Aalto University
School of Arts, Design
and Architecture

Care 2

CARE THROUGH ***CONNECTION***

Continuity of Understanding -
Supporting Bilingual, Inter-professional Care Pathways

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Executive summary

Context to project brief

Finland's health and social care systems have faced structural reforms and significant financial pressure in recent years. The Sote reform reorganized how care is delivered, redistributing responsibilities across wellbeing services counties (WBSC), hospitals, and national institutions. Yet reorganization alone did not resolve a more fundamental problem. For long-term mental health and substance abuse patients, effective care depends on the continuity of understanding across transitions between professionals, organizations, and languages. Finland's constitution guarantees the right to receive care in either national language, yet for Swedish-speaking patients this right frequently breaks down in practice.

Brief

This project responds to a brief on continuity of understanding and is carried out as part of the Design for Government course at Aalto University, in collaboration with HUS, the Western and Eastern Uusimaa wellbeing services counties, and Kela. Through interviews with care professionals and administrators, a stakeholder roundtable, and policy and systems analysis, our research found that the core problem is not a lack of information. It is a lack of shared understanding across the system. Knowledge breaks down not because data is missing but because the organizations, professions, and languages carrying that data operate under different logics, incentives, and accountability frameworks, with no mechanism tying them together across patient transitions.

Grounded in three key insights around the shared theme of understanding, our proposal introduces a vision for connected CARE and three strategic entry points for change:

- **Facilitate holistic CARE by bringing broad expertise and care paths under one roof**
  Reduce the distance between care actors by placing professionals from different organizations and disciplines in shared physical and operational settings, lowering the structural cost of coordination at the point most likely to break down.
- **Make the diagnostic and application criteria between providers and Kela more transparent**
  Make expectations visible across organizational boundaries so that transitions are governed by shared standards.
- **Mapping existing bilingual services and maximising retention of Swedish-speaking care workers**
  Give both patients and providers an accurate, up-to-date picture of available Swedish-language services, their locations, and their access conditions, so that language rights are realised consistently rather than a left to chance

This is a proposal for a shift in how care continuity is understood across organizational boundaries. This shift moves beyond compliance with constitutional obligation toward a model where shared understanding is structurally supported, and where the people with the most complex care paths no longer bear the cost of fragmentation.

Glossary

Emotional language - In this proposal, *emotional language* refers to the language in which a person feels most comfortable expressing personal or emotionally significant experiences. This coined term draws on research showing that first or preferred languages may carry greater emotional resonance and support fuller expression (Pavlenko, 2005).

Entry point - An entry point is a strategically chosen, actionable spot in a system that serves as an initial, concrete place to begin improvement work and open up broader shifts. (Steinberg, 2026)

Insight - An insight is a clear, deep, and sometimes sudden understanding of a complicated problem or situation (Cambridge Dictionary, n.d.).

Provider - In this proposal *provider* is used as an umbrella term that refers to both care providers in our partnering wellbeing service counties, as well as Kela workers as service providers for public insurance.

Third-sector - The third sector refers to organizations that are independent of government and not primarily driven by profit, such as voluntary organizations, community groups, and NGOs (Alcock, 2010).

Vulnerability - In this proposal, vulnerability refers to increased risk of harm, exclusion, or unmet needs arising from overlapping disadvantages that cannot be understood or addressed in isolation (Crenshaw, 1989). In our context, this includes people facing intersecting mental health, substance use, financial, social, and language-related challenges.

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DESIGN FOR GOVERNMENT

Kela

HUS

Itä-Uusimaa Östra Nyland Hyvinvointialue Välfärdsområde

Länsi-Uudenmaan hyvinvointialue
Västra Nylands välfärdsområde

Figure 1 Left to right: Jasmin Joshi, Vivian Katajainen, Caroline Sjöström and Otso Koiso-Kanttila

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Introduction

This report presents the outcome of a 12-week design research project developed during the Design for Government course at Aalto University. From our brief Continuity of Understanding: Supporting Bilingual, Inter-professional Care Pathways, we present our proposal; **CARE through connection**. This proposal examines how health and social care services in bilingual Finland can be improved for the most vulnerable population, with a specific focus on mental health and substance abuse service users.

Vulnerable target groups rarely experience isolated, single-issue difficulties; instead, they frequently face complex, overlapping socio-economic and personal challenges. While public resources exist to address individual issues, the organizations providing them often operate in administrative silos.This forces individuals to coordinate their own care across Kela, primary health centres, specialised care, and non-profit organizations which likely causes cognitive overload. Consequently, critical personal context and continuity of understanding are frequently lost as patients are bounced between these structural boundaries.

Furthermore, in bilingual regions, equitable service delivery is not always achieved. Swedish-speaking individuals routinely experience gaps in care. While Finnish law mandates the provision of healthcare in both national languages (Language Act 423/2003), significant gaps in implementation remain.

This systemic fragmentation is likely reflected in a **sharp decline in public confidence**. Data from the Finnish Institute for Health and Welfare (THL) shows that public trust in the healthcare system dropped from 76% in 2020 to 54% in 2024, while trust in social care networks fell from 60% to 42%. The public sector is facing a 240-million-euro healthcare spending cut projected for 2027 (Valtioneuvosto, 2026), together with health centre visit fees that are expected to see a 73% increase between 2023 and 2027 (THL, 2024-2026). This places additional strain on low-income groups and people with complex needs.

National assessments indicate that 20% of the population utilizes 80% of all healthcare and social resources (Valtioneuvosto, 2020). This 20% represents the complex, multi-problem cohorts attempting to navigate the fractured care pathways targeted in this study. For these groups, seamless and rapid care is particularly important. This report will explore how we could bridge these gaps to create a more sustainable and cohesive health and social care system and rebuild public trust.

