DATA BRIEF 22/2020

Outpatient care arrangements at health centres 2019 – Co-operation with social services and specialised medical care

MAIN FINDINGS

- The introduction of social workers and social counsellors to a health station clearly increases the satisfaction of health stations with the co-operation between primary health care and social services.
- A social worker or counsellor works regularly at one in three health stations.
- Health station customers need the most social services in financial matters and substance abuse problems as well as in matters related to the needs for support for older people.
- The most common specialist services provided at health stations are geriatric, psychiatric and child and youth psychiatry services.
- On-site services provided by physiatrists at health stations are rare, even though musculoskeletal disorders are the most common reason for visiting health stations.
- Clinical trials supporting the work of physicians are mainly implemented as the hospital district's operations. However, the focus of clinical trials related to some national diseases seems to have shifted from specialised medical care to primary health care.
- Smaller organisers use private service providers more often than large organisers in specialist consultations and clinical trials.

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. Strengthening the services that are the responsibility of the health centres and their interoperability with other social welfare and health care services is essential in order to respond to the ageing of the population and the growth in service needs. This publication describes the organisation of social welfare services at health stations and the views of health station management on the smooth running of co-operation with other social welfare and health care actors. As regards co-operation with specialised medical care, specialist consultations and clinical studies supporting outpatient care practice will be examined. The organisation of services for special workers at health stations is also described.

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.

Smoothness of co-operation with other social welfare and health care actors

The management of health stations were asked to assess the smoothness of co-operation in customer service chains within primary health care, and with parties carrying out specialised medical care, services for the elderly or social services and actors working to promote well-being and health (welfare and health care work), such as municipal sports services or organisations (Figure 1).

Co-operation is perceived to be most effective within primary health care, where nearly 90 per cent of health stations are fairly or very satisfied with the smooth running of the co-operation. Two-thirds in the management of health stations were at least fairly satisfied with the co-operation with old-age services. More than half of the respondents also assessed co-operation between specialised medical care and primary health care positively.

There is clearly more need for development in the co-operation with actors involved in social services and the promotion of welfare and health. With respect to co-operation with social services, less than one-half, and for co-operation with welfare and health promotion actors, only one-third of the health stations stated that co-operation is running smoothly. In addition, some health stations reported that co-operation with actors in the promotion of welfare and health is not essential in the work of the health station. It seems that health stations have less established co-operation structures with welfare and health promotion actors than with others.

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 second. The first report, Outpatient care arrangements at health centres 2019—outsourcing, personnel, work inputs and transfers of tasks, was published in the Tutkimuksesta tiiviisti (Data brief) series in December 2019.

Compared to 2015, satisfaction with co-operation has increased in co-operation with services for the elderly, specialised medical care and social services. Satisfaction with internal co-operation in primary health care has remained unchanged.

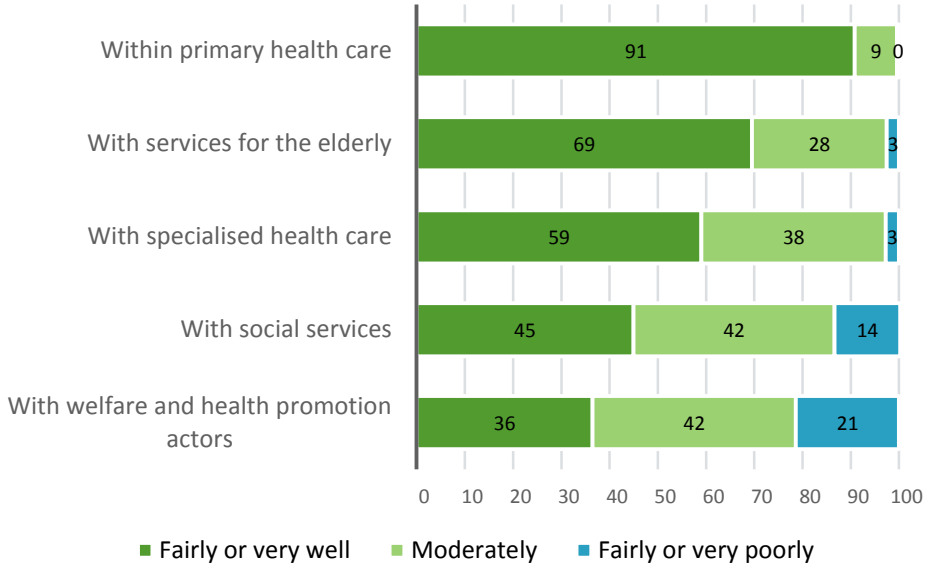

Figure 1. Smoothness of co-operation in customer treatment chains with other social welfare and health care actors (% of health stations)

