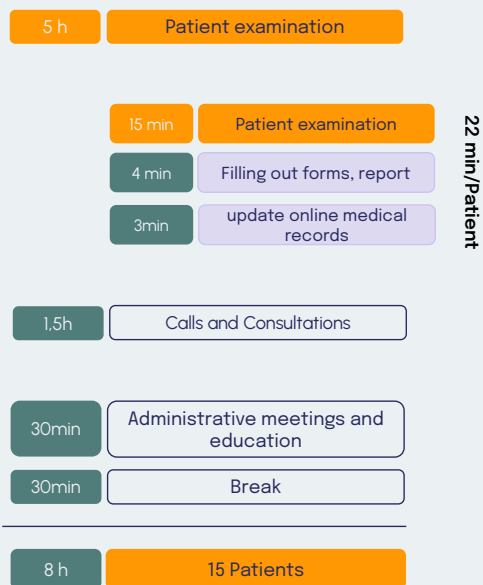


Nurse - Workday (8-16)



Fig. 8: Visualization of a doctor's and a nurse's daily schedule, highlighting non medical tasks

Doctor - Workday (8-16)



Nurse - Workday (8-16)

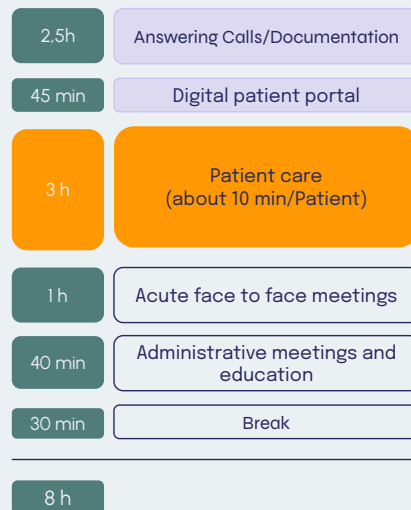


Fig. 9: Visualization of an optimized doctor's and a nurse's daily schedule

Team based care

Redistributing medical tasks among medical team members offers numerous benefits.

“Implementing team-based care has been shown to reduce the time physicians spend on patient care by one-third, significantly enhancing operational efficiency and patient capacity in healthcare settings.”

Porter et al. (2022)

Our proposal aims to reinforce the primary medical team dynamics and consists of four different stages: The pilot phase, the expanding phase, integrating Interdisciplinary education, and finally team-based care.

These stages would happen simultaneously over time so that the next phase will get maximum benefits from the learning gained from the earlier phases.

Pilot „Symphony“

To gain a more comprehensive understanding of what would be an ideal medical team for primary healthcare we propose a pilot program.

The focus of this pilot program shall be directed toward an area that mirrors the demographic composition and healthcare service demands of Finland ten years from now.

This location is anticipated to have an aging population and varying healthcare service requirements, thereby serving as a litmus test for the adaptability and resilience of this pilot proposal.

