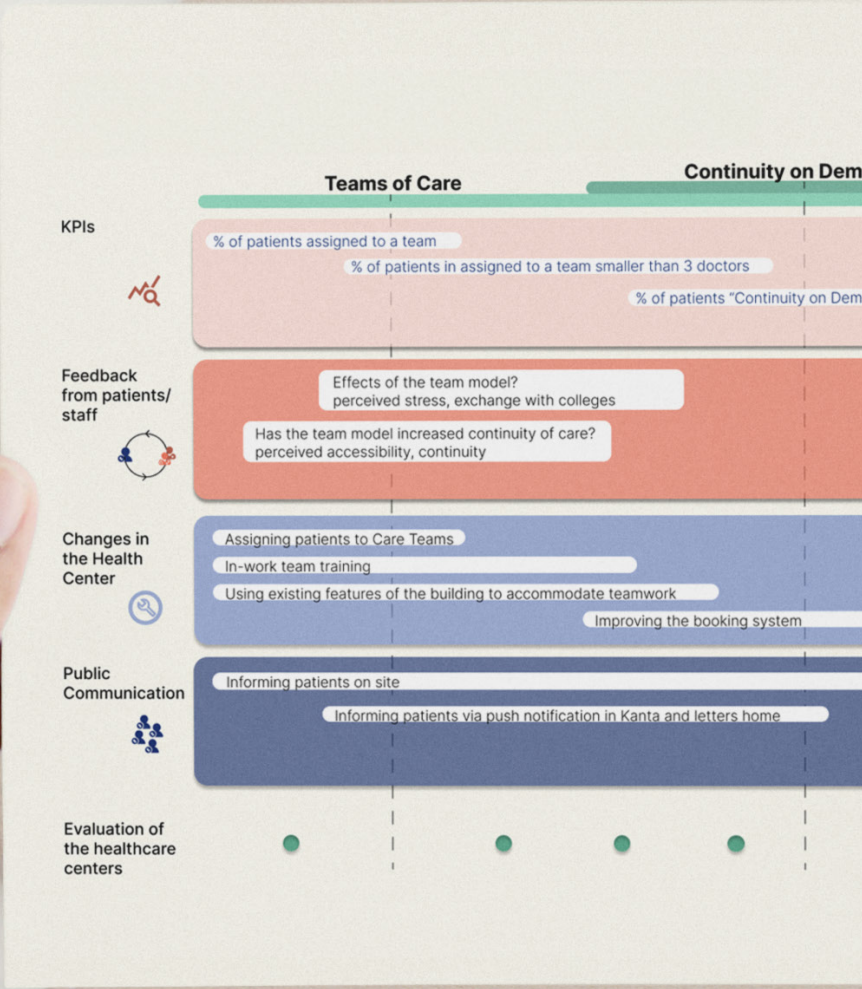


# From *Sick Care* to Health Care.

An evolving action plan towards Continuity of Care



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# Executive Summary

As emphasized by the World Organisation of General Practitioners (WONCA) “Continuity of Care” (CoC) is a key element in primary care. Scientific evidence demonstrates that CoC enhances the quality of care, significantly reduces morbidity and mortality, lowers the overall need for and cost of health services, and improves patient satisfaction (Eskola et al., 2022).

This is particularly important in the context of Finland, where the healthcare system is currently challenged by long queues and a fragmented access-to-healthcare landscape.

Developed by a multidisciplinary group of students in collaboration with Kela, the Social Insurance Institution of Finland, and the Ministry of Social Affairs and Health, this proposal aligns with the ongoing creation of a long-term vision for a new reimbursement model supporting CoC.

Our proposal addresses this pressing need for CoC by offering a strategic action plan for a transitional process within Health Centres.

Our research findings highlight the fragmented nature of the Finnish healthcare system, characterized by inconsistent practices across different Health Centers (HCs). These HCs vary significantly in size and operational methodologies, each operating within a unique contextual framework influenced by factors such as geographic location, population demographics, funding mechanisms, and local healthcare policies. Consequently, HCs exhibit distinct organizational structures, care delivery models, and operational processes tailored to their specific contexts.

Inspired by a conversation with a general practitioner (2024), we have defined the current system as providing reactive “sick care.” Our proposal aims to transform this into a proactive “health care” system that has the capacity to offer prevention and see the bigger picture of a patient, instead of just fighting the symptoms and consequences of sickness. As highlighted by research, building stronger patient-clinician relationships has a lot of benefits, such as reduced mortality (Eskola et al., 2022). Based on this, three key concepts have emerged during our process:

- 1. Teams of Care:** Assigning patients to teams of healthcare professionals with benefits for both patients and healthcare providers: increased likelihood of patients seeing the same doctors during their visits and increased collaboration and job satisfaction of professionals.
- 2. Continuity on Demand:** Enabling patients to see the same doctor throughout their treatment, ensuring consistency of care during critical moments.
- 3. Personal Doctors for Superusers:** Provide a personal doctor to high-need patients.

In our proposal, these three concepts form the foundation of a broader, strategic, and evolving action plan that supports the development of all Health Centers towards a more cohesive and patient-centered healthcare system in Finland.

# The Team



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# Key terms and abbreviations

## Continuity of Care (CoC)

CoC is a multifaceted concept that encompasses three key dimensions:

- Relational continuity: provision of care through an ongoing patient-clinician relationship
- Continuity of information: the use of information on past events and personal circumstances to make current care appropriate
- Management continuity: a consistent and coherent approach to the management of a health problem

We see CoC as a cohesive patient journey that allows for a broader overview of the patient's health. It is associated with increased patient and doctor satisfaction and may positively affect other health outcomes: Adherence to treatment, uptake of preventive services, and decreased hospitalizations (Eskola et al., 2022).

## Wellbeing Service County (WSC)

The Sote reform, which became effective in the beginning of 2023, aims for a more equal and centralized provision of healthcare and social welfare services. The reform divides the country into 22 Wellbeing Services Counties + the municipality of Helsinki (Kangas, Kallioma-Puha 2022).

## Health Center (HC)

Health centers, both private and public, are the access point for primary health care in Finland. HCs describes both the physical building and an organizational body. In some cases, they consist of one main location and smaller, so-called "health stations" that provide primary care in the surrounding areas (Tynkkynen 2019).

## General Practitioner (GP)

A General Practitioner is a primary care physician who serves as the first point of doctor contact for patients seeking medical assistance (Eskola et al., 2022). GPs may administer long-term care in addition to the initial status assessment. In Finland, a GP is expected to diagnose and treat patients independently to a degree typically seen in specialized care in other EU countries. Nonetheless a Finnish study showed that around 50% of acute cases can be handled by a nurse without the physician's assistance (Tynkkynen 2019).

## Kela

Kela is the Social Insurance Institution of Finland, a government agency that provides basic economic security for everyone living in Finland. (Kela, 2024)

## THL

THL is an expert and research institute that provides reliable information for decision-making and activities in the field of health and welfare. (Finnish Institute for Health and Welfare, Finland - THL, 2024)

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# Vision

Three subgroups worked on the topic of “Continuity of Care.” As a guiding principle, we created a vision including the core aspects of trust, sustainability, and meaningfulness for both caregivers and care recipients and equity in healthcare:

*“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.”*

This vision has driven our own team’s process toward a healthcare system that transcends the current “sick care” model in Finland. Furthermore, we envisioned a system that puts patients in charge of their health, trusting the advice of different healthcare staff instead of “consuming” health as a service. Reducing the pressure on the healthcare system is therefore a crucial step toward our vision, but we also aim to change the underlying principles of healthcare on a broader scale.



Figure 1: Workshop with stakeholder (2024, May 3).

