

THE FINNISH MEDICAL SOCIETY
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Who benefits most?

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Disclosures

TIMO LUKKARINEN · HEALTH INSIGHTS 2026, KUOPIO

Employment	Suomen Lähilääkärit Oy · Medical Director
Consulting	Duodecim Medical Publications Ltd · clinical expert, Health Benefit Analysis
Ownership	Shareholder, Suomen Lähilääkärit Oy · owner, Lukkamed Oy
Other	Research of healthcare management in Kanta-Häme

Relevant to this talk: the Health Benefit Analysis presented in the final part is developed at Duodecim, where I work.

A negotiation, 2019

*“If this saves specialized care that much money,
let specialized care pay for the sensors.”*

my proposal to hospital leadership

The case for continuous glucose monitoring:

- fewer complications
- less intensive care
- fewer patients on dialysis
- less physician time

Built almost entirely on savings.

THEY LAUGHED

Real enough to justify buying.
Not real enough to pay for.

The same argument, made and unmade inside a single meeting.

To be or not to be a saving



Savings disperse

A saving is real only when something stops existing. Freed minutes become capacity, and capacity refills the same day.



Internal walls

Autonomous divisions, own internal prices. Drugs on one budget line, staff on another, equipment on third. Nobody owns all sides of the trade.



The counterfactual

A saving is a comparison with a cost curve nobody will ever observe, and the assumed gain is cut from the frame in advance.

The benefits are real, and systematically invisible.

Prevention as a chain



One missing link in a prevention process can leave everyone looking extremely busy while nothing is delivered.

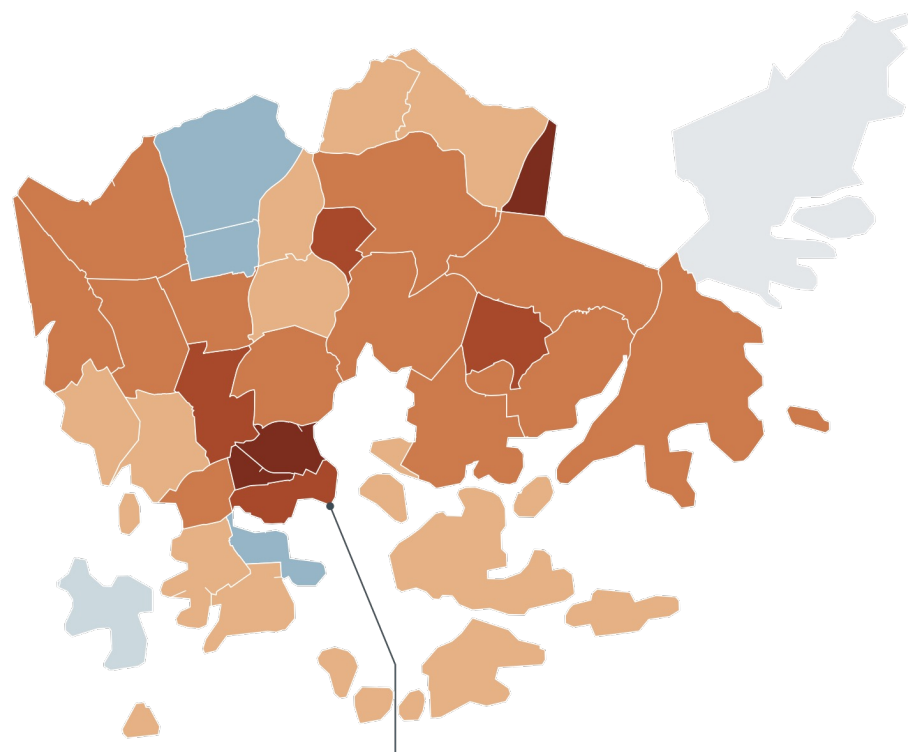
Who owns the chain?

