DATA BRIEF 21/2020

Outpatient care arrangements at health centres 2019 – outsourcing, personnel, work inputs and transfers of tasks

MAIN FINDINGS

- Approximately 8% of the population, or 430,000 inhabitants, are covered by outsourced health centre services.
- Almost half of the personnel are nurses, and a little short of 40% are doctors.
- Around one in four health centre physicians are specialists in general medicine.
- Almost half of the doctors at health centres are in different stages of the training.
- General practitioners without specialist training are the largest group of doctors at small organisers' health centres and outsourced health centres.
- The personnel profiles of outsourced health stations and of the municipalities and co-operation areas differ.
- Half of the doctors' working hours are spent with actual reception work, the rest is divided into indirect appointment work and other tasks that are the responsibility of the health centre.
- Eight per cent of health station nurses have limited prescription rights.
- The majority of health stations utilise the direct reception of physiotherapists, but the activities are still small-scale.

Introduction

The municipality or co-operation area responsible for providing primary health care maintains a health centre, in which one or more health stations operate. Appropriate personnel resources and appropriate division of labour between professional groups are essential to meet the population's service needs. This publication describes the organisation of outpatient care in primary health care, the personnel structure, the use of the work contribution of nurses and doctors and the transfer of tasks between professional groups.

The report is part of a survey conducted by Finnish Institute for Health and Welfare in spring 2019 on the arrangements and operating practices of outpatient care centres. The purpose of the study is to create an up-to-date overall picture of the practices of outpatient care practice nationally. The results are mainly examined at the organiser and health station level and in relation to the size of the population base of the organising area. In addition, the results are compared with the corresponding survey conducted by Finnish Institute for Health and Welfare in 2015.

Organisational models and population bases

In mainland Finland, 133 municipalities or co-operation areas are responsible for providing outpatient care in primary health care in 2019. There are 74 municipalities providing health centre services as their own activities. There are 59 co-operation areas, of which 33 are joint municipal authorities and 26 operate under the responsible municipality model. Compared to 2015, the number of organisers has decreased by 18. However, the number of joint municipal authorities of the size of the provinces has increased. The Finnish Institute for Health and Welfare published a report on the models for organising primary health care in autumn 2019 (Parhiala, 2019).

Half of the organisers are municipalities or co-operation areas with fewer than 20,000 inhabitants, but they only cover 11% of the population (Table 1). Around one-third of all organisers are medium-sized regions with 20,000–50,000 inhabitants. Of the population, they account for about a quarter. One-fifth of the organisers are large municipalities or co-operation areas with over 50,000 inhabitants. Two-thirds of the population live in the area of these large organisers. Based on the survey, there are a total of 510 health stations offering a doctor's appointment. Slightly less than half of these are located in the area of large organisers.

How the research was conducted:

The health centres' outpatient care arrangements survey was carried out for the third time (previously in 2013 and 2015). The two-part survey was sent to all 133 Continental Finland health centres in May 2019.

The first part of the survey was directed to the management of health centres and the second to the management responsible for the daily activities of health stations. The response rate for the survey aimed at health centres was 99.2% (n 132). It was possible to reply to the questionnaire addressed to health stations with responses covering individual health stations or with consolidated responses from several stations. A little over 200 responses were received. They describe the activities of 445 health stations, which is about 87% of the health stations providing physician's appointments. In addition to the organisers' own health stations, the material includes outsourced health stations.

In addition to the responses received from the survey, the websites of the health centres were used as material. Some of the material was supplemented during the analysis phase of the study in autumn 2019.

The results of the survey are published as three results reports, of which this is the first.

Table 1. Number of primary health care organisers, number of health stations offering a doctor's appointment and population according to the organiser's population base 2019

	Less than 20,000 inhabitants	20,000–50,000 inhabitants	More than 50,000 inhabitants	Total
Organisers	67	43	23	133
%	50%	32%	17%	
Health stations	119	160	231	510
%	23%	31%	45%	
Population on 31 December 2018	600,235	1,270,971	3,616,924	5,488,130
%	11%	23%	66%	

Outsourcing

Some municipalities and co-operation areas have outsourced primary health care outpatient services to private service providers. At the time of the survey, the number of outsourced health stations was 58, or 11% of the 510 health stations providing a doctor's appointment. Private health stations participating in the service voucher experiment were not included in the material. At the time of the survey, outsourced health stations were responsible for the services of some 430,000 inhabitants. 7.8% of the mainland Finland population live in an area assigned to the responsibility of outsourced health stations. Compared to 2015, the figure has risen by 2.4 percentage points. The number of outsourced health stations has increased by ten compared to the previous survey.