2
Research methods

The findings in this project are derived from a design-based research approach structured around the Double Diamond model (see Figure 8). The scope focused on the continuity of understanding within mental health and substance abuse care from both system-level and human-centered perspectives, with a particular emphasis on bilingual services.

The research began with a six-week foundational phase to map the healthcare landscape, split into three workstreams examining patient, provider, and administrative perspectives. Following this, the teams merged into two groups to conduct more targeted fieldwork. Ultimately, the process progressed from analyzing system structures to mapping lived experiences, concluding with collaborative validation and refinement alongside project partners.

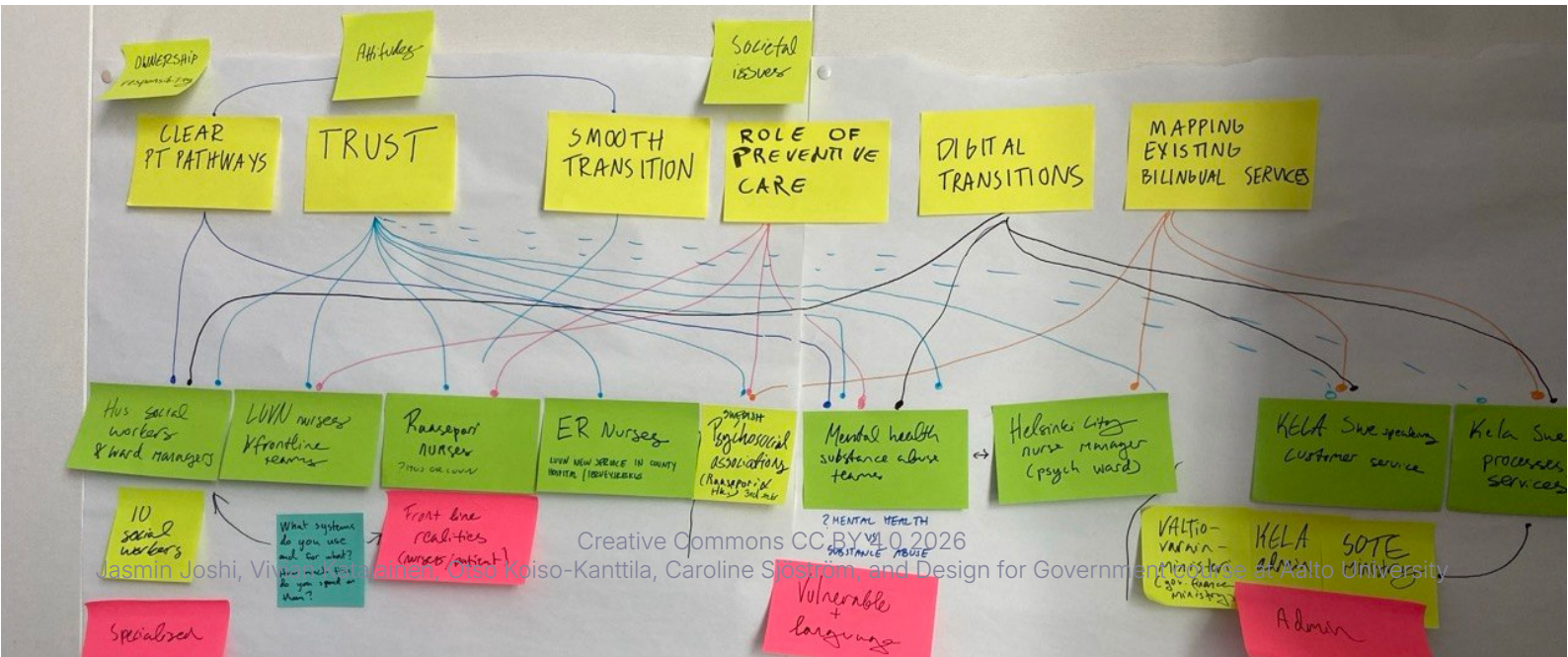
2.1 Setting the context

Desk research - Each workstream gained a broader understanding in their specific focus, to later share with the other workstreams.

Expert lectures and meetings - To add qualitative depth to our desk research, we were joined by topic expert lecturers, and met with professionals from organisations including HUS, Western Uusimaa wellbeing services county (LUVN), Western Uusimaa wellbeing services county (IU) and Kela. These findings provided a system-level foundation for the next phase of research.

Roundtable discussion with partners- We hosted a round-table discussion with five members of our project partners. The aim was to gather more understanding in specific areas, focusing especially on the bilingual landscape within care, where the issues within Kela may be, and where understanding might break down between points of care.

Figure 2 Affinity mapping themes from research



2.2 Fieldwork

In the fieldwork phase we focused on understanding how the system is experienced. In addition, following the midpoint of the project, we reorganised the original work-streams into two project groups, allowing the patient, provider, and administrative perspectives to be examined together.

Semi-structured interviews

To gain a deeper connection to the field, our research included:

- 11 semi-structured interviews with 17 care professionals across HUS, IU, LUVN, Kela, and the third sector.
- Site visits to Raasepori Hospital, Aurora Hospital, Porvoo Hospital and an Ohjaamo center in Länsi-Uusimaa.

Focus group with third sector service users

To include lived experiences within the research, we organised a focus group with a Swedish-speaking third-sector mental health support group. Four participants discussed their experiences of seeking care, navigating services, and receiving support.