Model	Screen	Prioritize	Intervene	Hold on	Verify
Blood biomarker panels	◐	◐	○	○	●
Self-measurement kiosks	◐	○	○	○	◐
Targeted diagnostics	●	◐	○	○	●
Multidomain intervention	○	◐	●	●	●
GP with a patient list	◐	◐	●	●	◐
Integrated care centre	○	◐	●	●	◐
Health Benefit Analysis	●	●	○	○	●

● performs the link itself ◐ partial or conditional ○ relies on others · Screen graded against the whole population

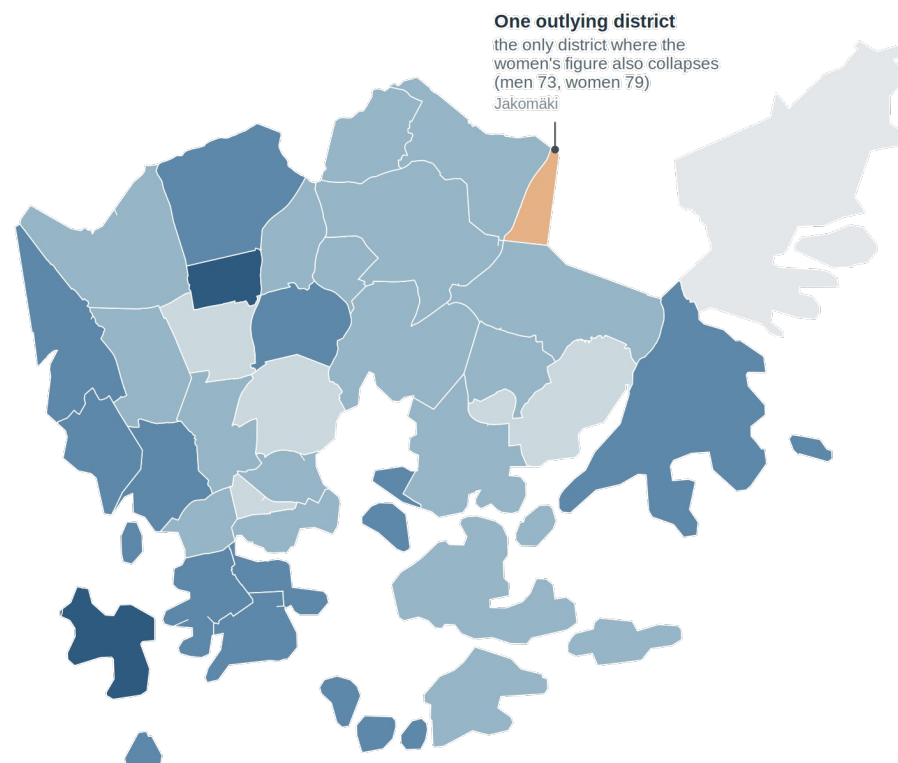
The chain has one owner, and no operator. Prevention fails at individual links.

MEN – Helsinki average 77.6 yrs

**Three central districts**

men 73–75 yrs, women 82–84 (at the city average)
Vallila, Alppiharju, Kallio

WOMEN – Helsinki average 83.4 yrs

**One outlying district**

the only district where the
women's figure also collapses
(men 73, women 79)
Jakomäki

73–74 yrs 75–76 77–78 79–80 81–82 83–84 85–86 87–88

Same colour scale on both maps.

Life expectancy by district, Helsinki 2017, rounded to whole years. Data: Statistics Finland & City of Helsinki Urban Research and Statistics; calculations: Netta Mäki.
Grey = no published figure (Östersundom). District boundaries: City of Helsinki (HRI) & National Land Survey of Finland. Graphic: author's own.

A classroom question

HELSINKI, A HIGH SCHOOL HEALTH EDUCATION CLASS

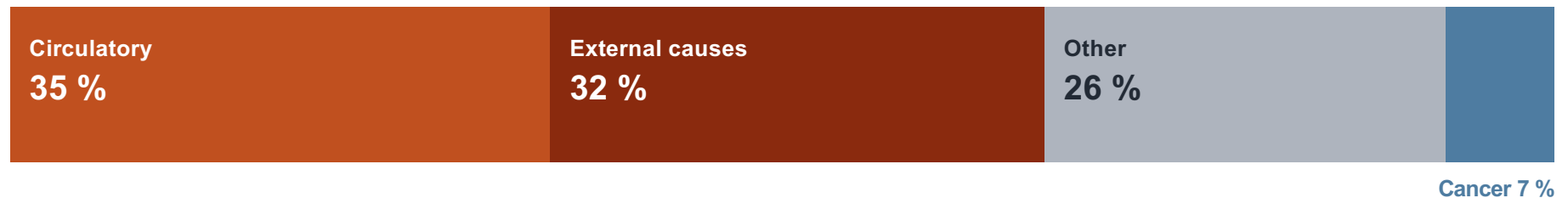
“What do you think explains the differences?”