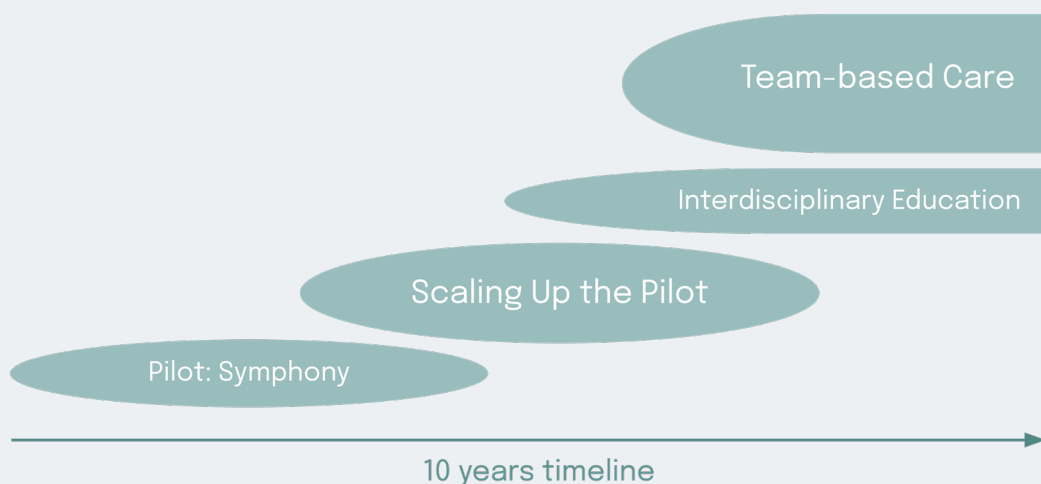


Fig. 10: Scaling up from the pilot to team based care

1. Piloting Hanko

Hanko is being considered as a potential piloting area because of its aging demographics and varying demand for healthcare services during the peak of the population during the summer time tourism.

We intend to extend an invitation to the personnel at the Hanko Health Center to voluntarily participate in this pilot endeavor. The local medical director, in collaboration with an external consultant, will be responsible for recruiting healthcare professionals and determining the most suitable team structures.

Multiple different teams should be constructed to find out how different team compositions compare. These medical teams may consist of nurses, doctors, medical administrators, AI specialists, and team assistants

2. Balanced Worktasks

To find out an optimal task distribution is the most important part of this pilot. So after pilot teams have been decided a thorough list of tasks similar to that presented earlier will be formulated to create job descriptions for all pilot team

members. The primary aim of this pilot is to experiment with diverse team compositions and ascertain the most effective configuration of team composition and task distribution within them.



Fig. 11: How to create different teams within the pilot

3. Ensuring harmony and trust in the team

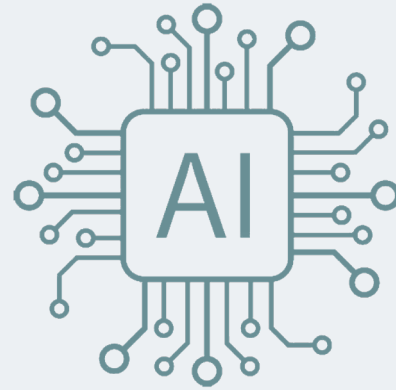
In this pilot project, it is also extremely important to us that the team dynamics are harmonious from a social point of view, in addition to efficiency. Social interaction between colleagues is particularly important in the medical field, and not only does it increase the sense of well-being at work, but good teamwork also ensures that everyone in the team feels comfortable and can speak their minds openly. This not only reduces the number of errors that occur during work, but also lowers the threshold for hierarchies, which are often very pronounced in medicine. The pilot should work towards a team with a low hierarchy, where everyone feels understood and trusts each other. Building trust takes time, a study by Towers Watson found that it takes seven months to build trust with people, and we are taking this into account when planning the pilot. To gain trust, we want to create opportunities for teams to get to know each other outside of the often stressful work environment. We also want to ensure that positive team behaviors such as transparent communication, collaborative decision-making, and training practices that foster empathy and teamwork are reinforced and sustained.

4. Vocational Training for teammates

As the proposal suggests integrating new workers as part of the team, it needs to be clarified how they need to be trained to best support the team. In the countries we benchmarked, these workers are either trained in a vocational training profession, i.e. a combination of practical work in the practices and schooling in a vocational school. At the same time, they often employ lateral entrants who are trained directly in the practices, but whose responsibilities are often more limited than those of fully trained staff. This freedom in hiring is mainly due to the fact that doctors in other countries often work as entrepreneurs and are independently responsible for the staff in their practices. Since the health centers in Finland are provided by the welfare districts, the responsibility for training would also lie here. Depending on their position, it would be important for the employees to know medical procedures and organization in the workplace, i.e. how to use the systems and how to handle patient data, in order to support the medical team in the best possible way. In other countries, this training takes about 2 - 3 years, depending on the level of qualification.