Of the primary health care organisers, 30 (about one in four) have outsourced at least one of the health stations in their area. 19 municipalities or co-operation areas, or one-fifth of the organisers, have outsourced primary health care outpatient health care appointments entirely. Outsourcing has been implemented by both small and large organisers, but 16 of the 19 providers that have fully outsourced their outpatient health care appointment activities are small organisers. Outsourced service providers are responsible for nearly 16 per cent of the inhabitants of the areas of small organisers.

When examined by hospital district, the number of outsourcings varies considerably (Figure 1). In the Western Ostrobothnia Hospital District, almost 90 per cent of the population live in the area of outsourced health stations. About half of the population in Päijät-Häme, one quarter in Kymenlaakso and nearly one in five inhabitants in Tampere Region receive outpatient health care services in primary health care from an outsourced health station. Of the residents of Päijät-Häme, some 100,000 are covered by outsourced services, which is the largest number in the whole country. However, there are only a few outsourced health stations in most hospital districts, and their population coverage among the entire population is limited. There are no outsourced stations in five hospital districts.

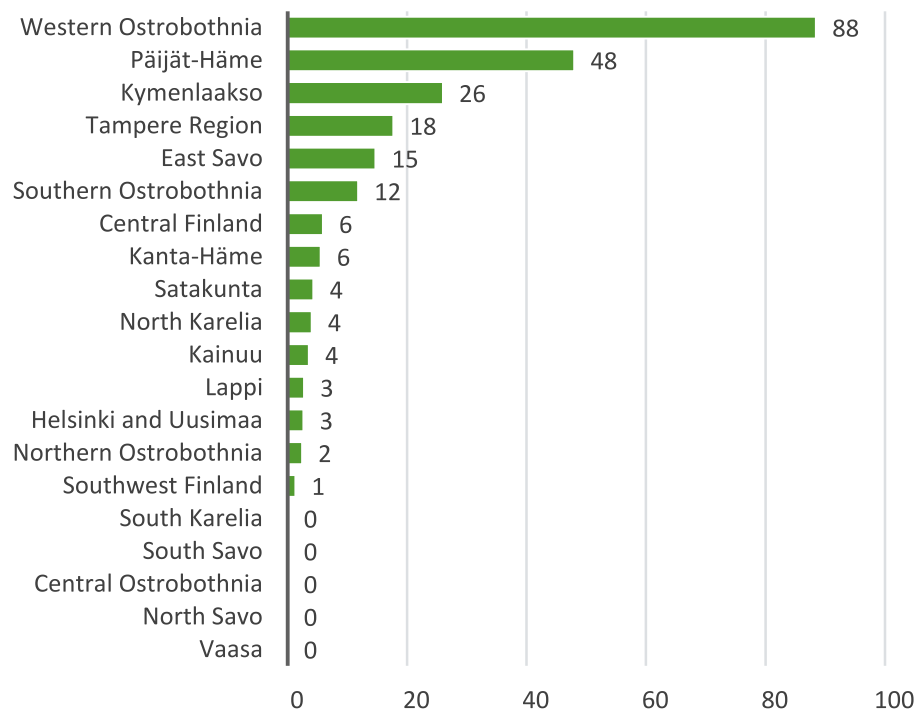

Figure 1. The share of the catchment population of outsourced health stations in the total population of the hospital district (%).

Health station staff

The number of health station staff was examined by occupational title. Respondents were asked to indicate the number of occupational groups working at the health station on the day of the survey response.

Staff structure

The largest group in outpatient reception practice in primary health care consists of nurses and public health nurses, who account for 47 per cent of all health station employees (Figure 2). Nurses account for 38% and public health nurses for 9% of the staff. The proportion of doctors is about 37 per cent. There are 1.27 nurses and public health nurses per doctor working at health centres. At outsourced health stations, the corresponding ratio is somewhat larger, i.e. 1.41 nurses and public health nurses per doctor.

