

Cutting Oneself on Too Sharp an Administrative Knife: Problems of Implementation in Finnish Health Care Planning

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Introduction

It has often been observed that Finnish politics changed profoundly around the mid-sixties. In the parliamentary elections in 1966, the socialist parties obtained a majority of seats. They also won a majority in the cabinet that was formed after the election. During the decade that followed, many large reforms were carried through, especially within the area of general welfare policies. Although many of the reforms had been put on the agenda before this election they did not mature until the late sixties and early seventies (Vartola, 1978).

In retrospect it seems possible to underline two guiding elements in the welfare reforms: *equality* and *administrative centralization*. The unequal access to public services across classes and regions was perceived as a major problem, and central governmental intervention was regarded as a means of equalization. The public health care reform of 1972 probably grew out of many other concerns as well, but it nevertheless seems appropriate to consider the reform a typical child of that welfare reform era (Ahlbäck, 1978).

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In this paper I shall limit myself to consider some *administrative* aspects of the public health care reform. I shall discuss administrative aspects of the reform that, as I see it, created considerable difficulties in the administrative implementation of the newly created system. Since the administrative aspect of the reform pertains mainly to the new planning system engendered, I shall first discuss a planning theoretical frame for interpreting the administrative problems of implementation. Following a short description of the reform itself, I shall discuss some crude indicators of how the new planning system works from an administrative point of view. Finally, I shall consider whether it is likely that the subsequent attempts that have been made to alleviate the problems I am discussing will be successful or not.

Although I start out by formulating some hypotheses as to how the health planning system is likely to perform from an administrative point of view, I want to advance a more disarming ambition than that of striving for causal explanations. All I hope to achieve is to suggest a reasonable framework for interpreting the difficulties that the health planning system has run into.

Technical Intentions in a Political World: Toward Some Hypotheses

An important administrative element in the public health care reform was the creation of a public health care planning system. In order to give a general interpretation of what that planning system is like, we need to ask what planning is in general and what types of planning exist.¹

The controversies surrounding planning often touch upon either of two questions: Should we plan at all and if yes, how should we plan. It therefore seems appropriate to define planning in a very general fashion and then to distinguish between different types of planning. In this vein, planning to me suggests a particular type of decision-making process. This process is characterized by coordinative and visionary ambitions. That is, *planning is defined as a decision-making process within which many decisions are prepared simultaneously (the coordinative ambition) with regard to their consequences in a long-term perspective (the visionary ambition)*. Thus planning can be distinguished from decision-making processes concerning investments (few decisions, long-term perspective) and from budgetary processes (many decisions, short-term perspective).

Needless to say, this general definition of planning does not tell us how planning should be carried out. In order to make such decisions, we need

to have a typology of planning. It seems to me that one crucial administrative aspect of planning is the extent to which it is *formalized*. We can take the view that planning is programmable, that is, we can a priori determine who is doing what, when, and how. This is the bureaucratic view on planning. We can, on the other hand, hold that planning is a complicated bargaining process which is difficult and unnecessary to program in any detail, thus permitting the process to be flexible and adjustable to the forces in it. This is the political view on planning.

Regardless of the view we hold as to how formalized planning ought to be, we can also hold divergent views as to *how dependent we are* on conditions outside the planning system. We may think that we are fairly independent, i.e. that we can, if need be, include outside conditions as manipulable in our planning. We may hold such a view either because it corresponds to our real power or just because we think, perhaps wrongly, that we have such a power or that we can get it. Relative independence means that we have few givens and that we must choose among alternative goals as well as means.

Contrary to the view above, we may hold that we are fairly dependent on conditions that we cannot determine within our planning system. The view of dependency leads us to adjust to given outside conditions.

According to these views on the planning venture, we can suggest a typology of planning:

The degree of formalization is:	The dependency of the planning organization is perceived to be:	
	high	low
high	Trend-planning	Technical planning
low	Corporative planning	Political planning

I am not here going to dwell upon the characteristics of these four types of planning (Ståhlberg, 1978, a). Rather I want to point out that the various types of planning can be used in two different ways. Firstly, the typology can be seen as an enumeration of planning *intentions*. Thus we may say

that planners or the planning organization strive for one or the other of these planning types. The types are seen to represent descriptions of ambitions.

We may, secondly, see the typology as representing four ideal types of planning that actually exist. This is the *causal* view, in that we may then inquire into the conditions that bring these ideal types of planning about.

It seems to me, as I already suggested, that the causal and the intentional aspects of planning may not point in the same direction. The conditions surrounding the planning organization may well favor one type of planning, even if the planners strive for another type. In fact my argument is that the public health care planning is characterized by *technical intentions* in a *political world* (see also, Isaksson, 1980).

In a causal sense, technical planning, I assume, is brought about under conditions of *centralization* and *real relative independence* of the planning organization from its environment. If, on the other hand, the planning system is *not totally centralized*, but is fairly independent, I expect political planning to arise. I argue that the public health planners strive for technical planning within a system that would seem to favor political planning. The conflict between intentions and causes thus seems to center around the administrative dimension of formalization, which was the dimension in which I defined political and technical planning.