Figure 3 Left - Focus group sticky notes

Figure 4 Right - Waiting room in LUVN Raasepori mental health department

2.3 Collaboration with partners

We were engaged with project partners throughout the project. Representatives from HUS, LUVN, IU, and Kela contributed perspectives from different levels of the healthcare system, helping us validate findings, challenge assumptions, and connect research insights to real-world contexts. We met with partners during following milestones:

Midpoint review - We presented initial findings and system-level observations to six project partner members to test early assumptions. Partners validated key desktop research themes, notably the fragmentation of care pathways and the critical need for Swedish-language services.

Figure 5 Left - Roundtable discussion with project partners

Figure 6 Right - Midpoint review with project partners; capturing opportunities for further research

Ideation session - Following fieldwork, we presented insights and potential entry points to eight partner members. The session focused on framing, feasibility, and defining where to initiate change, providing clear direction for our final proposal.

Final session & panel discussion - At Helsinki City Hall, we presented our final proposals, vision, and future directions to project partners, interviewees, and broader stakeholders. The event concluded with a panel discussion, enabling direct audience engagement with the project team and partner organizations.

Our research helped us identify key points where continuity of understanding becomes challenged across the healthcare system. The following insights examine these challenges across different scales, beginning with individual experiences and gradually expanding toward the wider system in which they occur.

Figure 7 - Final presentation at Helsinki Town Hall

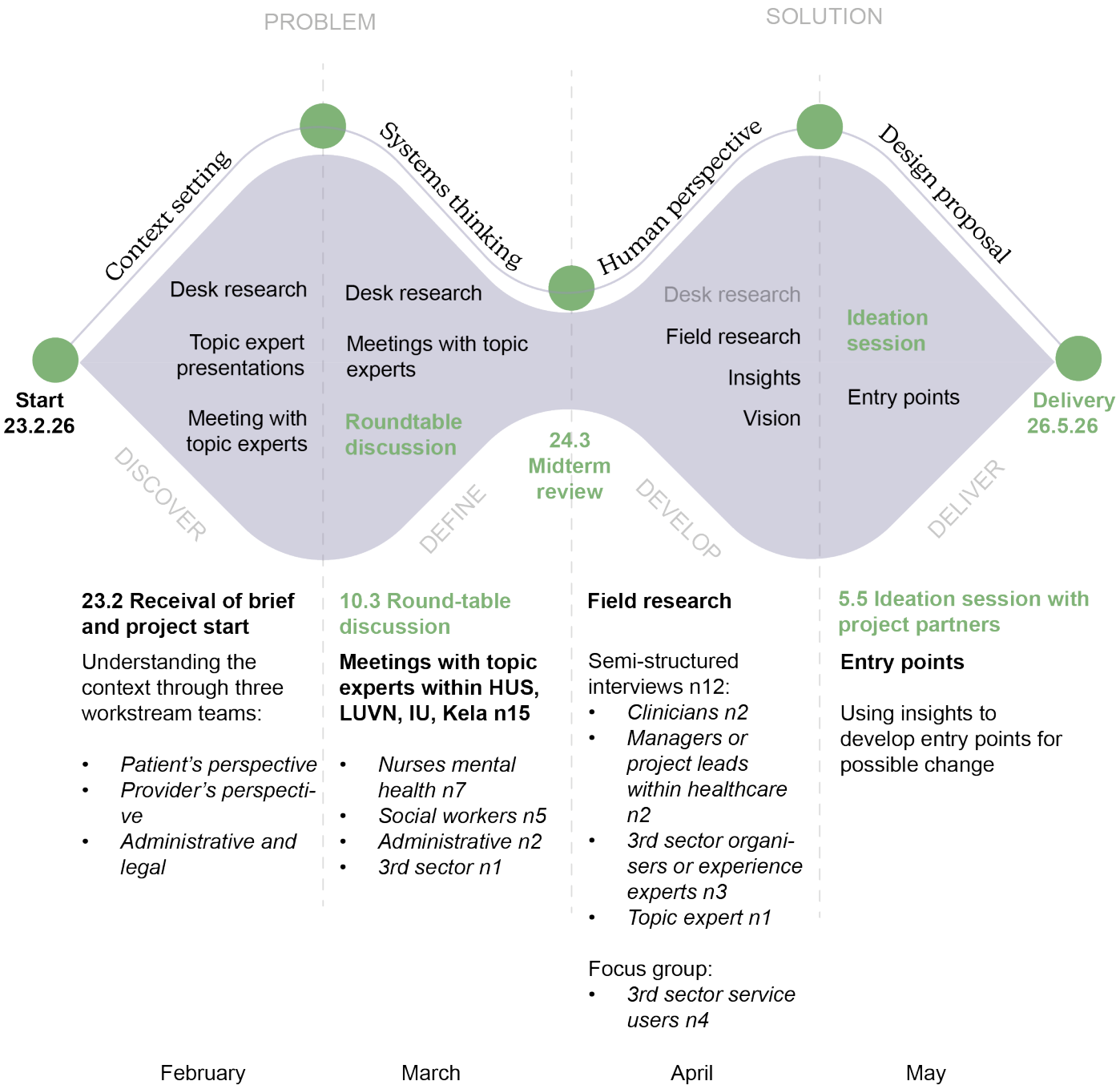


Figure 8 - Research prosess and timeline depicted with the Double Diamond method

3
Insights

Through the synthesis of desktop research, human-centered fieldwork, and partner collaboration, we identified a set of recurring themes that appeared across multiple perspectives and contexts. These themes form the foundation of the following insights that build upon one another, examining continuity of understanding across different scales of the healthcare system. We begin from the perspective of the individual service user and gradually expand outward to the wider structures, organizations, and conditions that shape care.

