Health Policy 111 (2013) 221–225

Contents lists available at SciVerse ScienceDirect

Health Policy

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

# Purchaser–provider splits in health care—The case of Finland ☆☆

Liina-Kaisa Tynkkynen[a,*], Ilmo Keskimäki[a,b], Juhani Lehto[a]

[a] University of Tampere, School of Health Sciences, School of Health Sciences FI-33014 University of Tampere, Finland
[b] National Institute for Health and Welfare, P.O. Box 30, FI-00271 Helsinki, Finland

ARTICLE INFO

*Article history:*
Received 28 March 2013
Received in revised form 21 May 2013
Accepted 22 May 2013

*Keywords:*
Purchaser–provider split
Commissioning
Outsourcing
Contracting out
Public procurement
Finland

ABSTRACT

The purchaser–provider split (PPS) is a service delivery model in which third-party payers are kept organizationally separate from service providers. The operations of the providers are managed by contracts. One of the main aims of PPS is to create competition between providers. Competition and other incentive structures built into the contractual relationship are believed to lead to improvements in service delivery, such as improved cost containment, greater efficiency, organizational flexibility, better quality and improved responsiveness of services to patient needs. PPS was launched in Finland in the early 1990s but was not widely implemented until the early 2000s. Compared to other countries with PPS the development and implementation of PPS in Finland has been unusual. Firstly, purchasing is implemented at the level of municipalities, which means that the size of the Finnish purchasers is extremely small. Elsewhere purchasing is mostly implemented at the regional or national levels. Secondly, PPS is also applied to primary health care and A&E services while in other countries the services mainly include specialized health care and residential care for the elderly. Thirdly, PPS in health and social services is not regulated by any specific legislation, regulative mechanisms or guidelines. Instead it is regulated within the same framework as public procurement in general.



## 1. Introduction

In this article we describe the development of the so-called purchaser–provider split (PPS) in the delivery of health care and elderly care services in Finland. While a single definition for PPS is difficult to find, the concept subsumes certain basic assumptions, the relevance of which varies across the countries that have implemented PPS in their service delivery. In PPS public third-party payers are kept organizationally separate from service providers and the operations of the providers are managed by contracts [1]. The incentives built into the contractual relationship are believed to lead to improvements such as cost containment, greater efficiency, organizational flexibility and improved responsiveness of services to patient needs [2].

There is little consensus on how the purchasing function should be formulated or organized in order to achieve these goals [3]. However, a general assumption is that the purchaser is able to articulate the needs and wishes of the population and make plans for service delivery based on this knowledge. In addition it is assumed that a separate purchaser agency is able to be more explicit about the costs and the quality of the services and also to match political decision-making and service system priorities better with the allocation of the resources. PPS also allows competition

☆☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author. Tel.: +358 44 521 7569.
*E-mail address:* liina-kaisa.tynkkynen@uta.fi (L.-K. Tynkkynen).

0168-8510 
http://dx.doi.org/10.1016/j.healthpol.2013.05.012

between providers, which is often believed to yield benefits such as efficiency, cost-effectiveness and improved quality to name but a few.

The idea of implementing PPS in Finnish municipalities was to a large extent adopted from abroad, mainly from the UK (particularly England), Sweden and New Zealand. In these countries PPS was implemented in the early 1990s and was mainly applied to specialized health care services (excluding A&E services). The purchasing organizations in these countries have mainly been regional or national, although the arrangements have gone through several reforms since the early 1990s [4]. In England purchasing is mainly primary care – based and currently implemented by Clinical Commissioning Groups. Compared to PPS in these countries the Finnish case, however, is somewhat different in terms of the purchasing agency, the services purchased and in terms of the regulative framework applied to the procurement of health care and social services in Finland. In the following we describe the development of PPS in Finland and discuss its peculiarities in terms of how PPS has been implemented in other countries. The paper contributes to the already well-established literature exploring the PPS applications in different health care systems [3–7].

## 2. History of the purchaser–provider split in Finland

The development of PPS in the management of health and social care services in Finland was launched in the early 1990s. A factor prompting the application of PPS models was the 1993 reform in the state subsidy system for municipal health care. Before the reform central government transfers for hospitals were allocated directly to the public hospitals. The reform, however, channelled the state funding for hospitals through the municipalities as a part of general non-earmarked block grants, which *de facto* made the municipalities the purchasers of hospital services. However, the hospitals were and still are owned by federations of municipalities and thus the state subsidy reform introduced a model of internal contracting in the Finnish health care system.

Another segment of the Finnish health care system in which purchasing was developed in the early 1990s is rehabilitation services funded by the public health insurance. The Social Insurance Institution (SII) reimburses a proportion of the cost of prescription drugs in outpatient care, and of visits to private physicians, likewise the costs of employers for occupational health services. However, a form of competitive purchasing was developed for rehabilitation services in which since the 1990s the SII has selected the providers of the rehabilitation services through competitive bidding. [8]

Soon after the split was created in specialized health care the municipalities responsible for organizing primary health care services in Finland also started to express interest in implementing PPS models for organizing primary health care services. The 1993 subsidy reform was partly marketed to the municipalities by underlining the potential benefits offered by PPS, such as more effective cost containment. However, as a reaction to the severe economic recession in the early 1990s the adoption of the new administrative model was postponed. Some hospital districts developed management by contracts arrangements, which involved negotiations between purchasers and providers as well as fairly weak contract instruments. However, PPS really got back onto the agenda only in the early 2000s, since when several municipalities have decided to implement PPS in the practice of health and social care management. According to a survey by the National Institute for Health and Welfare about one third of the 378 municipalities in 2009 reported that they were developing some kind of a "purchaser-provider model" for their health and social care management [9]. Recent Governments have also supported the adoption of PPS in the organisation of health care and social services.

At the level of the municipalities PPS has been implemented by creating a fictional market within the administration of the municipality. The idea of this so-called *internal PPS* draws to a large extent on the "management by results" tradition [10], which began to gain popularity in Finland in the 1980s. "Management by results" is based on the idea that the providers need to have more autonomy and distance from the political decision-making and municipal administration in order to provide services efficiently and in innovative ways. In small municipalities these internal PPS models have been used mainly as strategies to manage services organized jointly by a number of municipalities. Particularly in larger cities internal PPS has meant substantial administrative reforms inside the municipal organization as the administration has been split into purchaser and provider organizations.

A second emerging version of PPS has been the increasing involvement of the *private service providers* in the delivery of publicly funded health care and social services (i.e. *contracting out*). Municipalities have contracted out parts of their services to private service providers since the early 1980s. At the time contracting out was mainly implemented in housing, public transport, waste management and technical maintenance. However, there is also a tradition of the municipalities collaborating with the private, mainly non-profit provider organisations in elderly care services. Until the 1980s the activities of these non-profit providers were funded in the form of block grants for supporting benevolent associations. Thus awarding the grants did not involve the providers in any exact obligations regarding volume or service quality. However, as a national level decision the EU regulations on competition and public procurement were also implemented in health and social services in the early 2000s. This changed the relationship between the municipalities and private providers towards one emphasising competition and contracting rather than collaboration. The role of the private sector in the delivery of public services has likewise increased. According to some estimates the proportion of public services provided by the private sector is about one fourth of all health care and social services. However, the proportions vary locally as well as between services. [11]

As the market for private service provision has expanded, private for-profit providers have also entered the market. Recent studies [12–14] on the municipalities in Finland suggest that health and social care managers as well as politicians have several reasons for including private providers in the public service provision. These include