I shall advance two hypotheses as to the consequences of formalizing planning under the condition of a conflict between planning aspirations and causes of planning. The first assumption I call *the hypothesis of bureaucratic inertia*. If the planners strive for technical planning they try to program the planning in every detail. They also, presumably, choose a rationalistic approach to planning, asking for goals and analyzing alternative means. If the planning organization or the system is not centralized, that is, if there exist a large number of participants in the system that are not wholly commanded by the power center, there will be considerable difficulties in carrying out the planning program. In other words:

Attempts at technical planning under conditions that favor political planning causes bureaucratic inertia.

The second assumption will be called *the hypothesis of the vicious bureaucratic circle*. The technical planning aspiration assumes that planning can be programmed, but it *also* assumes that the planning organization is fairly independent on outside conditions. Even if this second assumption may at times be correct, we can safely suppose that at times it

may not hold true. If, in reality, relative independence does not exist and if the planning system is not sufficiently centralized, we have said that the conditions tend to favor corporative planning, characterized as non-formalized and dependent in its ambition. If we try to formalize planning under these conditions, we create a non-redundant administrative system. This very formalization makes for further bureaucratic inertia as soon as we have to adjust ourselves to some environmental change that we falsely assumed we could control. Our ambition to control the environment leads us into creating rigid organizations that make this control more difficult, in that we are forced to use our resources on the bureaucratic inertia we have caused. In other words:

If, by technical planning, we strive to bring stability into an instable world, the very formalizing ambition causes self-defeating bureaucratic inertia.

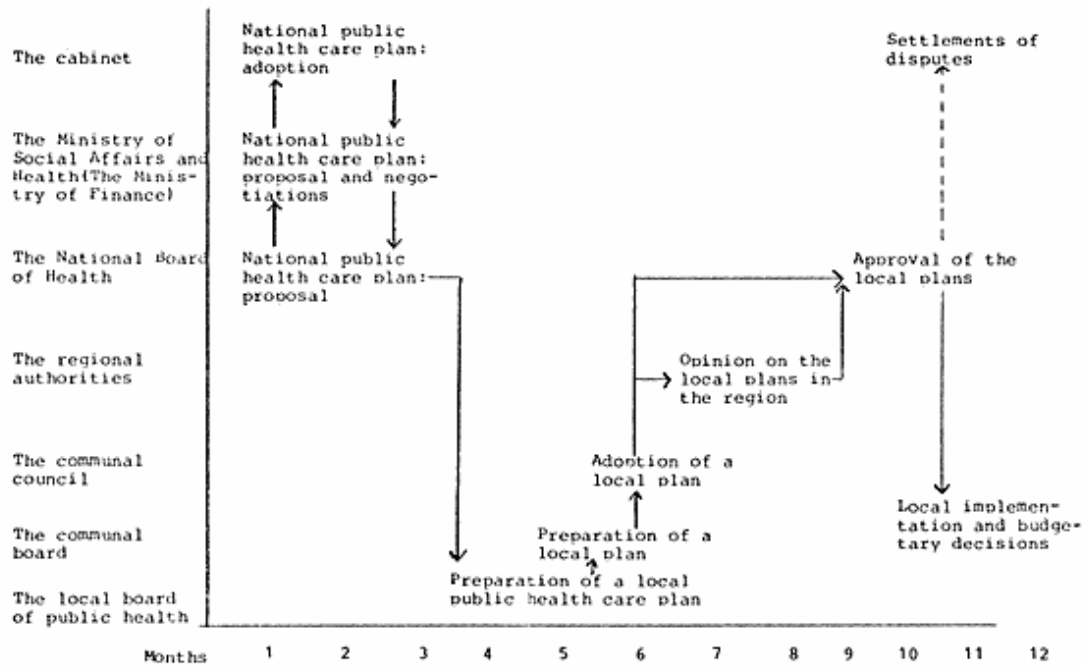
It is my intention to try to illustrate these hypotheses in the light of some empirical observations on the administrative aspect of the Finnish public health care planning system. In order to do that I must, however, first turn to a short presentation of the public health care reform.

The Planning System Created by the Public Health Care Reform in Finland in 1972

The public health care act was passed in 1972 and regulates the public health care services mainly at the local level (Ahlbäck, 1978). One of the main reasons for passing this act was the heavy emphasis that had earlier been put on hospital services. The new act aimed at shifting the focus of these services to the open care sector which has traditionally been a function at the local level.

The public health care act can be seen as an act regulating the *financial* and *administrative* relations between the local governmental sector and the state. On the financial side it was decided that the state would participate in the financing of primary public health care services. This financial participation is redistributive in nature, that is, those local governmental units, communes, that are well-to-do receive less support than poor communes. The state pays between 39–70% of the local expenses depending on the wealth of the local unit. The financial system is very complex in nature and I shall not concern myself with this side of the reform.