INSIGHT 1

Complex Care Paths

People with the most complex needs are often required to navigate the most fragmented parts of the care system.

INSIGHT 2

Points of discontinuity

Every transition between services creates a risk of losing information, context, and shared understanding.

INSIGHT 3

The bilingual gap

Access to care in Swedish is shaped by challenges that extend far beyond individual care encounters.

3.1 Complex Care Paths: The Reality of Vulnerable Care Journeys

People with the most complex needs are often required to navigate the most fragmented parts of the care system.

The people with the most complex care needs are precisely the ones who suffer most from the discontinuities in the current system. Patients dealing with co-occurring mental health and substance abuse issues often require support from multiple providers across basic care, specialized care, and the third sector. They may also depend on Kela for housing support or financial assistance. Their care paths are not linear. They move in multiple directions across organizational boundaries, and each transition carries the risk of information loss or delayed support. This description of a vulnerable patient was created in collaboration with professionals in the field (see research).

There are many steps in the care pathway

- 3rd sector service user

A discussion with a care provider from a WBSC revealed that economic vulnerability compounds these risks rising from complications. When support from organizations like Kela fails to materialize at the right time, the consequences can be immediate and severe. An example case described in the discussion involved a patient returning from a rehabilitation facility with no apartment arranged, facing the prospect of homelessness and likely relapse. **Mental health and substance abuse are also frequently interlinked, yet the care system often treats them as**

separate conditions with separate pathways (Ministry of Social Affairs and Health, n.d.; 2026a). Patients can complete a lengthy care path for one condition only to be placed at the start of another.

Still, the system's structural fragmentation does not affect all patients equally. Those with the greatest needs, the fewest personal resources, and the most complex care journeys bear the largest burden. For our project, this underlines that designing for continuity of understanding is not an abstract organizational concern.

> *I'm waiting to meet my social worker to look over my benefits, but she's probably very busy*
>
> - 3rd sector service user

For many patients, these challenges emerge not from a single service but from the accumulation of multiple transitions across the care pathway. Understanding why these moments of fragmentation occur requires looking more closely at the transition points where care, information, and responsibility are handed over from one actor to another.

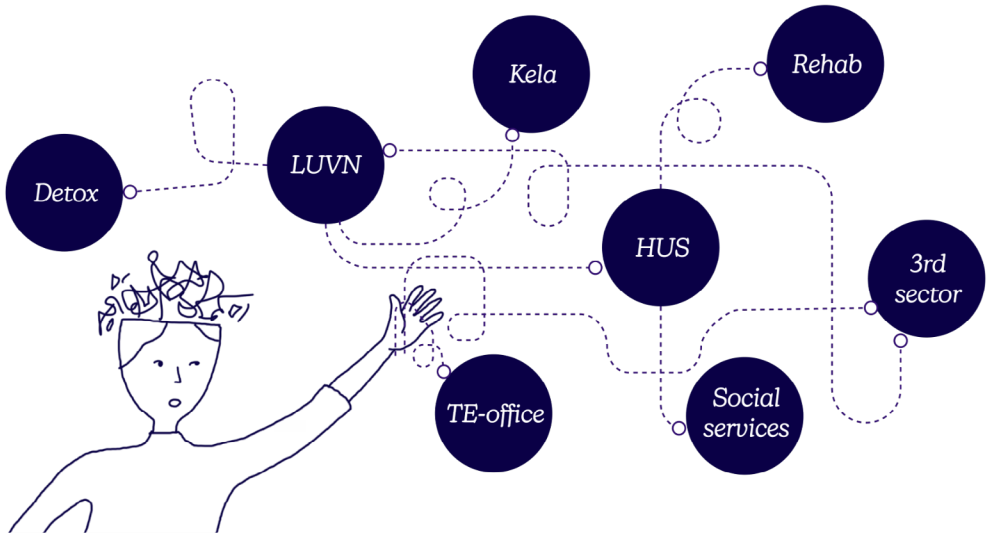


Figure 9 - Person trying to get a grasp of their complex, entangled care pathways.

3.2 Points of Discontinuity: The Challenges of Shared Understanding

Every transition between services creates a risk of losing information, context, and shared understanding.

WBSCs, HUS, and Kela each operate as separate entities with distinct areas of responsibility along the care path (Ministry of Social Affairs and Health, 2026b; YTA Agreement, 2024). Each organization develops its own practices, systems, and ways of working. Within organizations, care is further divided into functional units such as mental health, substance abuse, and social services. Each of these units may also be divided into separate sub-units where further silos emerge. **Patients whose needs span multiple of these areas must navigate across both organizational and internal boundaries.** At each of these transition points, information, context, and tacit knowledge must be transferred between providers. These are the points where continuity of understanding breaks down.

Several structural factors contribute to these breakdowns of understanding. Organizations use different information systems (such as Apotti), communication channels, and

professional practices. A WBSC may use separate systems for social care, healthcare, and housing services, creating discontinuities even within a single organization. When a patient is referred from a WBSC to HUS, the transition involves aligning across separate organizational logics. There is a need for an overarching mechanism tying accountability together across these boundaries. As noted in insight 1, patient needs are multifaceted, but **the current care system is built around siloed categories of care** that do not reflect this.

This matters because these **points of discontinuity** make care paths long and unnecessarily complex from the patient's perspective. Information is lost or degraded at the very moments when it is most needed. The challenge is not only between organizations but also within them, creating systematic friction at every handover.

While these discontinuities affect many service users, they can become even more pronounced when communication takes place across languages. The next insight explores how continuity of understanding is further challenged within Finland's bilingual care system.

"We don't really cooperate so well. My wish is that we would... they often send patients back and say: did you try this?"