The views of health stations on the smoothness of co-operation vary according to the organiser's population base (Figure 2). Health stations in both large and small areas are satisfied with internal co-operation in primary health care. In co-operation with other social welfare and health care actors, the health stations of large organisers of over 50,000 inhabitants are clearly less satisfied than those of smaller regions. Only a quarter of the health station respondents of large organisers expressed their satisfaction with co-operation with social services. However, compared to the survey conducted in 2015, the satisfaction of the health station management has increased at the health stations of large organisers. Satisfaction in small organisation areas with less than 20,000 inhabitants has remained unchanged.

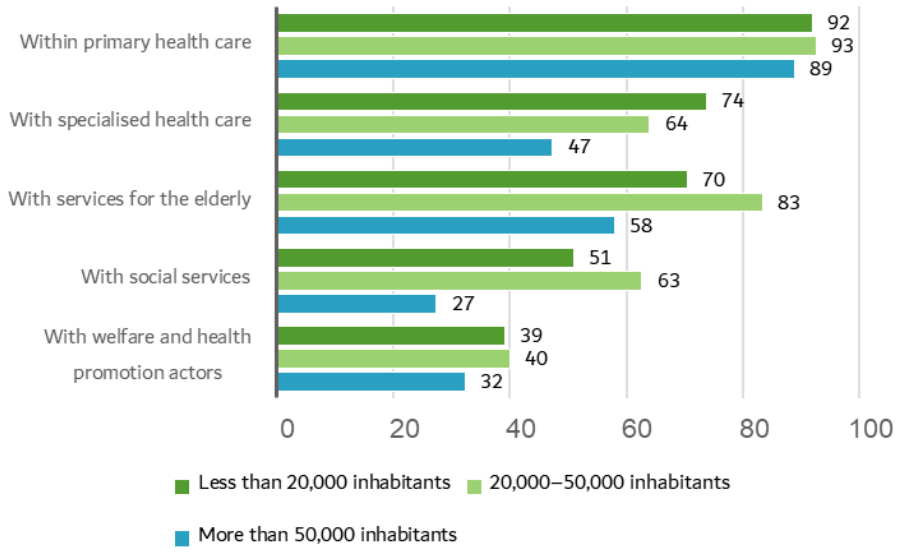

Figure 2. Smoothness of co-operation with other social welfare and health care actors works fairly well or very well (% of health stations according to the organiser's population base)

Need for social services at health stations

The health stations' management were asked to select the three most typical situations in which the client has a need for advice and service provided by a social worker or counsellor (Figure 3). The greatest need for co-operation with social services is caused by the clients' financial problems, the needs for services and support of older people and substance abuse problems. Viewed according to the population base of the organiser, health centres with fewer than 20,000 inhabitants have the greatest need for social services related to support for older people. This is natural, as a large proportion of small organisers are in regions where the share of older people in the population is higher than the national average.

Large organisers, on the other hand, have a much more frequent need for services related to work or functional capacity than small organisers, as working-age population and unemployment problems are concentrated in large cities. Service needs related to support for families with children and young people are not among the most important service needs. Child and family counselling services contribute to reducing the need for services related to these services. However, small health centres feel the need for co-operation with social workers and counsellors in support issues for families with children and young people more often than in large areas, despite the fact that the share of children in the areas of small health centres is smaller than in the area of large organisers. In large cities, social services needed by families with children are often provided in family centres.