# Process

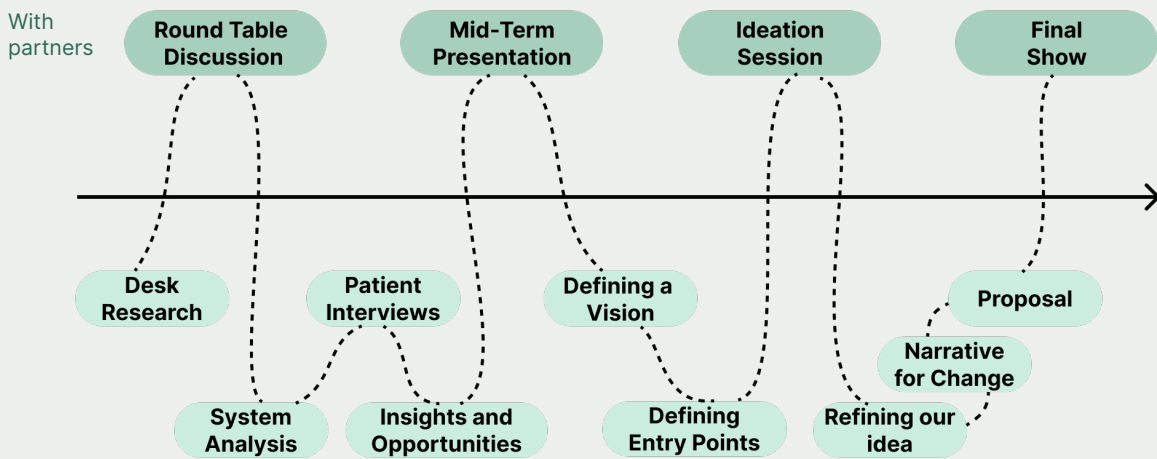


Figure 2: Visualization of team-working process

Our exploration of the Finnish healthcare system began with extensive desk research. The different areas of our research included: The history of the system leading up to the present state, different working models in HCs around Finland and different healthcare practices around Europe for reference.

## Current Finnish Primary Healthcare

The cornerstone of the Finnish healthcare system is the right of all people to the services provided by the system. Finland has three parallel publicly funded health care service systems: A municipal system based on health centres and hospital districts, a system partly funded by Kela and based on private medical practices, and a system based on occupational health care (Eskola et al., 2022). Health care for university and college students, is provided by the Finnish Student Health Foundation (FSHS / YTHS), which can be regarded as a separate health care system equivalent to occupational health care (Heikkilä, 2020).

## History of Finnish Primary Healthcare

Before the establishment of health centers (HCs), Finnish health care was hospital-driven by. In the 1980s and 1990s, experiments with family- and personal doctors and population responsibility schemes, proved to be successful. It seemed that the challenges encountered in the experimental activities could be overcome and that there would be no obstacles to a wider spread of population accountability schemes. However, subsequent reforms in the early 1990s, such as the development of hospital district systems and changes in government oversight, weakened the position of HCs relative to specialized and private care. Primary health care resources have clearly been affected. Changing circumstances led to cost cuts, which made the work of the self-employed physician unmanageable. This led to a crisis in self-employment and a shortage of physicians in health centers (Eskola et al., 2022).

**“The crisis we have in the Finnish healthcare system is due to decades of underfunding and underappreciation for the primary healthcare / healthcare centres.”**

- Interviewee, Researcher at THL

This crisis is felt on both the side of the patient and the doctor:

**“Sometimes you feel that the doctors are not feeling they are dealing with human lives but only with sickness”**

- Interviewee, chronically ill, aged 22

**“There are no health checkups, it’s usually a sickness checkup. [It’s] not health work, it’s sick work.”**

- Interviewee, GP in public primary health care

## Finnish Health Centers

Different Wellbeing Services Counties (WSCs) organize their HCs in various ways to adapt to the specific needs of their populations, providing a centralized location for very diverse services. Typically, HCs provide services such as ambulatory curative care for both acute and chronic patients, preventive services including maternity and child clinics, home nursing for older people or selected groups of chronic patients, dental health services, various forms of rehabilitation, and mental health and substance abuse services (Tynkkynen et al. 2019). Other services, such as physiotherapy, psychotherapy, speech and language therapy, occupational therapy, and medical specialist consultations, may be available depending on the municipality.

Patients can choose their HC once a year from all centers in the country. If they do not exercise this right, they will be assigned to the nearest HC. However, the number of HCs is decreasing as they merge into bigger entities.



In the Lapland WSC for instance, all patients are already assigned to a personal doctor and a personal nurse. Tuula Saukkonen, Director of Disease Prevention and Treatment in the WSC, attests that this model has effectively addressed access to care issues. Additionally, it has led to improved employee satisfaction due to favorable working conditions. The necessary cost savings have been achieved by reducing contracts with high-cost private GPs (MOT, 2024).

**“When everyone works for the public healthcare center directly, they’re on equal footing with each other and feel a sense of responsibility for the development of the community. There’s a focus on the stability of the work community, which also enables continuity of care.”**

- Tuula Saukkonen, Director of Disease Prevention and Treatment in the Lapland Wellbeing Services County (MOT, 2024).

On the other hand, a different kind of pilot is being implemented in the WSC of Western Uusimaa. The pilot aims to get entrepreneurial physicians on the private side to take responsibility for some of the citizens in the WSC, explained the county’s Chief Administrative Physician Veli-Pekka Puurunen in our roundtable discussion(2024). These physicians work and see patients at the HC while being self-employed, and not on the payroll of the WSC. This approach of self-employment is an unusual way of organizing a personal doctor for patients in Finland today, yet similar practices exist elsewhere in Europe and North America (Aalto, 2024). It is supposed to offer many of the benefits of working in private healthcare for the doctor, such as increased flexibility in their working hours, while still alleviating pressure from the WSC by assigning some patients from the county to the entrepreneurial doctor.

## Primary Care Practices in European Countries

Our desk research included an exploration of primary care practices across various European countries. In nations like Netherlands, Denmark, or Norway, most inhabitants are listed with a general practice or a named regular general practitioner (RGP) who is responsible for taking care of their medical needs. This was established not only to increase CoC, but also to prevent unnecessary spending by introducing the RGP as a gatekeeper.

For example, Norway introduced the RGP Scheme in 2001, allowing all residents to select their own RGP. According to a study based on Norwegian registry data (Sandvik et al., 2021), more than half of the patients emphasized the importance of retaining a GP they already knew, particularly among older individuals with poor health. This study also provides robust evidence that continuity of care by an RGP is linked to reduced reliance on out-of-hours services, fewer acute hospital admissions, and lower mortality rates in a dose-dependent manner. Specifically, maintaining an RGP-patient relationship for over 15 years decreases the likelihood of these events by 25-30% (Sandvik et al., 2021).

## Insights from Project Partners and Desk Research

During an intensive roundtable discussion with the project partners, we established shared foundations on which to begin building our project.



Figure 3: Roundtable discussion (2024, March 6).

Firstly, the discussion allowed us to align our understanding of the main concept of CoC and its benefits in the healthcare system.

The prolonged lack of funding in the public health system has led to doctors leaving public healthcare due to stressful working conditions. This has resulted in a shortage of GPs in HCs, causing long waiting times for patients (Keskimäki et al., 2019; Vuorenkoski, 2008). To understand the intricate structure of the Finnish healthcare system and the fragmented process patients navigate, we created system maps and user journey maps. Since all of the HCs in Finland have different working practices, their patient journey can hardly be generalized, but these visualizations helped identifying bottlenecks in the user journey, prevalent in the lower performing HCs.

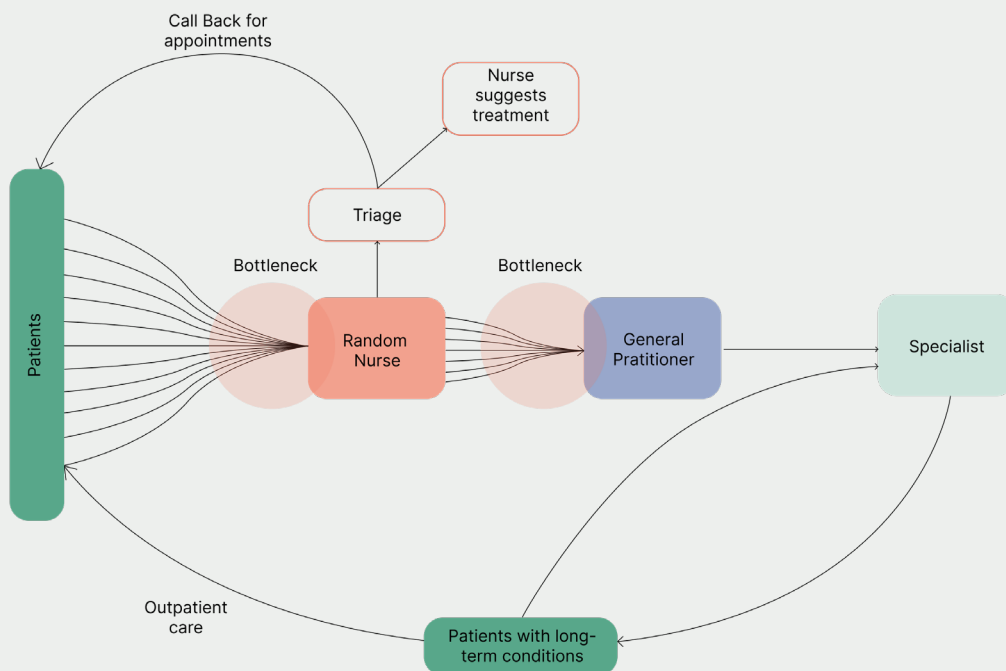


Figure 4: User-journey of patients in the public health centre

**Insight**

A common issue in health centers (HCs) around the country is the mismatch between supply and demand, creating several bottlenecks in the patient’s healthcare journey.