-Social worker about sharing information with the healthcare system

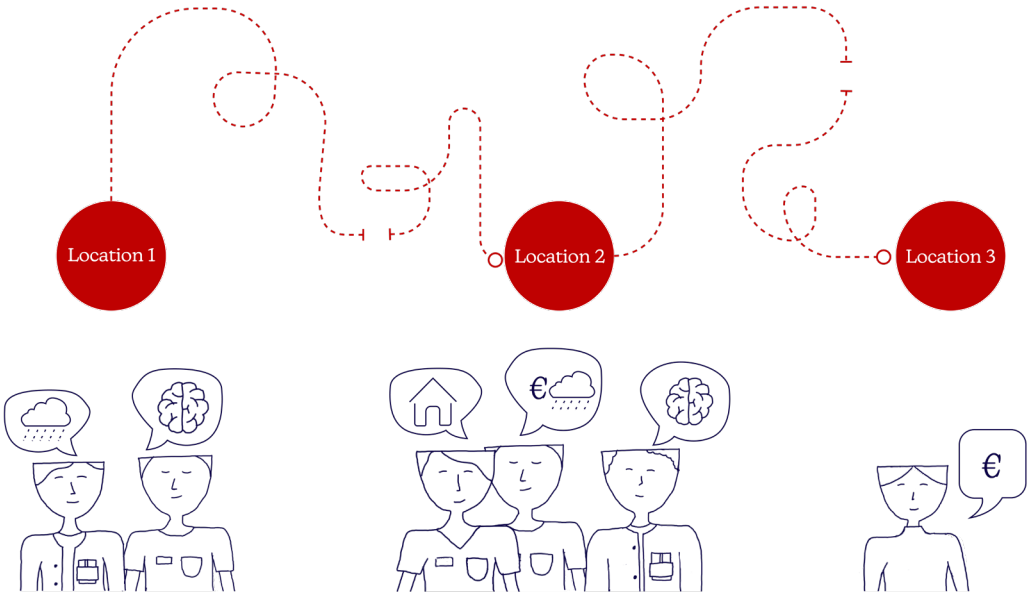


Figure 10 - A care pathway with points of discontinuity in transitions between locations

3.3 The Bilingual Gap: From Policy to Practice

Access to care in Swedish is shaped by challenges that extend far beyond individual care encounters.

Finland's constitution guarantees the right to receive care in either national language (Language Act 423/2003). In practice, the availability of Swedish-language care varies significantly across the healthcare system (Kuntaliitto, 2025). Some regions and facilities operate bilingually with strong capacity. Others face a chronic shortage of Swedish-speaking staff (Länsi-Uudenmaan hyvinvointialue, 2025). This creates uneven access that is difficult for patients to predict or navigate.

Several observable consequences follow from this gap. Health records may be written exclusively in Finnish even when the provider-patient interaction took place in Swedish, creating a situation where patients cannot meaningfully access their own records. A care provider from HUS described their observation of some patients choosing Finnish despite being Swedish speakers due to a fear of worse or slower care in Swedish.They effectively accommodate the system's inability to deliver on a legally mandated right. Providers interviewed also pointed to a decline in the quantity and quality of Swedish-language education in healthcare-related higher education. This means that when graduates enter the workforce, employers must compensate for gaps that the education system did not address

"I feel I have been stamped as a Finnish speaker in the care pathway and rarely get Swedish service."

- Mental health patient about getting Swedish-speaking care (translated from Swedish)

This insight highlights **how interconnected the challenge of bilingual care is**. The problem is not limited to a few understaffed clinics. It runs from education policy through workforce planning to the daily interactions between patients and providers. Saving resources in one part of the system, such as language education, does not eliminate the need. It merely shifts the burden elsewhere.

The same pattern can be seen beyond language services. These insights reveal a common pattern. Continuity of understanding is rarely lost because of a single failure in the system. It's rather **gradually weakened through fragmented pathways, disconnected services, language barriers, and structures** that struggle to address people holistically while shifting the burden of responsibility elsewhere.

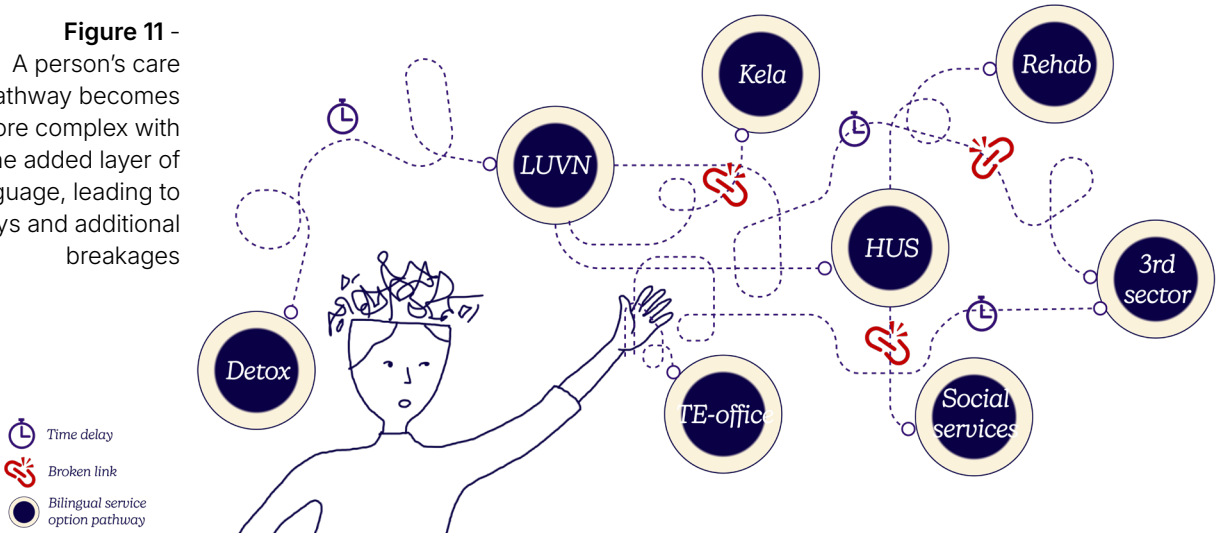


Figure 11 - A person's care pathway becomes more complex with the added layer of language, leading to delays and additional breakages