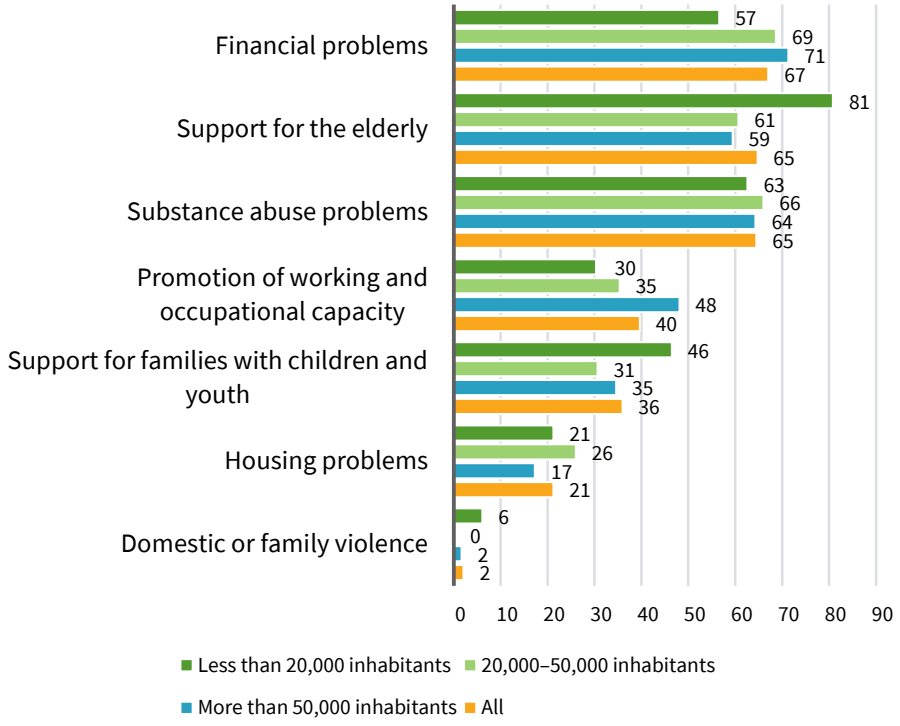

Figure 3. Co-operation needs with social workers and social counsellors by theme (% of health stations by population base of the organiser)

Services of social workers and social counsellors at health stations

The survey examined how the services of social workers and social counsellors were implemented at health stations. Social workers and counsellors from both social welfare and health care services can work at health stations. Social workers and counsellors provide advice and guidance on social benefits and services. If necessary, social workers in social services can also make official decisions on, for example, supplementary and preventive social assistance and social services. On the other hand, social workers and social counsellors working at health stations do not make official decisions.

Approximately one in five health stations, or 21 per cent, reported that a social welfare employee works regularly at the health station at least once a week. The average number of workdays of social welfare workers is 2.2 per week at these health stations. Some 15 per cent of health stations regularly have social workers or counsellors from health services. The health services' own social workers work at these health stations 4.2 days a week on average. Some organisers have social workers or counsellors from both social and health services at the health stations. In total, approximately one in three health stations (32 per cent) have a social worker or a counsellor working from either social or health services at least once a week (Figure 4).

Almost half of the health stations, or 46%, reported that a social worker or counsellor visits the station less often than once a week or as required. Slightly over one fifth of health stations have organised co-operation with social services in other ways. In most cases, this means that customers in need of social services are directed to contact the social services of the municipality or co-operation area. In this case, the health station's staff can also contact social services on behalf of the client.

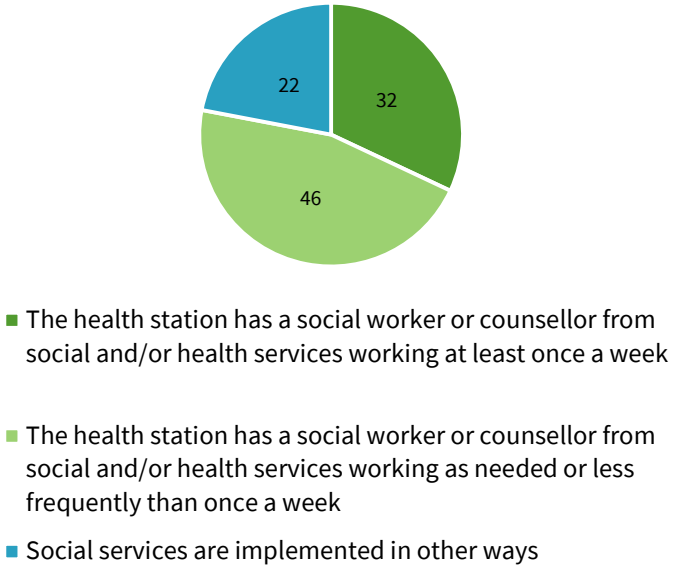

Figure 4. Organisation of co-operation with social services at health stations (% of health stations)