The differences between large and small organisers in the relative shares of different professional groups are minor, but the share of doctors in the staff of small organisers is slightly lower than that of other organisers.

In addition, a significant personnel group consists of practical nurses and nursing assistants, who account for about nine per cent of all those working at health stations. Physiotherapists account for three per cent. The share of social workers and social counsellors remained at less than one per cent. The group Others includes special workers, such as psychologists, occupational therapists and nutritional therapists. In addition, health stations have some staff classified as assisting employees.

In addition to the licentiate of medicine degree, a **general medicine specialist** has specialist rights in general medicine, for which s/he has completed the studies required for the specialisation in general medicine for 6 years. Only a specialist in general medicine may be appointed as a physician in charge of the education in a specialisation phase or the special training in general medical practice.

A **general physician** is a licentiate of medicine, which means that s/he has completed 6 years of basic training for physicians.

A person who has completed a licentiate of medicine degree may be admitted to the **special training in general medical practice** (so-called YEK training). The scope of the training is two years, including a health station service of at least nine months. The training gives the right to work as a doctor within the scope of health insurance in other EU countries. The special training in general medical practice is compulsory for a specialising doctor regardless of the specialisation.

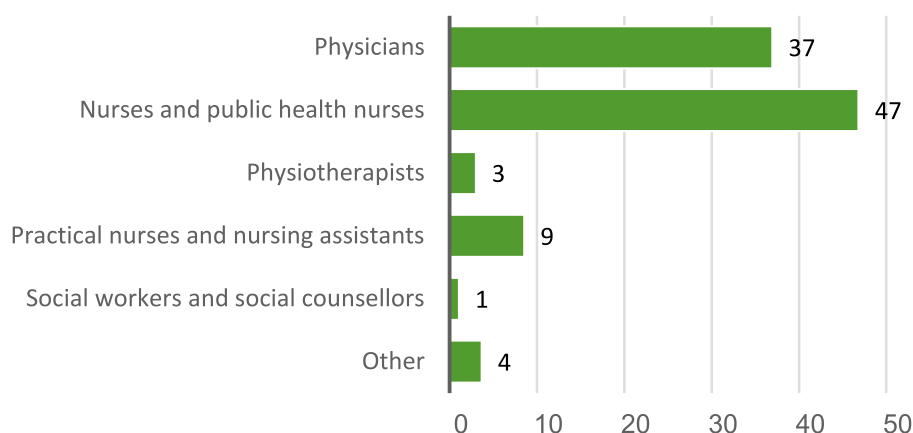

Figure 2. Distribution of occupational groups working at health stations (%).

Training of doctors

The number, competence and training of health centre physicians should be sufficient to meet the population's service needs. In addition to patient work, it is the responsibility of general medicine specialists to instruct physicians at different stages of their training, whose studies include working at health stations. The groups in the training include doctors specialising in general medicine and doctors completing the specialisation training period in general medicine (so-called nine-month YEK training, which is compulsory for specialising doctors regardless of their specialisation). In addition, health stations may temporarily have medical students working as physicians.

Figure 3 shows the doctors' shares by education in the whole country and by the organiser's population. The material contains information on 2,460 health centre physicians, 158 of whom work at outsourced health stations. Around one in four health centre physicians are specialists in general medicine. Although general medicine specialists form the largest group in the material as a whole, this group is the largest when inspected by population only in the area of medium-sized organisers. The share of other specialists in the personnel working at the health station is about five per cent. Geriatrists, psychiatrists and internal medicine doctors were mentioned most commonly. Small organisers have slightly more specialists at health stations than larger ones.

The second-largest group of doctors are general practitioners without a specialist right. One in five health centre physicians belong to this group, but one in three at the health stations of small organisers. General practitioners without specialist rights clearly form the largest group of doctors at the stations of small organisers.

Of the doctors in training, the largest group is doctors in special training in general medical practice, who, at the shortest, only work at the health station for a few months. Almost one out of four health centre physicians are in special training in general medical practice. At large organisers' health stations, doctors in special training in general medical practice form the largest group (27%). In terms of continuity of treatment, the large number of doctors in special training in general medical practice may be problematic.