4
Proposal

4.1 Vision

Our vision is of connected CARE.
The backbone of the Finnish welfare state where the holistic needs of people and communities are understood and met through interconnected solutions.

This vision statement encapsulates a reframed direction driven by research findings and insights from our partners. Connected **CARE**, represents **a reframe from siloed services to treatment that meets people as individuals instead of a sum of individual needs.** Within this smoothly functioning system, trust becomes implicit between the patient and provider. Similarly, because bilingual services are guaranteed by law, their seamless availability is embedded in the system and not added as an afterthought.

> ***Multidisciplinary cooperation is needed in both financial and customer matters. The need for collaboration increases when working with vulnerable patients who need to be supported, for example, when staff changes or long-term care ends.***
>
> Expert from a psychiatric outpatient clinic
>
> *Translated from Finnish

Based on our four insights, we have identified three entry points where change towards the envisioned future can begin. The following sections describe guiding concepts, concrete examples, and the intended impact area for the entry points.

4.2 The Proposals

Facilitate holistic CARE by bringing broad expertise and care paths under one roof

The concept of effectiveness enables care providers to focus on their specialties, yet brings silos into organizations. Because of these siloes, collaboration between providers suffers, causing needless back-and-forth and waste of resources. (Hyytiälä, 2021) WBSCs can improve collaboration between organizations and currently distinct parts of the care path by connecting experts from each area of CARE. During our research, physical proximity was repeatedly raised by our partners as a concrete way to facilitate holistic care. Bringing different expertise under a

single roof can enable more natural collaboration and ensure smoother CARE paths for the most vulnerable. This also increases trust in the system.

There are diverse examples of successful models already in place, both internationally and in Finland. Most inpatient hospital wards in Finland run on this multi-professional setup to ensure safe and appropriate discharges. It works because they have close, oftentimes, physical collaboration. The Ohjaamo centres already provide low-threshold support for youth from help with Kela benefits to initial mental health care. Another prime example is the Dutch outreaching community care model, Flexible ACT (van Veldhuizen & Bähler, 2015) was designed for persons with severe mental illness, and has expanded to several countries e.g. Sweden and Canada. It combines multidisciplinary teamwork, with close coordination across community and hospital services within one integrated team.

We are proposing to expand existing local models to also include services such as employment and benefit navigation, together with active empowerment. In practice, smaller specialist multi-professional teams would be working in the same physical space dedicated to mental health and substance abuse needs. This could mean a psychiatrist, a social worker, a nurse, and a doctor would all collaboratively address a patient's overlapping needs, without needing to send them across several services and locations. In some cases, it is inevitable that some providers are physically far from each other; however, by **fostering a cultural shift towards collaboration** these transfers can run smoother.

Centralizing services also unifies the customer experience, as holistic CARE becomes associated with a single place rather than a fractured landscape of services and locations. The centralization of expertise also improves the continuity of understanding, as **a single person leaving the team does not necessarily mean that understanding disappears**, as it is retained by many people and through daily interactions. Strengthening collaboration within public care may also improve collaboration elsewhere. As presented in our insights, the 3rd sector is essential in offering peer support and filling the cracks in the public sector. With this model, collaboration between care providers and the 3rd sector could be improved, as it would simplify communication and foster localized integration.

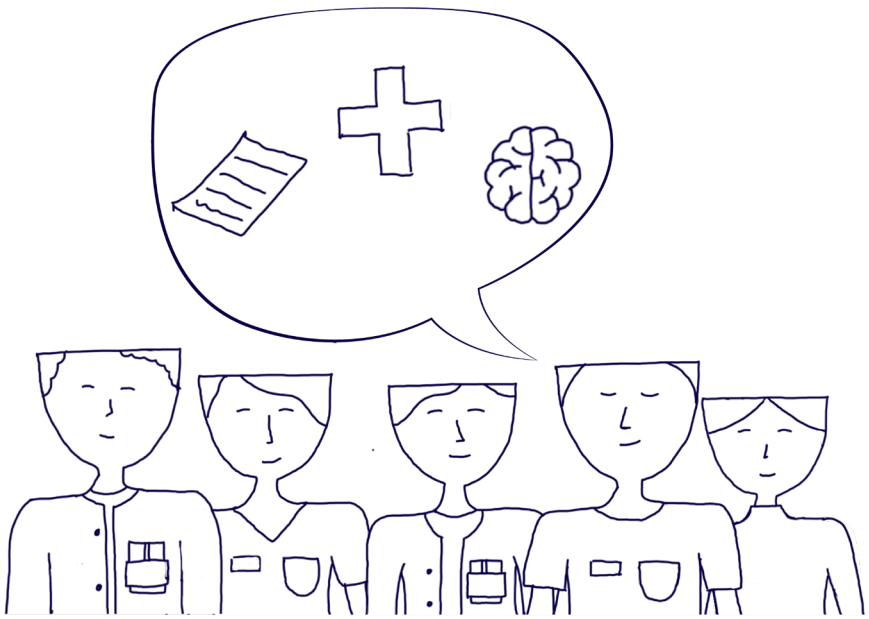


Figure 12 - Holistic care is made possible when multiprofessional teams convene to discuss a patient's needs with them

Make the diagnostic and application criteria between providers and Kela more transparent

Our partners described excessive patient bouncing caused by a **mutual lack of understanding regarding each organization's service criteria**. These issues arise in both collaboration between WBSCs and HUS, as well as between care providers and Kela. The lack of understanding leads to unnecessary work for providers, longer care paths for patients, and wasted resources for the WBSC. Creating transparent diagnostic and application criteria makes referrals and application processes smoother and more efficient for all. This entry point envisions improvements in information flows through technological solutions.