5. Use of Artificial Intelligence

The pilot will also provide an opportunity to look more closely at the role of AI in healthcare, in particular the benefits and limitations of AI. In any case, AI can simplify administrative processes, such as writing or interpreting reports or updating medical records.



6. Benefits of the pilot

By employing a team-based approach, we believe we can enhance job satisfaction, which, in turn, can reduce the likelihood of doctors transitioning to the private sector or opting for part-time work and by redistributing tasks medical professionals have more time to do what's in their expertise. This will result in patients having more time with their doctor. Ultimately, our goal is to establish a primary care system comprised of passionate and purpose-driven professionals capable of delivering exceptional continuity of care.

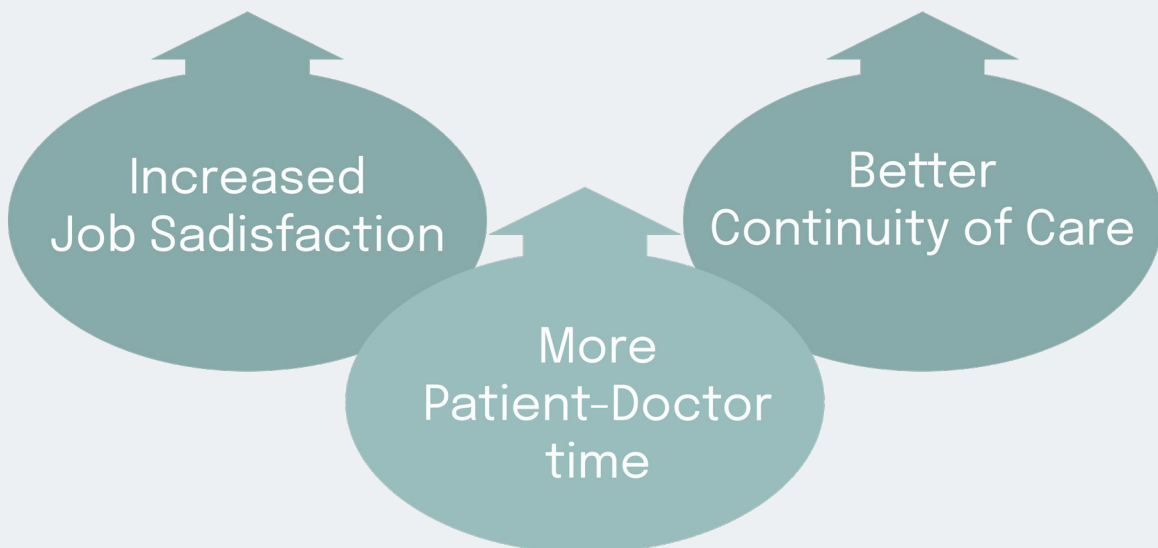


Fig. 12: Benefits of a team base approach to care

7. Scaling up the Pilot

Given the diverse healthcare needs of Finland, owing to variations in population demographics across different regions, it is evident that a single model cannot feasibly cater to the nation as a whole. Thus, our subsequent step will involve the testing of this approach in various locations in Finland, with a continued emphasis on gathering feedback to ensure the customization of the model to suit each unique region.

The scaling-up phase should take place after satisfactory results have occurred from the first pilot phase. However, the scaling-up process could be ongoing simultaneously as the first phase is still running not limiting the overall process. Ideally, the scaling up should be completed within the next ten years so that the findings and circumstances from the first pilot phase would not have changed too dramatically.

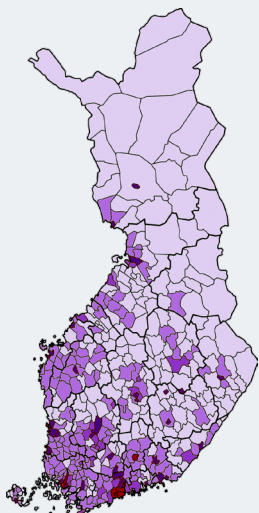


Fig. 13: Map showing the varying population density of Finland

Future Vision

Our overarching aspiration is to raise a new generation of medical professionals who naturally embrace a collaborative approach in their work. To achieve this, we assert the significance of collaboration skills within the educational curriculum of doctors and nurses. We propose the integration of joint classes where future medical practitioners can familiarize themselves with one another. Through these joint classes, we aim to prevent the development of hierarchies within the medical sector and support team dynamics in future working communities.

