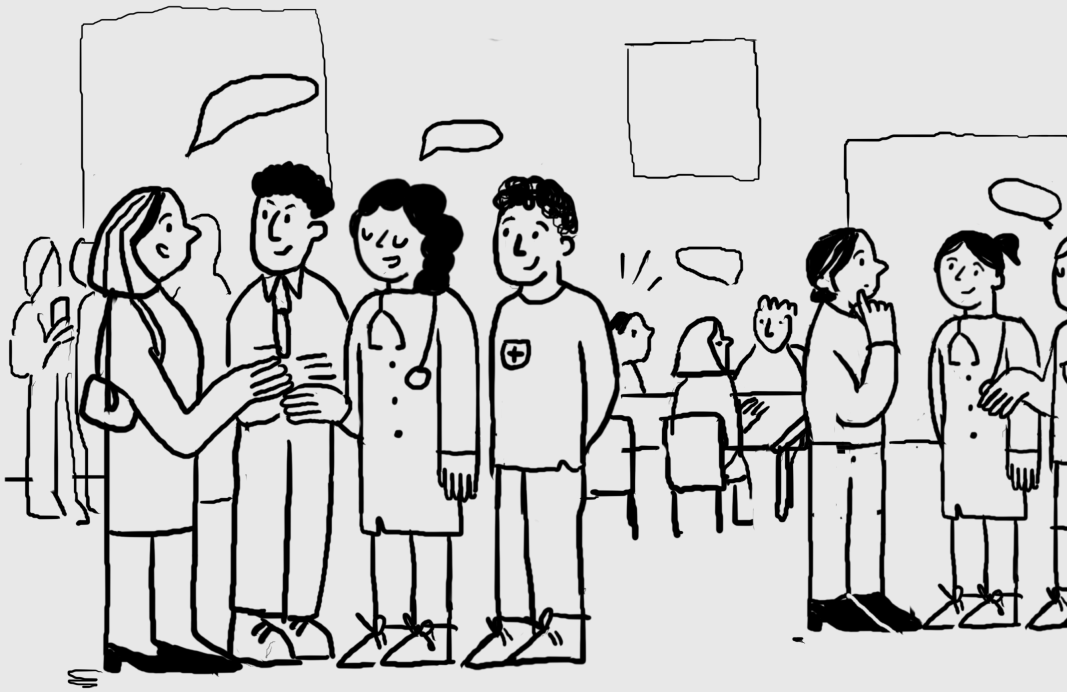
# Co-Innovate.

## Fostering follow-up culture in Finnish healthcare.

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# Executive Summary

**Problem**
The Finnish healthcare system faces significant challenges in establishing continuity of care. These challenges are most evident in primary healthcare, where general practitioners experience barriers such as fragmented patient interactions, inconsistent follow-up practices, and a lack of systemic support for long-term patient relationships. These issues contribute to reduced patient satisfaction, and problems for public health to retain workers.

**Recommended Solution**
This project proposes a bottoms up approach that supports individual health centres in innovating solutions to increase follow-up culture. By supporting the development of follow-up culture, the abundance of the issues in doctors working conditions can be addressed. Through the suggested Co-Innovation Programme, health centres develop their own innovations and receive support from each other, Kela, and possible other stakeholders. Subsequently, a number of health centres are chosen to implement their innovation. During the implementation, value based outcomes are measured and the innovations are evaluated continuously within and between the participating health centres. Finally, the reports from the trials are published and other health centres may implement the knowledge developed.

**Benefits**
Health centres across Finland operate within different population density and demographic structures which makes it difficult to create one solution that fits all. By allowing health centres to create their own innovations, we allow knowledge creation for these individual cases. Furthermore, by establishing networks across health centres the produced knowledge can be shared, adapted and further developed. In addition to strategically targeting the described challenges through establishing follow-up culture, the proposed solution establishes a shared development goal for all health centres.

**Conclusion**
The proposal allows individual health centres to innovate solutions for follow-up culture. These innovations will solve problems related to the working conditions of doctors, which in return will increase the continuity of care. The established routines and value based measurements create the basis for further developments towards continuity of care. To achieve this, government stakeholders must assume a role which supports bottom up developments, and support health centres in knowledge creation. Furthermore, a shift from numbers based to value based measurements is needed to ensure the continuous development towards continuity of care.

## THE BRIEF

# Towards a better healthcare system: Exploring continuity of care as a new Kela reimbursement model.

### Kela and the Ministry of social affairs and health

The current Finnish healthcare model presents a fragmented and unequal access-to-healthcare landscape. Healthcare costs have been rising without a corresponding improvement in the quality of care outcomes, resulting in patients experiencing discontinuities in care.

This situation is financially and socially unsustainable. To bring about change, actions are needed at different levels: changes in law, new funding mechanisms, and new approaches to test and implement a new incentive model.

The goal is to explore ways to evolve the Kela reimbursement model to support continuity of care and create a better impact on healthcare in the long term.

Kela is working to develop a revised patient reimbursement model to enhance the continuity of patient-doctor relationships, improve the availability of healthcare services, and ensure more equitable access to healthcare services, while reducing costs and preventing future increases.

The role of the groups was to identify incentives that will foster the desired behaviours toward continuity of care in primary healthcare and to determine how the reimbursement model can support these behaviours. Additionally, it was crucial to consider this ideal outcome from the different perspectives of the actors involved and to understand the barriers to achieving it.

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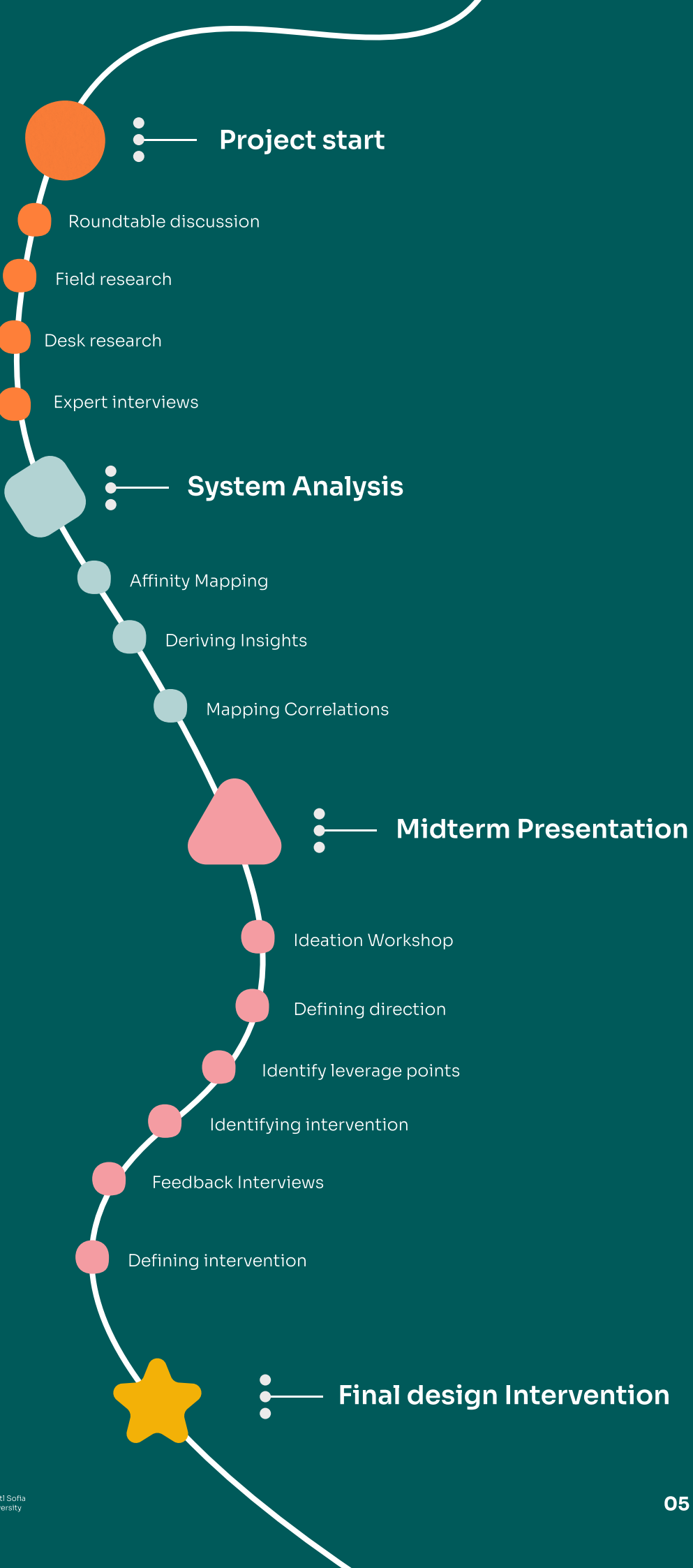


# 2. Research


Figure 1. The two worlds of AI.

# Roundtable discussion

Based on the brief provided and after reviewing documents on the New Kela Reimbursement model(Uusi Kela-korvaus: Kuinka Se Toimii?, 2023), The health reform in Finland (Saltman & Teperi, 2016), The SOTE reform (Finland's Health and Social Services Reform,2022) and the Continuity of Care model (Hoidon Jatkuvuusmalli, Omalääkäri 2.0 -selvityksen Loppuraportti, 2022), many questions arose about the actual functioning of the current Finnish healthcare system and the efforts being made towards Continuity of Care. This preparation guided us in formulating the questions and queries for our first roundtable discussion session which also included discussion on our perceived meaning on continuity of care. Our initial roundtable discussion brought together all members of the Super group working on this brief, as well as our partners.

It included healthcare professionals such as the Medical Director at Kela's Research Unit, a general practitioner and specialist in public health medicine, a general practitioner who also heads the policy department, and our partners from Kela, including the Senior Lead at Human Foresight and Strategy and the Lead Service Designer at Kela's Innovation and Growth Department.