One in five health centre physicians is specialising in general medicine. The specialisation training in general medicine requires working at a health station under the supervision of a specialist in general medicine. There are slightly fewer general medicine specialists at the stations of small organisers than at the stations of large organisers.

Medical students working as physicians also temporarily work at health stations, accounting for about six per cent of the material as a whole. The differences in the classification by population base of the organisers are small.

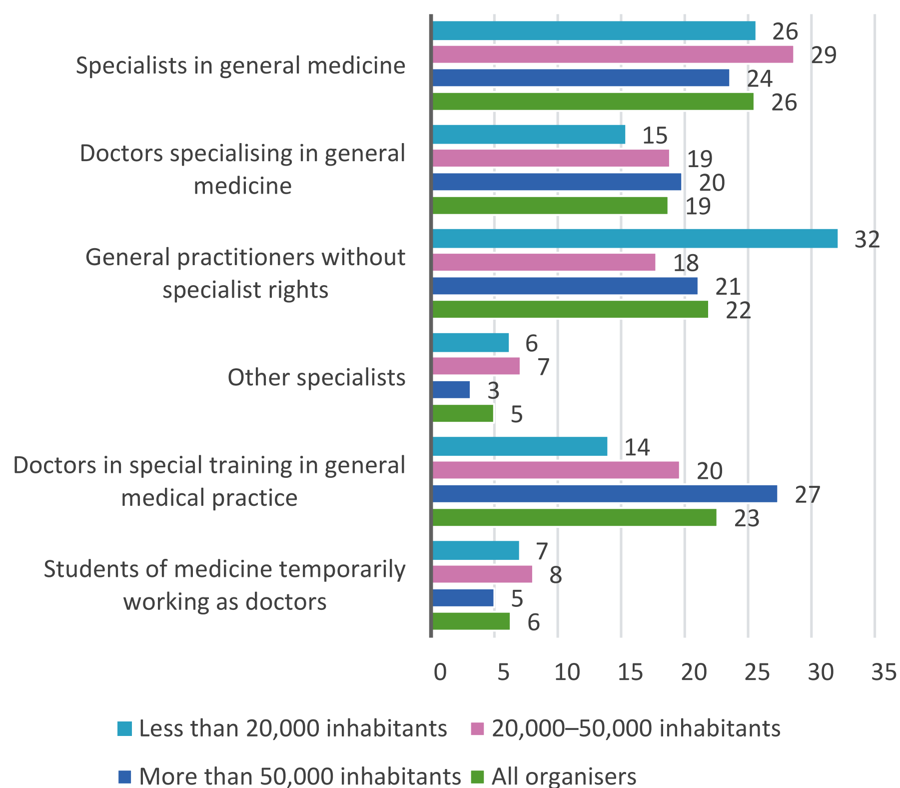

Figure 3. The level of education of doctors working at health stations by population base of the organiser (%).

Doctors at different stages of education account for almost half of all health station doctors (48%). At the health stations of small organisers, the number of those in education is approximately one in three doctors, and at the stations of large organisers, more than one half. For one specialist in general medicine, there are on average 1.38 physicians in education at the health stations of small organisers, whereas the number at the health stations of large organisers is clearly higher, 2.21.

Based on the results, the staff structure of large organisers' health stations with respect to doctors is more challenging than that of small organisers, as specialists in general medicine clearly have more training obligations. There are also differences in the possibilities of securing the continuity of patient care.

The question about the staff structure was answered by 35 outsourced health stations, which account for about 72% of the population under the responsibility of all outsourced stations. The training of physicians at outsourced health stations differs somewhat from other health stations (Figure 4). At outsourced health stations, the number of doctors in different phases of medical education is significantly lower than at other health stations. Approximately one out of four physicians at outsourced health stations are in the training phase. In particular, the relative share of doctors in the special training in general medical practice at outsourced stations is low.

The largest group by far consists of general practitioners without a specialist right. This group comprises almost half of doctors at outsourced stations, which is considerably more than in the municipalities' and co-operation regions' own service production. The share of general medicine specialists is lower than in other health stations.

