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Priority-setting in Finnish healthcare

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Abstract

The characteristics which affect priority setting in the Finnish healthcare system include strong municipal (local) administration, no clear separation between producers and purchasers, a duality in funding, and the potential for physicians in public hospitals to practice in the private sector. This system has its strengths, such as the possibility to effectively co-ordinate social and healthcare services, and a strong incentive to take care of local needs, because of municipal responsibility to finance these services largely through local taxes. However, the municipalities are typically too small to take advantage of these potentials, their knowledge is scarce especially of secondary care and their negotiating power with respect to hospitals is low. Local politicians also have a dual role: they represent the needs of the local population but simultaneously they are decision-makers in hospitals. Full-time physicians are allowed to act in a dual role as well; they can run a private practice, which is paid for on a fee-for-service basis, while the hospital pays (mostly) a fixed monthly salary. The share of financing which flows from the National Sickness Insurance system to healthcare users may have adverse effects on the local use of resources. The broad national consensus statement on patient-level priorities did not reach any general rules on priorities. Strong support was given to citizens' equal right to access all healthcare services. In healthcare practice, this general rule has some exemptions. First, the reimbursement schemes for prescribed drugs vary depending on the severity and chronic nature of the disease. Secondly, the tax-financed dental services for the young are clearly prioritised over those of older citizens. In the consensus statement, emphasis was put on improving the efficiency of producing health services in order to avoid having to impose patient-level priorities. © 1999 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

During the 1990s the Finnish healthcare system has experienced rapid and even dramatic changes. The economy suffered from a deep economic recession which led to extensive unemployment and an abrupt increase in public debt. At the same time, the financing of the healthcare system was thoroughly reformed. Taking into account costly, advanced medical technology and the ageing population as well, the importance of the appropriateness of healthcare choices, or what we may term ‘priorities’ in Finnish healthcare, has grown.

All choices inevitably involve priorities, but in healthcare the principles adopted for prioritising should be applied in practical decision-making. Healthcare priorities are set and applied at several decision-making levels of the healthcare system. Therefore, in this paper we will first focus on the Finnish healthcare system and its financing, and on the major characteristics of this system which influence the actual allocation of resources. In this we attempt to highlight the peculiarities of our system as compared to those of other countries. Some of its structures include incentive patterns which influence the choices made at the patient level. Secondly, we will discuss some prioritisation mechanisms incorporated into the economic incentives of the system. Then, we look at the major officially-manifested principles which are applied in priority-setting for patient-level choices. These will be compared to principles which, according to research findings, the Finnish population feels are right to endorse. Finally, we report on some studies which have looked at the degree of success that these principles have had at the patient level.

2. Who prioritises and at what level?

The Finnish healthcare system includes two main financial mechanisms [1]. The priorities embedded in these mechanisms differ. About 70% of health expenditure is spent on health services provided by local governments, the municipalities. Partly complementary and partly supplementary to the municipal services is the National Health Insurance (NHI) scheme, which reimburses part of the costs accrued by clients who use private health services.

2.1. *Municipal services*

Municipalities are responsible for providing primary and specialised health services for their citizens. Municipal taxes, state subsidies and user charges finance these municipal services. Municipal taxes are not allocated entirely to healthcare but also to other services such as education and social services, including care for the elderly.

Primary healthcare is provided by health centres, which are owned and mostly financed by municipalities. Small municipalities have formed federations in order to run health centres together. Health centres cover a wide range of services, including general healthcare, dental care and occupational healthcare services and preventive

healthcare. Health centres even maintain inpatient wards, which are mostly intended for elderly patients with chronic diseases and with limited needs for specialised care. Twenty-two hospital districts provide specialised care mostly through their own hospitals. Federations of municipalities encompass particular hospital districts. Normally a hospital district owns general and psychiatric hospitals. Municipalities typically purchase hospital services for their inhabitants from their own hospital district. However, since 1993 they have been allowed to purchase these services from other districts or even from private providers.

Regarding municipally-provided health services there is no single fixed budget. Instead, the allocation of resources is defined in the budgets of the central government, of the municipalities and of the producers (e.g. hospital districts). The most important economic decisions are made in 455 municipal councils (elected for 4 years), which make annual decisions about the amounts of money to be devoted to healthcare services. These resources are allocated to primary and specialised care via municipal budgets. Also the resources in different parts of the country devoted to municipal health services are primarily defined in these budgets.