The discussion was semi-formal and broadly structured into **four areas that we wished to touch upon: understanding continuity of care, understanding the specifics of the brief, understanding how the reimbursement model currently works with private healthcare and its specifics, and finally, the finances involved.**

After the roundtable discussion, we charted out some aspects of the healthcare system and understood our challenge from that perspective.

We understood the Finnish healthcare system in a simplified manner, to have four doors. These doors are divided into public, private, occupational, and student healthcare. In reality, these doors cannot be segregated so strictly and are quite intertwined concerning the patients at each door. We realised that the line in front of the public door is the longest. The new reimbursement model proposed by Kela seeks to equalise the lines of patients by enabling users of the public doors to knock on private ones. They plan to do this through patient reimbursements.

After further discussions, we were convinced that these efforts will not render all doors equal but only shift the problems from one part of the system to another. More importantly, we realised that general practitioners behind the public door face many challenges, and we speculated that general practitioners prefer working in the private sector because of the current working conditions, resulting in a lack of general practitioners in the public sector.

# Site Visit

Our team visited a health centre in Nummela, Finland to experience firsthand the processes and workflows within the facility. Despite being housed in an older building that does not meet the current medical standards of newly built hospitals, it was fascinating to see how the medical team operates in such conditions and how the facility's limitations shape their work.

This trip was essential for us to better empathise with the context of our design project and understand the environment faced by primary care workers. We observed the patient triage process and received detailed explanations on how healthcare professionals, including doctors, nurses, and therapists, collaborate. Additionally, we gained valuable insights into the daily patient load managed by general practitioners.

Furthermore, the managing physician of the hospital gave a presentation comparing this health center's operations to other centers in the Uusimaa region. This experience provided us with a comprehensive understanding of the operational challenges and dynamics in a primary care setting, especially within older facilities.

Figure 2. Nummela health centre

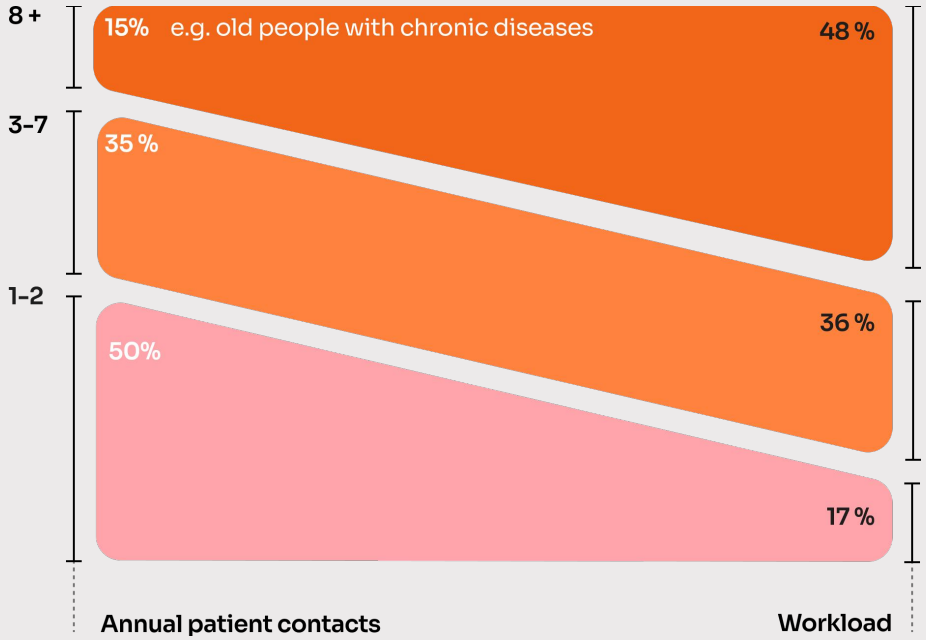



Figure 3. Data from Nummela health centre

# Desk research

Further desk research found from the Nummela healthcare centre report showed that 15% of annual patient contacts account for 48% of the staff workload (Fig 3). This group primarily consists of older individuals with chronic diseases, who naturally require more attention and a closer connection with medical staff. We also learned that this group will continue to grow as Finland has one of the world's fastest-aging populations. As more people develop diverse acute and chronic problems, it could eventually create an unmanageable workload for the medical staff (Nummela Healthcare Center/Länsi-Uudenmaan hyvinvointialue, 2024)

Our research also showed that the number of practising physicians in Finland is lower than the EU average. According to the Finland Health System Summary 2023, it is common for doctors who practise in public hospitals to also work in private healthcare clinics as general practitioners. Many public specialised doctors take on out-of-hours shifts in private clinics and often also completely switch to the private sector. (Finland: Health System Review, 2019) In the public sector, factors such as high stress levels, resource constraints, and monotony in their work also often prompt doctors to pursue specialisation, further exacerbating the shortage of general practitioners.

This led us to concentrate and focus on the needs of the general practitioners mainly in the public sector. Through understanding their needs, motivations, and working conditions, we hoped to understand how we could possibly maintain the existing number of general practitioners and recruit new ones. We realised that understanding this perspective is key to developing applicable changes to the industry that can shift the system towards increased continuity of care for all patients.

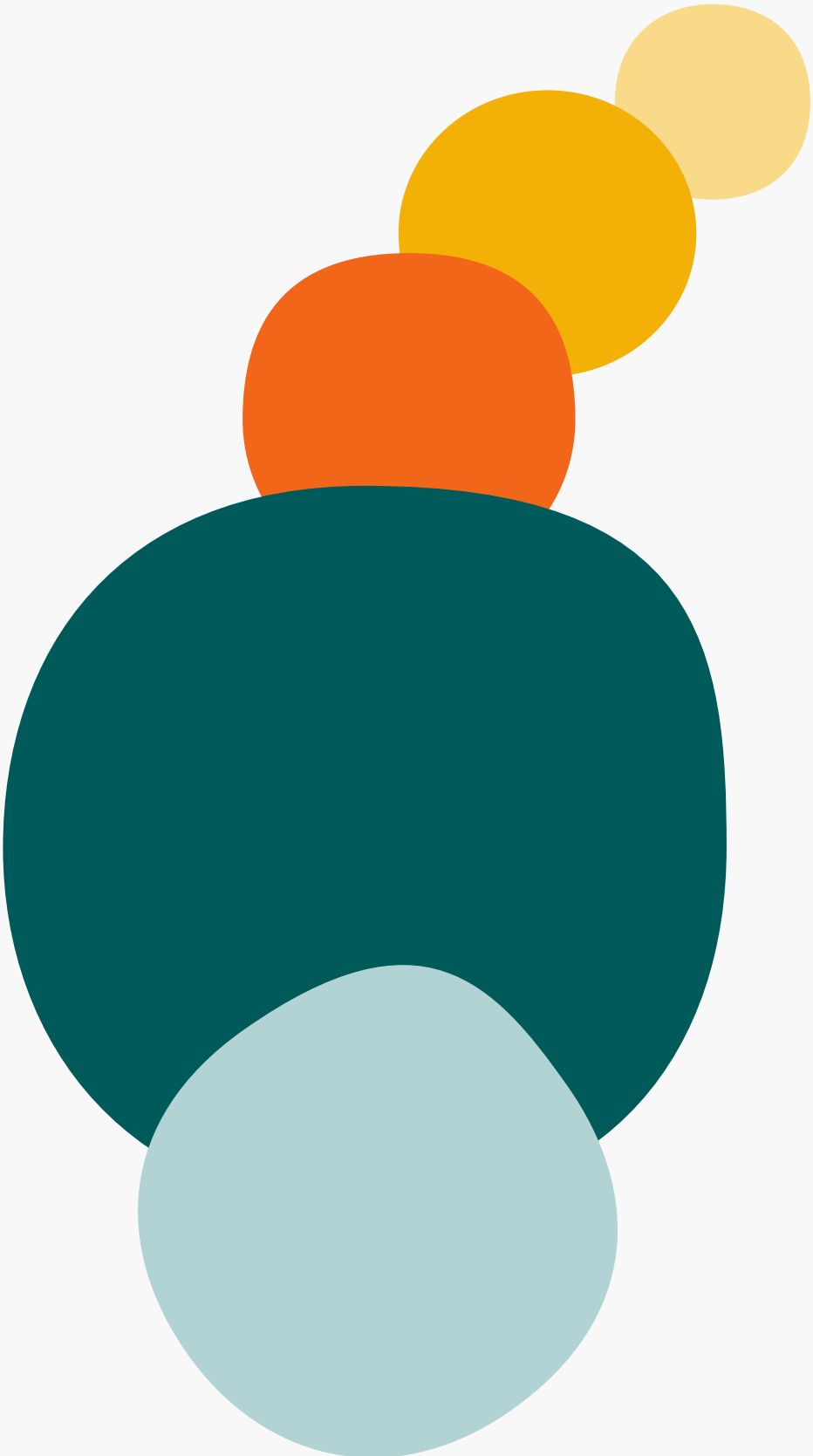

# Interviews with medical staff

Figure 4: System mapping with a healthcare professional

Figure 5: Healthcare professionals interviewed

In order to find more information about this, we conducted interviews with six healthcare professionals (Fig 5) who have experience as general practitioners in the public sector, to gain specific insights from their perspective. Our goal was to understand their motivations for entering and contributing to the public sector, any apprehensions they may have, and, if they had left the public sector, their reasons for doing so. The interview was accompanied with an activity to map the current healthcare system and the stakeholders around it in order to get a broader understanding of the system (Fig 4). We also wished to understand the differences between the public and the private sector.

The experts highlighted the importance of continuity in the care system from the doctor's perspective and the poor working conditions they faced. This information gathered was further grouped and analysed to derive insights.



# 3. System analysis

# Affinity Mapping

After gathering all the information we started making sense of it by using different tools - affinity mapping, system map and causal loop diagram. These tools helped us discover overlapping information that, consequently, lead us to the main insights.

These insights gave us a new understanding of doctor's perspective and were the foundation that led find effective entry points that could create positive and variable change within the system.

Although we cannot obtain all information due to time and resource constraints—for example, we cannot interview everyone in the medical field—we can still make an informed prediction or explanation if the sources are well-chosen to cover the specific area of investigation. (Douven, 2021).