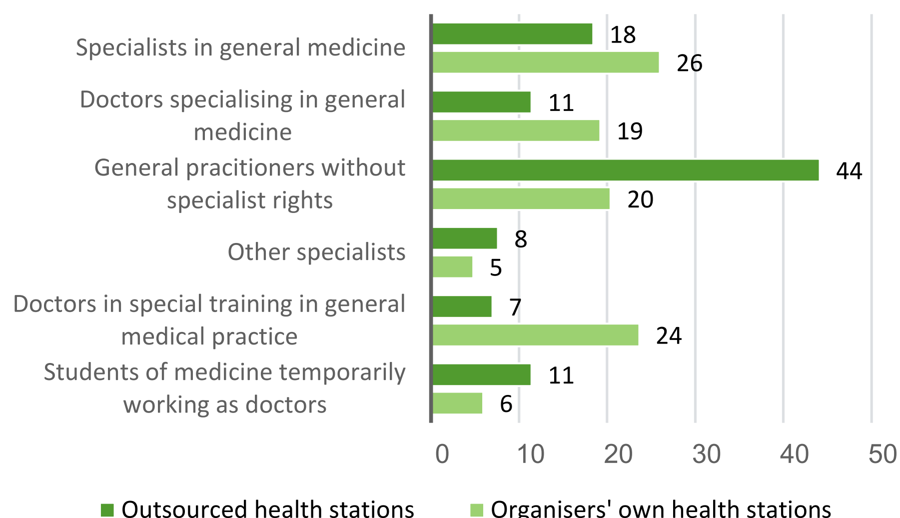

Figure 4. The level of education of physicians working at health stations in outsourced and the organisers' own health stations (%).

Distribution of work inputs

The distribution of the reception work input of nurses and doctors was investigated by asking the management responsible for the daily activities of health stations to assess the working time spent on different tasks. For nurses, the results were compared with the results of the 2015 survey. The distribution of the doctors' work input was not examined in 2015.

Nurses' work input

Non-urgent reception takes about 30 per cent of the nurses' working hours. Almost equal time is spent with the urgent reception, which also includes an assessment of urgent matters by telephone. Telephone counselling accounts for about one fifth of all work of the nurses. The changes compared to 2015 are minor in non-urgent reception work, emergency reception and telephone counselling. The assessment of the need for non-urgent care accounts for slightly over 10 per cent of the nurses' working hours. The share has fallen slightly since 2015. Several respondents reported that the assessment of the need for care is part of the general telephone counselling provided by nurses and, to some extent, also part of the emergency reception.

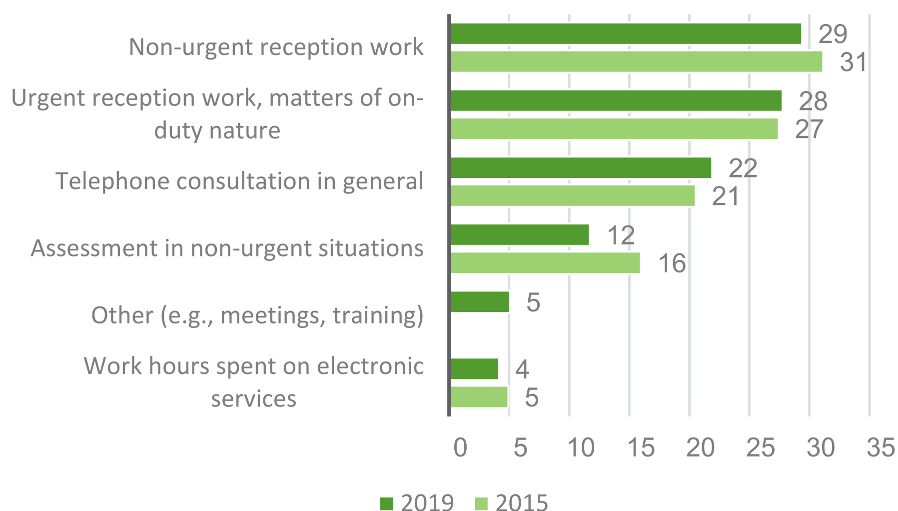

Figure 5. Distribution of nurses' work input by task at health stations in 2019 and 2015 (%).

