maternity and child health clinics, dental health services, and mental health and substance abuse services. The health centres are managed by about 170 primary health care authorities, which are administratively either joint municipal bodies or single municipalities [9, 16, 19]. Most of the municipalities have merged the earlier separate administrations of health and social care services under one administration. The municipalities provide social and elderly care services that include social work and guidance, family counselling, social rehabilitation, and assisted living and home care for the elderly. In most of the municipalities, home nursing and home help services have been merged into home care.

Due to local arrangements, the health and social services in Finland are under two separate types of regional administration. The regular way to arrange services, which is defined in legislation, involves a separate authority for specialized health services and then several independent municipal authorities for primary health care and social services (which may or may not work in an integrated manner). The specialized health care authority is responsible for coordinating health services but how this is practiced varies between regions.

A new type of regional administration is a regional joint authority, which municipalities form through voluntary agreements. Currently, eight out 20 regions have a joint authority of this type. On average, these regions are smaller, and altogether they constitute around 20% of the Finnish population (Table 1). In these regions, all public specialized, primary and social care services are under one unified administration and management, which allows the integration of various aspects of services and other operations. Six out of eight of these joint authorities were founded after 2018.

The municipalities and the health and social care authorities in Finland have developed their health and social services in extreme uncertainty for the last 15 years due to the government's series of failed attempts to reform the health and social care system [4, 5, 7, 16, 20]. In general, government policies have adopted integration and regional administration, but the reform proposals have been quashed for legal and constitutional inconsistency related to complex and extensive legislative packages and political disputes on issues, such as the role of the private sector.

In terms of developing service arrangements and integrated care, the situation in each region has constantly changed, and the municipalities and the health and social authorities have adapted their operations to government policy processes and local circumstances, which has resulted in variations in the pace of reforms, such as implementing integrated care.

At the beginning in 2023, the so-called "well-being services counties" will take responsibility for organizing all health and social care services. After the reform, Finland will have 21 new well-being services counties. In addition, Helsinki will organize and continue to produce its own social and health care services in the future [21].

As in many other countries, the aging population in Finland significantly influences the development of health and social services. The life expectancy of the Finns at age 65 now exceeds 20 years. In 2017, 21% of the population was 65 and older. Three in five of those aged 65 or older reported having at least one chronic condition or disability, which is a higher proportion compared to other EU countries [19]. In addition, Finland is sparsely populated due to rural depopulation and internal migration to urban areas. The delayed system reform is an additional factor affecting the development of health and social services in Finland [16, 19].

The general aim of the study is to assess governance of health and social care integration in Finland. First, we explore regional approaches to integrated care in Finland by using Nicholson et al.'s [6, 10] conceptual framework. Second, we systematize regional approaches to integrated care, addressing both regular regions and regions with integrated unified administration as well as the ways the two approaches support implementation of integration in the regions. Third, we evaluate how Nicholson et al.'s framework can be applied to an analysis of social and health care governance.

RESEARCH METHODS

The study is a qualitative review that consists of two phases (Table 2) comprising administrative and planning documents on health and social services ($n = 176$) from the 20 regional care authorities and additional interviews of national health and social care evaluation officers ($n = 5$).

REGULAR (MUNICIPAL) ADMINISTRATION ($N = 12$)	REGIONAL JOINT HEALTH AND SOCIAL CARE AUTHORITIES ($N = 8$)
• Statutory • Special care authority = hospital district = municipal federation • Independent municipal authorities for primary and social care (practices for integration vary) • Planning responsibility with hospital district (disease-based care pathways often applied)	• Voluntary – agreement by the municipalities (est. 20% of the Finnish population) • All public specialized, primary and social care under one administration (HR, financing). Potential for integrated planning and work practices • Often-shared electronic client information system • Six of these organisations were founded between 2018 and 2019

Table 1 Unintegrated and fully integrated administrations of regional health and social care authorities in Finland.

secondary care), and some had a unified system in health and social care, even though at the time of the study the client records could not be used across health and social care due to legal restrictions.