This process was determinant for the development of our proposal and enable us to make connections and find new directions.


Figure 6. Main Clusters of the affinity diagram.

# Private Sector vs. Public Sector

GP = General Practitioner

## Primary care **Private sector**

### PROS of working as a GP in Private Sector

- ⊕ Flexible schedule
- ⊕ Potential returning patients
- ⊕ Selects the number of patients

### CONS of working as a GP in Private Sector

- ⊖ Lack of teamwork
- ⊖ Less challenging patients
- ⊖ Less challenging patients

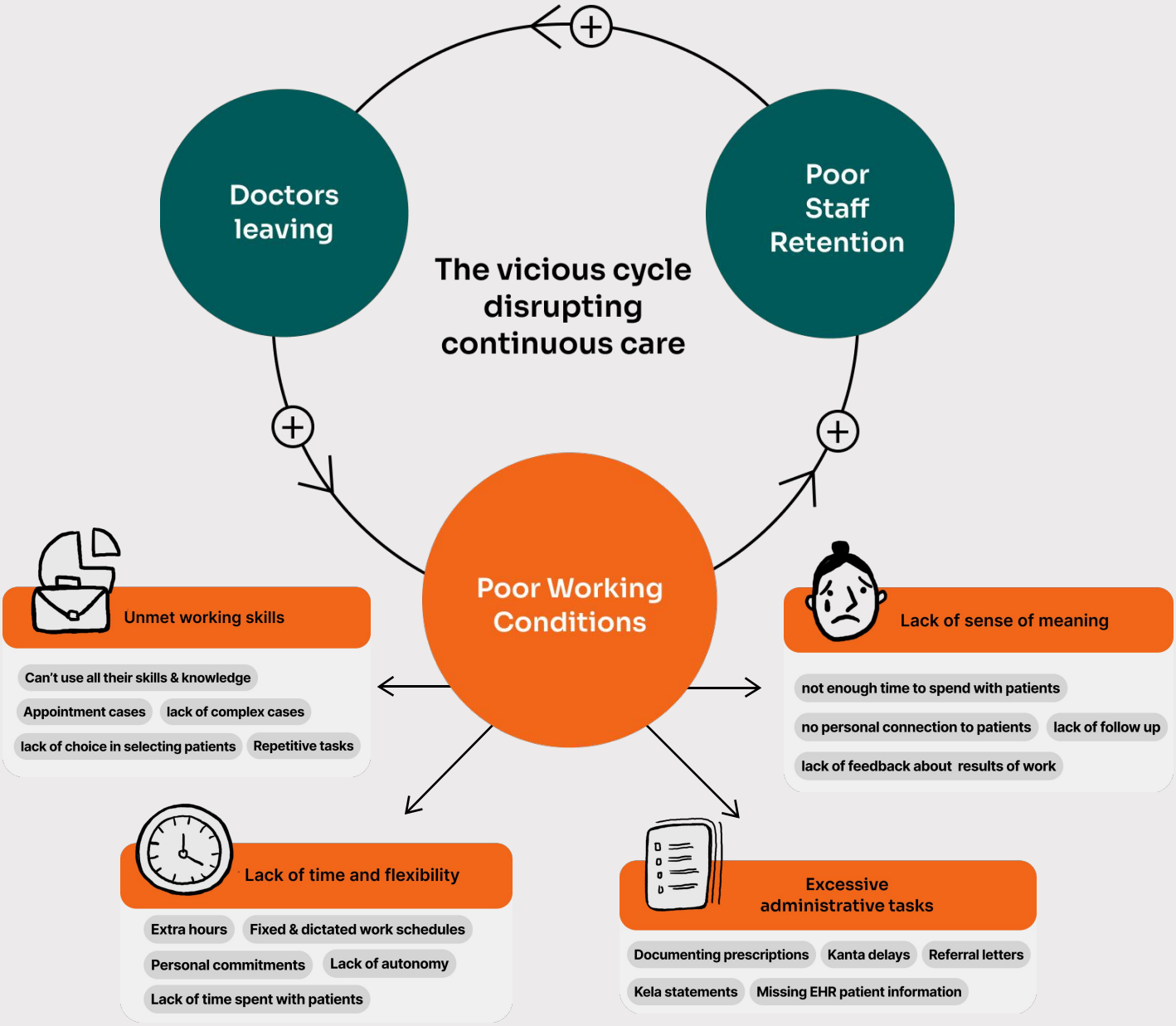
## Primary care **Public Sector**

### PROS of working as a GP in Public Sector

- ⊕ More Teamwork
- ⊕ Shared responsibilities for patients
- ⊕ More challenging patients

### CONS of working as a GP in Public Sector

- ⊖ Fixed working schedule
- ⊖ Never see cured patients
- ⊖ Stress




# The vicious cycle

Once insights have been gathered, we realised the existence of a recurrent cycle that kept on negatively impacting the working conditions of general practitioners. Poor working conditions leads to high turnover rates and that in turn reduces staff productivity because there is limited personnel to complete the tasks.

# Causes for poor working conditions

After going back to the analysis of interviews we started to better understand doctors' frustrations and motivations, and what were the specific underlying issues causing "poor working conditions" experienced by the medical staff in general.

We found 4 main pain points: excessive administrative tasks, lack of time and flexibility, unmet work skills and lack of sense of meaning.

# Insights

## Insight 1

### General Practitioners are dissatisfied with their work conditions as they rarely see the same patient again.

**Doctors want to be able to see the results of their work for motivational purposes, therefore there is the desire to see the same patient again.** This is not achieved, specifically in public primary healthcare where patients can't choose the doctor, and the system is based on single-service appointments. With rarely seeing the same patient again and the lack of feedback channels between patients and general practitioners' continuity of care is blocked and doctors feel demotivated.

**"Continuity of care was the one thing that mattered to me because it is important not only for the patient but also for the physician [...] It's always acute diseases and never long-term relationships. I don't want to work like this."**

-Occupational physician at Terveystalo

**"Seeing the patient again and again gives you a sense of meaning."**

-Public general practitioner at Lapland Health centre

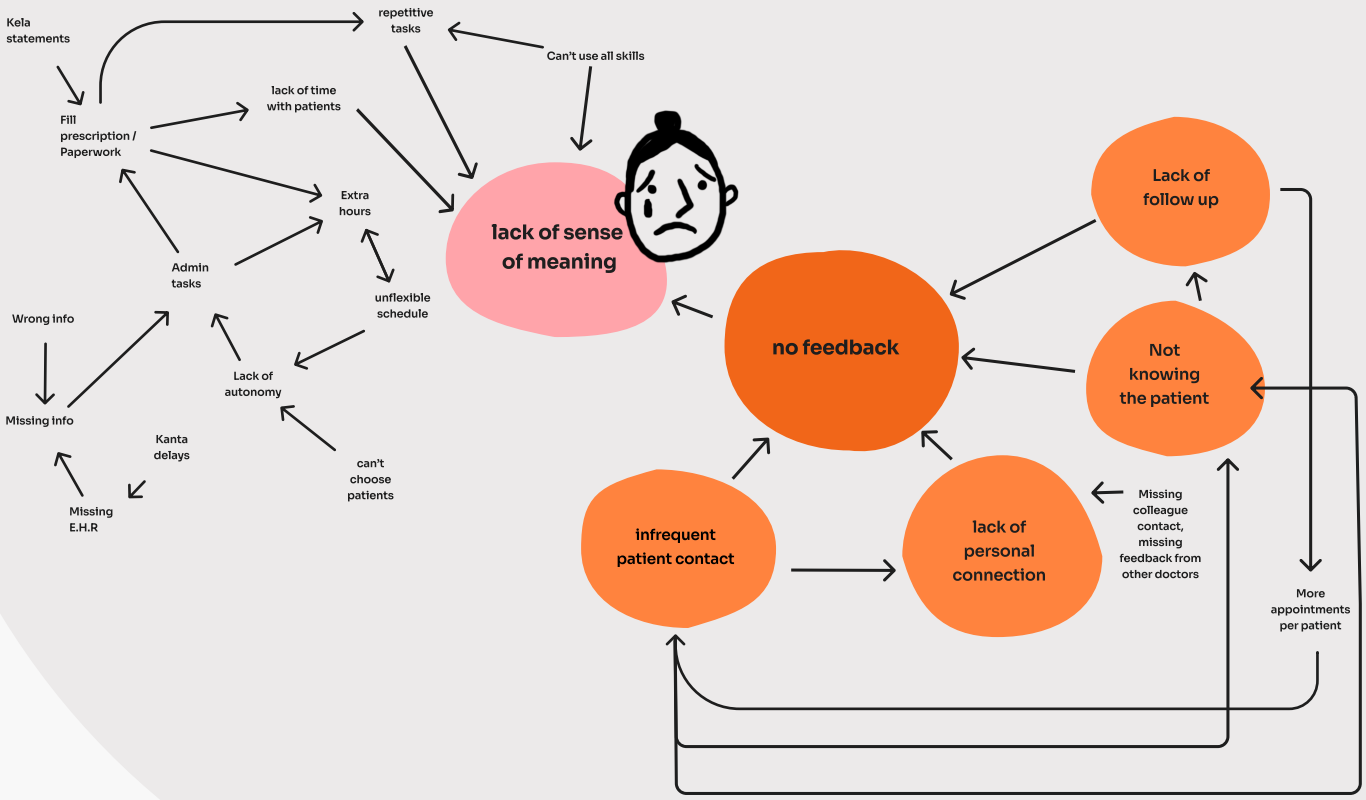
## Insight 2

### GPs in the public sector have high-stress levels, & resource constraints, & find monotony in their work.

Overall, the number of practising physicians in Finland is lower than the EU average. (Finland Health System Summary 2023). **In the public sector, factors such as high-stress levels, resource constraints, and monotony in their work often prompt doctors to pursue specialisation, exacerbating the shortage of GPs.**