Figure 1. The public health care planning process in Finland 1972-78



The state, however, rarely pays out without strings attached. In order to receive state support, the local governmental units must abide by the administrative stipulations in the act. At the local level all public health care activities are gathered under one umbrella called the public health care center. This center thus provides public health care in the schools, dental care, ambulance services, health care for students, the local primary level hospital, different types of open care, and health information. The content of these services is not stipulated in the act, it merely empowers the National Board of Health to issue directives as to how the health care centers ought to organize their services. In this sense the public health care act provides a frame only for the production of services, it does not directly bear upon the material content of those services.

The public health care center can be organized by one commune alone or by several communes that form a union. It was hoped that the population base for a center would be at least 10,000, although no binding stipulations were made. Today there exist roughly 200 health care centers, about half of which are administered by one commune alone.

The most important aspect of the new act is the creation of a public health care planning system. This is a multi-level sectoral planning system which ties together the state, the regional authorities, and the local governmental units. In order to receive financial support the communes must have a five-year plan for the public health services which has been ap-

proved by the National Board of Health (today this planning system has been changed and approval of the plans is to be given by the regional authorities. I shall turn to this reform in the final part of the paper – here I will deal with the system as it operated 1972–1978). In order to present the planning system I will give an idealized version of how the system was administratively supposed to work. This is done in Figure 1 opposite.

The planning process can be described stepwise as follows:

1. The preparation and adoption of a National public health care plan

The National Board of Health prepares a national plan that contains two parts, one for the hospital sector and one for the public health care according to the public health care act. I am here concerned only with the second part of the national plan. This plan is adopted by the Cabinet in February and is presented to the Cabinet by the Ministry of Social Affairs and Health. Before submitting the plan to the Cabinet, the ministry has to negotiate with the Ministry of Finance as to the economic consequences of the plan proposal. The national plan is published in the format of an act.

The plan lists the goals that are to be achieved during the next five years. These goals are very general in nature and it is hence difficult to ascribe any clear steering capacity to the goals. They seem to represent more of a superstructure than real guidelines.

The main services are dealt with separately in the plan, and the main functional solutions to be used over the five year period are enumerated. This enumeration is more concrete than the formal goals, but it can be said that it leaves many interpretative possibilities open.

The most important part of the plan concerns resources. The plan contains a listing of the number and type of personnel that may be employed during the period of the plan. It also contains the maximum amount of state support that can be given to the building of new local hospitals or other local health care facilities. Establishing the general resource frames for health care activities thus seems to be the number one function of the national plan.

2. Planning directives to the local public health care centers and the local governmental units

The National Board of Health interprets the adopted national plan and gives directives to the communes. In these directives the resource frame given in the national plan is regionalized. They also contain forms that must be used in the local planning. All plans are thus standardized. In the beginning these forms contained about 60 tables that had to be filled with

data about the local health care activities. Most of the tables had to be filled with data not only for the next year but regarding the whole five year period of the plan, year by year. And the directives contain in many cases very detailed instructions as to how the tables are to be filled. These instructions often set norms as to how many persons form the bases for the specific activity or as to how the proportion of different services ought to be planned in relation to each other (i. e. how many visits to a doctor corresponds to a certain number of visits to a nurse).

The directives also refer to additional standing directives that have been issued by the National Board of Health. They are sent to the local governments sometime in April (usually about one month or so late).

3. The preparation of local governmental public health care plans

The local governmental units have one or two months to prepare their plans. This work starts in the local board of public health, which is a board composed of laymen. The board submits the plan proposal to the communal board which in turn submits its proposal to the communal council. If the health care center is administered by a union of communes, the process is more complicated. From the health board of the union the plan proposal is submitted to the union board. It is then sent to the board of the member communes, and from these to the councils in the member communes. Then the plan proposal again is considered by the union board and submitted to the union council for final local approval (Ståhlberg, 1977).

The local plan is prepared in accordance with the national plan and the directives issued by the National Board of Health. The plan is further based on information about local services during the preceding year. These data have been sent about one month earlier to the National Board of Health which requires the communes to submit these details to the Board. The plan had originally to be submitted by the end of June to the National Board of Health and to the regional authorities. Later, during the period we are here dealing with, the plan had to be submitted by the end of May. It is hardly necessary to point out that the communes are given very little time indeed to prepare their plan proposals, especially if the communes wait for the state directives before they start preparing their plans.

4. Submitting the local public health care plan to the regional authorities and to the National Board of Health

The local plans are simultaneously sent to the regional authorities and to the National Board of Health. The Board requires the regional authorities to consider the local plans within their areas and to put the local requests in

order of preference within the framework of the national plan given to the regional authorities and the directives issued by the Board. Before submitting its considered opinion to the National Board of Health, the regional authority receives a report from a regional public health advisory board. The regional authorities are expected to submit their opinion by the end of August.