The technological solutions for transparency **can be reached through data sharing by unifying systems across WBSCs, HUS, and Kela**. Some shifts towards increased transparency and unified data sharing are already in motion. WBSCs have already taken concrete steps to unify their internal patient information systems under singular platforms to streamline data flows. LUVN and IU are both adapting the same, unified patient information system in 2026 (Itä-Uudenmaan hyvinvointialue, 2026; Lääkärilehti, n.d.). Our neighbor, Estonia, already has a single national patient health information database and cross-referencable health and social service systems (Frost & Sullivan Institute, 2023). This proposal situates itself in these ongoing integrations, scaling them to bridge the gaps between separate public authorities and moving from isolated regional data management toward a synchronized feedback loop between healthcare, social services, and Kela's benefit systems.

A solution within a digital system is **Kela applications that could provide immediate feedback on whether statement criteria are met** and prompt the supplementing of information to ensure a successful application. This could be done through **AI-integration in the platform**. A practical application of this would be that when a psychiatrist knows exactly what Kela needs in a medical statement, the application goes through the first time. The clarity avoids back-and-forth and delays. It will also remove self-doubt among staff, wondering if their justification will be accepted by Kela. Similarly, **standardized checklists for diagnoses and referral criteria**

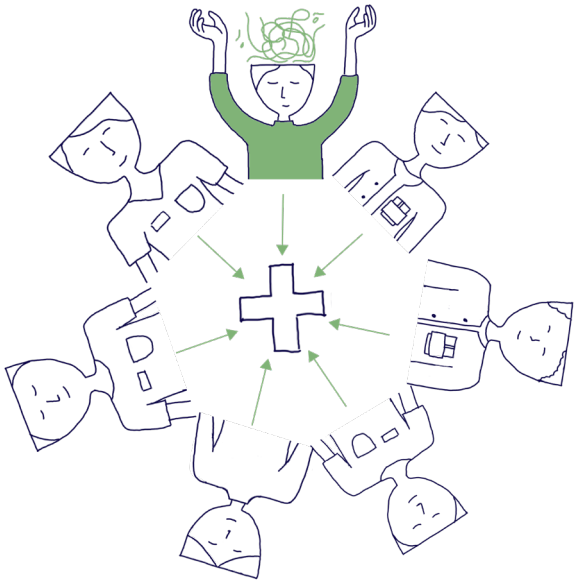


Figure 13 - When professionals have a shared understanding of criteria, care becomes simplified

created collaboratively and shared between WBSCs and HUS can reduce back-and-forth between primary and specialized care. The checklists can be integrated into a digital platform or be simple documents.

By **establishing transparency and enhanced communication**, necessary referrals and transfers become straightforward, predictable, and efficient. Through this shift, major friction points are removed from the system, subsequently saving valuable administrative time and public resources. Most importantly, patient care is optimized; by removing the burden of system navigation from the most vulnerable, a care path becomes an experience that still retains the patient's dignity and builds trust in public services.

Mapping existing bilingual services and maximising retention of Swedish-speaking care workers

Our research indicates that efficient Swedish-speaking services in the Uusimaa region exist but remain hard to locate for both the patients who need them and the professionals trying to make referrals between WBSCs. Currently, navigation relies heavily on word-of-mouth and unverified assumptions, which can disrupt care paths. **Systematically mapping existing Swedish-speaking services** and care providers works as an immediate strategy to make care supply more transparent.

LUVN is already piloting a mapping strategy, matching Swedish-speaking patient volumes against Swedish-speaking doctors per facility. This proposal scales this map into an **interactive cross-organizational tool** that is shared across providers, administrators, and patients. One practical example is that a social worker or a Kela coordinator can open this shared map during a consultation to accurately direct a patient to psychiatric care or substance abuse counseling in their preferred national language. As LUVN is responsible for developing Swedish-speaking healthcare for all WBSCs, this scaling can be a natural extension to LUVN's work in collaboration with other WBSCs. To ensure long-term sustainability, this digital tool must be paired with wider ongoing structural incentives, such as expanding language bonuses for providers and actively promoting bilingual learning to medical and social work students during their studies.