This lack of capacity reduces trust. Patients have to advocate strongly for their need for care in order to receive it, which came up both in our interviews with patients and healthcare professionals. One researcher from THL noted during an interview:

“Patients say that once you get inside the system, the care is good and cheap. But you have to be able to present your case in order to get access.”

Additionally, a student with experience in both the Finnish and Norwegian healthcare systems remarked, “[In] Norway, [..]you had sort of one point of contact [the personal doctor] through which you could like open up, [...] it’s something like trust or having a friend [...]”.

**Insight**

The healthcare system is very complicated, characterized by long waiting times, lack of information and insufficient guidance and support for the patients.

Analyzing the user journey represented in Fig. 4. We found that when patients call the HC, they are usually assigned to a random nurse, resulting in an inconsistent point of contact. The nurse evaluates the patient’s condition and may suggest treatment for minor cases or book an appointment with a GP. Due to the shortage of GPs, nurses need to prioritize urgent cases, through a triage process. After triaging, the nurse calls patients back to book appointments. This delay is inconvenient for patients, as they have to wait for an appointment with a randomly assigned GP.

As shared by an interviewee (2024), patients with specialized needs, experience greater CoC during treatment when referred directly to specialists. However, this is not always the case. In Finland, GPs are highly trained to handle most illnesses and are responsible for the majority of treatments, but the shortage of GPs creates significant bottlenecks in the system.

**Insight**  
**Patients have a “ping-pong role”, going from one professional to another.**

– Interview with University Researcher and former chief physician

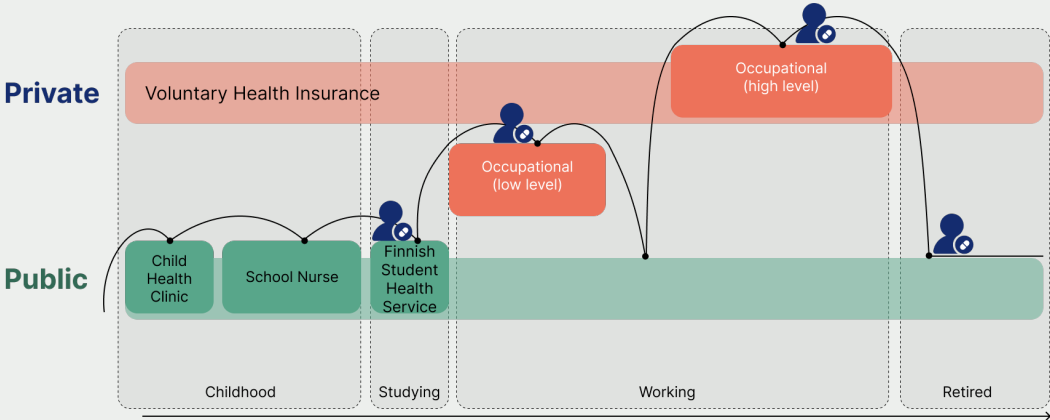


Figure 5: Visualization of “ping-pong role” of the patients during their lifespan through different healthcare systems. The patient-symbol points out which systems our interviewees were using at the time of the interview.

As visualized in Fig. 5, this dynamic persists throughout the patient’s lifespan due to Finland’s parallel healthcare systems.

**Insight**  
**Significant life events such as completing studies, changing jobs, and retiring, often lead to a disruption in CoC as patients lose access to their previous primary healthcare provider. Additionally, these different systems have varying levels of quality of care and CoC, making for an unequal healthcare landscape in Finland.**



## Patient Perspectives: Insights from Interviews

Throughout our research, we conducted six semi-structured interviews with patients. We aimed to gain the perspective of people utilizing different healthcare services: General public healthcare, the Finnish Student Health Services, lower level occupational healthcare, higher level occupational healthcare, out-of-pocket private healthcare, as well as private healthcare through voluntary health insurance. Of course, these were only the main services they were using, as there is always the option of using public healthcare. For example, Interviewee 2 provided insights into their diverse occupational experiences, having held multiple jobs with varying levels of healthcare coverage over their career, as well as being self-employed for a period and only using public services at that time. She also mentioned a period of living in Sweden and using the public services there. An other interesting case was provided by interviewee 6 who briefly lived in Norway and experienced the process of being assigned a personal doctor there.

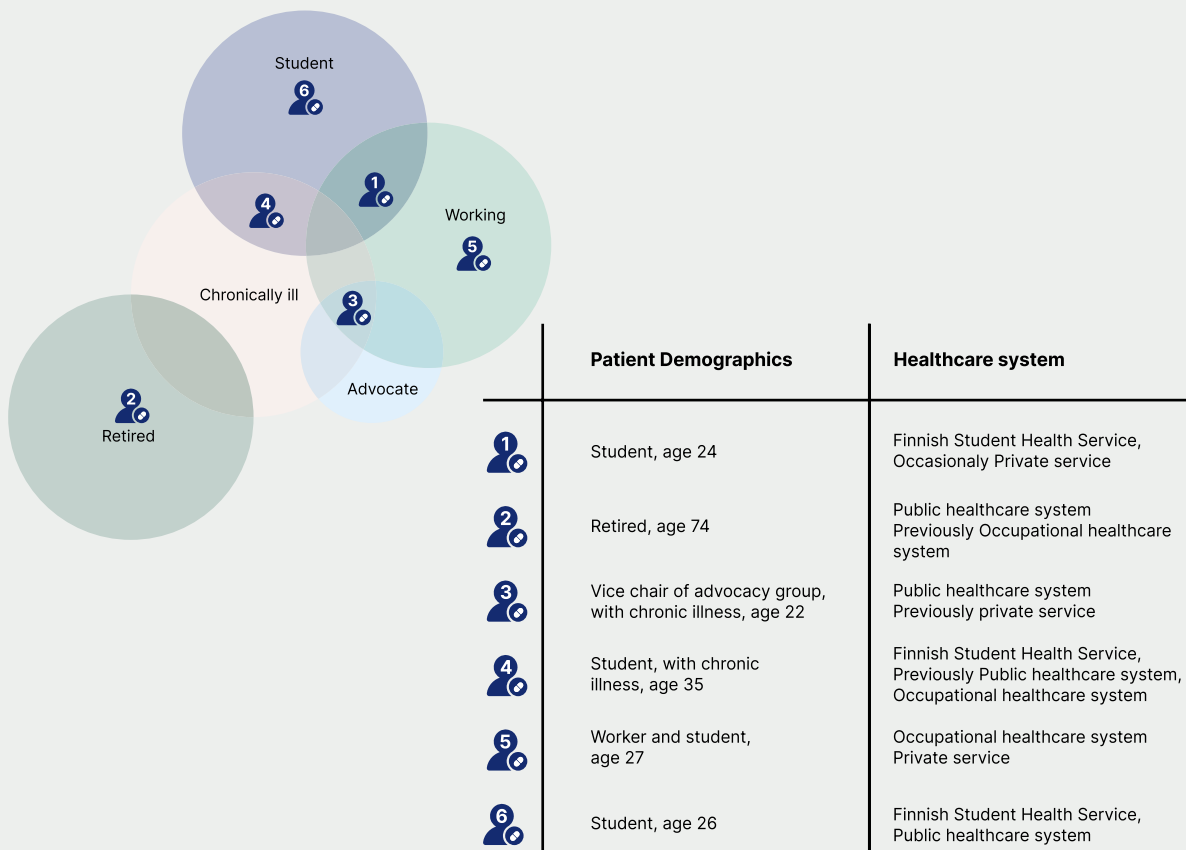


Figure 6: Distribution of Interviewees Across Different Patient Groups

Interviews with patients from diverse demographics and health conditions revealed different issues within the healthcare system. For example, interviewee 3 had a history of chronic illness and faced a long and difficult process to obtain the correct diagnosis for it. Interviewee 2 dealt with challenges due to living in a remote location without access to a car, making distance from the services the primary factor affecting her choice of healthcare provider.