**"It is a lot of hard work and stress to be solely a GP in the public sector."**

-Public general practitioner at Lapland Health centre

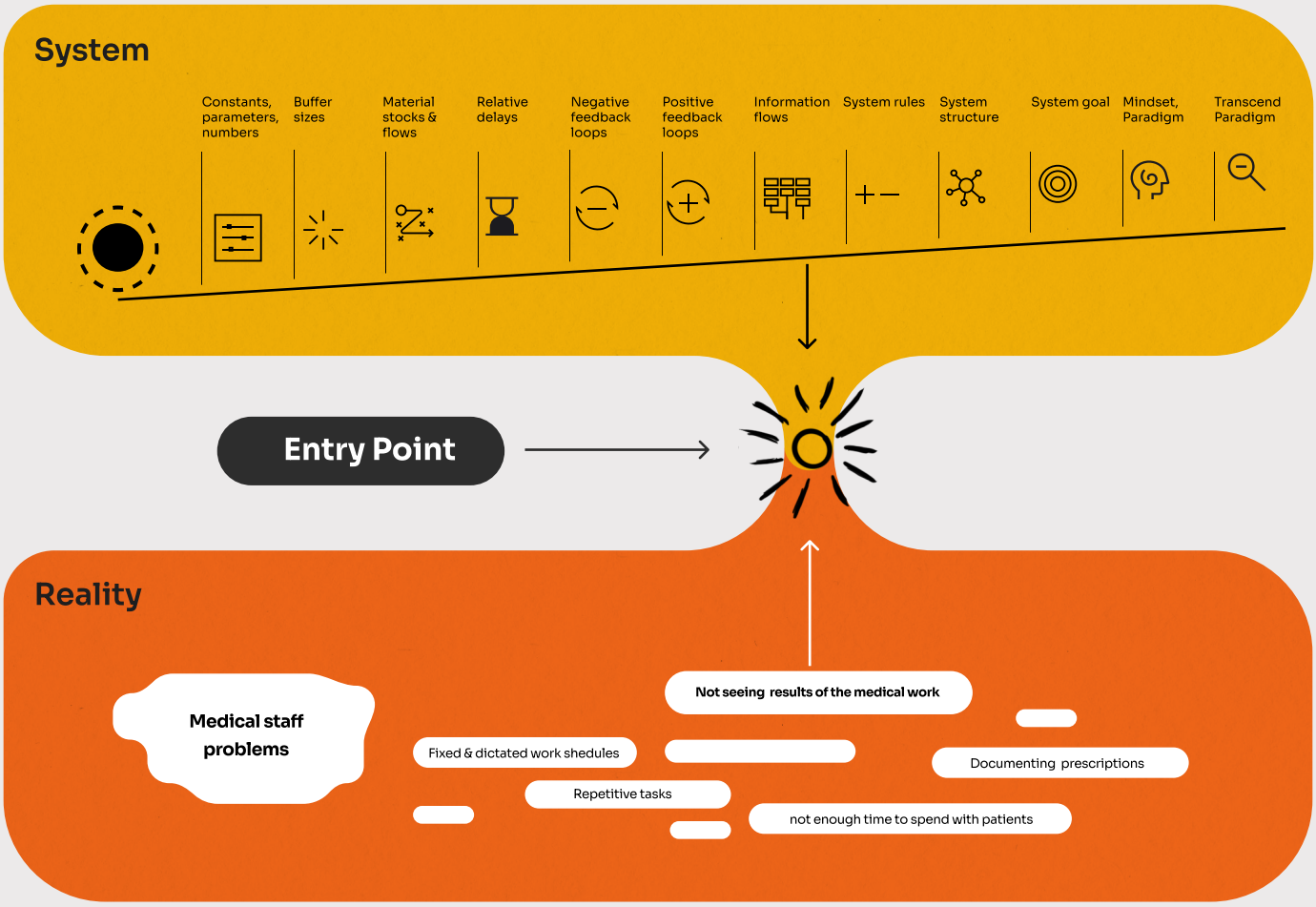



# Mapping the correlations

To determine which identified problem areas held the most potential for impactful change, we created a relationship map illustrating the connections between various issues. This mapping process revealed how certain problems are interrelated, some even causing one another, and highlighted areas with numerous connections that could be focal points for our interventions.

Specifically, we found that a central issue faced by general practitioners working in Finland's public healthcare system is the lack of feedback from patients, both positive and negative. This feedback is crucial for maintaining practitioner motivation, as without it, doctors may feel their work is meaningless. Factors contributing to this feedback deficit include infrequent patient contact, an appointment system that prioritises visit frequency over continuity of care (preventing patients from consistently seeing the same doctor), and a lack of opportunities for follow-up, which impedes building deeper patient relationships.

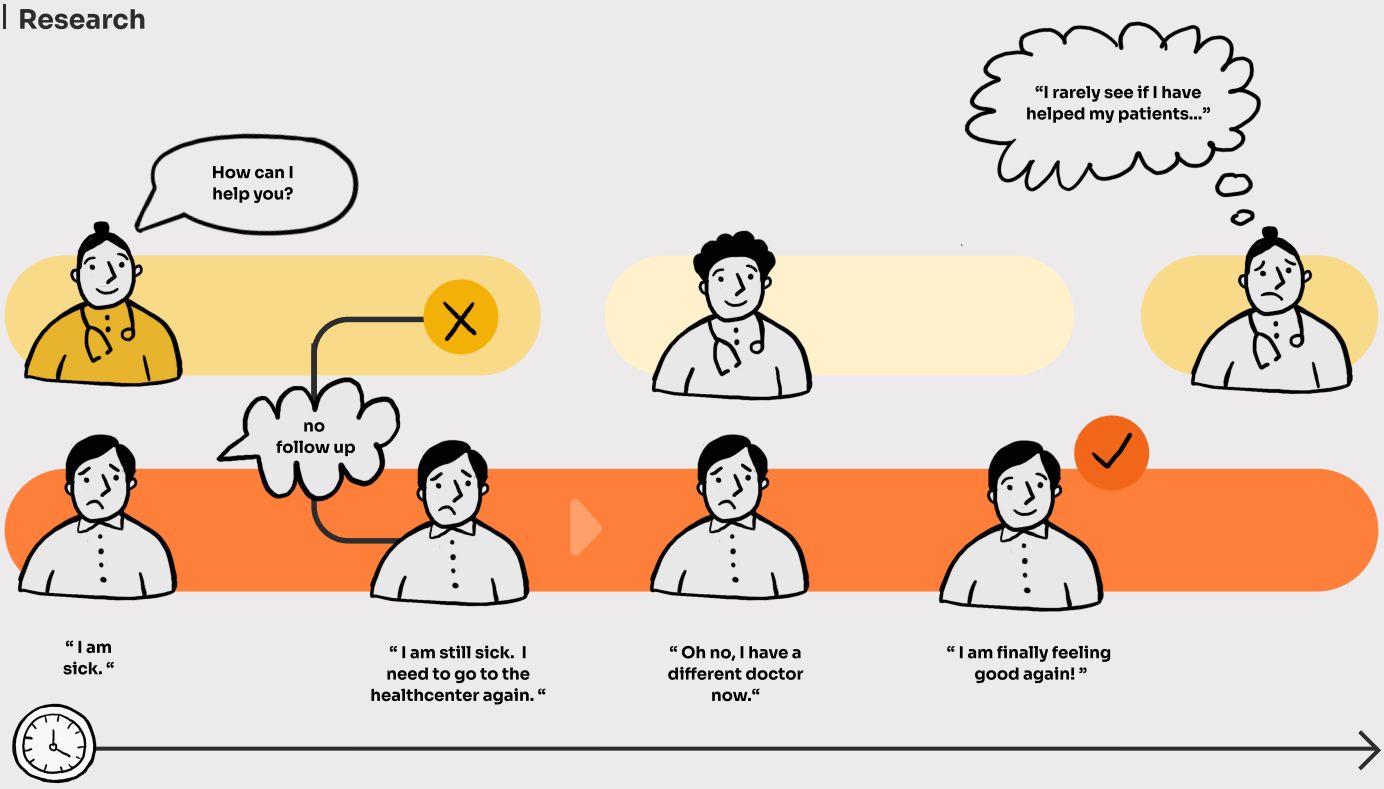
**Given the siginficant densitiy of connections we found, we decided to focus our government design intervention on enhancing feedback mechanisms within public healthcare, based on our finding that a lack of feedback to doctors is significantly connected to broader problems and contributes to general practitioners feeling their work is meaningless, driving them away from the public sector.**




# Defining an Entry point

Having identified the lack of feedback and follow-up for patients as a core issue through our relationship map and insights from interviews and desk research, our next step was to assess the potential impact of intervening in this area. To evaluate the possible impact our design intervention could create, we utilised Donella Meadows' theory of leverage points (Meadows, 1999). According to this theory, altering different mechanisms or structures within a complex system can lead to varying degrees of change. Much like the principle of a lever: the higher the leverage point, the greater the force or impact that is created. To assess the impact magnitude of our identified areas, our team analysed various problem areas, including the lack of feedback, to determine what kind of leverage point it corresponded to. We discovered that our entry point—the lack of feedback—aligned with a high-leverage point: The restructuring of information flows. This alignment assured us that intervening in the area of following up on patients, and improving feedback for doctors could have a big potential for change within the healthcare system. This analysis allowed us to pinpoint our strategic starting point, or "entry points": A carefully chosen location within a system where efforts to improve the system can begin (Steinberg, 2024)".

# 4. Identifying the intervention




# The problem

**General practitioners in Finland are leaving the public healthcare sector due to a lack of motivation and feeling that their work is meaningless. This is largely since they don't see the results and the value they bring to their patients. What is needed is a culture which is enabling them to observe the impact of their efforts.**

To ensure the effective continuity of care within the healthcare system, it is crucial that general practitioners maintain long-term positions at the same health centres. This stability is not only vital for building strong patient-doctor relationships but also crucial for enhancing the flow of information among different healthcare actors. According to Donella Meadows' theory on leverage points in a system, such uninterrupted information flow can dramatically influence systemic change (Meadows, 2008).