At the central level, the preparatory work starts after the local plans have been received, but the final decisions on the plans are not taken until the regional authorities have submitted their opinions. The consideration given to the local plans in the National Board of Health is very detailed. Primarily the plans are examined as to their legal effect and to the extent that they fit the policies in the national plan. A local plan that does not fit into the guidelines in the national plan will not be approved.

The National Board of Health must either approve or refuse approval of the local plans. It cannot change the plans. It was, perhaps, originally thought that the local plans as a rule would be approved by the Board. This, as we shall see, happens very rarely indeed. If the plan is not approved, it is sent back to the local governments which must then consider the plan anew, using the same procedure as they used in preparing the original plan. In this situation the local governments either abide by the wishes expressed by the National Board of Health when it refused approval, or they maintain their original position. In the latter case the dispute between the local government and the National Board of Health is settled by the Cabinet. There have not been many instances in which the local governmental units have challenged the opinion of the National Board of Health.

The National Board of Health ought to approve the local plans in November or early December (preferably even earlier, but that is for purely administrative reasons almost impossible). If the communes get the final approval by the end of November they still have at least theoretically a chance to take the approval into consideration as they approve the local budget. This is what is supposed to happen since the local units are expected to do what has been included in the plan, and no more. The communes cannot get state funds for activities that the state has not approved in the plan. At the latest, therefore, the local plans must be approved before the first year in the plan begins.²

* *

To this general description of the planning system I am going to tie some empirical observations. First, however, we may ask about the general

goals in this reform or about the principles that were used when the system was created (Ahlbäck, 1978). In the reports of the governmental commissions that prepared the reform and in the governmental proposal we can find several general principles. I shall only note some of them. Administratively the reform was seen as a centralization of the public health care sector. This centralization means that the central government is given a more prominent role in developing public health care services. The role of the National Board of Health is more important than before. If we note that communes cooperate in unions in maintaining the health care centers, we can also say that the public health care system has been geographically centralized.

The principle of planning is an additional administrative principle in the reform, one which has centralizing implications as well. An important principle underlying the planning system is that of an equal provision of services. All persons, regardless of residence and wealth, ought to be given about the same health care services. The planning system is seen as perhaps the main instrument in furthering this principle of equality. So are the financial aspects of the reform, especially the redistributive nature of the state support for the communes and the health care centers. Another financial aspect is the principle of free services. All local health care services are not totally free, but the fees are nominal rather than real for most of the services. And it is a goal for the system that all services should be free as soon as the funds can be found for that purpose (as of this moment some opposition has arisen against totally free services).

The reform also, hard as it may be to believe, tried to create a flexible system. The principle of flexibility seems to mean that the communes no longer have to submit single service proposals to be approved by the National Board of Health. Now most of these approvals are given by the approval of the local plan. There are, however, some very notable exceptions to this rule. Large investments must be planned not only once but several times before the communes are entitled to state funds. This iterative part of the system makes for an administrative mess that I shall not touch upon in this paper.

One final point has to be made. The public health care planning system is only one part of the complex set of ties between the local governments and the state. The system is an a priori control device. The state also, as I mentioned, has an additional a posteriori control device in the work accounts that must be submitted to the National Board of Health by the local governments. Only after these accounts have been given will the final decision be made on what activities should be partly financed by the state.

The Bureaucratic Inertia: Hypothesis 1

According to my first assumption, bureaucratic inertia is seen as a consequence of a conflict between technical planning ambitions and a reality which favors political planning. In the preceding section I have tried to advance the view that the planning ambition is indeed technical. We have also found that the system is quite large and that it encompasses more than 200 health care centers. In addition, 12 regional authorities are involved in the system. Especially the communes have traditionally enjoyed at least a certain amount of self-rule. Thus it seems that there are many competing actors involved. This can be seen as an indicator that the system is not as centralized as it ought to be in order to succeed in its ambition to have formalized planning. The question is whether such a centralization would be at all possible to achieve. In any case, it seems the system has been designed to match technical ideals in a rather competitive political world.

The assumption then is that the Finnish public health care planning system ought to show considerable bureaucratic inertia. This inertia was probably bigger as the system was introduced, but I expect it to remain considerable because of the conflict between ideals and reality of planning. Even if the initial implementation difficulties can be overcome, I expect considerable difficulties to be impossible to overcome due to the design of the planning system.

In order to find simple empirical measures of the bureaucratic inertia we have looked at the planning process and tried to see whether the process fits the ideal process with regard to the time-table of the actual planning experience. All communes or unions of communes that prepared plans for the years 1974–78, 1976–80, and 1978–82 were observed by taking data out of the diary kept by the National Board of Health. In this diary is recorded the date when the communes have submitted their plans for approval, when the first decision has been taken by the National Board of Health, when the communes have resubmitted their plans and when the final approval has been given by the Board.