The state subsidies that go to municipal welfare and health services are intended to ensure regional equality. State subsidies are allocated to municipalities according to certain criteria of need (capitation formula). The Parliament annually decides on the total amount of subsidies, which are paid directly to the municipalities. The municipal councils are free to decide on the budget (now including state subsidies) for individual spending programmes such as welfare spending or basic education. The central government gives only general guidelines, and retains only limited monetary steering powers regarding large investments. Because the state subsidy has decreased over recent years, the municipalities have an increased economic responsibility in service provision.

Although, in theory, the municipalities have a central role in priority-setting in specialised care, their role as producers is also crucial. For example, hospital districts mainly make decisions concerning the supply of specialist services. By law, a hospital district is responsible for providing hospital services and co-ordinating the public, specialised hospital care within its area. Each municipality located in the district area is legally obliged to be a member of the hospital district. Typically, at the top of the administrative organisation of a hospital district there is a council whose members are appointed by each municipality; below this, there is a board appointed by the council and below the board there is executive management. Municipalities do not negotiate a formal contract with a hospital district; instead they make an agreement with some hospitals for the provision of certain specialist services. Although, formally, the district council decides the hospital district's annual budget, professional opinion has a strong influence. Budgets and operative plans are usually prepared by leading officials of districts and hospitals, who usually have a medical background.

Under these macro-level constraints and economic incentive structures there is no formal regulation of doctors' clinical choices. However, choices are restricted for patients: in public primary care, the patient cannot choose his or her doctor. In addition, patients cannot choose the hospital where their treatment takes place

because the health centre of the patient's municipality of residence makes the referral decisions.

To conclude, the municipalities are responsible not only for financing healthcare but also for setting healthcare priorities for the services supplied to their citizens. Because the municipalities are administered by elected councils and a considerable proportion of the municipal budget is collected through local income taxes levied by the municipal councils, the system is very democratic. Moreover, because the municipalities are responsible not only for healthcare but also for social care, such as care for the elderly, they have ample opportunity to organise these services in a manner that maximises their efficiency.

2.2. Services covered by the National Health Insurance (NHI)

The NHI covers sickness, maternity and special care allowances for all its members (i.e. all residents of Finland), and a proportion of students' health services, rehabilitation services and medical expenses (including drugs prescribed by a doctor, examinations done by private physicians and treatments performed or prescribed by a doctor, dental care for young adults and transportation). In addition, the NHI covers occupational care provided by employers.

Usually the NHI reimburses a certain percent of costs exceeding a fixed sum (minimum-per-purchase or the so-called basic tariff). Thus it covers only a part of expenses and the patient's share of expenses is higher for private services covered by the NHI than for municipal public services.

There is no official budget for the financing of the NHI. The level of employers' and insured persons' (the population's) contributions are decided annually in the central government's budget. Therefore the amount spent on NHI payments is not fixed. The allocation of NHI resources to different types of care and their regional distribution is based on demand for these services as well as on the reimbursement system. In the NHI scheme, patients may fix an appointment with a private general practitioner or specialist of their own choice.

Thus, prioritisation in the private sector, covered by the NHI, is based on completely different mechanisms than those within municipal services. These systems are separate and independent. However, all physicians, including those working either in public health centres or hospitals, are allowed to run a private practice. In addition, the senior specialists in public hospitals are permitted to take their private patients to public hospitals for hospital treatment. These patients have a higher special charge category (SCC), which means that they pay a higher daily hospitalisation fee plus supplementary fees for the doctor's services and for diagnostic and other services.

Indeed, in most cases, specialised physicians who hold a full-time post in a public hospital also provide private services on a part-time basis. Therefore, as much as one third of consultations with specialists are private, while only about 20% of all consultations are private.

3. Prioritisation mechanisms

User charges can also be seen as a method of explicit prioritisation because in Finland such charges are decided upon, for the most part, by the central government. However, municipalities have a right to choose whether or not to charge for services, and to set the level of these charges up to maximum limits decided upon by the central government. According to law, municipalities must provide services such as preventive healthcare, maternity care, healthcare in schools, psychiatric ambulatory care, immunisations and the examination and treatment of some communicable diseases free of charge. Moreover, it is not permissible to charge for physician consultations if the patient is a child under 15 years of age.