In the survey, electronic services referred to various forms of services and tasks that have been transferred as part of electronic user and service systems. These include, for example, the health data and care instructions of the Omakanta service, electronic pre-information forms, virtual health examinations and other electronic communications services. According to the survey, the time spent on electronic services by nurses has not increased since 2015. The significance of electronic services in the overall work input remains low, or about 5%. Other tasks, such as meetings and training, also take about five per cent of the working time. Other tasks were not included in the 2015 survey.

Doctors' work input

The actual reception work in outpatient care includes both non-urgent and urgent reception. They take up slightly less than half of the working hours of physicians working at health centres (Figure 6).

Other patient work is also known as sectoral work. It includes, for example, physician services for child health clinics, school and student health care, the inpatient ward of the health station, housing units, home care and physician services in home nursing. Sectoral work accounts for almost one fifth of the doctors' working hours, on average one day a week. The sectoral tasks that are the responsibility of physicians at health stations are usually circulated among physicians at the health station. The share of sectoral work in large organisers' health stations is lower, or 14 per cent. This is partly explained by the fact that the survey focused on outpatient care, which means that only physicians performing sectoral work are not included in the material. In large cities, for example, primary health care providers have their own geriatric units in services for the elderly.

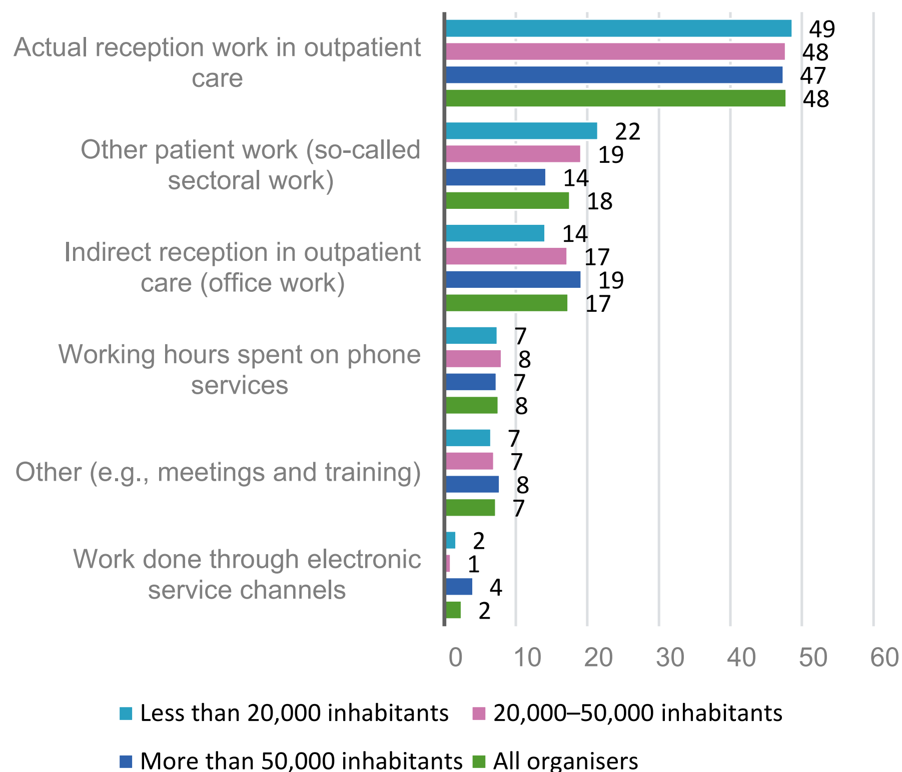

Figure 6. Distribution of doctors' work input by task at health stations in 2019 (%).

Even though the share of sectoral work in the working hours of health centre physicians of large organisers is smaller than with small organisers, the share of work time spent on outpatient care reception work is not correspondingly higher. On the contrary, almost one fifth of the working hours of large organisers are spent on office work related to outpatient care, i.e., indirect reception work necessary for the patient's care. This includes, for example, the interpretation of laboratory responses, the preparation of statements and the renewal of prescriptions. Prescriptions for patients treated in specialised medical care and the private sector are also referred mainly to health stations. Some 19 per cent of the working hours of health centre physicians of large organisers are spent on indirect reception work, but with small organisers, this is somewhat less. The rest of the working hours of a health centre physician is telephone services, work done through electronic service channels and other tasks, such as meetings and training. The proportion of doctors' working hours in electronic service channels is still small.