Our recent research into the Finnish public healthcare system reveals that general practitioners face numerous challenges that could impact their long-term retention and the effectiveness of care they provide. These challenges range from overwhelming administrative duties to rigid, inflexible work environment that restricts the use of their full range of diagnostic and medical skills. More critically, these issues converge on a significant problem: a pervasive lack of motivation among doctors, stemming largely from their limited and non-continuous interaction with patients.

A particularly detrimental factor to both patient care and practitioner satisfaction is the appointment system used by Finnish health centres, which prioritises acute cases. This system often prevents patients with chronic conditions from consistently seeing the same doctor. Instead, they are treated by any available physician, which disrupts continuity of care. This lack of consistency not only compromises the quality of care for patients, but also deprives doctors of the opportunity to observe the outcomes

of their treatments—whether therapeutic successes or failures—thus impeding their profes-sional learning and growth.

This absence of a feedback loop in the daily practice of general practitioners not only hinders their ability to learn from their experiences and mistakes but also affects their job satisfaction. It contributes to a sense of ineffectiveness and disconnection from the impact of their medical interventions, leading to demotivation. This situation renders the role of a general practitioner less appealing compared to other medical professions where a robust, functioning feedback system is in place, thereby reinforcing professional fulfilment and motivation.

To face this issue of demotivation, it is therefore important for general practitioners to follow up on their patients and their outcomes to create a better, and more effective, flow of information.

**What is needed is a follow up culture.**

# Ingredients for follow up culture

## How does follow up culture look like?

The truth is we don't know what a Finnish follow-up culture will look like. And, a 'one serves all' policy is not an effective strategy, due to various factors such as demographic changes, funding, the size of health centres, and their geographic locations within Finland. Therefore, the goal of establishing a follow-up culture should not be to create a rigid framework. Instead, it should involve a process of step-by-step testing and evaluation to determine which practices are most effective and make sense for integrating into Finnish healthcare. This adaptive approach allows for the continuous refinement and customization of follow-up practices to meet the unique needs of the healthcare system.

## Building a culture through habits.

Building a culture through habits.
To establish a functioning continuity of care, health centres need to develop new processes and habits that encourage regular follow-up with patients. Historically the Finnish healthcare system does not prioritise patient follow-up, because it lacks a culture that supports it. According to the article "The Elements of Culture" by Northeast Wisconsin Technical College, every culture consists of basic elements: shared symbols, common language, artefacts, rituals, shared values and beliefs, and accepted norms ("The Elements of Culture," n.d.). By using these elements as foundational blocks, the goal is to build a culture that inherently supports and maintains follow-up habits within healthcare practices.
Taking these building blocks, a successful guide for creating functioning culture of following up will be: 1. Create Common values and beliefs, 2. Establish Rituals, and 3. Create Norms

### 1. Create Common values and beliefs

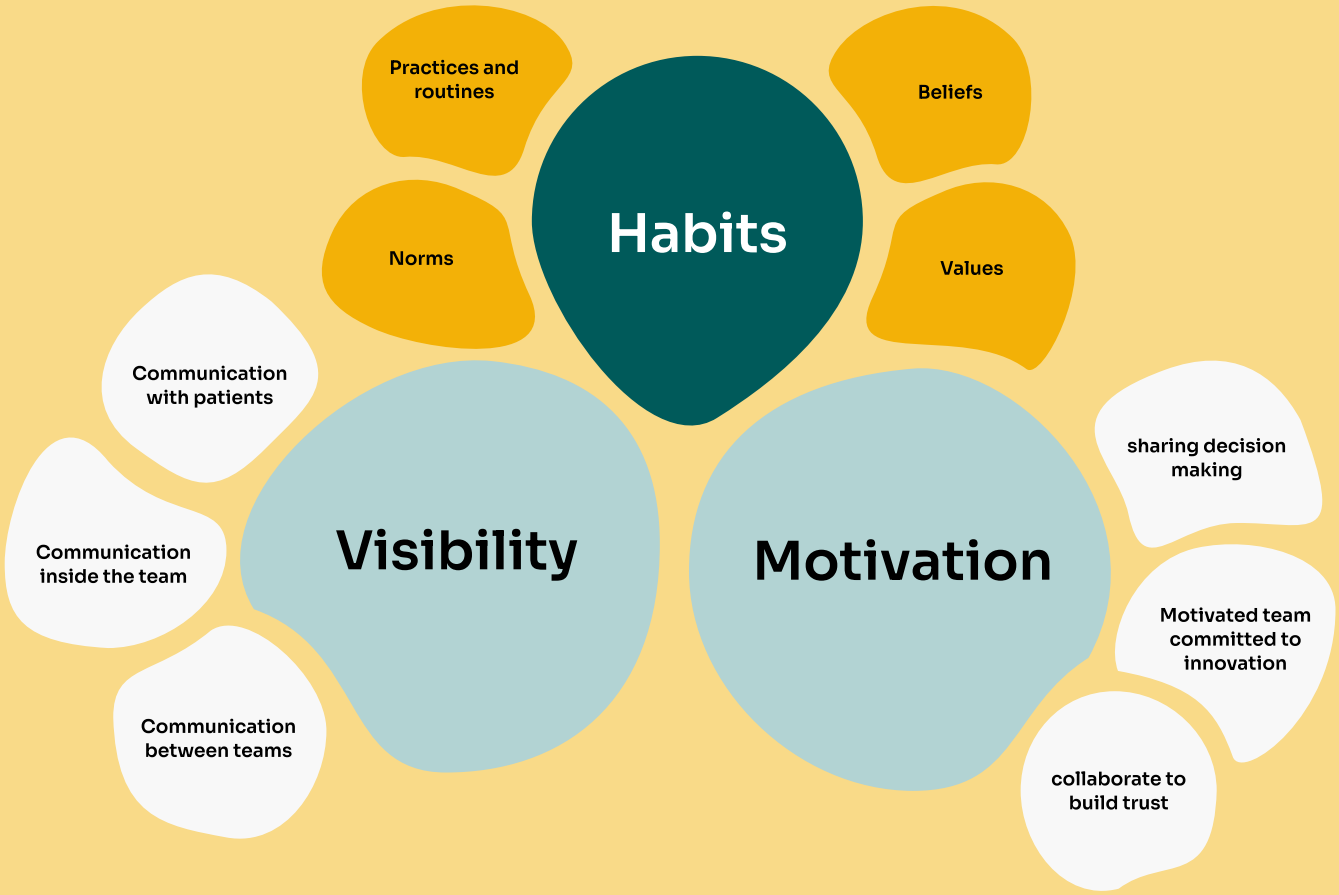
The current Finnish healthcare system operates on a service transaction model, where each appointment is treated as a distinct service. However, as noted by American economist Michael E. Porter in his article 'The Strategy to Fix Healthcare,' an effective healthcare system should not merely focus on the delivery of services. Instead, it should focus on the value and improvement in life quality that these services provide to patients (Porter & Lee, 2013). Adopting a value-based care model, rather than a service-based one, should become the foundational principle and standard throughout the Finnish healthcare system. Furthermore, our intervention should communicate and emphasise this idea of creating value for patients rather than merely providing services.

### 2. Establish Rituals

In the context of Finnish health centres, rituals are practices designed to foster a follow-up culture. However, without existing precedents, health centres must independently explore and implement these practices to enhance patient follow-up effectively. Establishing these rituals necessitates a commitment to experimentation and innovation within the health centres to develop processes that support these new practices and to continuously develop them further.

### 3. Create Norms

Norms and standards, such as hygiene protocols and patient assessment practices, form the foundation of healthcare systems. Similarly, to develop a sustainable follow-up culture, it is essential to establish equally strong standard procedures and norms. These will facilitate a uniform and nationwide approach to implementing an effective follow-up culture.




**Visibility.**

To foster a follow-up culture in Finnish healthcare, it is crucial to establish common values, practices, and norms. However, building these components requires a foundation similar to that of any culture, which includes common language, artefacts, and shared symbols that facilitate mutual understanding among its members. In healthcare, effective communication within and between different parts of the system plays a critical role, like the role of language and symbols in broader cultural contexts.

For example, the article "The Bell Curve" by Gawande (2004) highlights the significant advancements in treating cystic fibrosis over the past fifty years, achieved through medical teams sharing outcomes and practices. This sharing fostered an upward spiral of innovation and even helped underperforming teams to improve by learning from others. Similarly, in establishing a follow-up culture, it is essential not only to enhance communication between patients and healthcare staff but also to ensure that patient outcomes are communicated effectively among team members of a medical team. But simultaneously there is a need for sharing improvements and well functioning practices across different teams regionally and nationally. This approach will not only help integrate and reinforce the follow-up culture across the Finnish healthcare system, but also help to continuously improve it

**Motivated teams lead innovation.**

To establish a follow-up culture in health centres, it is essential to place medical teams in an environment that nurtures innovation alongside their standard practices. This environment should provide adequate funding, enhance feedback loops within teams, and promote transparent and collaborative decision-making structures. The overarching goal is to foster an attitude committed to constant learning and innovation, where improvement ideas are openly shared, and the necessary resources and funding are available to implement them. This supportive setting enables teams to develop and sustain effective follow-up practices, crucial for improving patient care continuity. The Finnish welfare counties, Kela, and the Ministry of Health and Social Affairs play a crucial role in nurturing this innovation culture.