The cost for the patient is greater for NHI-covered private-sector services than for public sector services. Moreover, in the NHI reimbursement scheme there are clear patient-level priorities. The costs of most prescribed drugs are reimbursed only partly and patients have to pay the remainder, but drugs for some diseases, such as blood pressure medications, are classified to qualify for a high or even full reimbursement. This classification changes every now and then, depending on the severity of the condition, the technical development of medicines and the fiscal situation.

Goods and services that are totally excluded from municipal healthcare and NHI subsidies include over-the-counter drugs, spectacles, private examinations and treatments not prescribed by doctors and alternative medicine (e.g. chiropractics). In addition, in Finland there is clear discrimination by age in dental care. There are no public subsidies (not even from the NHI) for dental care for adults born before the year 1956. Exemptions to this apply to Second World War veterans and patients suffering from chronic diseases.

In the Finnish healthcare system physicians cannot be considered to be gatekeepers, although a patient is expected to have a referral from a health centre physician for specialised (non-emergency) hospital care. A considerable proportion of referrals originates from the private sector. Since many specialists who work in public hospitals also have private practices, they can also refer their own private patients for public hospital care.

Since the 1960s the central government, medical associations and regional health authorities have published numerous consensus statements, clinical practice guidelines and national or regional treatment programmes. Nowadays 'evidence-based medicine' is receiving much attention in Finland. At present, a number of guidelines exist and several new ones are under development. Their scientific quality varies greatly. As in other countries, the vast majority of Finnish healthcare guidelines include no cost-effectiveness information. A major study has been launched to assess the most efficient way of implementing the new guidelines [2].

4. Criteria for priorities

As mentioned above, the Finnish healthcare system is universal, offering a wide

variety of services to all citizens. The principle of equity is manifest in almost all health policy documents created since the 1960s [3]. Moreover, according to the 1998 Eurobarometer survey, the population firmly supports the present public healthcare system [4]. Indeed, even though the general public has never widely supported private production as an alternative to these services, during and after the economic recession of the early 1990s the use of privately provided welfare and health services lost support even further as a potential alternative to the public system [5].

However, already at the beginning of the economic recession in the early 1990s, it was quite clear that public funding for healthcare had to be reduced. Moreover, many countries were in the process of reforming or had reformed their healthcare systems. These reforms, such as the Medicaid priority list (in Oregon, USA) or the basic service packages (in The Netherlands) included elements of patient or service selection. As a result, discussions and debates on healthcare priorities emerged for the first time among Finnish healthcare professionals and researchers.

The most active participants in these discussions were physicians and other healthcare workers: there was only scarce input from politicians or elected representatives. This discussion was partly carried out in the media, reflecting its public interest. The conclusion was that prioritisation was considered desirable, even imperative. However, there were concerns about the fair distribution of health services to those in need.

In 1993 the most prominent Finnish institutions in medical science, and in healthcare research and development (the Academy of Finland, the Finnish Medical Society Duodecim and the National Research and Development Centre for Welfare and Health) held a consensus meeting on priority-setting in healthcare. The meeting was a reflection partly of the prior discussion and debate among healthcare professionals and in the media, and partly a reflection of a foreseeable widening gap between the population's needs, the increasing costs of advancing medical treatment and even tighter resource constraints.

In the consensus statement much emphasis was given to measures which could assist in avoiding choices at the patient level [6]. Indeed, one of the main conclusions was that if effective healthcare is provided using the most productive means of organisation, no priorities are needed; all patients and diseases can be treated.

However, the consensus stated that if choices must be made, the crucial principles involve the dignity, autonomy, equality and equity of the patients. In addition, each patient must receive the examinations, effective care and pain relief he or she needs. Finally, when decisions about resources are made, the overall effects they have on the health of the population (in addition to the structure and quality of services) must be assessed [6].

The consensus statement strongly opposed age, gender and lifestyle as sole criteria for patient selection. However, it stressed that attention must be paid to a

patient's expected health gains, which might be influenced by age or life habits. For example, the prognosis of a heavy smoker might be worse than that of a non-smoker under similar conditions. The prognosis, but not smoking as such, should influence choices [6].

To conclude, the consensus statement paid the most attention to the removal of inefficiencies from the system. Regarding patient-level choices, equity was considered to be the most important criterion. This is the natural conclusion in an egalitarian welfare system, where all citizens are regarded as equals for access to all public services, independent of demographic or socio-economic factors or geographical area of living.

