Letter from . . . Finland

Same goals—different philosophy

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Health centres for the general practitioner

The GP should be provided with a primary centre which was foreseen as a GP hospital and diagnostic centre; to be provided among other facilities with radiology, laboratory, and a common-room to serve as a meeting-place for GPs of the district. He would work with other practitioners and specialist colleagues. . . .

In 1971, Sir John Brotherston¹ quoted the above excerpt from the Dawson Report² which everyone interested in the organisation of medical care should read. I spent an academic year in beautiful Edinburgh studying this and other subjects. When I read those fascinating texts I got a funny feeling of déjà vu. In my own country we did not have Lord Dawson, nor do we have Sir John Brotherston, but we have created a system which comes quite close to the picture they painted.

Finnish developments

In 1972 the Finnish health service was reorganised locally. Primary health care has always been mainly the responsibility of the local authority (as indeed is the hospital sector today). In 1972 the Community Health Care Act came into force, a major Act which brought to Finland the concept of the health centre.³

Unlike its British counterpart the Finnish health centre is not regarded merely as a purpose-built centre, but as an institution which is also responsible for activities outside the building itself. The functions of the health centre (which the Act defines as the local authority's responsibility) are: (a) antenatal and postnatal care, health education, family planning, screening; (b) medical care for residents of the district; (c) transport service for the sick; (d) dental health; and (e) school health. The walls of this type of health centre are the boundaries of the local authority district (or districts, if more than one local authority forms a health centre).

A British doctor should understand that in Finland the local authorities have always had relatively strong autonomy as a right. During the last 10 or 15 years this right has gradually been eroded because of the trend towards more centralisation. The 1972 Act brought with it a systematic national five-year health plan, controlled by the central health agency, which is revised annually and into whose frame the local health plans have to fit.

In practice

On studying the Finnish system, we notice that the previously low number of doctors has increased rapidly: between 1965

and 1973 the number increased by 63%, and during the same period the number of medical students starting the course increased by 54%.⁴ Consequently, by the end of 1973, the ratio of doctors to population had been reduced to 1:790. The methods of obtaining medical care in Finland are slightly more numerous than those in Britain. First of all, residents of the health centre districts may choose between the doctors in their health centres—in other words, the doctors do not have lists as they do in the British NHS. Instead of going to a doctor, the patient may visit the public health nurse in the health centre—for example, to have his blood pressure or haemoglobin measured, or perhaps his urine culture taken. He or the nurse can then consult the doctor if the results of the tests indicate that this is necessary.

Apart from going to the health centre, our patients may also seek advice from doctors in private practice. Here the specialist and non-specialist private practitioners often work side by side in group practices (medical centres), with laboratory and x-ray facilities and other diagnostic equipment. The patient may go to these centres without referral, though these days most clinical specialists do work on a referral basis. Finally, in acute emergencies, the patient may be taken directly to the casualty department of the central or university hospital. Most of our district general hospitals (central hospitals) have been built during the last 20 years and a few have still to be built. This is reflected in the distorted ratio between the number of doctors working in primary health care in health centres and those working in hospitals. In 1973 this ratio was roughly 1 to 3, compared with the 1971 British NHS ratio, which was about 1 to 1.⁵

If we look at the use of primary care services in Finnish centres in 1973 we see that the annual rates of doctor/patient consultations are much lower than in the NHS. In 1973 there were about five million face-to-face consultations because of sickness and for health examinations, excluding those in child health, antenatal, and school health clinics, (just over one consultation per head of the population). Of these, the proportion of home visits was about 1.1%. Hence our doctors working in health centres do not visit patients' homes very often. Conversely, a few years ago a Scottish GP spent about 14 out of a total 38 hours a week on home visits.^{6 7}

Diagnostic facilities

By the end of 1974 there were 269 health centres in Finland. Of these, 94 had been formed by a federation of communes, and 175 by a single commune.⁸ In comparison, by October 1973 there were 52 health centre buildings in Scotland. But there is an interesting difference—that concerning investigative facilities. Of those 52 Scottish health centres, only 10 had radiodiagnostic equipment and none had laboratory facilities, except for "side-room" testing. On the other hand, records of procedures in the laboratories and x-ray departments of our health centres in 1973 show a different picture: about a million visits to health centre laboratories and about 350 000 visits to the x-ray units. At the end of the year about 900 doctors were working in health centres. (In 1973 the total number of visits to hospital outpatient departments was about four million.)

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The total number of laboratory tests in that year was about nine million—about 5.7 million in health centre main laboratories; about 2.3 million in side-laboratories (in other words, these were done mainly by public health nurses); and the rest either in hospital or government laboratories outside the health centres. At the same time about 560 000 x-ray examinations were done, only 64 000 or so of these being done outside the health centres.⁹

Twin benefits

Both the general practitioner and patient benefit from the former's ability to continue his patient's treatment in hospital—for example, when the practitioner has hospital beds at his disposal and under his control without being subordinate to a specialist in the hospital.¹⁰ In the Finnish system in 1973 about 5800 beds in health centre wards were under the control of the practitioners working there—a ratio of 1.25 per 1000 population. This represents about 20% of all general hospital beds and over 10% of total hospital beds. The cost of a bed in a health centre hospital then was 60% cheaper than that in a central hospital.

Hence there are interesting differences in the present Finnish system compared with the British system—an aspect dealt with more thoroughly in other articles.^{11 12} Nevertheless, the concepts first mooted over 50 years ago in Britain are now being applied both there and in other countries such as Finland, modified

in the latter by national and local priorities and circumstances and also by different medical and health care delivery systems. Given the facts of recent medical history in Britain it was obviously necessary to change the status of the British GP, who over two decades had become isolated before the introduction of the charter—an opinion even confirmed by an official publication.¹³

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Occasional Survey

Angiographic appearance of carotid bifurcation in patients with completed stroke, transient ischaemic attacks, and cerebral tumour

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Summary

The angiographic appearance of the carotid bifurcation was compared in groups of patients aged 50-59 suffering from transient ischaemic attacks (40 cases), cerebral infarction with completed stroke (44 cases), and cerebral hemisphere tumour (66 cases). Carotid occlusion was found in 14% of those with infarcts and 5% of those with transient ischaemic attacks. Carotid stenosis was found in 40% of those with ischaemic attacks and 14% of those with infarcts. Minor irregularity of the carotid arterial wall was equally common in all three groups.

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Introduction

The prevalence of abnormalities of the internal carotid artery in the neck in patients with cerebrovascular disease has been frequently studied. While it is accepted that embolism from ulcerated carotid atheroma may cause transient ischaemic attacks,¹ studies of patients who have suffered a major cerebral infarction have confirmed only the role of carotid occlusion.² There have been few studies, however, in which the angiographic appearances of major neck vessels have been compared in patients with transient ischaemic attacks, cerebral infarcts, and a control population. We thought that such a comparison would be of value. Patients undergoing carotid angiography for hemisphere tumours were chosen as a control group.

Methods

Patients of either sex in the age group 50-59 were studied.

Transient ischaemic attacks—Forty patients (7 women, 33 men) aged 50-59 had angiography by low common carotid artery puncture during investigation by one of us (JM) for more than one transient ischaemic attack in the carotid territory. These patients were from the larger group discussed elsewhere.³