The Challenge of System Innovation in Finnish Health Care
From a Local Benchmarking Tool to a National Tool for Governance of Municipal Health Care Services?

Eveliina Saari & Sirkku Kivisaari (VTT Technical Research Centre of Finland)

Ph.D. Eveliina Saari, VTT Technical Research Centre of Finland, P.O.Box 1000, 02044 VTT, tel +358 40 5261643, fax: +358 20 722 5888, eveliina.saari@vtt.fi

Ph.D. Sirkku Kivisaari, VTT Technical Research Centre of Finland, P.O.Box 1000, 02044 VTT, tel +358 40 5409915, fax +358 20 722 5888, sirkku.kivisaari@vtt.fi

Draft 18.8.2008
The language of this paper has not been revised

Paper presented in conference organised jointly by The Society for Social Studies of Science (4S) and European Association for the Study of Science and Technology (EASST) “Acting with science, technology and medicine”, Rotterdam, The Netherlands, 20th - 23rd August 2008.
Introduction

The need for systemic change has been well recognized in most health care systems. In Western countries health care systems are struggling to find ways to meet challenges related to ageing of population. On one hand, more and better care services for the elderly will be needed, on the other hand the health sector is being pressured by demands for cost effectiveness.

The Finnish public health care system is organized and paid mainly by municipalities many of which are small, and the system is dispersed. There is an urgent need to find new management models and tools to make the governance of municipal services more transparent and to secure the availability of high quality services at reasonable cost also in the future. Also, new management tools are needed for measuring the quality and cost effectiveness of health services. In a general sense, this can be considered as part of the trend of the New Public Management and its emphasis on accountability, performance and output legitimacy.

Among scholars of science and technology studies, STS, there recently emerged an opening of a methodological discussion about the need for middle range theories, MRT (ST&HV vol. 32, no 6, Nov 2007). On the one hand, STS have been concentrated too much on analysing complexity, local situatedness and contingency, which has made it difficult to find larger and long-term patterns or mechanisms. On the other hand, macro-level grand theories in sociology have not given explanations or tools to concrete empirical analyses. MRT suggest combining macro level understanding to micro level analyses.

According to Geels (2004, 2007) diffusion and breakthrough of system innovations take place as the outcome of linkages between developments at multiple levels. He proposes a multi-level model and the use of various scales of analysis in examining transition processes. In this paper, we apply this evolutionary multi-level approach to understand how a system innovation is co-produced between different local, regional, and national actors. In this transition management framework three levels are distinguished for analysis and understanding the complex dynamics of socio-technical change. Socio-technical landscape refers to relatively stable, slow-changing factors such as cultural and normative values, long-term economic developments and societal trends or surprises. Socio-technical regime refers to the semi-coherent set of rules carried by different actors such as users, policymakers, scientists, public authorities etc. All these actors tend to generate incremental innovations. However, according to Geels radical innovations are generated in niches. In our interpretation of the transition management, niches represent the local and “grassroot” level of change and activity.

These metaphorical levels and interaction between them offer an analysis framework to understand the path of an innovation in its societal context and era. Typically, it takes several years from the emergence of a system innovation to its breakthrough, wider use and diffusion. A system innovation has been characterised as a transition from one socio-technical system to another (Geels 2005, 2). The transition may consist of process of gradual changes, discontinuities and periods of slow and fast development, even spanning one to two generations (25-50 years) (Kemp & Rothmans 2004, 139). Geels (2004, 37) explains that radical innovations break from the niche-level when the external circumstances are right, that is, when ongoing processes at the levels of regime and landscape create a window of opportunity. In this paper, a case of a system innovation in Finnish health care is analysed in its early and vulnerable phase without knowing whether the transition process leads to a sustainable outcome.

Innovation journey from an embryo to a sustainable model, which could be called a transition from one socio-technical system to another, lasts even decades. This analysis of a pathway of a local version of a new management model, called purchaser-provider model from Raisio to Mikkeli...
region has covered only few years so far. Geels (2004, 39-43) has conceptually divided the journey of a system innovation into four phases: 1) In the first phase the novelty emerges as a solution to a local problem. 2) In the second phase, dedicated community of people make the novelty more institutionalized, the solution is improved and best practices established. The solution is developed in the interaction with the users. 3) In the third phase wider diffusion of the novelty can occur. The diffusion gives it more visibility and it enters a competitive relationship with the established regime. 4) In the fourth phase, the new solution, in our case the new model of governance in health care replaces the old one. This usually happens in a gradual fashion, because it takes time to create new infrastructures, new user practices, new policies and new organizations.

We study how an embryo of a system innovation is taking shape when it is being transferred from its original local environment to wider use. In its early phase, the innovation embryo appears as a benchmarking tool for comparing the cost effectiveness of municipal health care services but it has a potential to become a sustainable tool for municipal purchaser-provider management model. However, there are several matters that have to be resolved with the users of the new management model. How to develop the management tool of one municipality to be used in a multi-municipal environment? How to develop local performance indicators of health care services to nationally approved standards? How to measure the quality of primary health care services beside their cost effectiveness?