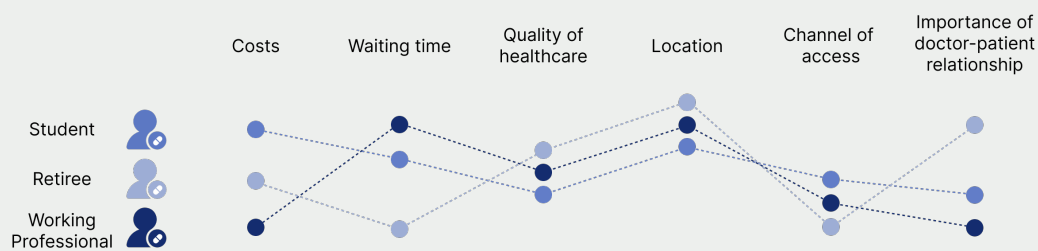


Figure 7: Prioritization of different factors by patients interviewed.

### Insight

CoC is understood and perceived differently by everyone. Even within one demographic, factors such as lifestyle and chronic conditions lead to highly individual prioritizations.

Additionally, even within the life of a person with higher-than-average care needs (e.g. chronically ill person) and thus a higher prioritization of CoC, there were specific moments when they had a greater need for CoC. One such moment is the diagnostic process, during which a good overview of the patient's health is instrumental or sometimes even vital in reaching an accurate diagnosis.

**"Weeks, at least, I could wait, it is not a matter of days so as to get to the same doctor. It is important to get to the same doctor if there is not something acute on that side, [but if there is,] then you have to go to whomever you happen to get to"**

- Interviewee, retired, aged 74

**"When working as a physician, I asked an access versus continuity question [in a patient feedback survey] and there was a division. Patients without long-term issues [would answer] "would be nice, but would be okay with another [professional]". Patients with long-term issues would want to go back to the same doctor they have been with for 20 years now or even just 2 years. I wish we would value the patients' side more. If a diabetic doesn't mind waiting for two weeks for the next appointment, their opinion should be valued."**

- Specialist in General Practice and Researcher at Tampere University

## Customer vs. Patient

One interviewee made the distinction between “patient” and “customer” in healthcare. He felt that in public healthcare, the users have the role of a patient because they trust the judgment of both nurses and doctors, and they are willing to wait longer. Users of private healthcare, on the other hand, have the role of a customer, because they can use whatever services they want, when they want them, according to what they believe they need. Since the private sector has much more capacity, it’s able to provide these services (e.g. specialist visits without triage first).

The fact that people with higher incomes have better access to healthcare, and can establish relational continuity in the private sector if they choose to visit the same doctor on different visits, increases inequality in Finnish healthcare. A report by THL from 2021 looks into this:

**“Roughly speaking, those most in need of healthcare have the greatest difficulty in accessing it. High-income earners in Finland have comprehensive occupational healthcare and use it extensively by international standards, while low-income earners queue up for public services. High-income earners can also afford to buy the medicines they need, which is not necessarily possible for low-income earners.”**

The issues brought up by inequity were further detailed by an Amnesty International report from 2023:

**“Inadequate resources mean that many specific services are often inaccessible in the public healthcare system, because of lengthy waiting times and or high out-of-pocket payments. These include services such as oral healthcare services, gynecological services, and mental health services; similar services offered by private providers are too expensive for many on lower incomes.”**

The existence of different healthcare services, however, has its upsides. Aalto (2018) emphasized the importance of choice for positive health outcomes. It is believed that choice empowers patients to manage their health more autonomously. It’s seen as a critical component in patient-centered healthcare, where individual preferences, needs, and values guide all clinical decisions. Therefore, interventions for increased CoC should not unnecessarily restrict people’s ability to choose their healthcare.

One crucial benefit of having relational continuity is the familiarity between patients and staff. This builds trust, and increases compliance with the treatment. One interviewee highlighted the importance of this familiarity for elderly people, especially those with memory loss, as well as children:

**“Yes, I think at least the elderly, why not the younger ones as well, [relational continuity is] important for them too – if for example, their children have to go to the doctor a lot and so on. It would be nice to have the same person there every time. . . to meet them, so they would not be so scared.”**

*- Interviewee, retired, aged 74*

In brief, some patients are willing to compromise on factors, such as a longer waiting time, to achieve CoC. To represent these different attitudes towards CoC, we utilized a version of the “Technology Adoption Curve” introduced by Rogers (1962). This model illustrates, how a new technology is diffused into society. In our case, this “technology” is relational continuity in favor of other factors when booking a visit to a HC (if it would be possible, for patients to chose the same health professionals during subsequent visits). We defined the different groups in this regard as following:

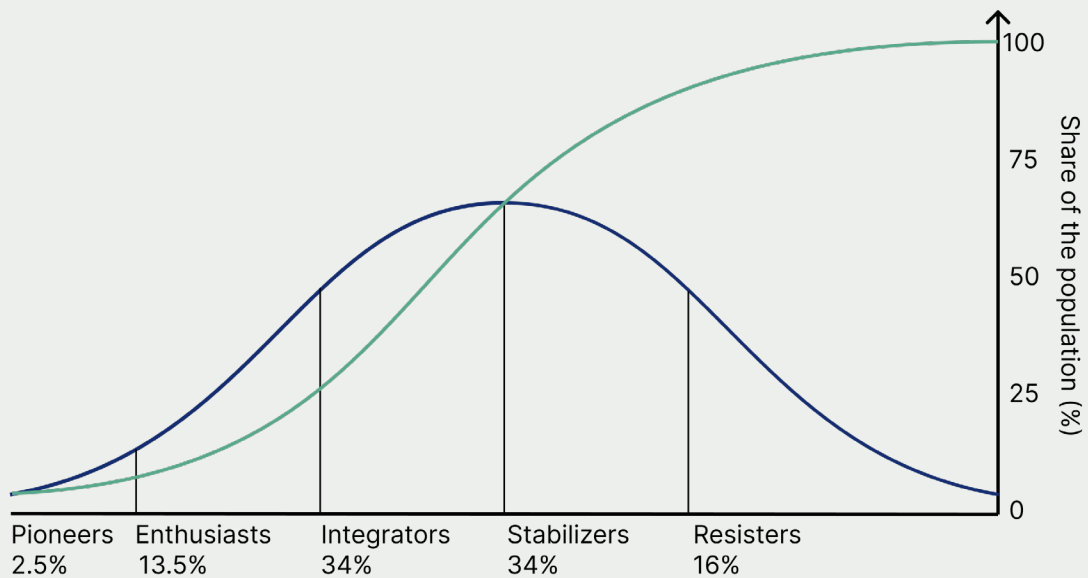


Figure 8: Personal continuity adoption curve. An adaptation of the Technology Adoption Curve introduced by Rogers (1962) to our case.

- 1. Pioneers** - These are the people who have a direct need for relational continuity due to complicated medical situations (chronic illness etc.). They will immediately adopt the model when available.
- 2. Enthusiasts** - They are passionate about improving their well-being and are educated about the preventive benefits of personal continuity, even if they may not have a great need for relational continuity right now.
- 3. Integrators** - They are pragmatic individuals who balance conservatism with openness to change. Before long, they recognize the value of relational continuity and actively influence their peers.
- 4. Stabilizers** - They are more resistant to change but eventually adopt the relational continuity model. They prioritize stability and reliability, and appreciate healthcare practices that are already familiar to them.
- 5. Resisters** - They resist the relational continuity model due to fear of change or lack of awareness about its benefits. This lack of awareness may be due to healthcare providers failing to give out sufficient information, or from personal attitudes. They may perceive any sacrifices necessary to achieve relational continuity as unacceptable. They prefer to hold on to familiar healthcare practices.



There is a willingness on the part of some users to prioritize CoC – however, the current healthcare system does not accommodate this. This is why the focus of our intervention started to shift from the patients to the healthcare system that would not only open the possibility for those who want it, but also educate those currently not interested in it.