Working on the same premises increases the satisfaction of health stations with the co-operation with social services (Figure 5). At the stations where a social worker or social counsellor from social services is present at least once a week, two thirds of the health station's management are satisfied with the co-operation. If services from social services are not regularly available at least once a week, the share of those who feel the co-operation is smooth remains at 40%.

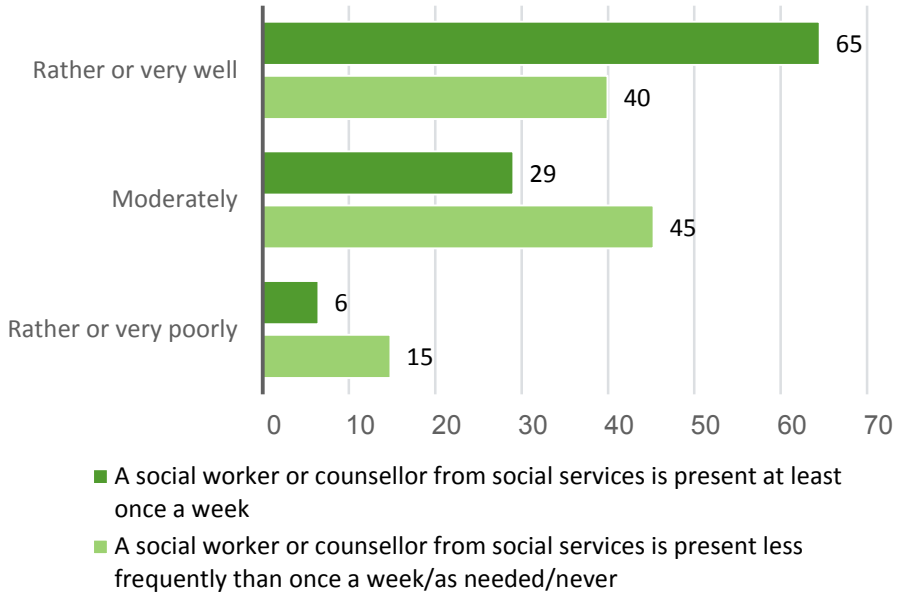

Figure 5. Smoothness of co-operation with social services (% of health stations)

Specialist consultations

According to the Health Care Act, specialist medical services can be provided on the basis of appropriateness both in specialised medical care units and in connection with primary health care. A health station physician can always make a consultation request or a referral to the specialised medical care unit of the hospital district. In addition or alternatively, the organiser of primary health care may also provide specialist services on its own, or it may agree with the hospital district on the visit of specialists to the health station. The organiser may also procure services from private service providers. A specialist of a private service provider may visit a health station, or the patient may be given a payment commitment or a service voucher to a private service provider.

The health station management was asked whether the health centre uses means other than traditional consultation in co-operation with specialists (Figure 6). If the item was left blank, it was interpreted that the health station only utilises traditional consultation. In this context, the prevalence of different operating methods has been examined by specialisation according to population coverage.

A consultation request or referral to a hospital district unit is the most common operating method in co-operation between primary health care and specialised medical care. Health centres also make use of other operating methods, especially in the fields of geriatrics, psychiatry, child and youth psychiatry and cardiology. Some 85 per cent of the population lives in an area where the health centre utilises not only the traditional request for consultation on specialised medical care but also other consultation methods in the field of geriatrics. In the field of psychiatry, the population coverage of these practices is approximately 75%. However, in most specialised sectors, consultation requests to parties other than the hospital district are rare.

