Health Policy 96 (2010) 20–27

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Child psychiatry in the Finnish health care reform: National criteria for treatment access

Pälvi Kaukonen[a,*], Raili K. Salmelin[a,b], Ilona Luoma[a], Kaija Puura[a], Mervi Rutanen[a], Tarja Pukuri[a], Tuula Tamminen[a,c]

[a] Tampere University Hospital, Department of Child Psychiatry, Finland
[b] University of Tampere, School of Public Health, Finland
[c] University of Tampere, Department of Child Psychiatry, Finland

ARTICLE INFO

Keywords:
Health services accessibility
Access criteria
National criteria
Child psychiatry

ABSTRACT

Objectives: As a part of the Finnish National Health Care Project, to develop and validate nationwide standardised criteria for assessing the need for non-urgent child psychiatric specialised medical care (SMC).
Methods: The Finnish criteria tool, a cutpoint measure indicating access to SMC, was developed on the basis of the Western Canada Waiting List Criteria Tool. The Finnish criteria were widely discussed at national level and finally confirmed by a national child psychiatric consensus meeting. The testing data included 949 new cases, aged 5–18 years, from SMC, family guidance clinics, primary health care and child protection.
Results: The Finnish Child Psychiatric Criteria Tool covers the entire case-mix of child psychiatric disorders. Danger to self or others and psychotic symptoms have been combined into a threshold item. This alone suffices to indicate access to SMC. Sensitivity of the tool was 82% and specificity 74% with cutoff point 16/75.
Conclusions: Child psychiatric non-urgent SMC is provided in accordance with national criteria, publicly accessible in the Internet. The criteria development process evoked multisectoral discussion on organising child mental health services and, by determining the need of treatment requiring SMC, defined health policy.

1. Introduction

The Finnish health care system, following the welfare model applied in all Nordic countries, is public, equality-based and tax-based, covering the whole population. Health care services are provided on two main levels, primary health care (PHC) and specialised medical care (SMC). PHC services are arranged in municipal health care centres. SMC is organised in hospital districts which provide both inpatient and outpatient SMC in five university hospitals, 17 central hospitals and several less specialised hospitals. All these institutions are non-profit-making organisations owned by municipalities or federations of municipalities. Private clinics offer complementary services. The state directs the health care system at the national level through the health policy legislation and guidelines [1].

Child psychiatric and child psychosocial services are provided by both health care and social services. Child psychiatric SMC is provided by the child psychiatry departments of the university and central hospitals, usually offering both outpatient and inpatient services. In PHC, the well-baby clinics and the school health services covering the whole population are responsible for the psychosocial

* Corresponding author at: Tampere University Hospital, Department of Child Psychiatry, P.O. Box 2000, FIN-33521 Tampere, Finland. Tel.: +358 3 31165994; fax: +358 3 31164375.
E-mail address: palvi.kaukonen@pshp.fi (P. Kaukonen).

0168-8510/$ – see front matter © 2009 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2009.12.009

wellbeing of children and their families. The country-wide network of family guidance clinics, administratively as a part of social services, provides psychosocial services to children and families on an outpatient basis. Thus, the infrastructure of child psychiatric and psychosocial services is scattered, although the amount of resources for these services in international comparison is high [2].

Until recently, the Finnish health care functioned well, but towards the turn of the century increasing demands quickly led to problems common in all western countries. According to OECD comparisons, Finland produced plenty of health services, and staff numbers in health care were high in proportion to the population size [3]. However, the provision of health care services showed high regional variation and the problems of long waiting lists for SMC were significant. Therefore, in April 2002 the Government of Finland adopted a resolution to safeguard the future of the health care services, which led to the National Health Care Project organised by the Ministry of Social Affairs and Health through the years 2002–2007 [4]. The project aimed to further develop health care in line with the constitutional principles of equality and justice by ensuring everyone access to good quality health care services when needed, regardless of personal wealth or place of residence.

One of the main themes of the project was to ensure access to non-urgent treatment within legally defined time limits. Since March 2005, patients must be assured of immediate contact with a health care centre, and initial assessment by a PHC professional must be provided within 3 days. Assessment by an SMC outpatient unit must begin within 3 weeks of receiving a referral. Access to medically justified treatment must be granted within 6 months, in child and adolescent psychiatry within 3 months.

The working group on access to care and waiting list management, as a part of the National Health Care Project, proposed developing and implementing nationwide uniform access criteria for the most common and frequently sought types of treatment, covering 80% of the non-urgent treatments in all medical specialties [5]. The hospital districts of Finland accepted the task of developing such criteria under the management of the national steering committee appointed by the Ministry of Social Affairs and Health. In April 2004, the Tampere University Hospital and the Pirkanmaa Hospital District, covering a population of 450,000 in the southwestern part of Finland, were given the task of creating, by the end of 2004, the criteria for child and adolescent psychiatry, which in Finland are separate medical specialties. Consequently, the criteria development processes for children and adolescents were independent, and the description of the adolescent psychiatry process has been published elsewhere [6].

The aims of this paper are to describe

1. The development of nationwide standardised criteria for assessing the need for non-urgent child psychiatric SMC.
2. The validation of the nationwide criteria among child psychiatric patients.

2. Materials and methods

2.1. Description of the process

In the field of medicine, explicit or implicit forms of prioritisation are generally applied as the health care systems are not able to provide all services facilitated by modern medicine to the whole population. A survey of the research literature of the last few years revealed, however, that no identical research projects focusing on uniform national access criteria were available, but studies related to prioritisation and waiting list management have been reported. Clear recent trends in the prioritisation discussion are the involvement of explicitness and the underlining of ethical values [7].

Various models and experiments for explicit prioritisation have been published in several countries, e.g. in Sweden [8–11], the UK [12,13] and Canada [14]. Explicit prioritisation has been implemented by means of scoring systems and point-count measures for the management of waiting lists, for instance for elective surgical patients in the UK, New Zealand and Canada [15–19]. In an evaluation study on the New Zealand health care reforms the prioritisation was found to be more explicit and access to treatment had changed, but there was some resistance to the use of the new methods [20].

The Western Canada Waiting List Project (WCWL) seemed the most promising for Finnish purposes, in both child and adolescent [6] psychiatry. The WCWL was a federally funded comprehensive project that aimed at addressing problems in waiting list management for five types of health services, among them, for the first time, child mental health services [21,19,22]. The project focused on developing, testing, and refining clinician-scored priority criteria measures for assessing and comparing the relative urgency of patients on waiting lists. As for child mental health (CMH), a multiprofessional CMH panel developed a set of priority criteria covering the entire case-mix of children and adolescents aged 5–18 years awaiting CMH services [22]. The criteria were applied to 817 CMH patients. Statistical methods were applied to find the criteria weights that best predicted clinicians' global urgency ratings. Finally, the criteria were refined according to the test results and clinical experience. The resulting WCWL Children's Mental Health Priority Criteria Tool consists of 17 items concerning the severity of the child's illness as well as psychosocial and outcome factors. The weights of item scores vary from 1 to 15, the overall range being from 0 to 100. The interrater reliability and the test–retest reliability of the criteria tool were good. The WCWL criteria assess urgency on the waiting list prior to diagnosis as well as urgency for treatment after diagnosis.

The WCWL Criteria Tool was selected as the basis for developing the Finnish criteria tool, which was to be a point-count measure with a cutoff point indicating access to SMC. The advantages of the WCWL Tool were the generic approach, covering a broad range of clinical diagnoses, and adequacy for different services. It is more reasonable to assess the severity of a child's psychiatric disturbance