The total number of health care centers are given below with information about the number of missing observations:

	number of centers	missing observations
1974–78	244	27
1976–80	221	18
1978–82	218	6

Above is reported the maximum amount of missing observations. For some specific measure that I give the average may have been computed on some of the missing communes also. The number of missing observations is interesting in that it may be seen as a measure of the difficulties encountered by the National Board of Health in the early implementation phase of the new planning system. In interpreting the numbers it is important to note that I have not included the first or in some cases even the second plan in this report. The planning system came into effect by April of 1972 and in most cases the first plan was made for the years 1973–77.

Two general observations can immediately be made. First, we found that each year only one or two local plans were approved after the first plan submission. The rule, practically without exception, is that the plans are sent back once to the local governments. In discussing hypothesis 2, I shall return to this question about the iterative nature of the first planning round.

Secondly, we found that only very rarely do the local governments fight the National Board of Health. During the first round that we observed not one commune fought the Board. During the second round the number was 3 and in the third round 4 communes caused the plan to be sent to the Cabinet for settlement. Thus, by and large we may say that the communes seem to be 'afraid' to challenge the Board, even if their courage seems slowly to be building up.

What, then, has been the time-table during the planning processes we have observed for the large majority of all the communes? In the following table we have computed the average time per commune that has been used for different sequences of the planning processes.

The results show many interesting features in the planning system. First, bureaucratic inertia indeed seems to be large. During the last planning round the total time it takes to get a plan finally approved has slightly increased in relation to the first round we have reported on. By and large it has not been possible to approve the local plans in less time than a year. I shall return to this result later.

From column one, secondly, we find that the first part of dealing with the plans in the National Board of Health has taken slightly less time during the last round of planning than during the two preceding rounds we have investigated. But we are still talking about half a year to make the first decision that the local plans cannot be approved. Still we can probably infer that some routinization has indeed occurred at the central level. But it has not been possible to do away with bureaucratic inertia.

Thirdly, we find that the intermediate phases of the planning process

Table 1. The average time in months per commune that has elapsed for some parts of three planning processes in Finnish public health care planning.

Plan 1974-78	1	2	3	4
Communes	10.1	3.5	1.6	13.3
Unions of communes	6.9	3.3	0.7	8.9
Plan 1976-80				
Communes	9.7	2.7	2.1	15.8
Unions of communes	8.9	3.2	2.3	14.7
Plan 1978-82				
Communes	5.8	3.4	2.1	11.5
Unions of Communes	6.4	4.3	2.0	13.2

- Key: 1. The average time per commune in months elapsed from first submission of plan to the denial of approval by the National Board of Health
 2. The average time elapsed after the denial in 1 to the resubmission of the plan by the communes
 3. The average time elapsed after the resubmission to the final approval by the National Board of Health
 4. The average time elapsed from first submission to the final approval

have remained fairly constant as to the time they take. Thus, the National Board of Health seems to need about two months to see whether the local governments have abided by the Board's view after sending the local plans back. The local units also need 3-4 months to reconsider their plans. This time to reconsider even seems to have grown slightly, which could be an indication of the local governments being more prone to consider challenging the National Board of Health. However, since the increase in this respect seems to have occurred among the unions of communes, it seems more likely that there have simply been difficulties in getting all the required laymen-meetings held.

It is, fourthly, interesting to note that with the slight exception noted above, it does not take longer to reprocess the plans among unions of communes than among single communes. This is surprising because the number of meetings that must be held in the unions of communes are several times larger than the number of meetings that must be held in a single commune. I would interpret this result as an indication that circulating the plans in the member communes does not seem to affect the

plans very much. If circulation were to lead to changes in the plans, time consuming negotiations must be held, and this, according to our results, does not seem to be the case.

In Table 1, I have not taken into consideration the actual date of the plan submission from the local governments or the date of the final decision in relation to the ideal version of the planning process. This is to some extent done in Table 2.

We might almost have expected the result in Table 2 after having seen the results in Table 1. Still it is worth emphasizing that not once during the three planning rounds has the National Board of Health given its final approval to the communes in time, that is before the first year of the plan starts. Thus all through the years there have existed considerable difficulties for the local governmental units to adopt a correct budget for their next year.

We may separately note that for the years 1974–78 35 communes, 1976–80 45 communes, and 1978–80 14 communes obtained their final plan approval more than one year after the first year in the plan.

From a purely judicial and technical view alone these results indicate problems. In the Public Health Care Act it is stated that state support is not given for expenses that have been caused by services that have not been approved by the National Board of Health as it decides on the local plans. It is even stated that the Board can withdraw state support altogether if the

Table 2. The extent to which the local governmental units and the National Board of Health succeed in keeping the time-table required by the public health care planning system. (Absolute number of communes and unions of communes)

The local units submit their pro- posals:	The National Board of Health approves plans from:			
	communes		unions of communes	
	in time	late	in time	late
1974–78				
in time	–	104	–	55
late	–	26	–	34
1976–80				
in time	–	91	–	93
late	–	12	–	14
1978–82				
in time	–	96	–	101
late	–	9	–	7

local governments do not abide by the approved plan (Public Health Care Act, 66/1972). But how are the local governments to follow a plan that has not been approved? Either they do what they did before, which is usually to do too little, or they do what they suggest doing in their plan proposal, which is usually too much. In either case the local governments lose. Needless to say, the state has not been too eager to enforce these stipulations.