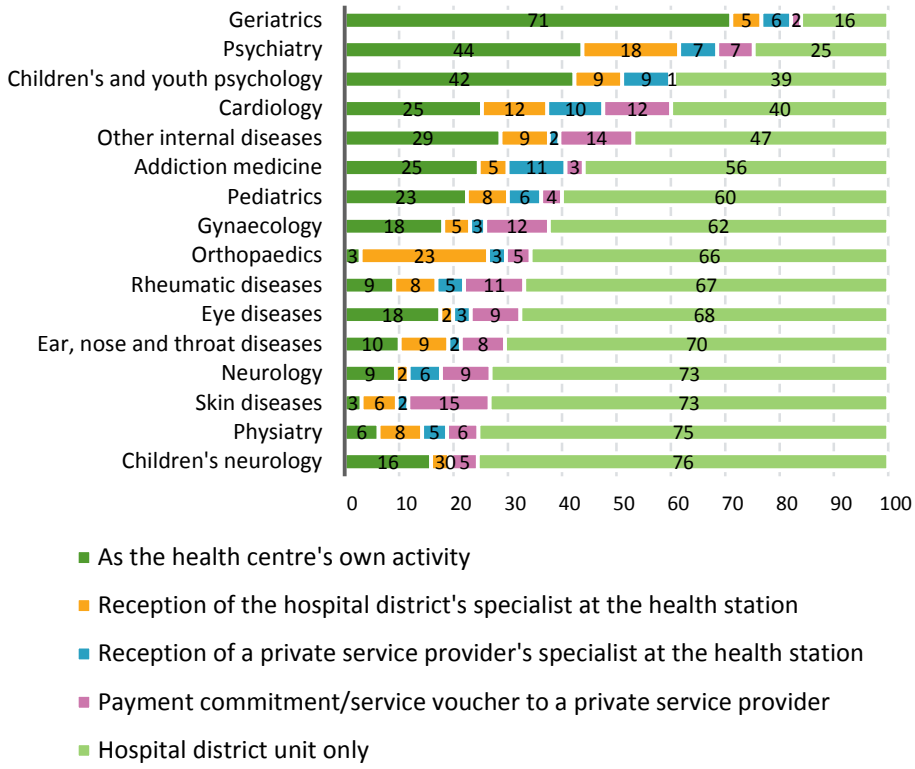

Figure 6. Methods of arranging specialist consultations at health centres by population coverage (% of population)

Of the different operating methods, specialist services provided as the health centre's own activities are most commonly utilised. For the specialisation of geriatrics and psychiatry, around 70% and almost 50%, respectively, of the population live in the area where services are provided by the health centre itself. Musculoskeletal disorders are the largest group of illnesses for health centre customers. However, this is not reflected in the specialisation of physiology. Health centres rarely have their own physiatrists, and on-site physiotherapy services provided by the hospital district are rare.

In most specialised fields, hospital district specialists rarely visit health stations. The most common reception held by hospital district physicians at health stations is in the specialisation of orthopaedics. In addition, in the field of psychiatry, the hospital district's specialist services are fairly common.

Inspected according to population coverage, the share of private service providers in specialist services is relatively small. However, small municipalities in particular and co-operation areas often utilise the consultation services of private service providers' specialists. On-site services provided by private service providers at small organisers' health stations are widespread, especially in the fields of psychiatry and geriatrics. Nearly 40 per cent of small organisers purchase on-site psychiatric services from private service providers. In addition, small organisers often provide customers with service vouchers or payment commitments , especially in the specialisations of skin diseases and cardiology.

Clinical studies

Health centres may organise clinical trials supporting outpatient care in primary health care, either as their own production or obtained from another public organisation, which is usually their own hospital district. As a third alternative, health centres can rely on private services by giving the customer a payment commitment or service voucher.