On average, the regions with integrated regional administration had higher grades in terms of implementing the different elements of integrated care governance, but for most elements, the difference was minor. In addition to the governance elements of *joint planning* and *integrated information communication technology*, the integrated care authorities made a difference to the regions with regular administration for the element of *change management* (e.g., shared vision). Only two of the integrated care authorities had been launched before 2019, which probably explains why integrated care governance elements had not yet strengthened in these newly established authorities. However, the region of South Karelia, which was established in 2010, received the highest grades for all the elements of integrated care governance (i.e., in strategy and practice in the whole region or at least in some municipalities; see also Figure 2), excluding *client/community engagement*. Strengthening of the client/customer engagement (e.g., panels of clients and so-called "experts of their own experiences") has been widely acknowledged and already demonstrated in most regions.

In Figure 1, the regional advance of integration is described in terms of the ten elements of integrated care governance. The light blue columns are intended to demonstrate joint authority administrations and correspondingly dark blue columns demonstrate regular (municipal) authorities.

Figure 2 shows the mean for the ten integrated governance elements in both joint authority administration and regular (municipal) authorities in Finland. In general, the regions with joint regional administration have higher grades for the integrated governance elements. The highest summary measure was assigned to the South Karelia region, which was established in 2010 as the first joint social and health care authority. However, some regions with only recently established joint regional administration have also proceeded well with integrated care governance of health and social services.

DISCUSSION

This study gives a picture of integrated health and social care governance in Finland in different administrations. In general, integrated care is already relatively well advanced in Finnish health and social care. Because local governments, municipalities, and municipal joint organisations run public health and social services, collaboration across sector borders has been relatively uncomplicated to organise. Still, challenges to organising co-operation and coordination between health and social care as well as between primary care and secondary and specialized care have arisen, because municipalities organise the first and hospital districts the latter. In recent years, in eight of 20 regions, the municipalities have voluntarily established the joint health and social care authorities running all health and social services under a single administration [16, 17, 18, 19, 20]. Now the regions are under pressure to promote integration because the well-being service counties will begin from the beginning of 2023.

Our results strongly suggest that the integrated organizations, joint management, and funding in the new joint authorities have an effect on integration. In the integrated joint authorities' joint planning, building shared priorities, change management, and integrated information systems were at a higher level. It is possible that building a joint strategy, shared values, unified organizational culture, and practices are easier when the management is under one executive team instead of executive teams of several municipalities and one hospital district, which is the case in the regions with regular administration. However, in several regions, despite the separate management groups, the integrated governance elements seemed to be well developed. However, because the analysis in the study is based on documents analysed using Nicholsson et al.'s [6, 10] framework and supplemented by evaluation officers' viewpoints, it needs to be noted that we do not have a picture of the way clients experience the integration in their service paths.

According to our experience, extending the presented ten elements to an analysis of the integration of social services with specialized and primary health care was feasible. In terms of a more granular analysis of elements of governance that support integrated care [16, 17], half of the ten elements were successful or well advanced in all regions. These elements were *joint planning*, *population focus*, *measurement of data*, *continuing professional development*, and *client/community engagement*. In our study, these five elements at least reach the level of "planned to be implemented in the whole region" in all regions. Several factors have contributed to this. Public health and social services funded and provided by municipalities and joint municipal organizations have obviously supported integration. In addition, government policies and reform plans have subscribed to integrated care in recent years [4, 18, 22]. However, substantial variations in approaches to and pace of development of integrated care exist across regions. The variation of the integrated governance elements we analysed was particularly high with *integrated information communication technology* and *change management*. In part, this may be because in a document-based analysis, the elements of change management in health and social care planning documents are challenging to identify and the ways to describe these elements in documents