Table 2 also shows that the communes indeed seem to learn, since they are increasingly keeping the time-table on their part. It should, however, be noted that I have been slightly generous toward the communes in that I have allowed the 'in time' period to go all the way to the end of August, even if the communes ought to submit their plans by the end of June or, as it was during the later periods, by the end of May. The reason for this judgement has been the routines in the National Board of Health that start with the final consideration of the plans in September. Also the regional authorities are supposed to give their views before this phase of the work really starts. Therefore it is reasonable to assume that the National Board of Health still has plenty of time to process the local plans even if some of them are submitted during the summer.

The Inbuilt Bureaucratic Inertia: Hypothesis 2

According to the hypothesis about the vicious bureaucratic circle, the planning system might in reality not be as independent from its surroundings as is assumed by the level of technical ambition. If under conditions of environmental uncertainty the planning is formalized it is likely that the formalization itself becomes self-defeating. If the planning system is complex, as is the case in the Finnish multi-level system, we have all the more reasons to expect self-defeating formalization.

Unfortunately I do not have direct data to bear on this hypothesis. Therefore I must use an indirect strategy which starts from an illustration of the dependency that in fact the planning system has on its environment. I shall use a very simple measure of this dependency, namely the changes that have been made in the projected resource base in the national plans, those plans adopted yearly by the Cabinet as the base for the local planning. As I said earlier, the national plan contains the resource frame for the next five years. Naturally all five years are not of equal importance in the plan. We could say that the two first years are important and it is reasonable to expect at least those projections to hold. The first year directly bears on the number of new personnel that can be hired etc. and

Table 3. The personnel resources according to three national public health plans for the years 1974, 76, and 78.

Type of personnel:	The year of plan/the year of activity:					
	1974/74	1974/76	1976/76	1974/78	1976/78	1978/78
Physician	90	100	150	150	250	30
Dentist	150	150	70	150	90	-
Nurse	300	300	200	300	160	150
Laboratory worker	70	70	60	70	60	10
Roentgen nurse	60	70	30	80	30	10
Physiotherapist	60	80	40	80	30	10

Source: National Public Health Care Plans for the years 1974-78; 1976-80; 1978-82.

the second year creates the future expectations of the communes. In Table 3 I have included some of the categories of personnel that have been used during all three planning rounds.

In passing it should be noted that the national plans have increasingly differentiated the types of personnel that are given attention in the plan. Those categories included in Table 3 have, however, been included in all three of the plans we have here observed. The interesting part of the numbers given can be found in the last three columns. In those we see the planned number of personnel in the 1974-78 plan for the year 78, in the 1976-80 plan for the year 78, and in the 1978-82 plan for the year 78. The numbers quite clearly show the heavy dependence of the planning system on its environment. This environment has two important components, the general economic situation and the competitive situation among state authorities that all want their share of a shrinking cake.

What the numbers given mean in this context, from an administrative point of view, is that the National Board of Health can in 1976 approve communal proposals to hire 250 physicians two years later. As we come to the year 78 (actually 1977, since the plan for 78 is made during 77) the Board can only approve proposals for up to thirty new physicians. This situation is administratively interesting. We can note that the large cuts in the national plan which have been made, often are made as the Cabinet considers the national plan proposal of the National Board of Health and the Ministry of Social Affairs and Health. The cutting is done almost overnight, presumably with rather meager considerations of possible effects of different cutting policies. As far as I know, the National Board of Health is not heavily involved in this final part of the national planning process, the part which may cut half of all the resources asked for by the plan proposal.

Here we shall, however, consider another aspect of the diminishing resource situation. My question is, what are those communes doing who in 1976 were promised totally 220 new physicians, but who see in preparing their plan for 1978 that not one of those 220 will be approved. How does a commune try to find out whether it is among those happy 30 that will be given a new physician? The answer is obvious: By sticking to its original plans, that is by requesting state support for a physician in accordance with promises given by the state. The consequences of this rational local governmental behavior is also obvious, with regard to 220 proposals on which the National Board of Health must turn its thumb down. And, as has been shown, this means that the local plans are not in accordance with the national plan and hence they cannot be approved. The plan must be made anew at the local level. According to the result in Table 1 this means the start of a half year sequence on an average.

It thus seems clear that under conditions of diminishing resources, the formalized multi-level planning system must by the logic of the system be self-defeating. Needless to say, the half year sequence claims considerable administrative resources both at the central and local administrative levels.

Under conditions of increasing resources these problems of the planning system are not as great. Still there exist during good times also dependencies which may interfere with the working of the system. Among these are, to name just one, the agreements reached between the large organizations within the corporative sphere (Helander, 1979). These agreements may cause changes also within the health care sector. In the early implementation phase of the system, there could be found examples of policy changes made during an ongoing planning process with the consequence that the local governmental units thought they were biding by the directives when in fact the directives had been changed. In judging the working of the system as a whole, these types of problems are, however, of curiosity value only.