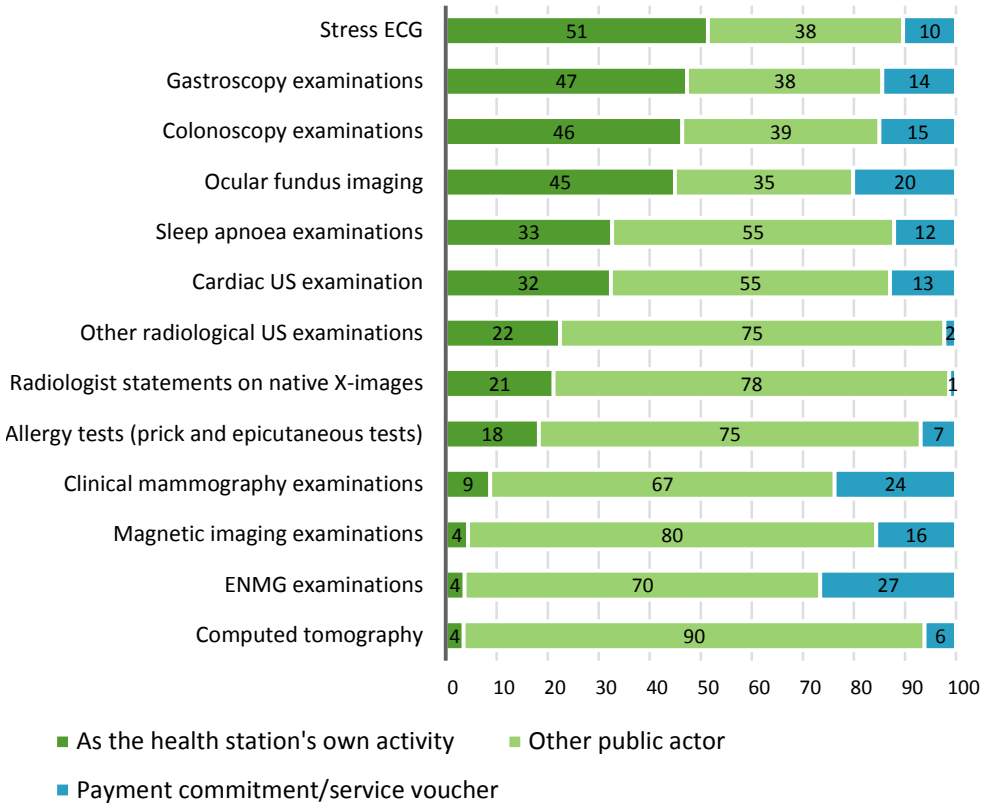

Figure 7. Main methods of organising clinical trials at health centres by population coverage (% of population)

More than half of the population lives in the area of a health centre where stress ECG studies are mainly carried out as the health centre's own activity (Figure 7). In gastroscopy, colonoscopy and imaging of the ocular fundus, the services of the population are usually produced at the customer's own health centre. In other clinical studies, the services are mainly provided by another public actor, usually the hospital district.

Smaller organisers give the customer a payment commitment or service voucher to a private service provider more often than large organisers. The share of private production is highest in ENMG studies to investigate damage to nerves and muscles.

Compared to the 2015 health centre survey, the changes are minor, with the exception of some studies related to the detection and treatment of national diseases. These include sleep apnoea examinations and imaging of the ocular fundus, which health centres increasingly produce themselves. Correspondingly, the share of hospital districts and private service providers in these studies has decreased.

Special employee services

Health centres usually provide the special employee services they need themselves, but private service providers are also used, especially in areas with a small population base. The services of a psychiatric nurse and substance abuse nurse are part of the basic activities of outpatient care practice, and approximately 90 per cent of the population live in an area where the health centre mainly produces these services itself (Figure 8). Customers using these services often need long care relationships and co-ordination of services, which is why health centres want to keep the services as their own production. Psychologist services are also almost always the health centre's own activities. Special employee services are rather rarely procured from other public actors, the own hospital district. They are most common in nutrition therapy, but even there the population coverage remains at 13%.

Inspected by population coverage, the number of special employee services purchased from private service providers using a service voucher or a payment commitment is low, with the exception of podiatric care services. Approximately 40 per cent of the population lives in the area of a health centre that procures podiatric care services mainly from private service providers. Health centres using private services in occupational therapy, speech therapy and nutrition therapy cover about 10 per cent of the population. Several health centres produce occupational and speech therapy services themselves and acquire some of the services from private service providers. Compared to the 2015 health centre survey, the share of special employee services purchased from private service providers appears to have decreased slightly.