“Access to doctors, and the quality of care.”

It is the answer often given. Julian Tudor Hart formalised it in 1971 as the inverse care law. In this case it happens to be wrong, and the way it is wrong matters.

What is a gap like this made of?

MEN, THE 5.7-YEAR GAP BETWEEN THE TOP AND BOTTOM LARGE DISTRICTS, 2006-2020



And the students' answer? **Access was fine. Quality no different.**

Source: Joonas Hytti, City of Helsinki / kaupunkitieto.hel.fi, 26 June 2026. Based on the author's master's thesis, University of Helsinki 2025.

The constraint is often outside the chain

2017: TYPE 2 DIABETES CO-PAYMENTS, A NATURAL EXPERIMENT



The WHO now cites the episode as a warning.

Right idea. Missing instruments.

HELSINKI, SINCE 2006: EVERY MAN TURNING 40 INVITED

What it could do

Invite every man in the city, year after year.

Examine those who came: labs, blood pressure, waist, guidance.

What tools of that era could not do

See who did not participate.

Support finding the persons in risk in the non health check related contacts.

Prioritize between patients

Counting participants is easy and often celebrated.

A curable disease, uncured

HEPATITIS C

>95 %

cured by a course of tablets in 8-12 weeks.
The cure is a decade old.

~3 000

estimated active carriers in the capital
region

~120

treated per year, until recently

A curable epidemic, a known cure, and a system curing roughly the number of people it happened to stumble on.

The barrier kept moving



*“The duration or speed of the care pathway is not the main challenge.
Reaching the patient and keeping hold of them is.”*

the field's own project plan

The treatments are ready. The doors are open.

On the shelf today

Atrial fibrillation: one daily anticoagulant, no INR clinic
Blood pressure: once-daily combinations
Cholesterol: effective, cheap, generic
Depression, alcohol, smoking: real treatments, real support

Set against the Helsinki gap

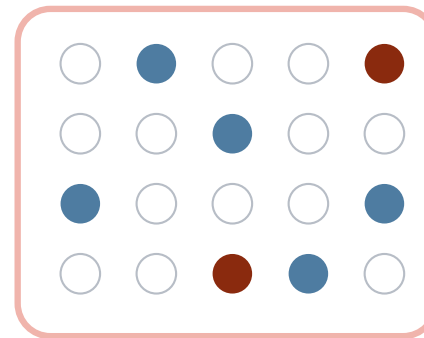
Circulatory causes 35 %
External causes 32 %, alcohol and suicide among them

Easy, effective, at hand. Used far less than they could be. Why?

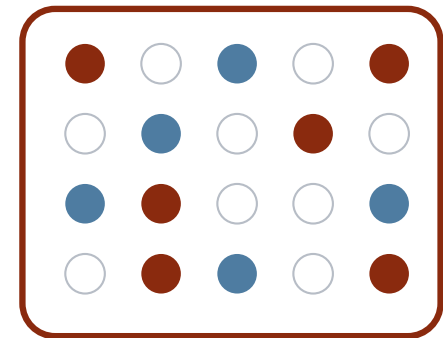
Measure the ones you cannot see. Reach and treat the ones who would benefit.

-  **Poor values, no visits**
highest unclaimed benefit: reach and treat
-  **No recent data at all**
status unknown: measure first
-  **Attending, in care**
not necessarily well; attention flows here

Visit-driven care works this list from the bottom.



Looks fine on average



Looks poor on average

● at risk, does not attend ● attending, in care ○ no recent data

WHAT PREVENTION RUNS ON

Funding

A working chain

The right tools

Who benefits most?

Not a segment. Find the ones your data already knows. Measure the ones it does not.

Who benefits most?

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