Despite the consensus statement or other general principles, in a study on doctors' attitudes on clinical treatment choices it was found that a patient's old age, residence in an institution (compared to those living at home) and unhealthy habits (e.g. smoking) were inversely related to doctors' willingness to refer the patients for elective surgical procedures [7]. A similar result was obtained in a study on practical choices in a hospital: younger patients received much more intensive treatment compared to older ones with a similar life-threatening condition [8].

It has been reported that socio-economic factors also cause variations in hospital use: although admission rates are similar in high and low socio-economic groups, the treatments vary [3]. For example, the rate of heart surgery is lower among patients in the lower socio-economic classes than among those in the higher classes, even though those in the lower classes have greater (medical) need [3].

Because the applied universality principle allows hardly any exclusion criteria, the basic means for rationing services are waiting lists. In Finland there are no general rules on how to rationalise waiting lists. On average, waiting times for elective surgery are rather long, but large regional variation exists, indicating practice-style variations between clinics. For example, the average waiting time for total hip replacement surgery varies between hospitals from 1 to 18 months. In addition, doctor's private patients in the SCC have, in general, shorter waiting times compared to patients in the regular charge category [3].

A few years ago, the Ministry of Social Affairs and Health suggested that hospitals should pay attention to the length of waiting times. Consequently, three (out of 22) hospital districts launched development projects, including volume and time limits for waiting lists (e.g. the goal that 75% of patients on the waiting list should be treated within 3 weeks). One of these projects managed to reduce waiting lists in some clinical specialisations, while two of the three projects failed to reduce the waiting lists in any specialisation [9]. However, these 'care guarantees' are still at the experimental stage and no standards have emerged. Aside from exerting strong moral pressure to reduce waiting times for primary and specialised care, the central government has no real means of enforcing local providers to act accordingly.

Public healthcare covers almost all diseases and treatments; only some cosmetic operations are not covered. The consensus statement put forward the idea (adopted from The Netherlands) of a minimum basic service package which should be guaranteed to all citizens in all circumstances but no suggestion was made that such a package should be designed or adopted.

Also the question as to what should be included in such a package remained unresolved. At present, the content of the package depends on the municipalities, which have relatively broad freedom to choose what or to what extent services are available to their citizens, especially with regard to elective procedures. The central government has very limited possibilities to influence these decisions. At present we have only limited evidence on the consequences of this municipal freedom for citizens' right to have access to similar public services.

Priority-setting at the macro-level was analysed in a survey in which members of the adult population (aged 25–79 years) were asked whether they thought that their municipality should spend more or less on health services than before [10]. Before being asked this question, information on their own municipality's healthcare spending compared to that of other municipalities was given to the respondents. About 60% of adults preferred the current level of spending, 4% preferred decreases and 20% preferred increases in expenditure. Women, low-income respondents and those living in low-cost municipalities showed a higher willingness to increase spending. Of those who wanted to increase spending, 11% were willing to increase local taxes, 32% to increase user charges and 40% to cut other public services. Among the last group, cutting public funding for cultural, sport or leisure activities was the most popular suggestion for financing healthcare services.

Public discussion has been focussed firstly on the services that could be excluded from universal healthcare coverage. A survey on healthcare cuts found that for primary care, all studied population groups showed the greatest willingness to cut expenditure on health education, occupational health services, hygiene inspection, substance abuse care, rehabilitation of war veterans and family planning services [11]. There were minor variations in attitudes between nurses, doctors, local politicians and the general public. In general, nurses and the general public showed the least willingness to accept any cuts, while doctors and politicians had quite similar (and greater) willingness to reduce expenditure. Unfortunately this survey did not ask the respondent to assess some hospital services in a similar way.

5. Incentives

In recent health economists' discussions the questions on priority-setting have been connected to problems of incentive structures embedded in healthcare systems. This relates to the fact that not only do some norms or guidelines affect the decision-makers' behaviour, but also economic or other incentives affect their behaviour as well. Some structural factors may encourage cost-effective or efficient or equitable allocation, while some prevent it.

There are some examples in Finland of such economic incentives. At present, the hospitals are free to set prices for their services. A recent trend among hospitals is the delegation of administrative and financial power and accountability to clinical units (e.g. for specialities and support services such as radiology and laboratory services). The revenues of these units are based on the services produced. This so-called 'management by objectives' means that clinical units have economic

incentives to produce those services that yield the largest revenues. This, in practice, has a considerable effect on the utilisation of services and may result in an allocation of resources which is based on what brings the highest income to the hospital rather than on the population's needs. So far, we have no information about the effects of such new management systems.