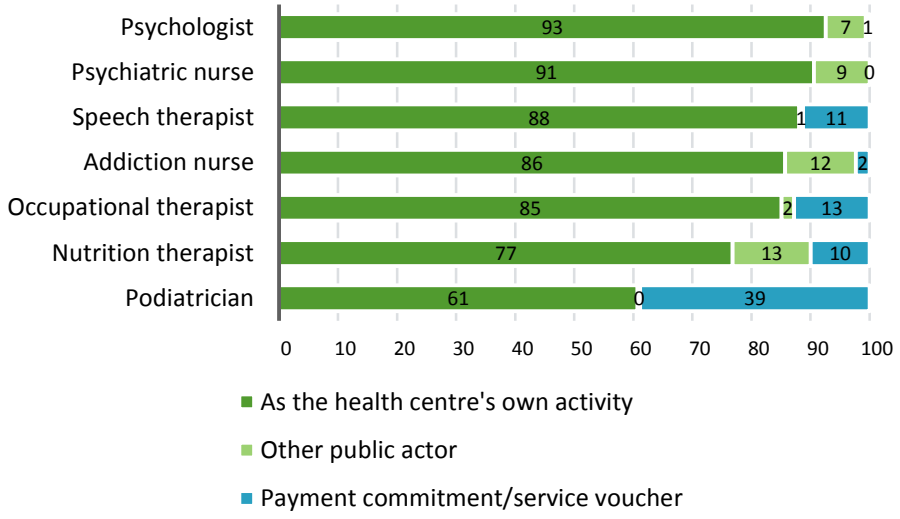

Figure 8. Main methods of organising special employee services at health centres by population coverage (% of population)

Conclusions

Health centres are responsible for the health and well-being of the population, and they must co-operate with other social welfare and health care actors in order to ensure the smooth flow and co-ordination of service and care chains. Provisions on co-operation between social and health care and primary health care and specialised medical care services are also contained in the Health Care Act.

Health station management's satisfaction with the co-operation with social services and specialised medical care has increased compared to 2015. One of the key objectives of the health and social services reform has been the internal integration of health care as well as the integration between health care and social services. Understanding of the needs of shared customers and the importance of co-operation structures may have been strengthened.

Half of the health centres are satisfied with the smoothness of co-operation between outpatient care and social services. Co-operation needs to be developed especially with large organisers. Co-operation between primary health care and social welfare is best realised when social welfare workers and counsellors work on the health station's premises. The presence of a social worker or counsellor at a health station streamlines multiprofessional teamwork and strengthens customer orientation, as the needs of customers who need multidisciplinary services can be met as quickly and seamlessly as possible.

Health centres co-operate with specialised medical care of their own hospital districts, for example in specialist consultations and clinical trials. Consultations with specialists are typically carried out with consultation requests or by referral to specialised medical care. In most specialised fields, specialist physicians have little on-site presence at health

stations, but the need for geriatric and psychiatric services has been identified in primary health care in particular, and these specialist medical services have been extensively introduced at health stations as the health centres' own services. Physiatry specialist services are rarely produced as a health centre's own service, even though musculoskeletal disorders are the main reason for visiting health centre customers. There are few physicians in the field of physiatry, and the number of physiatrists graduating from the field is significantly lower than required (Laine & Wasenius 2019).

In the first result report of the survey, it is indicated that smaller organisers of less than 20,000 inhabitants have outsourced their primary health care reception activities more often than large organisers (Syrjä, Parviainen & Niemi 2019). Small organisers also procure specialist consultations and clinical studies from private service providers more often than larger ones. The extensive use of service vouchers and payment commitments may fragment the care and service chains of customers and complicate the construction of an appropriate regional service package between primary health care and specialised medical care.

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Reference of this publication:

Syrjä V, Parviainen L & Niemi A (2020) Outpatient care arrangements at health centres 2019 – co-operation with social services and specialised medical care. Data brief 22, 2020. Finnish Institute for Health and Welfare (THL), Helsinki.

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ISBN 978-952-343-533-9 (online)
ISSN 2323-5179 (online)

http://urn.fi/URN:ISBN:978-952-343-533-9