We analyse the beginnings of the embryo of an innovation from a small Raisio town to Southern Savo region in Finland. In Southern Savo, eleven municipalities decided to join MAISEMA – project in October 2007. The first phase of the project consisted of benchmarking of cost-effectiveness of the local primary health care services of the eleven municipalities. The second phase of the project aims to start change management in the municipal social and health care and implement the purchaser-provider model. The paper is focused on an analysis of how the different interests, doubts and visions of local social and health care experts, municipal managers and consultants, who promote the change towards implementation of the purchaser-provider model, encounter. The questions that we explore are: How does an innovation embryo develop from a local experiment to regional and national model? What hinders or promotes this development process on national, regional and local levels?

We first introduce the main principles of the particular purchaser-provider model, which was originally developed in the Town of Raisio. This model and its management tools were later on named as MAISEMA model, when Sitra, the Finnish Innovation Fund, started to promote the effort. Secondly, we present the viewpoints of the national and regional actors towards renewing social and health care management in the municipalities. Then, we describe the starting points of the Southern Savo municipalities for adopting the new model, and what the benchmarking phase revealed. In the end, we examine the local reactions to the pressures for change. The interaction between health care experts and the consultants, who aimed to promote the change, is opened up and analysed. Finally, the challenges in the path of the innovation are summarized and the dynamics between different levels of systemic change are examined.

The Raisio version of the purchaser-provider model

The development of the so-called Raisio model started in the Town of Raisio in 2003 and the model has been utilized in Raisio’s social and health care since 2006. The initial stimulus for development was provoked by the need to adjust the municipal day care organisation to (diminishing) demand. The head of Raisio’s social and health care considered that the decision makers lacked understanding of the overall situation in service provision. This was the fundamental problem to be solved because the situation had led to suboptimisation and difficulties in cost control.
The Raisio model is not radically new. Instead, existing ideas have been combined in a novel way in order to improve the management of social and health care activities of Raisio Town. Raisio model is essentially a tool for *streamlining municipal budgeting process*. It makes service delivery more transparent. It also clarifies purchaser’s and provider’s roles and defines the Town Council (political decision makers) as the purchaser and the Social and Healthcare Committee as the providers’ representative. The idea is to make the connection of service quality to its expenses more visible. However, developing the quality indicators for social and primary care proved to be difficult and laborious. Studies of health care performance indicators have argued that the question whether a certain indicator indeed reflects the quality of care is endlessly debatable (Berg & al. 2005, 60). The indicators in Raisio model related to efficiency, productivity, use and availability of services. The model covers mainly purchasing of services produced by the city itself. Decisions to purchase private services are made by the Social and Health Care Committee, not by the Town Council. So, the purchaser does not open competition between internally and externally provided services.

The innovation potential of the Raisio model lies in its use as a management tool. The model enables Town Council to understand the overall situation of service delivery and, hopefully in the future, the connection between the quality and cost of services. Multiple variations of purchaser-provider model are used in Finnish municipalities. The crucial aspect that differentiates the Raisio model from the other applications is its fairly rough classification of services. The following figure is an overview of the service classification:

![Service Classification](image)

Figure 1: Service classification in Raisio social and health care.

The rough classification facilitates Town Council understanding of the ‘big picture’ of the service provision and the connection between quality and cost, while classifications in other purchaser-provider applications have been claimed to be excessively detailed for this purpose. The excel tables, on which the model is based, can “give a warning” if the costs of a service become too high, as the financial manager of Raisio explains:
“The red lights come through comparison. The red light is a signal for the need to do something. If the costs are too high, we need to ask whether our processes are good. Or, even if the costs are just right, it may still not reach the targets because there are, for instance, too much absence from work. Then we ask why. We can make comparisons between internal units, and also inside one unit and in time.”

This is why the model has the potential of serving as a management tool. The other Finnish models currently applied have not been used as tools for budgeting.

The Finnish variations of purchase-provider model as a whole differ from most international variants (e.g. those used in The Great Britain, New Zealand, Sweden) in two respects. Firstly, the Finnish variations are more focused on internal purchasing, i.e.they are less oriented to enhancing competition between private and public services. And, secondly, they are implemented on municipal level, not on national level. This is why direct conclusions of the applicability of purchaser-provider model to social and health care cannot be directly drawn from international experiences.