The Reform of the Planning System

We have found that the planning system that was created in 1972 has been plagued by considerable bureaucratic inertia and that this inertia seems to be virtually impossible to do away with within that system. In the late seventies the bureaucrats themselves recognized the difficulties and the system was changed. The new system was implemented starting with the considerations of the plans for the years 1980–84.³

The main changes pertain to the submission and approval of local plans. The local governments now must submit their plans for approval by the end of June. Thus they have again been given one month more in which to prepare their plans. The approval of the plan is given by the regional authorities; a considerable formal decentralization has therefore taken place. This decentralization is, however, not all inclusive. Large projects requiring capital investments must still be treated according to a three step sequence. Firstly the project must be approved in the public health care plan by the regional authorities. Then a funding plan is made which goes all the way to the Ministry of Social Affairs and Health for approval. This plan having been approved, a new detailed project plan has to be made by the local units and this plan again goes all the way to the Ministry. The Ministry finally approves this plan and at the same time decides on the state support to be given to the project. In all, this sequence of plans requires several years to be completed. What in this paper has been said about the public health care plans is very true also for the other two types of plans that are required in order to carry through larger projects.

I have not gathered systematic data on the consequences of the reform. It seems obvious, however, that it mainly influences the average time in column 1 of Table 1, that is, the time needed to arrive at the first decision regarding the local plans. I cannot see that the reform would in any important sense have an impact on the self-defeating features of the planning system. An interview with the representatives of that regional authority which had the largest number of health care centers within its boundaries, showed that only two out of 35 local plans could be approved directly. The rest of the plans had to be circulated back to the communes. By the end of February 1980 all plans except one were finally approved, that is, it still seems difficult to deliver the final approval in time.⁴

In order to think somewhat more systematically about the reform, we can make two distinctions. The reform may mean that only the handling of the plans is decentralized or not, or it may mean that the real decision-making power is decentralized or not. Combining these aspects of the reform we get:

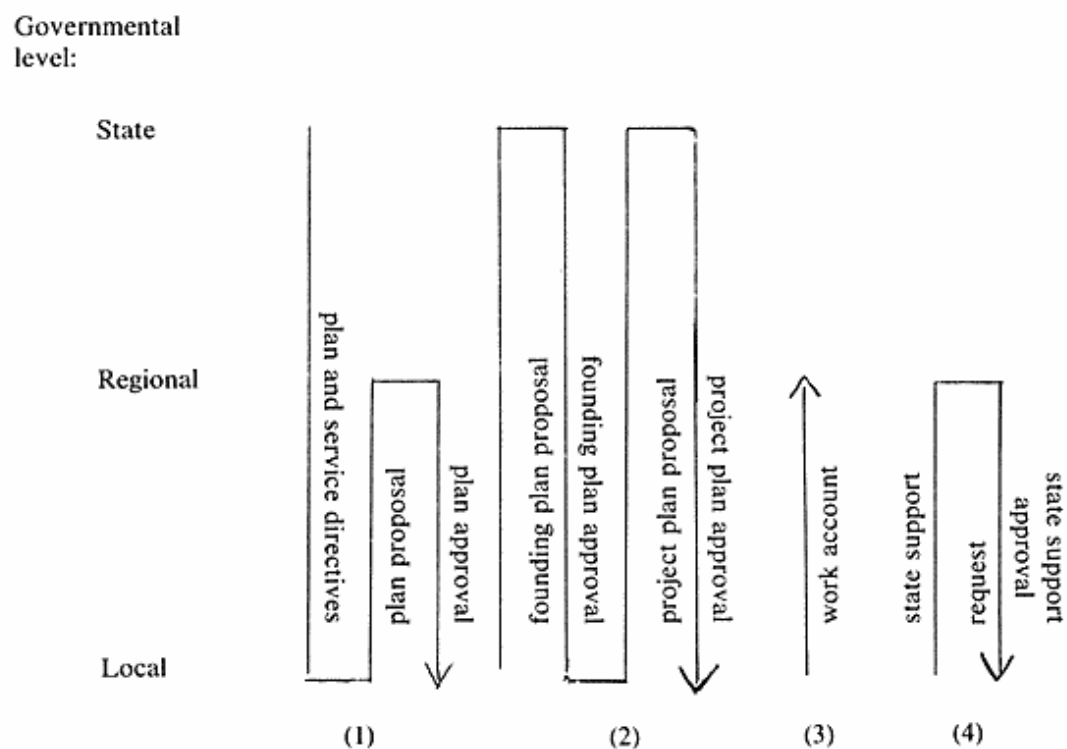
Decentralization in handling of plans:	Decentralized decision-making power:	
	no	yes
no	1972-78	
yes	↓ ⁽¹⁾ 1979 - - -	- - - ⁽²⁾ →

In terms of the fourfold table we can argue that the decentralization reform was only a reform with regard to the handling of the plans. This has a slight impact on the bureaucratic inertia of the planning system, but does not change the essential situation with regard to the conflict between technical aspiration and the political world. The National Board of Health still has a tight grip on the system in issuing resource frames and directives to the local governments as well as to the regional authorities. There is very little real decision-making power vested in the regional authorities as they consider the local plans.