This entry point empowers Swedish-speakers to seek care in their emotional language, ensuring more effective care and fostering trust between customers and

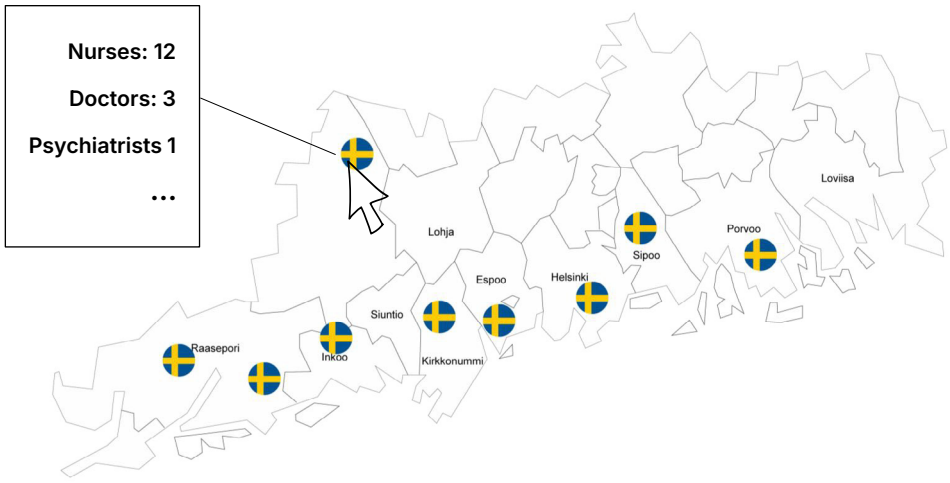


Figure 14 - Interactive map over Uusimaa depicting bilingual areas

care providers. While more Swedish-speaking staff is needed in many locations, this would maximise the use of already existing services, saving resources. This language mapping is a scalable model, and while it starts from Swedish as it is a national language, it **can be extended to other languages over time**, if needed. This can be highly beneficial as Finland has an increasing population of people speaking a non-national language as their mother tongue (Tilastokeskus, 2025). Likewise it would paint a more realistic image of demand and would show where supply should be increased.

4.4 Barriers & Mitigation

Implementing these shifts requires coordination, and several factors need to be considered during planning. Many barriers cut across all entry points. These include the **initial financial investment** into the implementations despite the long-term savings, the difficulty of fostering cross-organisational collaboration, shortages in the (bilingual) care workforce, and especially highlighted in the bilingual mapping, the need for **clear long-term ownership** and maintenance.

These barriers can be mitigated in several ways. The value of implementation can be demonstrated through continuous analysis, with evidence of system improvements and cost savings communicated clearly to stakeholders over time. Collaboration challenges can be addressed through **stronger alignment of incentives** across organisations and public bodies. For more structural changes, using pilot teams can help test procedures, build confidence, and clarify how new models compare with existing systems before wider application. Training, clear working methods, and regular coordination are also essential to making integrated models function well in practice.

These entry points build on models, practices, and forms of collaboration that are already emerging. For that reason, we see this work not as creating entirely new structures from nothing, but as strengthening and expanding efforts that are already in motion.

"Preventive work must be seen in financial terms. How much cheaper will treatment be if it is done on time?"

Expert from psychiatric outpatient clinic

*Translated from Finnish

5
Discussion

Finland's welfare state is built on a promise that everyone has equal access to the care they require, regardless of national language or complexity of need. What we discovered during our research is the distance between that promise and lived reality. The people most in need of a functioning system are precisely those it is least equipped to serve. Coming into the project, we had some expectation that there was some specific challenge that we needed to find and address, such as coordination between providers or communication. What we found is that the outcomes are structural in nature and that the most vulnerable patients with complex needs are the ones who expose those structural gaps.

Understanding does not break because the data is missing, but rather because the organizations and structures carrying that data operate under different logics, incentives, and languages. Our clearest "aha" moment came from recognizing that language and understanding are not purely an issue of having enough resources or Swedish-speaking staff. Although these certainly are part of the problem, the real problem is more systematic. What happens at one point of care is not where we should necessarily be looking for our solutions. **The real gaps emerge between points of care**, in the daily practices and interactions within and between providers, as well as in their technology.

Since our insights revolve around things happening between systems, many of the questions and proposals we pose are not only for the WBSCs or individual providers to decide, but rather are **matters of wider political will** and discourse on the government level. We aimed to formulate our entry points in ways that could be implemented at any level, however there are certain things that can only be properly addressed through political alignment and legislation.

Arriving to our reframing would not have been possible without the human-centered phase of our research. Interviews with providers and patients surfaced the things that our desktop research did not reveal. Each informant held part of the full picture, and everyone was motivated to provide the best quality care possible, but there were things in the way. We could not capture all relevant angles and viewpoints, and especially matters relating to the collaboration between Kela and the WBSCs would deserve more investigation. But by piecing together the stories we did find, we could begin to create a more comprehensive understanding of why things were not working, something that began to slowly take the shape of what this report eventually became.

Through this process, we also became more honest about what we do not know. Even with our research and interviews, we do not have or claim to have the full picture, nor do we believe it is possible to create such a picture of a system that is constantly in flux. Neither do we claim that our solutions can solve all the issues impacting the Finnish care system. Our proposals are grounded in research, and we believe them to be valuable, but the conditions required for them to work remain uncertain. Co-locating multi-professional teams requires organizational will, funding

models, and governance structures that this project did not have the scope to fully map. Transparent referral and application criteria depend on sustained cross-organizational dialogue that doesnt currently exist at scale and is hard to accomplish. The bilingual services map is perhaps the most immediately actionable proposal, but it also requires clear ownership and maintenance. Each of the entry points we have proposed is, in reality, an opening into a more complex implementation challenge than this proposal itself can resolve.

We believe this 12-week design research process is a well-grounded, evidence-based framing of the systemic problems around continuity of understanding, why it matters, and where change could begin. There are other angles to look at this care that would deserve a lot more attention, some of which we found interesting but did not have the time to pursue. More research would be required to further validate even our findings and proposed solutions. However, if this work prompts even one stakeholder conversation or action of collaboration that would not have otherwise happened, we feel the project has done its job.

"Even if laws wouldn't change, just changing the focus can bring change."

Expert from Kela, April 2026

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Note:
All figures and images included in this report were created by the authors

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