The perspective of the national and regional actors to purchaser-provider model and the renewal of the health care services

In the national level, the pressure for renewal of the social and health care system has been recognized. The following citation from the recent speech of the Minister of Administrative and Municipal Affairs from the Ministry of Finance to the elected officials of the municipalities describes the way the challenge is perceived:

“Already after a few years we will be in a situation were the implications of ageing will strike us at full stretch. The need for services will grow. At the same time the labour supply contracts. As a consequence of the wage solutions that have been made and also the pent-up investment needs we will loose control over the growth of costs.”
(22.4.2008, a speech in PARAS-seminar, Finlandia Hall)

Although, in Finland, there are sceptics of the New Public Management paradigm, currently the national level policy makers increasingly tend to view it favourably. Their understanding of what purchaser-provider model essentially stands for and their beliefs of its implications are, however, different. What they seem to share is the ambition to clarify the division of labour and the roles of purchasers and providers in public management with the help of purchaser-provider model. But some decision makers seem to fear that adoption of purchaser-provider model in municipal management will lead to more cost based competition and that quality aspects will be forgotten. Others favour the purchaser-provider model exactly because it is seen as a path towards increasing competition and privatisation. They believe competition will bring higher efficiency without sacrificing quality. The Minister responsible for Municipal Affairs in Finland, has recently officially recommended increasing use of pp-model in municipal management:

“Renewal of service delivery calls for extensive service strategy and commitment to the strategy. There are many means. Purchaser-provider models need to be adopted and the share of private companies and third sector in service provision must be increased. The effectiveness of service processes need to be increased. New technologies must be exploited and information systems must be standardized. There must be courage to go beyond old divisions of labour and professional borderlines in order to gain synergies. Cost accounting of services needs to be further developed.”
(22.4.2008, a speech in PARAS-seminar, Finlandia Hall)

Recently, the ministry of Social Affairs and Health has sent a bill concerning renewal of social and health care to a wide circulation for comments. The bill aims to increase the citizen’s freedom of choice regarding his/her personal physician or the hospital where he/she will be treated, to narrow the gap between primary and specialized care, and to force municipalities to organise health care in a sustainable way. The renewal is called health care law. The bill has been criticized because it
totally neglects the growth of private health care services and the problems related to the flow of information between private and public sector.

So far, the most influential action of the government, from the point of view of municipal organization of primary health care services has been setting up of the ‘project to restructure municipalities and service’ (the so-called PARAS project). With this action the government aims at formation of a sound structural and financial basis for primary services that municipalities are currently responsible for, so that they could secure the organisation and provision of the services in the future. Both organisation and production of the services will be considered. A skeleton law related to restructuring the renewal of municipal service structure came into effect in the spring 2007. The regulations pressure smaller municipalities to form consolidations or collaboration areas for joint organization of services. According to the law the consolidation or collaboration area of municipalities organising social and primary health care, needs to cover at least 20 000 citizens. The PARAS project has been criticised for giving too loose guidelines for municipal restructuring.

Even though the government has made several policy actions for renewal of social and health care system, the progress seems to be slow. In the spring of 2008, a representative of the Ministry of Social Affairs and Health summed up the situation as follows:

“The special challenge (for the health care bill) - which would have been extremely ambitious already as such - is that the PARAS project has almost come to a halt because of the forthcoming local elections. The PARAS project does not bring forth interpretations concerning the course of municipal restructuring. In practice, it is hard to draft a substantive bill so that it will endure for the next couple of decades. Presently, we have totally different conceptions of, for instance, the role of collaboration areas. The very fundamentals are open.” (interview)

In addition to national level policy makers, there are two major regional level actors who have something at stake in renewal of the municipal social and health care services. The first one of these is the Regional Council of Southern Savo. This public authority aims to guide general development of the Southern Savo province. The province of Southern Savo consists of 20 municipalities and the number of its inhabitants is 160 000. The region is characterized by increasing portion of elderly inhabitants and a weaker employment rate as compared to other regions in Finland. Two medium sized cities, Mikkeli and Savonlinna, are located in the area. The Regional Council provides a platform for working out the common will of the province, acts as an agent for economic development, and promotes the general interest of the region at national level. The Regional Council considers the needed scale of health care renewal broader than the municipalities:

“The reorganisation of social and health services cannot be done in a Mikkeli-centered way. Also Savonlinna must be taken into account…// At least regional scale is needed for renewal. I would even favour the scale of Eastern Finland.” (the director of the province, interview)

In the spring of 2008 the Regional Council hired an administrator to search for an optimal municipal structure for the region. This was to support the municipalities in their quest to meet the requirements of the above mentioned national project to restructure municipalities and services. The administrator made his proposition for the municipalities to consider. The proposal covered three options all of which were based on purchaser-provider model. The scale of the first option was regional, the scale of the second was Southern Savo Hospital District wide, and the third covered multiple collaboration areas in the region.