# Barriers

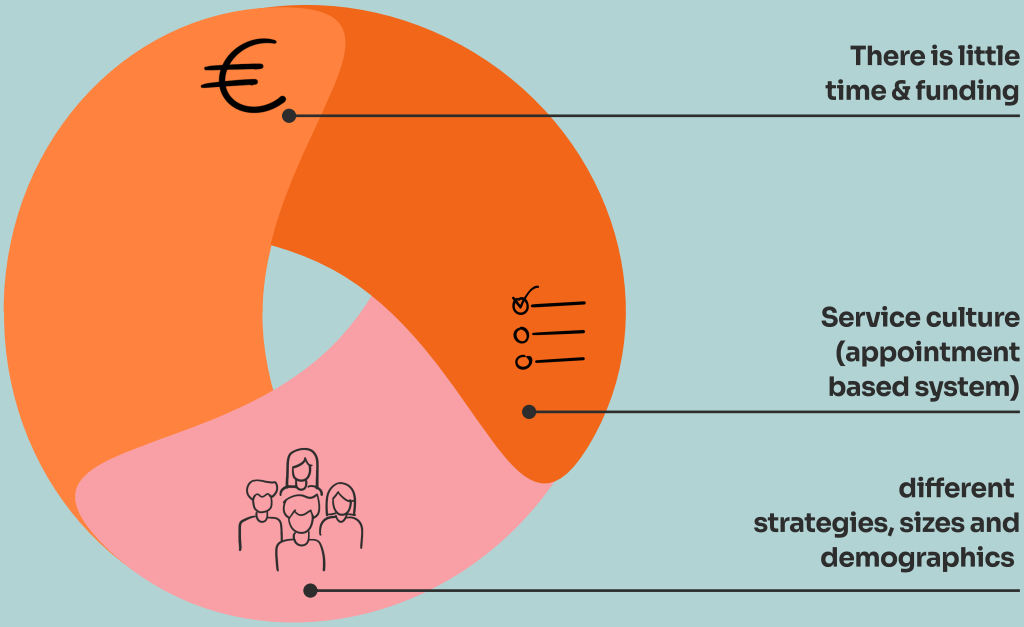
## The Finnish healthcare system currently provides limited scope for health centres to experiment or develop their own strategies to enhance patient follow-up.

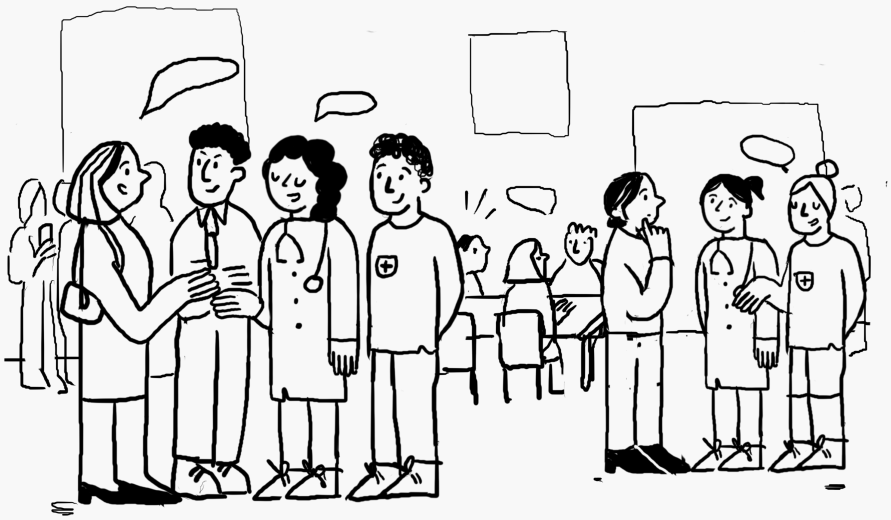
This constraint is primarily due to insufficient funding, which results in a lack of resources and time necessary for implementing significant changes in daily operations which are necessary for implementing a follow up culture. Health centres are embedded in an environment that views healthcare as an appointment-based service, focusing more on transactions than on creating long-term value for patients. Additionally, the wide variations in population density and demographic structures across different regions of Finland contribute to substantial disparities in how health centres operate. These factors collectively hinder the ability of health centres to innovate and adapt their practices to better serve their patients' needs.

# The intervention

The ‘Creative Councils program’ initiated by Nesta is a UK-based innovation agency for social good which supported local governments in co-innovating to address long-term community challenges (Cook & Steinberg, 2013). Drawing on insights from this project, It became clear for our team that integrating innovation processes within medical teams could be an effective strategy for implementing a follow-up culture in the Finnish healthcare system. And like in the Creative Council programme, these innovation processes would need to be supported by public agencies.

This strategy involves facilitating learning and knowledge exchange between teams to share successful practices and insights. Moreover, it is crucial to create an environment where teams feel motivated and supported by the necessary political, financial, and procedural resources to conduct long-lasting experiments and trials. As highlighted by Michael E. Porter in "The Strategy That Will Fix Healthcare," teams improve and excel by tracking progress over time and comparing their performance with peers (Porter & Lee, 2013).
This means that in addition to fostering the right environment, a structured framework must be established to evaluate the outcomes of these trials. This framework will assess their efficacy and potential for broader implementation across Finnish health centres. This dual approach of encouraging innovation, and systematically evaluating its impact, will ensure the development of a robust follow-up culture tailored to the diverse needs of the Finnish healthcare landscape.