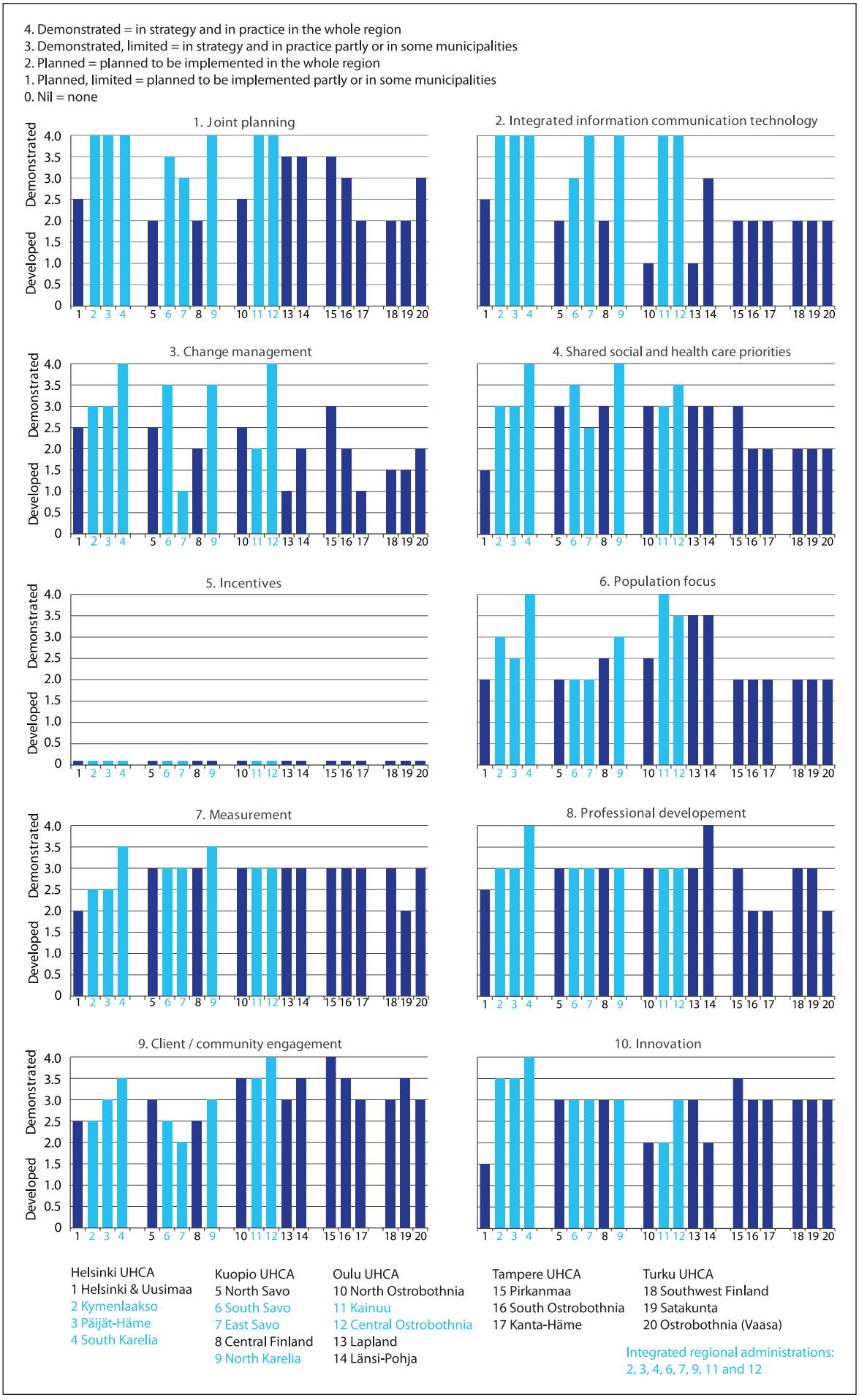

Figure 1 The level of integrated governance elements in different regions in Finland. (The light-blue columns indicate joint authority administrations; dark-blue columns indicate regular [municipal] authorities).