In private primary care, the NSI covers part of patients' expenses, including consultation and diagnostic tests. In particular, the reimbursement scheme is very liberal with regard to laboratory tests, guaranteeing considerable profits. This has resulted in a notable excess of laboratory services [12].

More generally, the fact that public funding comes from several sources may result in inefficiencies in resource allocation. In addition to the incentives created by the NHI scheme, a considerable amount of capital investment in healthcare is financed from the profits of the Finnish Slot Machine Association (FSMA). The FSMA is a government-owned monopoly for organising betting and slot game services. Its revenues are distributed to voluntary health and welfare organisations in order to support their service production and other activities. Public funding from the NHI and the FSMA does not affect the state subsidies given to municipalities. Therefore, the municipal decision-makers have incentives to make choices that minimise their own expenditure but not total expenditure.

Some local health policy actions have been aimed at taking advantage of economic and other incentives. Several municipal health centres have adopted a system where, in addition to a basic salary (on average 60% of total wages), doctors receive a capitation payment (20%) on the basis of the number of listed patients (adjusted for age and some other factors). Moreover, these doctors receive service fees (15%) and some local allowances. This system is intended to create a more durable relationship between patients and doctors. It is thought that this reduces the number of visits to general practitioners and generates for physicians an incentive to engage in preventive medicine. The study reports have, however, failed to show any consequent reduction in primary or secondary healthcare use. On the contrary, this system seems to increase the use of municipal healthcare services [13].

6. Conclusions

The special features affecting priority-setting in the Finnish healthcare system include strong local administration, no clear separation of producers and purchasers, duality in healthcare funding and the potential for physicians in public hospitals to practise in the private sector. The decentralised system has its strengths, such as the possibility effectively to co-ordinate social and healthcare services and a strong incentive to take care of local needs, not least because of the municipal responsibility to finance these services to a large extent through local taxes.

However, local independence has its drawbacks. The municipalities are typically too small to take advantage of economies of scale, their knowledge is scarce (especially with regard to secondary healthcare) and their negotiating power with hospitals is low. Moreover, regional policy rather than economic rationality influ-

ences healthcare choices. Because the municipalities also own healthcare producers, the local politicians have a dual role: they represent the needs of the local population, but at the same time, many of them are decision-makers in hospitals. A somewhat similar dual role is possible also for the full-time physicians who work in public hospitals: they are allowed to run private practices. The private practice is paid for on a fee-for-service basis while the hospital pays a (mostly fixed) monthly salary; the consequent incentive pattern also influences resource allocation.

The share of health and social care financing which flows from the NSI to healthcare users may have adverse effects on the local use of resources, especially concerning priorities in the local care of elderly patients. There is strong evidence that dual funding has generated a considerable excess capacity in laboratory services.

The deep economic recession that Finland experienced at the beginning of this decade has influenced priorities through two separate mechanisms. Firstly, it made it possible to conduct rapid and deep structural changes in the welfare system without strong opposition from the population. However, by and large, this resulted in a reduction in psychiatric hospital services only. Secondly, it was necessary to develop new mechanisms to manage healthcare. New systems, such as management by objectives, internal markets and new pricing mechanisms, were adopted into everyday use.

The national consensus statement took a low profile on patient-level priorities. The result is that there are no general rules on priorities, and strong support is given to citizens' equal rights to access all healthcare services. However, this general rule has some important exceptions. First, the reimbursement schemes for prescribed drugs vary depending on the severity and chronic nature of the disease. Secondly, tax-financed dental services for the young are clearly prioritised over those for older citizens. Moreover, the SCC system quite obviously creates allocation incentives and inequalities between patients: those who are in SCC tend to have shorter waiting times for surgery and other treatments.

Much effort has been put into improving the efficiency of health service production in order to avoid patient-level prioritisation. Indeed, this has been a successful endeavour but because wages and other costs have increased, resource allocation problems still prevail. Therefore, a second round of public discussion concerning priorities is emerging at present.

In addition to a lack of principles on healthcare priorities, Finland lacks research on priorities. There are a few finished population surveys on these issues, but these elucidate public opinions on priorities rather than the population's perceptions of choices made in conditions of scarcity. Moreover, these surveys are difficult to interpret from an economic and decision-making point of view. Are respondents expressing their attitudes on the needs of the population, on their own preferences concerning the compared services, on the citizen's right to have access to these services or on some other decision-making criteria? More research is needed to assess public perceptions of healthcare choices which are made when resources are scarce.

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