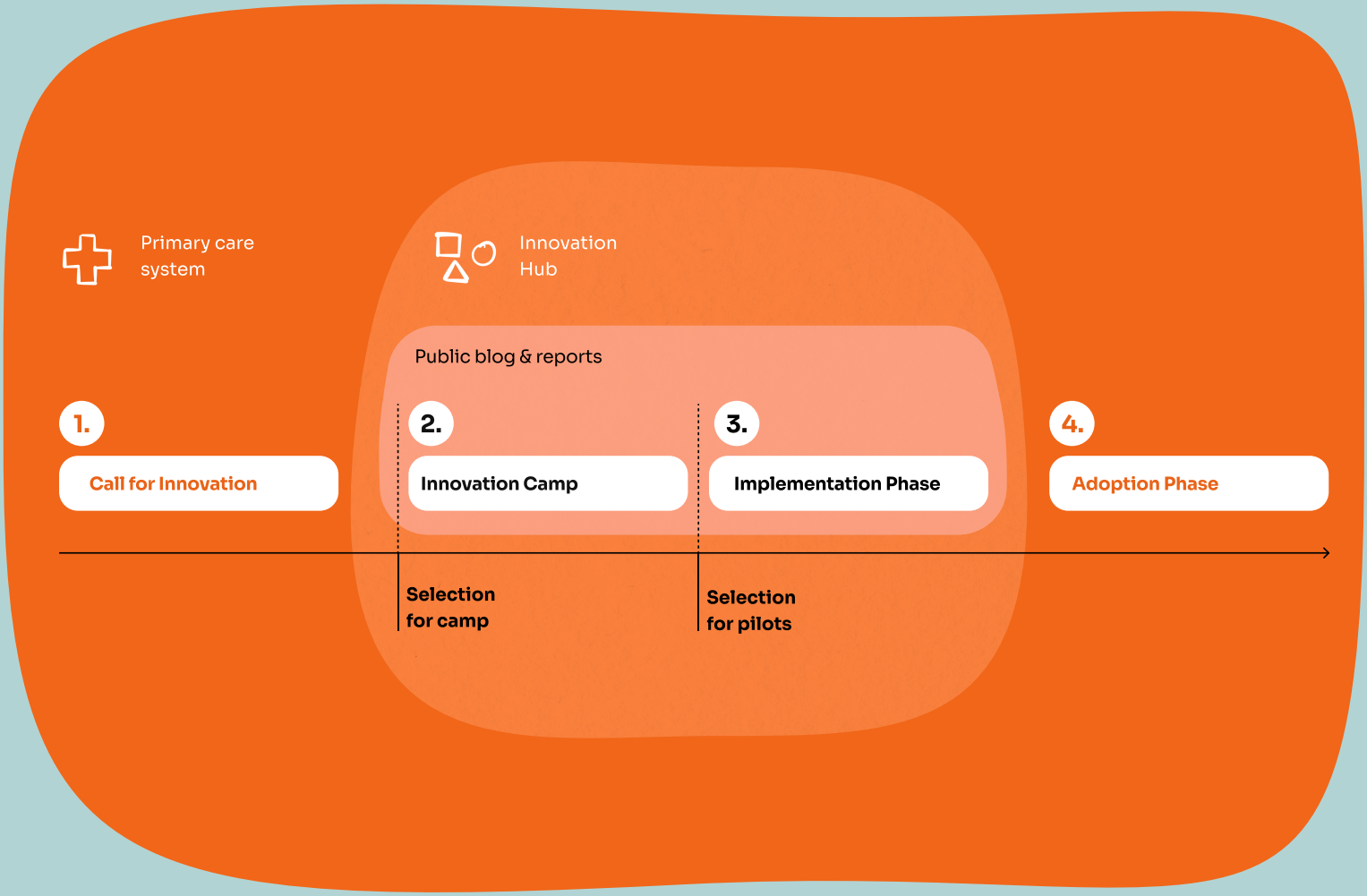


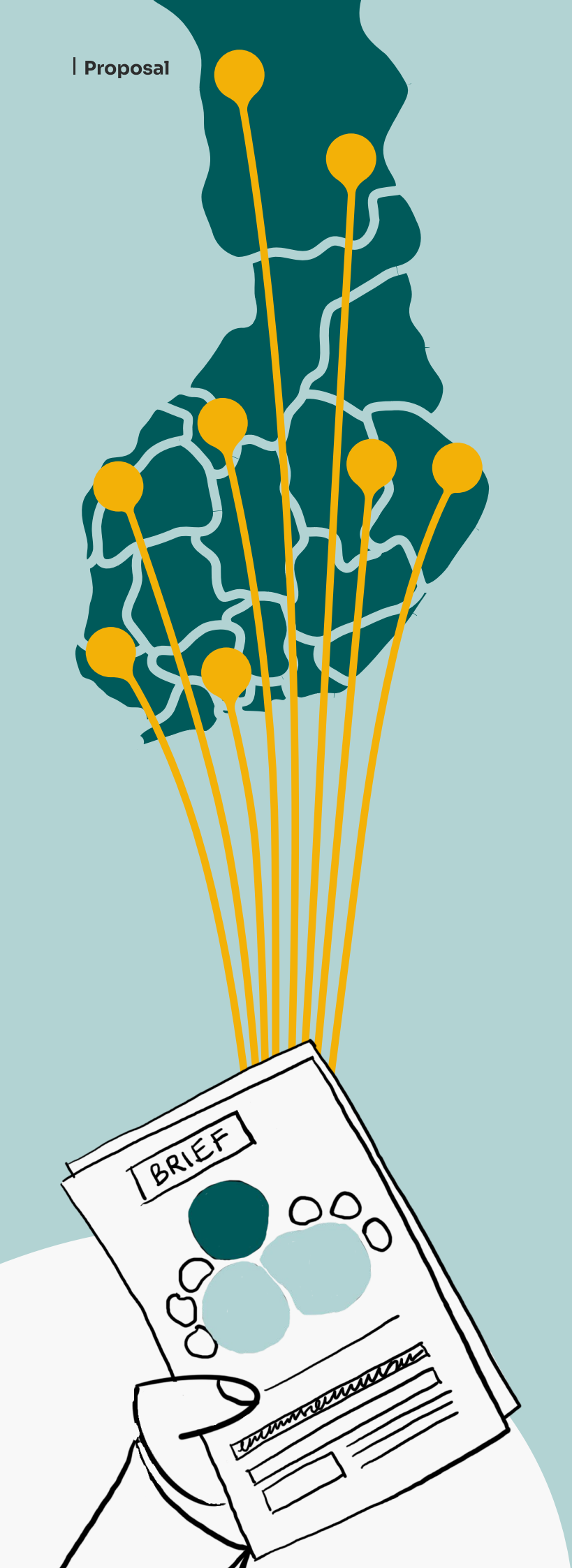
# 5. Proposal

# The Kela Co-Innovation programme

**Our design solution, The Kela Co-Innovation Programme, aims to foster Innovation and collaboration within and across health centres in Finland.**

The programme consists of four distinct steps: 1. Call for Innovation, 2, Innovation Camp, 3. Implementation Phase, and 4. Adoption Phase. Step 1 and 4 mainly happen within the various health centres of Finland, while step 2 and 3 happens in a select group of health centres that collaborate closer with each other inside the so-called innovation hub.






# 01 Call for Innovation

## Kela Brief

**The Call for Innovation step begins with Kela sending a brief across health centres of Finland.** This brief starts with an explanation and justification of the common goal of all health centres: Fostering continuity of care through the implementation of follow-up culture. Thereafter, follow-up culture is presented in depth with the main parts: visibility and motivation. Together these components create habits, which the health centres are asked to innovate for. Having each individual health centre create their own plan for a possible innovation is advantageous for two reasons: It allows health centres to work towards a larger unified goal, while maintaining autonomy and creating customised solutions that fits for the health centres' varying team and working structures. The health centres are asked to create a written plan for innovative changes within their team that promotes follow-up culture within their health centre.

The Brief also proposes assessment criteria which the success of the innovations will be measured by. These assessment methods should be based on principles of value based care. This is because value based care metrics and improvements within these metrics will result in increased value for patients and higher likelihood of improving continuity of care. Furthermore, by unifying the measurement practices of innovations, the success of the implemented innovations becomes directly measurable.

## Funding

**Lastly the brief should describe the financial aspects of how the innovations can receive funding from Kela** and/or possible other partners and private stakeholders like for example the Kone-Foundation. The lack of time and money are the two biggest hindrances for innovations within the Finnish healthcare services. Therefore, the last part of the brief should compliment the former sections by explaining how the funding will aid in the creation of the advantages of innovating for habits within follow-up culture. The benefits of the innovations can not be achieved without the funding, it is therefore the main motivator for the health centres to join the co-innovation programme.

After the health centres have composed and sent their innovation plans to Kela, the second phase of the Co-Innovation programme is ready to begin.

Proposal Viability

Proposal potential

Geographic location

demographic Structiure

Selection Criteria

# 02 Innovation Camp

Depending on the amount of innovation plans received by Kela there might be a need for evaluation of the plans to decide whom to invite for the Innovation camp. The evaluation criteria can be based on two main areas; characteristics and proposal. The characteristics are health centre specific details about the geographical location and the demographic specifications of its visitors. In Proposal the innovation plan potential is reviewed and the motivation of the health centre is assessed. Furthermore the viability of the proposal is evaluated according to potential to achieve the desired effect, and the possibility to scale the innovation across other health centres. After the review of the proposals, invitations are sent out to the relevant health centres to participate in the Innovation Camp.

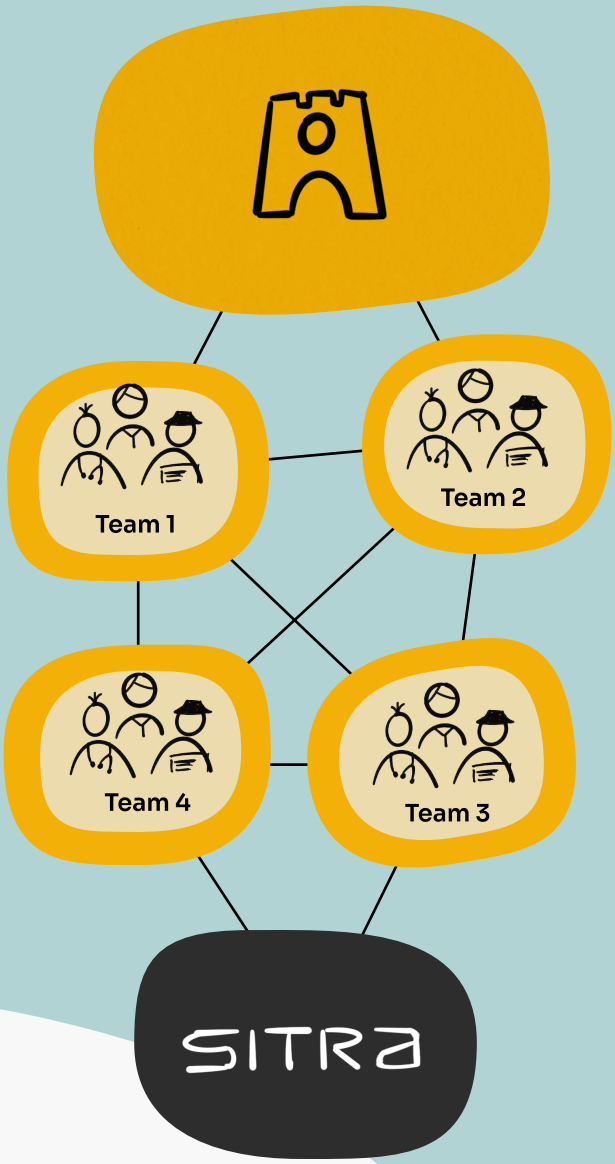
The Innovation Camp is a meeting of the innovation coordinators from each health centre. The aim of the camp is to share expertise and understanding of the various innovations and refine the proposals before implementation. During the Innovation Camp participants will present their innovation plan to other health centres. Thereafter they will receive feedback from other participants and discuss possible changes. In addition the event is a great opportunity for pitching ideas to each others, and to build colaboratory networks between health centres. The participants may also receive coaching from invited experts.

# 02 Innovation Camp

## Innovation Support

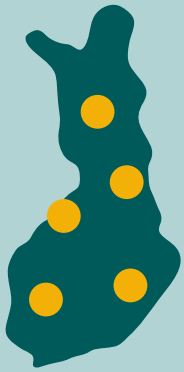
In addition to the participants from the health centres, patients, politicians, and country officials should also be invited. **Inviting a wider audience of stakeholders will create a wider common understanding of the problems within health services of finland and help advocating political changes necessary to support wider changes in the finnish health services**. Furthermore, there are multiple political and structural hindrances for certain changes, and inviting a wider audience will help shed light on these issues and create opportunities for solving them. In addition, Kela and other possible stakeholders might seek to collaborate on arranging the Innovation Camp with organisations like Sitra, who have broader knowledge and experience with similar events.

After the Innovation camp, health centres refine their innovation proposals and submit them to Kela to be reviewed for the next stage.

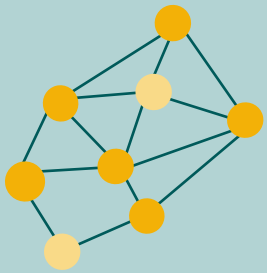



**3** M.v. Product
2 comparable
& 1 different

**5** Collaborative
areas for
healthcare



**8+** multi layered
network &
community



# 03 Implementation

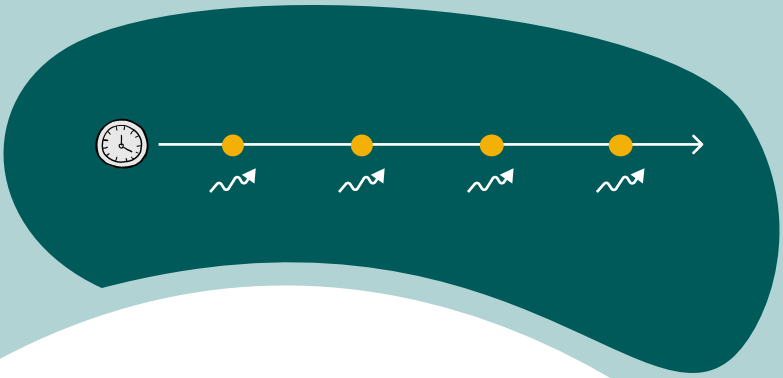
## Participant selection

Before the implementation phase the relevant participants need to be selected. In addition to reviewing the previously mentioned criteria again (characteristics and proposal), Kela should consider how many health centres to invite for this phase, and their relevance to each other. This is because in this phase the health centres will collaborate and share their results during the implementation of the innovation plan. It is important to consider how many health centres will participate in this stage. 3 health centres is the minimum amount for meaningful collaboration where the participants may be comparable and have the possibility to relate to each other. There might be political reasons for the number of invitations. For example, there are 5 collaborative areas within the Finnish healthcare services. There is also a maximum number of participants for fruitful collaboration, we estimate that this number is between 8-9. If more parties are invited we would suggest dividing participating health centres to smaller groups. Furthermore, the similarities and differences between the health centres and their innovation plans need to be carefully considered. The goal of this phase is that the participants learn by sharing knowledge between each other's trials, therefore the composition of the health centres chosen will be vital for the outcome of the innovation trials.