Task transfers

The division of labour in primary health care has been reformed by transferring tasks traditionally assigned to doctors to other health care professionals. The aim with task transfers has been to streamline primary health care reception activities and to speed up access to treatment. The health centres have for a long time utilised the independent reception of nurses and public health nurses. In recent years, independent work has been expanded by enabling limited right of prescription for nurses. In the treatment of musculoskeletal disorders, the utilisation of physiotherapists' direct appointments has started.

Nurse's independent urgent reception work

Health stations broadly use an approach in which patients coming to the emergency clinic are not automatically sent to a doctor's appointment, but the nurse assesses whether there is a need for seeing or consulting a doctor. The division of labour between nurses and doctors in the emergency clinic work at the health stations was investigated by asking

the health station management to assess how large a proportion of the patients coming to the emergency clinic are received and treated by the nurse without consulting a physician or receiving instructions from them (Figure 7). Approximately half of the nurses' emergency clinic work is carried out independently without the involvement of a doctor. Small organisers have a slightly smaller share of the nurse's independent work than at the stations of large organisers.

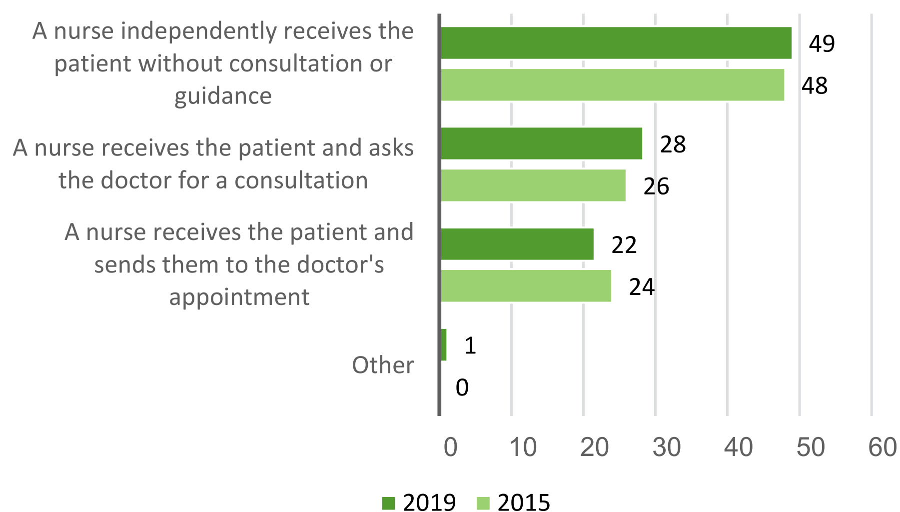

Figure 7. Operating practices in nurses' emergency clinic work in 2019 and 2015 (% of patients).

Approximately one quarter of the cases involve consulting the physician, and approximately one in five patients is sent to a doctor. For example, the section Other way contains new ways of sending to a doctor, such as a doctor's remote appointment. The distributions of the different operating methods are almost the same as in the 2015 health centre survey.

The nurse's limited right to prescribe medicines

It has been possible for nurses and public health nurses with additional training to make a prescription for the patient under certain conditions since 2012. The nurse's limited prescription right is utilised by 42 per cent of all outpatient health care organisers in primary health care (Figure 8). Slightly more than half of the mainland Finland population, or 51 per cent, live in the area of a health centre using this method. Two-thirds of the large organisers report using nurses with restricted prescription rights in their activities. However, of cities with more than 200,000 inhabitants, only Espoo makes use of the nurses' limited prescription right. Only one-third of small organisers utilise nurses with limited prescription rights.