During the **midterm presentation with the partners** (2024), we presented the main findings from the research phase. We focussed on patient groups (segments), and their varying needs and priorities. According to Saltman and Teperi (2016), some 10% of the Finnish population use 81% of health and social sector resources, we called this group “superusers”.

At the last meeting with our partners before the final show, the **ideation session** (2024), we proposed a first concept aiming for a smooth transition process of Finnish Healthcare. In our concept, patients would be assigned to increasingly smaller care-teams, opening the possibility for longer-lasting relationships for the above mentioned superusers. If those superusers are given more effective healthcare through personal CoC, it’s beneficial for the whole population. In the personal “CoC adoption curve” seen in Fig. 8, most superusers would fall into the pioneer-category.



Figure 9: Ideation session with partners (2024, May 8).

## Iterations of the Concept

To ensure our ideas were practical and effective, we sought validation through workshops and interviews with general practitioners and health researchers. They affirmed that some of our ideas were partially implemented in some HCs, proving their feasibility. However, we also recognized that even in these HCs, there was a lack of a cohesive direction and shared goal, resulting in varying perceptions of the effectiveness of these interventions.

Indeed, one GP who worked in a HC under a team model did not feel notable differences to the individual and randomized work presented above.

As reaffirmed by a former chief physician, without proper training these “teams” often represent just an administrative entity instead of a collaborative group.

They pointed out that, teams have a lot of potential for supporting CoC, but there is not as strong of an evidence-base from medical research for a patient-team relationship as for patient-doctor relationships. However, the team model has the benefit of not depending on just one person, as relational continuity is still maintained between the patient and the team even if the doctor changes workplaces. This is important to note, because a great portion of the doctor pool in Finland is made up of trainee doctors. They need to complete 9 months of work in different HCs in order to specialize, and are thus a very dynamic part of the system. Some specialists in general practice feel that the old personal doctor model is not the solution to the problems of HCs today, as described in a letter to the editor by Rantanen in Helsingin Sanomat (2022):

**“Health center work has changed enormously over the decades. Many of the issues being taken care of in healthcare centers need specific expertise. One doctor cannot manage all the information, and is not the best professional in all situations.”**

- Tuire Saloranta, a Health Center Physician and Specialist in General Practice (Helsingin Sanomat, 2022)

## Resulting Problem Statement

Our research, the interviews with the patients and the iteration of our first ideas with professionals allowed us to translate the abstract concept of the fragmentation of Finnish healthcare into three core problems.

- A common understanding of health care in Finland as well as a “clear path” for the transformation towards CoC is missing.
- The structure of HCs on paper is often not reflected in the actual experiences of the people working in and using the HCs.
- Exchange of information between pilot projects, that feature innovative ways of working, and other HCs is still a challenge.

# Entry Points

Despite our initially focus healthcare from the patient's perspective, we realized that the suitable scale for our intervention would be the HC. Usually HCs describe both the physical building in which patients consult primary health services, as well as an organizational body consisting of the main HC and the health stations as smaller subordinate contact points of one geographical area. At this scale, we identified several entry points, which are classified as smaller aspects of a system that hold great potential for the transformation of the broader system.



## **Focusing on the Development of “Lower” Health Centers:**

Best practices exist even among less advanced health centers. Emphasizing the development of the broader mass of health centers, rather than creating a few overly advanced ones, aims for a larger-scale change. The significant advantage of developing the “less advanced” HCs is the fact that there is a higher number of similar-sized HCs that may deal with a similar population.



## **Bringing Different Interventions in Chronological Order:**

Currently, various HCs are trying different interventions to improve in regard of Continuity of Care. These interventions might become part of a “mild transitioning” process in which they are divided into smaller, intermediate steps that lead to more continuity.



## **Increasing Feedback Loops:**

Evaluation and feedback are crucial for the improvement of the Healthcare system. Tynkkynen et. al (2023) state that “comprehensive assessment of the health system have been lacking until recently” (p. 14). In the realm of the Sote reform, THL was put in charge of evaluating the performance of the WSC annually. Those reports provide a basis for negotiations between the WSC and the government. In the past, the evaluation metrics differed among the counties. In every case, those measure health outcomes (i.e.waiting times, vaccination rates and hospital efficiencies). However, aspects like perceived CoC, trust, or working conditions for staff are not sufficiently covered by those evaluations.

One entry point is, therefore, to extend those evaluations that help with the allocation of financial resources with Feedback from Patients and Staff, not just from the WSC but from the individual HCs.

### **Patients:**

To understand how patients perceive the balance between continuity and the opportunity for choice (see “process” above), we cannot apply a “one size fits all” approach. We need to verify, after a set of interventions, how the situation has changed for the patients. By assessing their experiences and feedback, we can tailor our approach to better meet their diverse needs and preferences.

### Doctors:

As indicated in the “Process” section, the administrative structure of the HC often fails to align with the experiences of healthcare professionals. Therefore, it is crucial to regularly assess how changes affect the work of doctors and nurses.



### Comparison and Overview of HCs in Finland:

According to the Ministry of Social Affairs and Health (2019), Finland has a total of 142 HCs, averaging 6-7 HCs per Wellbeing County. Research has shown that these vary greatly in their functioning, financing, and perceived quality of care and working conditions. A general comparison, utilizing Key Performance Indicators (KPIs) and the aforementioned feedback loops established through our interventions, would provide a comprehensive understanding of healthcare across Finland.



### Help coming from the outside:

Our research revealed that Health Centers are often overwhelmed and need help to undertake transformation independently due to resource constraints. Therefore, external assistance is vital in sparking and facilitating transformation. This support can come in various forms, including expertise, resources, and guidance, to help Health Centers navigate and implement necessary changes effectively.



# Final proposal

To bridge the gap between the current system and a future system with more continuity of care, our final proposal is an adaptable and evolving strategic action plan that empowers healthcare centers. This plan will provide them with the tools and resources needed to transition from a reactive sick care system to a proactive healthcare system.

## Levels of the action plan

We envision the action plan as a phased transition with various levels, designed to support different HCs in Finland in their process towards more consistent CoC. Our action plan comprises three levels: “Teams of Care,” “Continuity on Demand,” and “Personal Doctors for Superusers.” We recommend that HCs implement the “basic level” of care continuity, realized through “Teams of Care,” before advancing to the next level. The organizational framework established for achieving “Teams of Care” remains in place as HCs progress throughout the Action Plan. “Teams of Care” offer significant potential for HCs, even in a scenario where every patient is assigned a specific doctor.

In contrast to an intervention where we simply envision the implementation of one desired state, this transitional process allows ongoing assessment of outcomes throughout the process. Additionally, it facilitates observation of the evolution of the “shadow curriculum” over time. As explained by a former chief doctor, “shadow curriculum” refers to the unwritten rules of communication, values, and actual functioning of the HCs, which often diverge significantly from the official guidelines and structures documented on paper.

The different levels that we envision stem from our research on team models and their effects but also draw from best practices in various HCs, which our stakeholders consulted or worked in as staff. These were located in Vantaa, Espoo, Lahti, pilot Western Uusima, Kalasatama HC, Tampere, Central Finland.

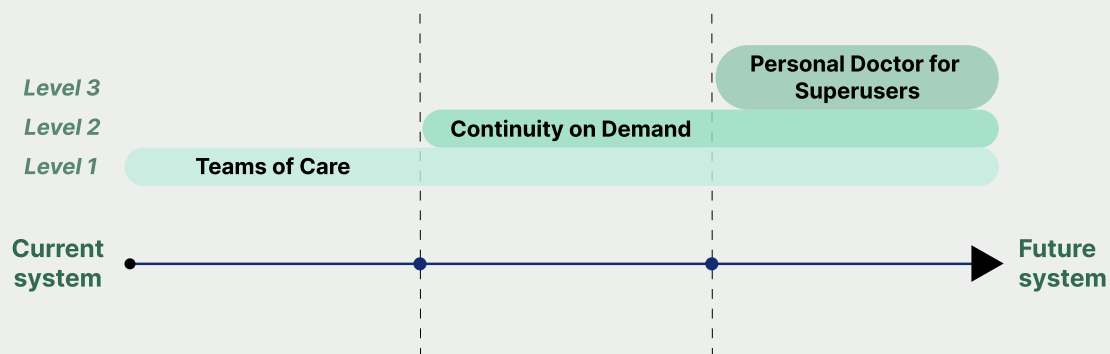


Figure 10: Levels of the proposed action plan

## Teams of Care

We suggest extending the team-based care model, already partially implemented in some cases (See “Iteration of the Concept” section above), across all feasible healthcare centres in Finland. This entails dividing the patient population into groups based on factors like location, age group, or health condition, and assigning each group to specific healthcare teams. This approach is tailored to fit the the organizational structure and patient demographics of each center.