By adopting this team-based approach, we anticipate heightened levels of job satisfaction among medical practitioners, mitigating rates of burnout and the migration of doctors to the private sector or part-time employment.

Consequently, we aim to cultivate a primary care system consisting of dedicated and purpose-driven professionals capable of providing outstanding continuity of care.

Team education aims to break down existing boundaries and reduce the risk of hierarchical development. When medical students spend more time together, more trust and empathy will be formed between them.

Possible limitations

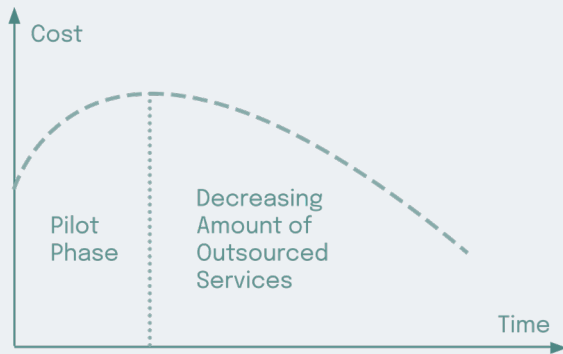


Fig. 14: Costs will be saved on the long run when adopting team based care

1. Cost savings in the long run

Undoubtedly, the implementation of the pilot and its underlying initiatives will necessitate substantial resources in the initial phases. This will encompass the recruitment, training, and integration of new personnel to form an efficient team. However, the ultimate goal of this team-based approach is to enhance the quality and efficiency of patient care, enabling the public sector to cater to a larger patient populace without the necessity of outsourcing care from the private sector. This, in turn, is expected to yield long-term cost reductions.

2. Changing the education system takes time and political will

University collaboration with the vocational school system can pose challenges for training new personnel. Implementing a new curriculum that targets the needs of a team-based care may take several years. So would implementing trainings for entirely new jobs, like the ones we are proposing in the pilot.

3. Limitations to the use of AI

Often there are very justified concerns as to how much AI should be allowed into the patient's room, whether and how AI should be part of the patient interview, how comfortable patients feel with the presence of AI, and whether it affects the trust between doctor and patient.

Bigger questions, such as responsibility for medical decisions or how patient data will be handled in the future, could be explored in this pilot, but will ultimately be left to higher authorities.

4. Challenges of integrating a low hierarchy mindset

Connection universities and vocational schools is a politically challenging issue. Breaking down the paradigm of working class versus white-collar workers in the education system may be more difficult than in the healthcare system. Discussing salaries can be particularly challenging when trying to form equally balanced teams and work tasks.

5. Building trust needs time and commitment

The studies show that building trust takes time and losing it is very easier. Strong trust in the medical team should develop naturally over time. This would mean that all team members are committed to the work and share a common vision.

The purpose of having a shared vision is to ensure that the medical team collaborates effectively as a unified entity. It is important to review and update this vision on a regular basis. However, finding the time and resources to conduct vision-building workshops regularly can be quite challenging and in some cases even impossible.

Personal critical reflections

Throughout this project, we faced several challenges and learned valuable lessons, which contributed to our professional growth and understanding of working within complex systems.

Firstly, we recognized the importance of speaking the same language as our client. Given that medical assistants were once part of the Finnish healthcare team, we had to craft a fit argument for their reintroduction. It wasn't enough to simply state that medical assistants were needed for continuity of care—our partners were likely already aware of this. Instead, we had to demonstrate that our proposal to reinstate medical assistants was both necessary and cost-efficient—which was the part our partners were the most dubious about. This required us to deeply understand our partners' perspectives and priorities, essentially putting ourselves in their shoes to ensure our proposal resonated with them.