The second important regional level actor is the Southern Savo Hospital District. In Finland specialized health care is provided by 21 hospital districts which are owned and run by associations of municipalities. All municipalities are required to belong to a hospital district. The municipalities of Southern Savo are divided mainly between two hospital districts, the hospital district of Southern Savo and that of Eastern Savo. Because currently the trend in Finland is towards closer
linking of primary and specialized health care services the hospital districts are potential partners in renewal of primary care. For instance, the CEO of the Southern Savo Hospital District has suggested that the renewal should be organized on the scale of the hospital district instead of organizing smaller collaboration areas:

"I have suggested myself that we should constitute a regional purchaser, ie. a joint purchaser of all municipalities in Southern Savo Region where there are 180 thousand inhabitants. Service production should be organised into production areas. Even our Central Hospital (of Mikkeli) would be just one production unit, Savonlinna would be one, Pieksämäki might be one. I have made this proposition but it may be a too radical model…// If Savonlinna does not want to join, the organisation could be made in the scale of Southern Savo Hospital District. “ (interview)

In the Finnish health care system the municipalities are responsible to organize the social and primary care services. Although PARAS project suggests that the collaboration area of municipalities organising social and primary health care, needs to cover at least 20 000 citizens, the agreements between the municipalities are currently diverse. The national level health care experts were not expecting any changes to happen in the municipality driven health care system in Finland although they bought out its obvious problems, as one of them assessed the possible future:

"There will surely be no changes in the responsibility for organizing (the primary services). We have chosen the municipal responsibility, but the amount of future debate on this issue will depend on the results of PARAS project. If a great number of consolidations of municipalities will take place and if the services will be organized for a higher average number of citizens, the present situation where municipalities have the responsibility will be supported…// But maybe we should discuss transferring the responsibility from municipalities to perhaps provinces or the new regional government that is being built. One option might be that provinces would have the responsibility for organizing. The municipalities would then participate the funding if the tax system is not changed. Or, perhaps the Social Insurance Institution would take the responsibility…” (interview)

While this paper was written, the pressure concerning the adoption of the purchaser-provider model and organizing the social and primary care services in a wider e.g. hospital district scale was fairly weak. Without a clear viewpoint or pressure for a certain solution, the organizing of the social and health care keeps developing in a dispersed, municipality-driven way. And, some of the municipalities may stagnate in their change, while waiting for clear directions for the restructuring of the public services.

The first phase of MAISEMA-project in Southern Savo

The Mikkeli region has decided to set up a collaboration area between eight municipalities to organize the social and health care services, from the beginning of 2009. These municipalities include Hirvensalmi, Kangasniemi, Mikkeli, Mántyharju, Pertunmaa, Puumala, Ristiina and Suomenniemi. The proposal of Sitra in summer 2007 about starting MAISEMA-project with these municipalities gave needed information about the current state of health care services in these municipalities in order to proceed with forming the collaboration area. Sitra has stood up as a national actor for promoting the diffusion of best practices in health care. As an independent foundation which is funded by the profit of the fixed capital and capital investment, its role differs from the other public agencies in this sector and its role is debated. As a foundation Sitra has more freedom in agency as compared to tax paid actors but its impartiality is often questioned because it simultaneously acts as risk investor and has business interests.

Besides the eight municipalities, three nearby municipalities, Pieksämäki, Juva and Joroinen, decided to join the MAISEMA-project in autumn 2007. The possibility to compare the current cost-effectiveness of the different municipalities seemed to serve as the main motive for the municipalities to join the first phase of the project. The benchmarking of the health care services of
the municipalities was expected to give a neutral starting point for formation of the collaboration area.

Figure 2: The municipalities of the Mikkeli region, which joined the MAISEMA-project

Even before the benchmarking started it was known that the costs of social and health care services of the Town of Mikkeli were 2.2% higher than the average among medium sized cities in Finland. The costs that were higher than the average consisted of psychiatric care, social welfare of the disabled and child welfare (Mikkeli region MAISEMA-project plan 1.9.2007).

The purpose of the MAISEMA project was in the first phase to use the Town of Raisio as a benchmark when comparing the costs of the health care services of the region. The analysis from all the municipalities was expected to trigger the next phase of the project, i.e. changing the structures of the health care services in the region. The overall target of the project was to increase transparency and productivity of health care in the municipalities. In addition, the purchase order for the specialized health care was aimed to be developed along the lines of Raisio purchaser-provider model in collaboration with Southern Savo Hospital District. The main principles of the MAISEMA model, such as using the purchase order and resource tables, were intended to be implemented in the first phase of the project as well. It did not turn out to be a simple task, because of the incompatibility of the health care information systems.

“It was noticed that filling these tables was complicated. It demanded a lot of knowledge, time and effort… Our information systems do not easily produce the information which was demanded to fill in those tables.” (interview, regional expert in health care)

The data for the benchmarking was collected partly manually and by combining data from different information systems.
The results of the benchmarking phase of MAISEMA

The results of the comparison of health care costs in nine municipalities were published in February 2008. The principal innovator of the Raisio model presented the results to the personnel of the social and health care and to the elected officials of the municipalities. He also presented the results in a press conference. According to the report the costs of the health care in different municipalities varied significantly and the differences were not explained by the variances in age structures or by sickness rate. The differences were at their greatest in costs of elderly care and in specialized health care. The level of costs in nursing services per every person over 75 years varied from 6900 to 9400 € in Mikkeli region municipalities. The positive effect of home care to the structures of health care services seemed to be weak, because the service production had been organized separately to home help service, elderly care, support services, and day care centres. The municipal differences in costs of psychosocial services for adults were great both in open and institutional health care services. The conclusion of the report was that the whole region could gain 39 million € savings by reorganizing the services. This sum was called the optimization potential. The results were presented in a graphic form, as a following example from the MAISEMA I report shows:

Figure 3: The optimization potential of the specialized health care (blue), elderly care (red), reception services (green) and dental care (purple) in Mikkeli region municipalities
When the results were presented, the developers of the Raisio purchaser-provider model argued that the model would function better for bigger consolidation of municipalities than for each small municipality or for a collaboration area of multiple small municipalities. This aroused confusion among local experts and managers. The consolidations of municipalities had not been discussed in the Mikkeli region beforehand because municipalities were reluctant towards such arrangements. However, the issue was not publicly discussed or debated. In the press conference the pressure of forming consolidations of municipalities was emphasized even more strongly by the representative of Sitra, as he stated:

“According to MAISEMA-report this region has 10-39 million optimization potential, which could be reinvested. Now the structure of municipalities should be taken into focus. Because there are about 100 000 inhabitants, in addition to Mikkeli, (in Mikkeli region) there is only room for two municipalities.” (Field report 20.2.08 Mikkeli)

As the Figure 3 shows the optimization potential was much greater in towns, such as Mikkeli, Pieksämäki and Varkaus, than in smaller municipalities. This fact did not attract small municipalities to collaborate with the towns. The benchmarking phase raised up a small municipality Pertunmaa as an exemplary in which the structure of the elderly care seemed to be optimal and the costs of the health care services reasonable. This exemplary was a treasure for the MAISEMA project, because it gave an example which was comparable with the other municipalities in the region as it had the same age structure and other features. So, Pertunmaa became a promising internal model for the region in terms of renewing the social and health care services and making them cost-efficient. For Pertunmaa itself, the study gave an objective recognition.

**Pertunmaa became a regional model**

The primary health care services of Pertunmaa\(^2\) used to be organized as a federation of municipalities together with nearby Mäntyharju. Only social services belonged to Pertunmaa’s own organization. The federation of municipalities was dissolved in 2000, because of disagreements between the elected officials. Pertunmaa had to find a new way to organize its local services. As a first step, the municipal social and health care services were organizationally united.

The change process seemed to be triggered by the regional development projects of health care. But simultaneously, the initiative of the personnel in reorganizing services was significant. For example in 2007, municipal home help service and home nursing services were merged because the nurses of home help and of home nursing had realized that they served the same clients and were willing to be trained to do both tasks during their visits. This evidently saved the resources of the municipality. The personnel has also been willing to work in different jobs in turns and simultaneously.

“Currently, I work as a department head in health care and I work also in the social services. Today afternoon, I assisted as a dental nurse in the dental clinic, because I have that education, too. I worked three hours as a dental nurse. And I can also work in the reception or in the department or in the day care centre. Versatility of the personnel is a prerequisite.” (Interview, regional health care expert)

The personnel has been organized in self-steering teams, which are motivated by the desire to do better quality in social and health care and which also have awareness on cost-efficiency of the services. Financial administration has been well planned and understood even on the grassroot level. “ We follow the realization of costs even monthly.” - said a health care expert of Pertunmaa.

\(^2\) Pertunmaa is located 60 km from Mikkeli and has 2021 inhabitants, but the number is almost doubled during summertime. It is a popular place for holidaymaking.
Pertunmaa has systematically diminished its number of beds in health care. In 2008 there are only four beds in the primary health care. Simultaneously, the emphasis of elderly care has shifted to support sheltered housing and home help care. The municipality has realized the significance of the associations for the elderly people and supported these activities. Communal spirit and encouraging management style have also played critical roles in the successful change of social and health care services in Pertunmaa. The head of social and health care stated as follows:

“The municipal units should be kept small because people can then sustain the strong desire to develop their own work. The wish to do more for his or her own community sustains. This has not been discussed during the MAISEMA-project meetings, yet. If we establish too big work units, the personnel loses its will to develop its own community.” (Interview, the head of social and health care services)

It is still unclear how the model of Pertunmaa is going to be utilized in the following change management phase of the MAISEMA-project. However, the surrounding municipalities have already been eager to get acquainted with the change management mode of Pertunmaa. After the benchmarking phase, the head of Pertunmaa’s social and health care started to work part-time in nearby Mäntyharju helping them to reshape their services. However, the endeavor to shift a model of Pertunmaa to another municipality turned out to be a hard task. The head of Pertunmaa’s social and health care returned to his original position only after a month.

A coordination group meeting as a bridge for starting the change management phase of MAISEMA-project

During the benchmarking phase of MAISEMA-project seven meetings of the coordination group were organized. The coordination group consisted of municipal heads of social and health care, and the meetings were chaired by the representatives of Sitra. The last meeting of the coordination group ended the phase of benchmarking. It turned out to be a critical turning point, in which the participants could decide whether they were willing to continue with the project to the next phase. It was chosen to be analysed in this paper, because in this meeting the differences between viewpoints of the actors became visible and the tensions between them were aroused.