# 03 Implementation

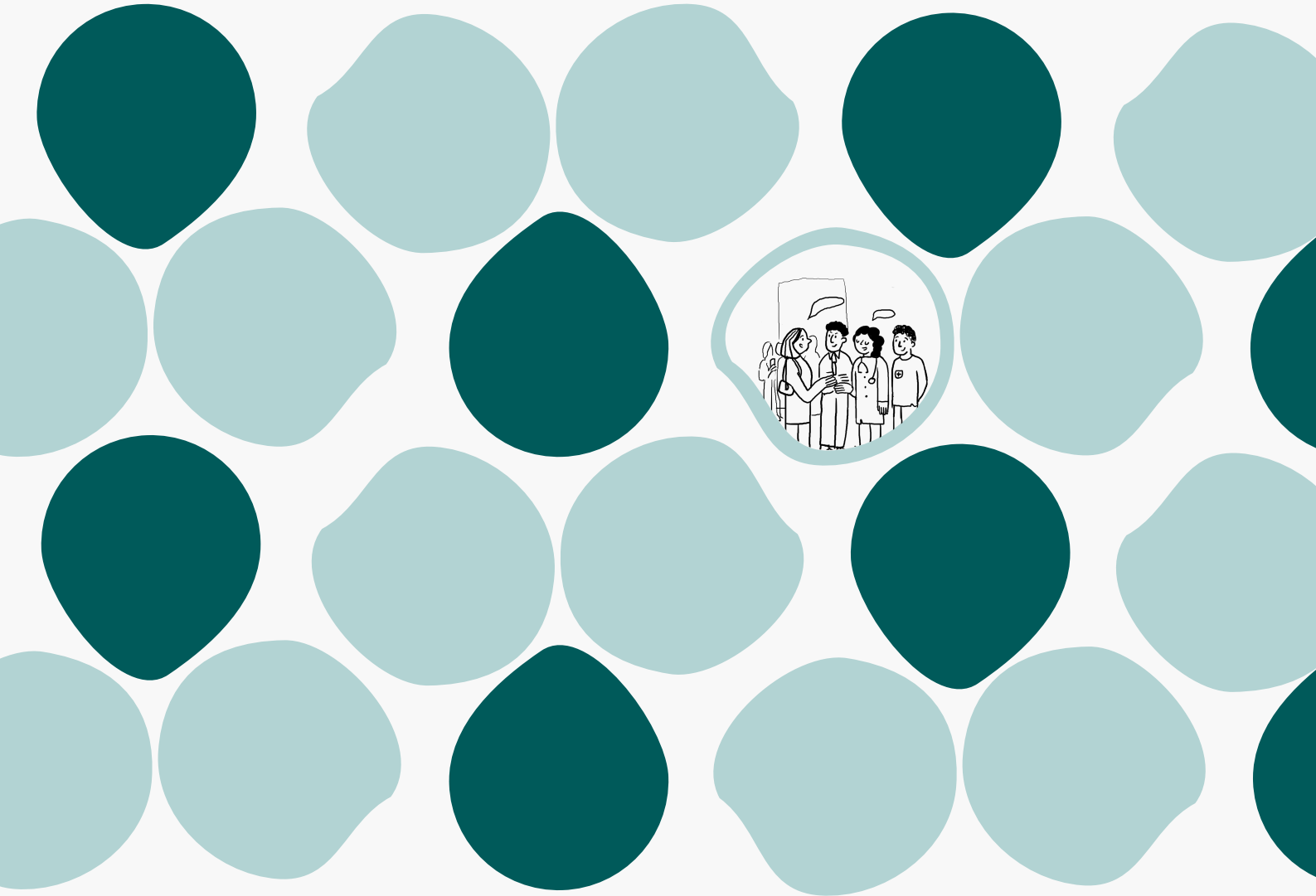
## Continous evaluation & communication

In the Implementation Phase health centres start the trials for their innovations. These innovations might include changes in working habits of structures, or they could be anything that the health centres argue would create a stronger followup culture. During the innovation trials, the value created for patients and the value created for staff should be measured in regular intervals. These measurements create the indicator for understanding the success of the trial and the basis for further developments and changes. Based on these results the working teams in the health centres will run internal monthly meetings to evaluate their progress and success. Biannual meetings will be run with the innovation coordinators from all the collaborating health centres. The aim of these meetings is to learn from each other, and to determine the best practices for a wider array of health centres. At the end of the trial each health centre produces a report on the outcomes of their implementation.



# 04 Adoption Phase

The adoption phase starts by collecting the innovation reports and starting a data bank of knowledge about innovations in health centres. The reports will all be made public so that other health centres have the possibility to learn about the trials and adopt the tried and proven best practices to their own working teams. This allows sharing and utilisation of best practices related to the creation of follow-up culture. Subsequently, all health centres across Finland can benefit from the Kela Co-Innovation Programme, even if they were not chosen to fulfil their own innovation plan.



# 6. Conclusion

# Limitations

## A Bottom-Up Approach

Throughout our research we found a number of issues related to doctors working practices as general practitioners. Our design proposal targets lack of feedback to address multiple of these found issues.

After successful implementation, it would be necessary to conduct further research to verify the deeper impacts of the innovations. If issues are left unaddressed after innovations have been implemented, a new innovation cycle addressing further issues may be considered. Furthermore, our research must have omitted other pressing issues in the Finnish Healthcare services, since we viewed the services mostly through the general practitioners perspective. Still. The general practitioners problems are key issues that need to be solved for implementation of continuity of care.

In the brief received from Kela and the Ministry of social affairs and health, it was indicated that the clients were looking for ways to direct their financial incentives for leverage towards continuity of care. However, our proposal does not suggest financial incentives directly. Instead, it contains a radical shift in the role of government to support developments through a bottoms up approach, rather than the usual top down. Our proposal could have suggested developments that would address the issues more in line with the original brief. Perhaps a reimbursement model that supports the created value for patients and doctors would suffice, and leverage the services to a more value based system.

As already mentioned, one limitation of our design proposal is the mindset within government and the usual top down approach to development of services. Our design proposal suggests a radical new way of governing bottoms up, where the measurement of impact is hard to determine beforehand. Traditionally this uncharted territory is hard for governing agencies to manoeuvre, because the financial investments made by ministries need some promise of return on investment.

However, the return on investment thinking promotes service based measurements which is the main reason for the struggles of public health care. Measuring how many patients can be treated for what amount of money does not solve the core issues, they only decrease the time of doctors appointments. To break this vicious cycle, it is necessary to find new and better measurements that promote a value based care system. These changes can be made through bottom up models like the one we have suggested. However, to successfully implement these solutions, ministries and governing bodies need to adapt a new mindset.

# Reflection

**The Kela Co-Innovation Programme aims to create a unified goal for all health centres across Finland. By encouraging health centres to share, before, during, and after innovation trial periods, the programme creates knowledge by experimentation and collaboration**.

This method also harnesses positive competition from a highly competitive field, and creates networks across health centres. Finally, it generates room for innovation in an industry which is ridden with lack of time and resources.

Although the benefits of our proposal are clearly defined, there is some uncertainty as to how it can be implemented, and perhaps more importantly, by whom. The proposal introduces Kela and the main stakeholder and facilitator of the events described, in addition Kela is proposed to finance the innovation plans. Traditionally Kela's funding of the healthcare services are more directly related to patients. However, there is very little leverage in directly financing patients. Through our field and desk research we have reached the conclusion that the long-term strategic changes to the healthcare system can only be achieved through enabling the health centres to innovate for themselves.

The health centres are filled to the brim with knowledgeable and creative minds that lack the time and resources to improve their working conditions. To achieve long -term changes towards continuity of care, it is essential that all new financing models are explored to enable innovation. and that Kela and other possible stakeholders broaden their understanding of their role in driving development in the healthcare services.

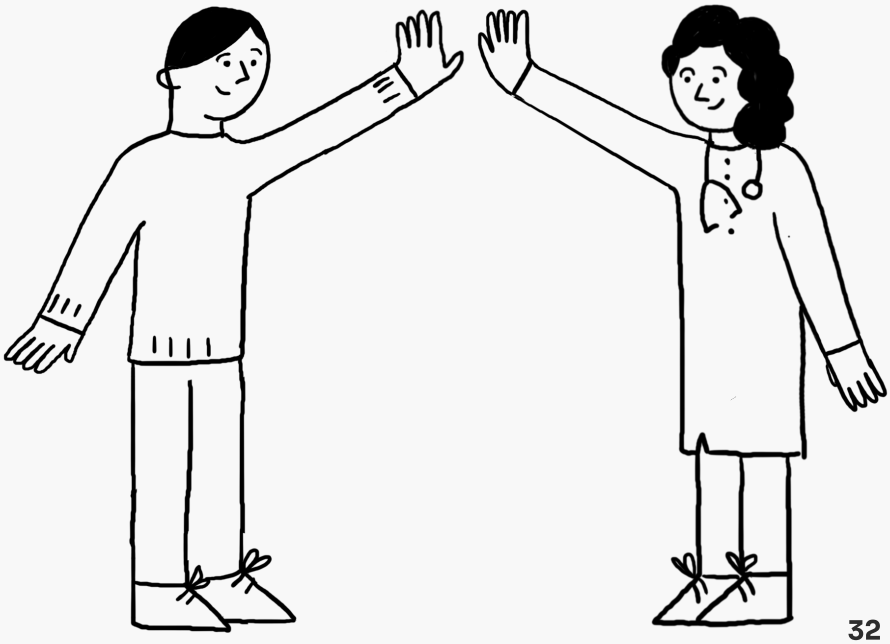
## Strengths of the Programme

**Encourages sharing outcomes**

**Fosters positive competition**

**Creates a network**

**Generates innovative solutions**



All visualisations in this report are owned by us unless stated otherwise.

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