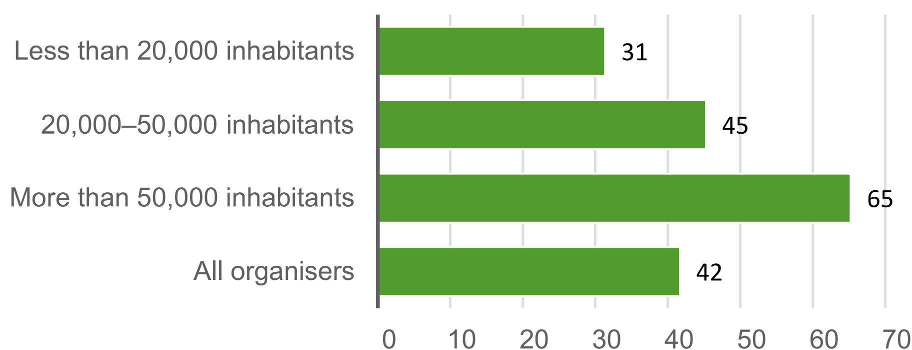

Figure 8. Utilisation of the nurse's limited prescription right by the organiser's population base (% of organisers).

About eight per cent of nurses and public health nurses who worked at the health station on the survey's response date had the limited right to prescribe medicines. At outsourced health stations, few nurses have the limited prescription right, as outsourced health stations have only been able to utilise the operating method since 2019.

Physiotherapist direct reception

There are many patients with musculoskeletal disorders in primary health care. A physiotherapist's appointment in outpatient medical care has traditionally only been accessible by referral from a doctor. In recent years, the number of direct appointments by physiotherapists has become more common. For example, because of acute pain, a patient is sent directly to a physiotherapist. The direct reception activities of physiotherapists make it possible to streamline the timely treatment of patients with musculoskeletal disorders. It has also been thought to be cost-effective.

Some 87 per cent of the health stations that responded to the survey stated that they were sending patients coming to the emergency clinic directly to a physiotherapist, but the open-ended responses indicated that the activities are still mostly small-scale and only developing. Similarly to the independent reception work carried out by nurses and public health nurses, extensive use of the direct reception activities of physiotherapists requires not only the commitment of the entire staff but also clearly defined operating methods for assessing the need for treatment and referring the patient to treatment.

Conclusions

The number of primary health care organisers has slightly decreased compared to 2015. Although the number of regional joint municipal authorities has increased, the responsibility for organising the services remains strongly dispersed. Half of the organisers are small areas with fewer than 20,000 inhabitants.

The number of people that are the responsibility of outsourced health stations has increased somewhat in comparison to 2015. Despite the growth, some of the organisers have moved outsourced health stations back into their own production. Regional differences in outsourcing are great, and in some areas the development of primary health care requires close co-operation with private service providers.

The increase in service needs due to the ageing of the population will increase the pressure to develop health centre activities. Key prerequisites for success include needs-based personnel resources and an appropriate division of labour between professional groups. The personnel's competence must be able to respond to the increase in the number of patients with multiple diseases. Almost half of the health centre physicians are in different stages of medical training. At the same time, only about one in four health centre physicians are specialists in general medicine. These doctors end up

simultaneously guiding doctors in the training phase and treating the most challenging patients at health centres.

The large number of physicians in the education phase makes it more difficult for health stations to take care of the continuity of treatment, as doctors in education work at the same health station for only a few months at the shortest. At small organisers' health stations, the factors of treatment continuity are better controlled, as the proportion of physicians in the training phase is lower than at large organisers' health stations. However, small organisers face recruitment challenges arising from the retirement of doctors. Already at present, small organisers, as a result of recruitment problems, have used the outsourcing of reception activities considerably more often than large organisers.

The job description of health centre physicians at large organisers' health stations is narrower than at those of small organisers. This is due to the lower proportion of sectoral work (such as home care doctor services and maternity and child health clinic services). Sectoral work makes the work of a health centre physician more versatile than just reception work. In addition, a health centre physician can use it to maintain extensive competence in the field of general medicine.

As in the previous survey, in urgent reception work, nurses receive approximately one half of the patients independently without contact with a doctor. The nurses' independent reception work has been utilised for a long time, and it has been extended by a limited right to prescribe medicines. However, in nurses' emergency clinic work, the share of independent work has not increased compared to 2015. Making use of the direct appointments of physiotherapists in the treatment of musculoskeletal disorders is justified from the perspective of smoothness, timeliness and division of labour.

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