At first, the chair from Sitra brought a message from the national level of policy makers. He reported that the Minister of Administrative and Municipal Affairs had emphasized how significant it is to establish an extensive strategy to renew the service production and to commit oneself to it. She had recommended implementing the purchaser-provider model and strengthening the collaboration between public, private and the third sector services.

Secondly, the main writer of the benchmarking report, originally the head of social and health care of Raisio, announced that Raisio, Nordic Health Care Group Ltd (a health care consulting company) and Sitra had established a company called Kuntamaisema Ltd, to continue the municipal benchmarkings of the social and health care service in Finland. This was an opportunity for him to do these benchmarkings as a full-time job, not just on the side. The company could develop the tools for the purchaser-provider model and promote change management in the municipalities.

The third topic of the meeting was to announce the benchmarking results of Juva and Joroinen. However, there were no participants from those municipalities to hear them. This was not obviously a good starting point for launching of the change management in these municipalities.

The fourth topic of the meeting was to wrap up the benchmarking phase of MAISEMA project. The total costs of the project were roughly calculated. The meeting then officially closed the first phase of the MAISEMA-project.
After a lunch break everyone was invited to discuss the launching of the change management phase. Only the Town of Mikkeli had so far announced that they were going to continue with the project to its next phase. Bearing Point Ltd. (BP), the management consultancy company paid by Sitra, was introduced to consult the municipalities in this new phase together with Kuntamaisema Ltd. An episode from the encounter of the heads of social and health care services and the consultants in 24th of April 2008 in Mikkeli is presented and analyzed in the following.

A collision between social and health care experts and the change consultants

A consultant of BP presented eight development projects, which have been started by the Mikkeli Town Council. These development projects had been planned by Mikkeli’s own experts and it was anticipated that these efforts would bring M€ 5 savings to the town. The first five projects were planned to be carried out jointly with Southern Savo Hospital District.

1. Define and tighten up the criteria for access to child welfare service
2. Tighten up the criteria for access to social welfare for the disabled
3. Diminish the institutional mental health care
4. Develop primary health care and its reception
5. Develop services of the elderly
6. Cut costs by reducing 100 people from the personnel
7. Define criteria for access to all the significant services
8. Define and tighten up the criteria for access to supported housing

Another consultant of BP stepped forward and started to challenge the local people for a stronger change. The tone of the presentation got more tense and the vocabulary he used came from the business management. He started the speech as follows:

“We try to understand where you are now. And we consider if we could think of the situation in a new way. We do recognize the need for change. It is evident. We know how much the services cost and we know the economics of the town (of Mikkeli). The formula is unsustainable. Now we have to discuss how big of a change this is all about. The will should be a decade bigger and more ambitious. Your point of comparison should not be the public health care of Finland. We should implement good models from the world. The change comes from outside, not from inside. A soon as we agree on the change, we should start to manage it in a professional way. For example, the connections of the previous projects to economical goals is unclear. Developing the operational activities is a good starting point. But getting really significant results requires structural changes. This is all about strategic reorganizing of your production of services!”

A few speech turns later, the following debate resulted as a reaction to the consultant’s presentation:

Head of social and health care, Mikkeli: It is difficult to understand from the high level. I need to understand (the change process) from inside. Surely we know, in which functions we are expensive. We should get our personnel to act for the change. Social and health care is different from all other kind of activities. We have a heavy demand for our services, and legislation and all. Everything pressures. I cannot see any other choice but to decide, what we should have less, and we’ll organize the services from that ground. You use a different language.

Consultant BP: Now the (planned) change seems to be like just finalizing your present situation… Have you made the difficult structural decisions about what services you should get locally?
Head of social and health care, Mikkeli (agitated): You tell me where the big structural solutions would be?! You tell us to strike to the structures! What structures?

Consultant BP (cool and calm): Now we get an impression that you have an existing production which you aim to make function as well as possible. You keep up the existing production capacity.

Consultant of Kuntamaisema (calming down): Currently the big challenges (in Mikkeli) lie in the structure of services. You need to think more concretely what the changes should be in home help services, institutional care etc. But now you (in Mikkeli) should start from those (services) which alert as red and improve them. You will suffocate if you start changing all at once.

Manager from Sitra (reassuringly): We are looking for the key thing here... There have been problems in Raisio, as well, such as its extremely closed relationship with the Southwest Hospital District.

The manager from Sitra closed the meeting by concluding that the decisions concerning the way to realize the change management phase in the region should be made within few months. The options were to start the project with only the Town of Mikkeli, with the Town of Mikkeli and four collaborating municipalities, or with larger number of municipalities. He concluded: “We will make you a proposal and then you decide if you continue with or without us. In any case, the agony is yours.”