**“Many of the problems addressed in healthcare centers require specialized knowledge. A single doctor cannot handle all the information and is not the most suitable professional for every situation”**

*(Helsingin Sanomat, 2022).*

Hence working in teams greatly reduces the pressure on doctors and nurses. Each team would comprise doctors, nurses, and other allied health professionals, dedicated to a defined segment of the population. The patients will be informed about their assigned Team of Care through different communication channels. After that, the patient can directly contact their teams of care when needed. This approach ensures that patients maintain direct contact with their care team, improving continuity of care and increasing the likelihood of patients seeing the same doctors during their visits.

The continuity provided by this team-based approach not only enhances the quality of care but also promotes patient accountability in managing their health. Familiarity with their care team during visits cultivates a sense of security and trust in the healthcare system. From the healthcare providers' perspective, working in teams offers better support and increased collaboration, leading to improved job satisfaction as they witness their patients' progress. Moreover, the teamwork and CoC contribute to a greater sense of purpose and meaning in their professional roles.

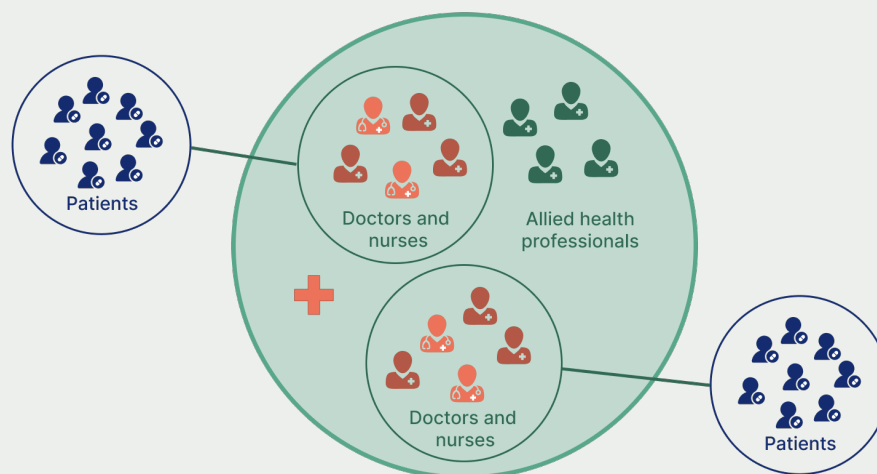


Figure 11: Connection of Teams of Health professional and groups of patients

## Continuity on Demand

The existing booking system in many healthcare centers presents a challenge, as patients often lack the ability to choose their preferred doctor for appointments. The concept of “Continuity on Demand” addresses this issue by allowing doctors to schedule additional follow-up meetings with their patients, thereby ensuring continuous monitoring until the completion of their treatment.

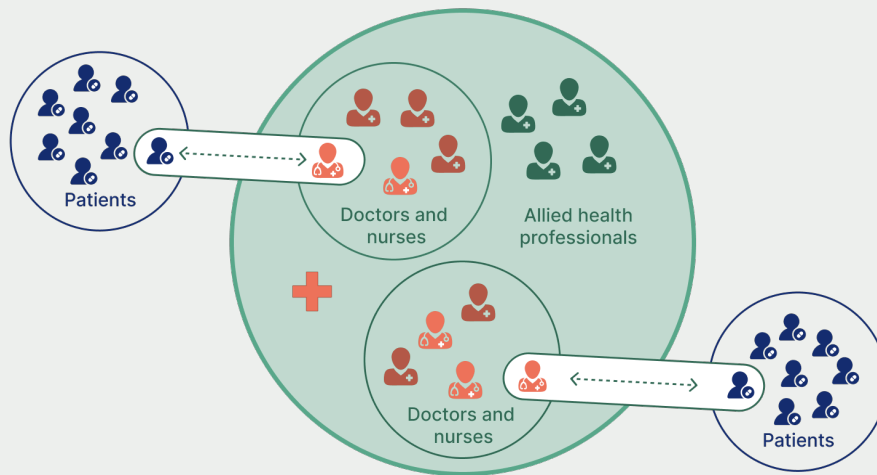


Figure 12: Continuity on demand for some patients

This system permits doctors to allocate a specific number of follow-up appointments, making it easier for patients to book subsequent visits with the same physician. Doctors can initiate discussions about follow-up visits with patients when they deem it necessary, and the system permits doctors to allocate a specific number of follow-up appointments.

As mentioned above, having the same general practitioner treating a patient, improves the quality of care and patient satisfaction, and significantly reduces morbidity and mortality (Eskola et al., 2022). By enhancing CoC, "Continuity on Demand" aims to mitigate the challenges posed by the current booking system, ultimately leading to better patient outcomes and more efficient healthcare delivery.

Implementing Continuity on Demand ensures that patients receive consistent care from the same doctor when they need it most. When integrated with the team-based care model, this approach becomes even more effective. Patients already benefit from the support of a multidisciplinary team, but Continuity on Demand enhances this by allowing them to see the same doctor throughout their treatment. Hence, this approach allows for CoC even when people use the public system for a limited timeframe (see "Ping-Pong role in "Process").

## Omalääkäri (Personal Doctor) for Superusers

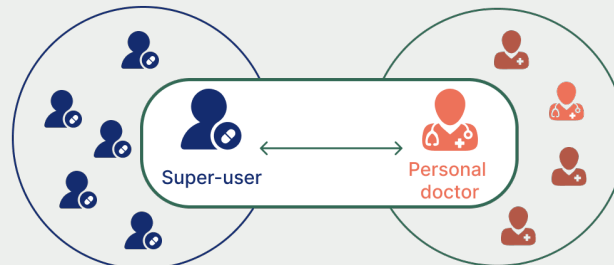


Figure 13: Assignment of Personal Doctor for Superusers

**"81% of health and social sector resources are consumed by merely 10% of the population"**

*-(Saltman and Teperi, 2016, p. 24)*

The final level of the action plan focuses on this 10% of the population, defined as "Superusers." As previously mentioned, these Superusers typically include chronically ill or elderly patients. We propose assigning a personal doctor to each of these Superusers, ensuring they consistently receive care from the same physician. In this way, we address a significant portion of the healthcare system's demands.

Assigning personal doctors to Superusers will alleviate the need for these patients to repeatedly recount their medical history to different doctors, thereby reducing consultation times. This approach builds stronger patient-doctor relationships, enhancing the efficiency of the healthcare system. Consequently, this will free up capacity within the system, reduce pressure on doctors, and allow them to deliver higher-quality care.

Given the current capacity constraints of healthcare centers in Finland, it is not feasible and not necessary to offer a personal doctor to every patient. Our findings reveal that not all patients prioritize CoC equally, with Superusers being the primary group that significantly benefits from it.



## Realization of the Action Plan in Finland

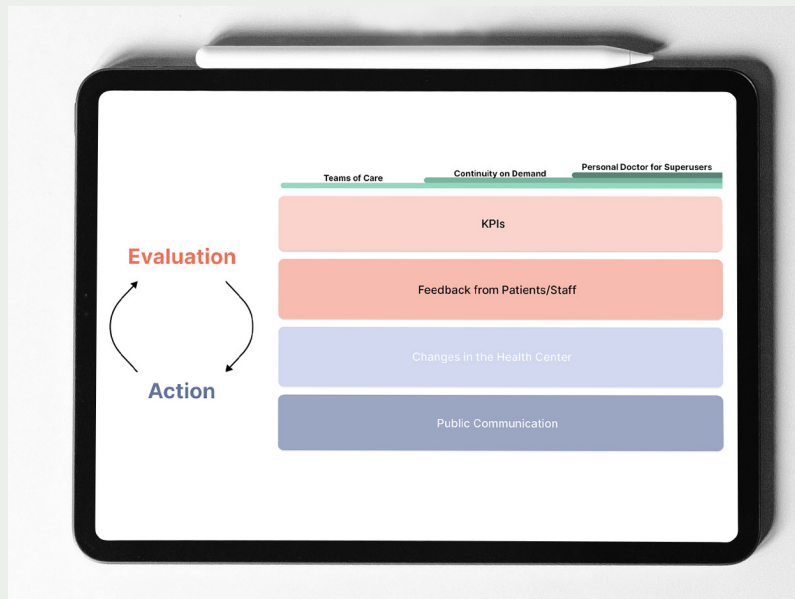


Figure 14: Symbolic representation of the action plan

With the implementation of our three-tiered action plan—comprising Teams of Care, Continuity on Demand, and Personal Doctors for Superusers—we aim to establish a comprehensive model for continuity of care that is both flexible and tailored to the diverse needs of patients, and optimizes the use of healthcare resources.