Coordination within the Supergroup was another significant challenge. With 12 highly motivated aspiring designers, each of us had our

own ideas and perspectives, which often made decision-making a tedious task. Effective communication within and between the groups was crucial, yet it sometimes proved to be time-consuming. We had to develop strategies to streamline communication and ensure that everyone's voice was heard without delaying progress.

Understanding the brief and the intricacies of the Finnish primary healthcare system also demanded considerable time and effort. Navigating the complexities of such a large and multifaceted organization like Kela provided us with a real-world professional experience. This process, while educational, often left us feeling confused and uncertain about the direction of our project. It highlighted the recurring nature of such challenges when working with complex organizations.

Despite these challenges, we are proud of the outcome of our work and how we managed our group dynamics. While our idea may not be groundbreaking or revolutionary, its simplicity is its strength. It effectively addresses the current administrative needs of the healthcare system, as evidenced by the positive feedback from our partners during our final presentation.

Overall, this project has been a rewarding learning experience, equipping us with practical skills and insights that will be invaluable in our future careers.

Conclusion

The collaborative project by Aalto University's Design for Government course, in partnership with Kela and the Ministry of Health and Social Affairs, has provided a comprehensive analysis of the administrative challenges impeding continuity of care in the Finnish healthcare system. Our findings have identified key barriers such as high workloads, administrative burdens, and fragmented communication, all of which contribute to reduced job satisfaction among healthcare professionals and compromised patient care.

By benchmarking against healthcare systems in Türkiye, France, Norway, and Germany, and through stakeholder engagement, we have developed actionable recommendations centered on optimizing team constellations within health centers. Our proposed pilot project in Hanko aims to test and refine these team structures, emphasizing the redistribution of administrative tasks, enhanced support staff roles, and the integration of AI for routine functions. This approach seeks better interprofessional collaboration and job satisfaction, to free healthcare professionals to focus more on patient care.

The pilot project represents a crucial first step towards creating a sustainable, resilient healthcare system where continuity of care is a foundational element. The iterative process of feedback and refinement will ensure that the solutions are adaptable, scalable, and therefore capable of meeting the diverse needs of different regions in Finland. Our long-term vision is a healthcare system consisting of cohesive, well-integrated teams operating, leading to improved health outcomes and higher satisfaction for both patients and healthcare providers.



Appendix

All original entrypoints:

A: Fostering Supportive Work Environments: Create environments that foster collaboration, camaraderie, and mutual respect among healthcare professionals. This could involve redesigning physical spaces to facilitate informal interactions, organizing team-building activities, and promoting a culture of appreciation and recognition for the contributions of all staff members.

B: Enhancing Interprofessional Collaboration: Foster a culture of collaboration and mutual respect between doctors, nurses, and other healthcare staff members. This could involve team-building activities, interprofessional training programs, and opportunities for shared decision-making and feedback.

C: Healthcare Policy Reform: Advocating for healthcare policy reform to establish effective teamwork models, aiming to redistribute workloads and improve the continuity of care provided by healthcare professionals.

D: Exploring the benefits of monthly get togethers (including a free lunch?): A monthly/weekly/biweekly get together to discuss worries/concerns within the health center. Helps with more open and healthier communication. If something like a free lunch is offered people might be more inclined to come ?

E: Interdisciplinary class with future medical team members (nurses, doctors, secretaries students): Creating a sense of familiarity between the future medical team members, from their education onwards. This would aim to foster teamwork skills and a deep understanding of each profession's role in patient care.

F: Support and communication for the workforce in the healthcare center: Providing the medical staff with an intranet platform on which they can ask whatever questions to the rest of the health center workforce (like the printer not working, a tool missing, or socializing).

G: Changing Primary Medical Team Public Image: Building common understanding for the patient by learning about the whole team. (nurse, doctor, secretary). This could be achieved by making a movie series where patients/regular people would learn about the team dynamics and understand how the healthcare process works to provide treatment to patients.

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