As the previous episode from the meeting showed, the actors from the social and health care had difficulties in agreeing with the consultants. The consultants talked about the need for “strategic reorganizing of the service production” and they called for radical structural changes. They expressed their ideas by using the language of business management; using words such as ‘production’, ‘outsourcing’, ‘cost-effectiveness’. The actors of the social and health care approached the change from inside and focused their attention to improving the contents and quality of the services, as their eight internal projects expressed. For example, the defining and tightening of the criteria for access to certain services were aimed to reduce the number of patients or customers.

These different languages carry different ways of understanding the change. These different languages also seemed to inhibit a fluent communication between the actors. Instead of starting to search for a solution together, their discussion became rigid. In the end of the episode, the consultant of Kuntamaisema Ltd and the manager from Sitra tried to soften the atmosphere by interpreting the talk of the Bearing Point consultant. However, everything was left open and it remained unclear if the local social and health care actors were for or against the starting of the next phase of MAISEMA project. After few months, we heard that Mikkeli did not accept the offer of MAISEMA project about starting the phase of change management. One reason for this was the reluctant attitude towards consolidations of municipalities in the region. Social and health care in Mikkeli was, however, going to continue and implement the tools of Raisio’s purchaser-provider model without the support from the consultancy firm Kuntamaisema Ltd.

Conclusions: The challenges in the path of the system innovation

This empirical description opened up the complexity of a pathway of a system innovation. In the beginning of this paper we set up two research questions: How does an innovation embryo develop
from a local experiment to a regional and national model? What hinders or promotes this development process in national, regional and local levels? We analyze the multi-level change process with the concepts of transition management.

In previous studies, the pathways of innovations have been analyzed within extensive time periods and the emphasis has been much on niche-level as the principle locus for regime change. The analyses have been criticized for neglecting the human agency (Geels & Schot 2007). Bearing this in mind, we have strived to point out the most active and influential actors, who have carried the shift of purchaser-provider model and its tools from Raisio to Southern Savo within the Finnish health care system. However, when the narrative concentrates into single actions, events and decisions, the details may make the links between the different levels of change seem obscure. Furthermore, we have only studied the chain of events within one year, from the summer of 2007 to the summer of 2008. Therefore, it is difficult to foresee the entire trajectories of change, yet. Taking these restrictions into consideration we summarize how we observe the linkages between the socio-technical landscape, regime, and niche levels of change.

The following figure describes pressures, challenges and obstacles in the pathway of the analyzed embryo of an innovation.
The ageing of the Finnish population and the labour shortage in public services among other trends have put pressure on renewal of municipal health care services and adoption of new models, such as purchaser-provider model. Some prominent national policy makers have even suggested the adoption of the purchaser-provider model to municipalities.

A concrete means to promote the renewal of the social and health care service structure is the current government platform which outlines the political goals in the development. In this document it is stated that the public sector will retain its responsibility for organizing and funding of social and health care. In order to secure the supply of professionally skilled personnel in social and health care services the government suggests emphasis on better wages, development of contents of work and management and improved learning opportunities. In addition, the document states that citizens’ equal access to services and the quality and efficiency of services must be improved. The new health care bill, in turn, focuses on increasing the citizens’ freedom of choice, strengthening of primary services and the integration of primary and secondary health care.

The government pursues reaching these goals through PARAS- and KASTE projects. PARAS-project aims to reshape the structure of municipalities and services. KASTE-project endeavours to support the creation of new organization models. In principle, the various policy measures of the government seemed to offer a window of opportunity to the renewal of health care. However, the changes do not take place only in a top-down manner. Local level actors need to participate actively to make the reshaping of the services and organizations feasible.

Despite all these measures, the processes of structural renewal of municipalities, the preparation of the new health care bill and renewal of health care service structure has been perceived to slow down in 2008. This can partly be explained by the municipal elections that will take place in autumn 2008. The present elected officials are hesitant to propose major structural changes in the end of their electoral period. The PARAS framework for restructuring gives much freedom for interpretation and long time horizon for municipal decision makers. Without their concrete decisions on coalition making and on the forms of collaboration areas that they are jointly willing to make, it is hard to foresee how the future municipal structure in Finland will look like. This has further complicated the preparation of the new health care bill. And further, without these political decisions of municipal structures and without knowing the contents of the forthcoming health care bill municipalities cannot make much progress in health care service renewal.

In spring 2008, the scale for structural changes in social and health care system was still open in Mikkeli region. There was no agreement among municipalities on whether the purchaser-provider should be implemented province-, hospital district or municipality-wide. This made some of the municipalities in Finland just wait for concrete decisions, but some of the municipalities could use this stagnant period as an opportunity to test and develop their own versions of management tools and models. As the case of Pertunmaa indicated, developing the way of organizing and managing the social and health care services maybe initiated by local actors, from inside out.