To realize the action plan, we would utilize the existing well-being services counties, which were established during the Sote reform. The action plan is designed to be distributed to all healthcare centers in the well-being counties.

Each of those counties recruits a “taskforce” that assists with the implementation of the action plan. On average one task force would be in charge of the transformation of 6-7 HCs, of one county. Due to significant differences in the size and population of counties (and therefore also in the HCs), this task force would need to be adapted accordingly. Part of this taskforce can be health-care staff, but also other disciplines that help with the realization, such as coaches, psychologists or experts for IT services. The advantage of one taskforce per county is that comparisons on a smaller scale can be made. Providing help from the “outside” is important since we found that the HCs are often overburdened with day-to-day business. The danger of external advice is a lack of understanding of existing dynamics and challenges. Therefore, we propose that the task force coming from the outside connects with internal representatives of the HCs. When the taskforce starts the improvement in the HCs, Evaluation and Action are repeated for each respective development stage.



Figure 15: Feedback-loops of the action plan

As mentioned in the 'Entry Points' section, THL is evaluating various performance aspects of health care in one WSC. For the transitional process guided by the action plan, we need to extend those evaluations, to get an understanding of what level the HCs are currently at.

For the first level, **"Teams of Care"**, we would measure the number of patients assigned to a care team. Furthermore, we would need to measure the size of those teams. In addition to this data which could be collected by THL in their yearly evaluation, we would create data about how those numbers reflect in the stakeholder perception of the HCs.

### Questions for patients (quantitative/qualitative)

*I am aware of the care team I am assigned to and the reasons for this structure at my healthcare center."*

*(Scale: Strongly agree - Strongly disagree)*

*I feel a connection to the healthcare team assigned to me."*

*(Scale: Strongly agree - Strongly disagree)*

*Please explain your feelings about your connection to your care team."*

*(Open-ended)*

*Have you noticed coordinated interactions among the different professionals in your care team that enhanced the continuity of your care?"*

*(Scale: Yes, significantly - No, not at all)*

*Please describe any specific experiences that influenced your perception of care continuity."*

*(Open-ended)*

*How would you describe the size of your care team?"*

*(Options: Too large, Too small, About right)*

### Questions for staff (quantitative/qualitative)

*"The care team structure at our healthcare center helps me make more informed and confident decisions."*

*(Scale: Strongly agree - Strongly disagree)*

*In my daily work, do I have enough time to discuss specific situations with my care team?"*

*(Scale: Strongly agree - Strongly disagree)*

*Does the physical environment of your healthcare center facilitate effective communication within the care team?"*

*(Scale: Strongly agree - Strongly disagree)*

*If there are tensions within the team, do you feel equipped to address them?"*

*(Open-ended)*

For the second level, **“Continuity on Demand”**, we would measure the number of patients receiving continuity on-demand appointments.

### Questions for patients (quantitative/qualitative)

*I am happy to sacrifice fast access time to see the same doctor in specific situations.  
(strongly agree - strongly disagree)*

*It was easy to get “Continuity on Demand” in my HC.  
(strongly agree - strongly disagree)*

### Questions for doctors (quantitative/qualitative)

*“Continuity on Demand” helps me to keep track of certain patient groups.  
(strongly agree - strongly disagree)*

*“Continuity on Demand” gives me more peace of mind.  
(strongly agree - strongly disagree)*

*Creating “Continuity on Demand” appointments for certain patients is convenient and easy.  
(strongly agree - strongly disagree)*

*Please describe how ‘Continuity on Demand’ has impacted your approach to patient care.  
(Open-ended)*

For the third level, **“Personal Doctor for Superusers”** we would measure the amount of patients assigned to their doctor.

### Questions for patients (quantitative/qualitative)

*How did getting your personal doctor change your healthcare experience?  
(It got better– it got worse)*

*Why do you feel that way?  
(Open answers)*

*Did having your “personal doctor” affect other aspects of your health services (e.g. access, waiting time...)?  
(Open answers)*

*Do you wait longer for appointments in comparison to before you had your personal doctor?  
(Yes more than 2 weeks longer, between 1-2 weeks longer, a couple of days longer, my waiting time has not changed, I get appointments faster than before)*

### Questions for doctors (quantitative/qualitative)

*How has having your own patients changed your work experience?"  
(Scale: Improved significantly - Worsened significantly)*

*Please describe how having your own patients has affected your work."  
(Open-ended)*

*How relevant is the team model to your work now that you have your own patients?"  
(Scale: It became unnecessary - It still helps a lot)*

These questions and the KPIs emerged from our research and interviews with different stakeholders. They illustrate how the evaluation of the performance can be enhanced, and cover a finer level than the evaluations of THL. Of course, more research would need to be conducted to adapt those questions. In every case they give more precise implications on possible interventions than performance aspects such as the vaccination rate.

## Tools for Interventions in the HCs

We envisioned a set of possible interventions that can be realized in the HCs for the respective level and based on the evaluation via the KPIS and surveys (qualitative/quantitative) presented above. Some of those interventions were in the past realized in some HCs, others are based on the observations of HCs or best practices from other countries.

### Tools for Teams of care

#### 1. Team-building activities

As previously highlighted, a crucial insight gained from interviews with general practitioners is that the mere existence of teams does not ensure their effective functioning as cohesive units. In order to avoid teams only having an administrative role, effective team-building initiatives are essential for fostering collaboration, enhancing communication, building trust among team members, and ensuring alignment with the centre's objectives and strategies.

One of our interviewees, a former chief physician and GP from a large health centre with approximately 30 GPs (2024), shared valuable knowledge and information on this topic. With experience in primary health care and in the Ministry of Social Affairs and Health, she is now focusing on "lean development" through research and coaching at various health centres. Her contributions include conducting workshops comprising exercise days, Plan-Do-Study-Act (PDSA) circles, and one-on-one or group meetings for team leads and managers.



Lean development, a philosophy popularized by the Toyota Motor Company, aims to identify and eliminate waste in processes to add value for patients. By applying these principles, health centers can improve patient satisfaction, streamline scheduling, reduce overtime, expedite paperwork, and boost revenues.

Using lean principles, all members of the organization, from clinicians to operations and administration staff, continually strive to identify areas of waste and eliminate anything that does not add value for patients. Improving patient satisfaction, scheduling appointments, decreasing overtime work, processing paperwork, and increasing clinic revenues are just a few of the areas where hospitals and other healthcare facilities are implementing lean principles.

Some lean healthcare examples include:

- Remove Waste from Over-Processing: Eliminate unnecessary tests, redundant forms, and duplicate data entry to save time and resources without compromising care quality.
- Reduce Waiting / Idle Time: Minimize patient waiting times, reduce idle time for staff and equipment, and ensure meetings start promptly to enhance overall productivity. (Catalyst, 2018)

## 2. Introduction of debriefing moments

Recognizing the importance of continuous improvement and reflection within healthcare teams, the introduction of debriefing moments emerges as a valuable strategy to share patient information effectively. These structured sessions provide valuable opportunities for healthcare teams, including nurses, general practitioners, and other professionals, to reflect on patient encounters, exchange insights, and enhance communication practices. Through collaborative dialogue, team members can share their perspectives, insights, and concerns, fostering a more holistic approach to patient care.