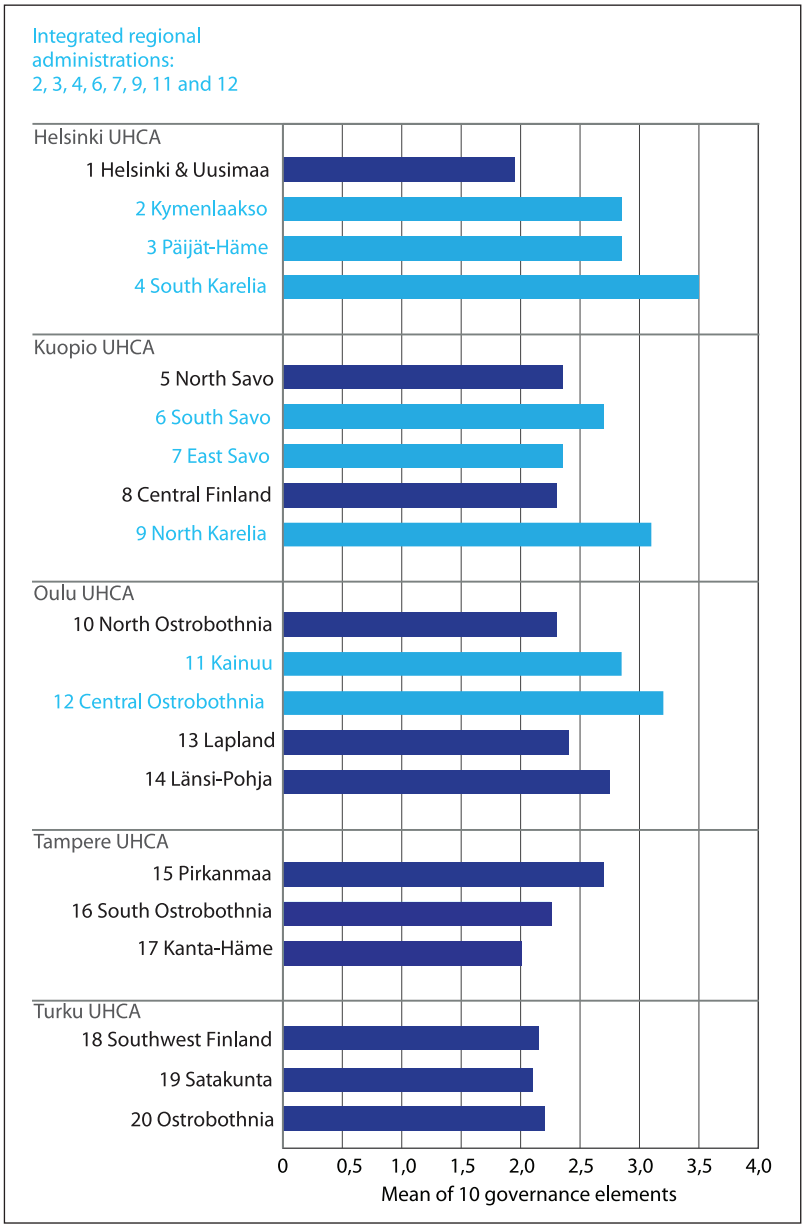

Figure 2 Overall picture of integrated social and health care governance in Finland. (The light-blue columns indicate joint authority administrations; dark-blue columns indicate regular [municipal] authorities).

vary regionally. The study confirms the contributions of previous studies that showed multiple elements are required to ensure successful and sustainable integration efforts. [6, 23, 24].

The interviews of the national evaluation officers confirmed our findings. The agreement was quite high. The main differences emerged over whether the district had planned to implement the element in question or whether the element was already implemented in some parts of the region. Care integration was often at a very high level in some municipalities, especially in the regions with traditional administration, but development was weaker in other municipalities. Although it is possible to analyse integration based on a specific theoretical model, deep knowledge of the region is highly important to draw an analysis of the level of integration. Nicholsson et al.'s theory has been applied in the Australian [10] health system in addition to the current study on the Finnish social and health system.

In summary, integrated care has been planned but implementation is partly fragmented and is dependent on regional features such as financial resources, aging of the population, and regional politics. However, integrated administration of health and social services does not determine how the integration has been developed in the regions, but it must be noted that the regions with integrated administration are represented by rather young organizations. In general, the integration has placed more focused on integrating primary care and specialised health care, rather than integration between health and social services. In the regions with integrated administration, integration between health and social services has seen greater development.