To conclude, although the external circumstances were aimed to encouraging the adoption of new models of governance to social and healthcare, but lacking clarity of direction partly delayed the change, and partly increased the variety of local versions of the purchaser-provider model. In Finland, bigger cities, such as Tampere, Oulu and Rovaniemi have already constructed their own versions of purchaser-provider model. Although the New Public Management paradigm and its models from abroad have encouraged Finnish health care system to adopt new models, such as purchaser-provider model, the change has been strongly driven by local actors. Although a window of opportunity for experimenting with new models has been opened on the regime-level, municipalities may need more concrete guidelines to promote the restructuring of the social and health care services. A critical question for accomplishing a system innovation is how to promote
this kind of initiative on niche-level, but simultaneously give clear guidelines from above, from the regime-level.

In the case studied, Raisio’s head of social and health care has been the main innovator in the early phase of the system innovation. As the narrative described, Raisio’s experts involved in designing the new management tools began transferring the ideas of the new purchaser-provider model to other regions by the side of their everyday work in Raisio. While demand for municipal benchmarking increased, they decided to found Kuntamaisema Ltd, to continue with the diffusion. This gave a more firm ground and resources to promoting MAISEMA model’s diffusion.

On the niche-level, the actors developing the tools for the purchaser-provider model encountered many challenges in transferring the model to other regions. First of all, the benchmarking phase was based only on indicators on cost-effectiveness while the development of quality indicators lagged behind. Furthermore, the Raisio version of the purchaser-provider model was originally designed for the governance of a single municipality, consisting of about 20 000 inhabitants. It was unclear how the model and tools would function in a more complex environment with coalitions or collaboration areas of municipalities. The way the change management was launched for the municipalities after the benchmarking phase, polarised the internal development logic of health care and the means of business-management way of improving the cost-efficiency of the services.

While the models of New Public Management emphasize the cost-efficiency and transparency of services, the experts of health care may experience them as stronger control of their work.

In the future, the benchmarking of the municipal health care services may produce different developments in different regions. Some of the municipalities may use the comparative information to improve their services without adopting the purchaser-provider model. Some of the municipalities may want to adopt the new management model and see how it improves the services in due course. In Mikkeli region the benchmarking did not facilitate discussion about forming consolidations or collaborative areas of municipalities that had initially been one of the goals. Instead, it brought forward a successful municipality, Pertunmaa, which became a potential example for the other small municipalities.

The case of Pertunmaa shows how important the motivation of the employees themselves is for continuous change of activity. The personnel in a small work community are able to observe the implications of the improvements of their work. The awareness of cost-efficiency of services has been derived from the grassroot level. The personnel have been flexible enough to work in different tasks, collaborate across professions and organize into self-steering teams. The organizational solutions have respected both the voice of the employees themselves and the cost-efficiency of the services. Pertunmaa has also been a regional pioneer in changing the structure of services and in diminishing the number of beds in elderly care already from 2000. However, it seems that transferring a management model from one municipality to another with the help of social and health care actors themselves is not easy either.

The question of agency in promoting the system innovation

Because there have been criticisms about the neglect of human agency towards previous analyses which have used the transition management approach, we would like to discuss this question based on our analysis. According to Geels, the explanation of the emergence of new regimes is that multiple developments gradually link up and reinforce each other. The approach needs to be complemented, however, with an actor-oriented approach working from the inside out. (Geels 2004, 43). We argue that linkages between multiple level changes do not just happen, they must be intentionally constructed by actors who move and interact between the regime and niche-levels.
In our case study, such actors were especially the representatives of Sitra and the former head of social and health care of Raisio, who became the CEO of Kuntamaisema Ltd. Sitra has been the change agent by promoting the transfer of MAISEMA model to several regions and enhancing the interaction between best practices. It has been able to shuttle between national level decision makers and local experts in health care. System innovation needs this kind of a carrier of the innovation. However, some of the institutional actors in developing social and health care have ambiguous attitude to their efforts.

We would like to point out that the multi-level analysis offers an understanding of the complex dynamics of systemic change. It also reveals the difficulty of synchronising the momentum between the levels. The system innovation needs several carriers of innovation, i.e. actors who give clear guidelines for the change in national and regional levels, and active local experimenters who develop the ideas into feasible tools and models, and “shuttles” who work for mutual adaption of innovation and its environment.

System innovation in its early phase

In our case study, the journey of a system innovation is only in its early phase. A dedicated community of people is about to make it more institutionalized, the tools and performance indicators used in purchaser-provider model are developed together with the users. A wider diffusion of the MAISEMA-model has not started, yet. Purhaser-provider model in Finnish health care has many versions and it has been adopted in the several larger cities. However, the establishment of the new model of governance is difficult because the structure of the municipalities is in motion.

What makes the pathway of the innovation also fragmental is that changes and developmental efforts are designed in projects both in regime- and niche-levels. Project-based change efforts are typically discontinuous by their very nature. It is often the role of management in the organizations to be committed and support the change even between the projects (Buchanan & Fitzgerald 2007, Longo 2007). He or she needs to build a bridge between development projects in order to keep the spirit of change alive. Our aim is to continue with this journey of a system innovation and follow the adoption process of the MAISEMA-model in few other regions. After a couple of years, we can better assess whether it has the potential to replace the existing governance models in Finnish health care.

References