## 3. Improving the built structure of HC

From different HCs researched, we found that they accommodate the exchange within the health teams to a different extent. Some of the HCs featured a “team space” whereas others just had individual rooms. “Improving the built structure” focuses on using the existing affordances of the buildings, for example putting staff of one team closer together in the building. If there are rooms in the building that can be repurposed, “team spaces” could be formed with room dividers to keep the staff of each team in the same space, which would e.g. enable rapid consultation of the team doctor(s) by a nurse on call with a patient. While infrastructure is a resource-heavy intervention, in a longer timespan teamwork could also be taken into account in the choices made when planning and building new HCs.

## Tools for Continuity on Demand

### 1. Improve the booking system

One deficiency we found was in the scheduling of appointments. Although this might seem like a minor adjustment, small efficiency improvements in this aspect can accumulate fast. In some of the HCs we examined, staff used Excel to give appointments. While this is not a big problem in the context of the randomized system that can be found in some “lower level” HCs in which patients are always assigned to a different doctor, it becomes an issue when more patients ask for Continuity on-demand/follow-up appointments. When we asked one of our stakeholders who worked as a GP in an HC in Lahti, about how follow-up appointments are currently realized in their HC, he mentioned:

**“You can scroll into the future, check your name, time, and reserve that box for the patient. You need to confirm with the patient that works for them. There’s luck involved that it suits you and the patient and there’s a time slot available.”**

This manual search for an appointment could be automated. If the doctor or the patient sees it as important to have a follow-up appointment, the platform could find a possible slot, prioritizing the schedule of the patients, or prioritizing that the appointment takes place as soon as possible.

### 2. Decision tool for Continuity on Demand

When an HC decides to move towards “Continuity on Demand”, we imagine that those follow-ups can be either suggested or even prescribed by the doctors as well as requested by the patients.

This decision-making can add up more stress for staff. The team and the HC can therefore decide together, considering the resources available, on their “protocol” for Continuity on Demand. With this agreement, stress is reduced, and team spirit increases.

### 3. Informing the Population

We advocate for more communication with the respective population throughout the transitional process toward more continuity of care. Our research has shown that users often get lost in the complexity of the Finnish healthcare system. We learned about those deficiencies not only from the patients (see “Process”) but also from a GP that has worked under the team model in the past: The only information patients received regarding their “care-team” was the number they were supposed to call to reach the nurse of their team. While patients do not need to be informed about the transitional process, informing them about their care team and the possibility of consistent follow-up care, can increase trust and therefore compliance.

# Future perspectives

Looking ahead, through the implementation of the action plan, a comprehensive overview and comparison of HCs across Finland will be available. This overview will not only serve as a benchmark for performance but also pave the way for targeted interventions and innovations.

The comparative analysis enabled by the action plan will play a pivotal role in piloting projects aimed at enhancing healthcare delivery. By identifying best practices and successful models from high-performing HCs, it's easier to replicate and scale these initiatives across the country.

Furthermore, having a comparative analysis of HCs in Finland will also facilitate the exchange of knowledge and experience among healthcare providers across health centers of similar sizes. Healthcare professionals will have the opportunity to spend time in different care centers, observe their practices, and bring back valuable insights to their own centers.

This collaborative approach will foster enhanced cooperation among diverse HCs, ultimately driving continuous improvement in healthcare delivery.

An essential feature of the action plan is its adaptability and responsiveness to changing dynamics within the healthcare sector. As the implementation progresses, there will be continuous refinement of strategies based on real-time feedback, emerging trends, and stakeholder input. This iterative approach ensures that the interventions remain effective, efficient, and aligned with the evolving needs of patients and healthcare providers.

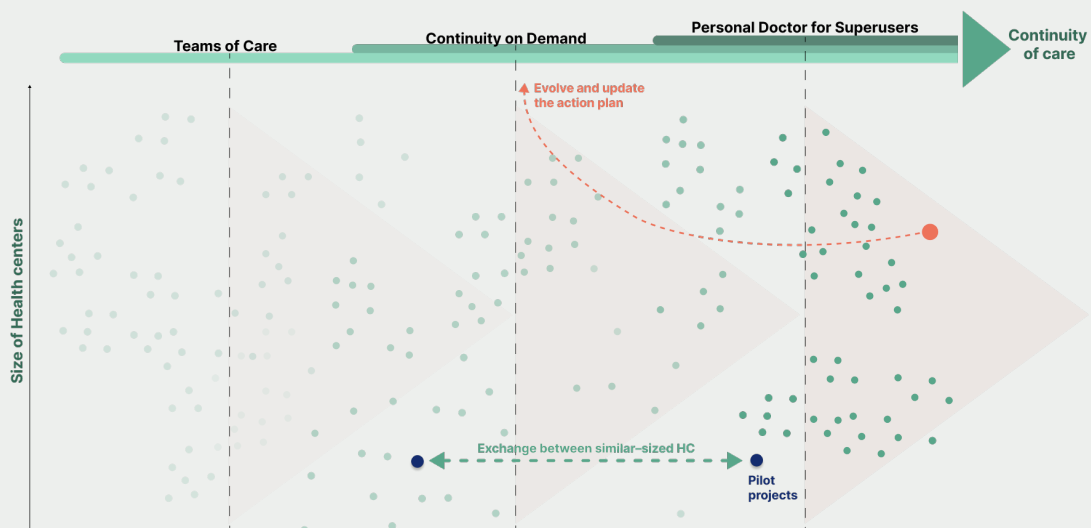


Figure 16: Overview of the development of HC towards CoC with representation of pilot projects, possible exchanges between similar-sized HCs and feedback to the action plan itself from high-performing HCs

## New Kela reimbursement, Why now?

Kela is currently developing a new patient reimbursement model proposal for 2025, which aims to enhance access to general medical care by reimbursing patients for visits to both public and private health centres. This reimbursement model broadens patient options and alleviates pressure on the public healthcare system by directing more patients to the private sector.

The reduced strain on public HCs represents an opportunity for systemic restructuring and development of public health centres.

We propose that Kela, in addition to covering individual patient visits, support these efforts by reimbursing specific interventions outlined in the Action Plan. For instance, interventions like the “Team-building activities” program that aim to improve collaboration among health professionals, fostering a more integrated approach to patient care.

These targeted interventions will allow each HC to evolve at its own pace within a shared framework, ensuring that improvements are both adaptable and sustainable. This flexibility ensures that health centres can implement solutions tailored to their specific needs while progressing towards common healthcare goals.

## Reflection

We initiated our research by familiarizing ourselves with the Finnish healthcare system, adopting the perspective of the patient – a viewpoint often overlooked but crucial as the ultimate end-user of the system. We soon started to recognize the interconnectedness between individual experiences and broader systemic issues within the healthcare system.

Gradually, our scope expanded to encompass broader systemic issues within healthcare. Through extensive research, we developed proposals aimed at addressing these challenges at a systemic level. However, we came to the realization that we were almost repeating the mistake we sought to avoid – neglecting the end user. This prompted us to circle back and reflect on how and which changes implemented at the level of HC could directly impact patients.

During our process, a key realisation came when we recognised that elements of our vision were already partially being implemented in some HC. This realization highlighted the importance of systematising these best practices and ensuring that all HCs benefit from them. The value lies in creating a shared approach that fosters a culture of knowledge exchange and continuous improvement. This would help the entire healthcare system transition towards a more cohesive and patient-centred model, ultimately leading to better health outcomes and more efficient use of resources.

In conclusion, human-centric approaches emerged as a common thread throughout all proposals to achieve more continuity of care. This shared focus on people, relationships, interactions, and feelings underscores the significance of leveraging design thinking methods - such as system thinking, strategic design, and behavioural-based design - in policymaking for complex societal issues.



# Sources

## Personal communications

### Patients

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- Retired, aged 74 from Central Finland (2024, March 22).
- Vice chair of advocacy group, with chronic illness, aged 22 years from South Ostrobothnia (2024, April 3).
- Student, with chronic illness, aged 35 years from Uusimaa (2024, April 3).
- Worker and student, aged 27 from Uusimaa (2024, April 4).
- Student, aged 26 from Uusimaa (2024, April 5).

### Healthcare professionals and researcher

- Researcher at THL. (2024, May 3).
- General practitioner with experience in public primary healthcare. (2024, May 10).
- University researcher, coach, former chief physician and general practitioner. (2024, May 14).

### Meeting with projects Partners

- Roundtable discussion - Design for Government (2024, March 6).
- Ideation session - Design for Government course (2024, May 8).
- Mid term presentation - Design for Government course (2024, April 10).
- Final presentation - Design for Government course (2024, May 29).

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