Above all the reform has done little indeed to create a more administratively redundant planning system that can cope with the environmental disturbances. The additional half year of handling the local plans seems to be a part of the new system as well.

Arrow 2 has been drawn in order to indicate the direction in which the system ought to be taken in order to arrive at the balance between the planning aspirations and the factors influencing the real planning process. The main reform should therefore do away with the vertical administrative processes and strengthen the local governmental decision-making power. This reasoning can be illustrated in a Fig. 2.

Figure 2. The principal components in the relation between local, regional and central governments.



In Figure 2 the main components are given according to the present system in the interplay between governmental levels. This situation according to the argument I am advancing, ought to be simplified in two respects (Ståhlberg, 1978b). Firstly the rounds (1) and (2) ought to be done away with in the present vertical form. By developing the types of directives on planning and on services and projects, it ought to be possible to achieve that regional balance in service production which has been a major argument for the planning system. The local governments then should prepare their communal plans, i.e. plans that the communes must prepare according to the new Local Government Act, and the plans need not be approved by the state or regional authorities. Large projects could be approved by the regional authorities according to directives given to them by the state authorities.

Secondly, rounds (3) and (4) ought to be put together and developed into an effective a posteriori control device for the regional authorities according to directives given by the National Board of Health. State support will then not be given for such services that have been provided by the local governments in disagreement with the directives issued by the National Board of Health.

By and large, then, these reforms would do away with the overformalization of the present system and create a more administratively redundant system that will not suffer repercussions from every environmental change in a way that consumes administrative resources. Still the instruments that make central governmental control and steering possible are retained. Therefore it ought still to be possible to achieve those goals that originally were aimed for by the reform of 1972 that created too sharp an administrative knife on which the planning system now seems to be cutting itself.

NOTES

- 1 The second part draws heavily on some of my earlier papers in which I have discussed types of planning rather extensively (Ståhlberg, 1978a, 1981).
- 2 In addition to the problem of coordinating the yearly budget and the health plan, there exists another coordination problem, that between the health plan and the communal plan. All communes must prepare communal five year plans covering all local governmental activities (service, land use, and economy). The health plan is, of course, an important part of the communal plan, but these two types of plans rarely meet in such a way that they could be in any sense unconditionally coordinated, see *Kommittébetänkande*, 1976.
- 3 It should be noted, although I am not here dealing with it, that there is now an additional large reform prepared. There exists a draft for a governmental bill which would in a sense do away with the present public health care planning and merge it with social planning into

a comprehensive public health and social welfare planning system. At the same time the governmental support system is made simpler and the planning system is somewhat debureaucratized. The fate of this bill is, however, far from clear at the moment.

- 4 Interview with a public health inspector at Länsstyrelsen för Åbo- och Björneborgs län, 14th of March, 1980.

REFERENCES

- Ahlbäck, I. 1978. *Planeringen för folkhälsoarbetet: Teori och praxis inom folkhälso-planeringen*, Department of Public Administration, Åbo Academy (Masters thesis).
- Helander, V. 1979. *A liberal corporatist sub-system in action: The incomes policy system in Finland*, Occasional papers nr 1/1979, University of Turku, Institute of Sociology and Political Science.
- Isaksson, G.-E. 1980. *KTS-planering: Ideal och verklighet*, Department of Political Science, RESPO nr 45/1980, Åbo Academy.
- Kommittébetänkande. 1976. Utvecklandet av kommunplaneringen för koordinering av statens och kommunernas ekonomi- och verksamhetsplanering, *Kommittébetänkande*, 1976/58, Helsingfors.
- Landau, M. 1969. Redundancy, Rationality and the Problem of Duplication and Overlap, *Public Administration Review*, 4, 346–58.
- Ståhlberg, K. 1977. Byråkrati och när demokrati: Två demokratiproblem inom den finländska kommunalförvaltningen, *Nordisk Administrativ Tidskrift* 3, 172–180.
- Ståhlberg, K. 1978a. *Politik och planering*, Stiftelsens för Åbo Akademi forskningsinstitut, Åbo.
- Ståhlberg, K. 1978b. Balans och obalans i kommunal planering, in Anckar, D. & Ståhlberg, K. (eds.) *Politik och förvaltning: 40 år statskunskap vid Åbo Akademi*, Stiftelsens för Åbo Akademi forskningsinstitut, Åbo.
- Ståhlberg, K. 1981. When, if ever, can be expect governmental planning to work: On premature programming of planning. In press.
- Vartola, J. 1978. *Administrative change, strategies of development and current problems in the central administration of the state of Finland*, Research reports 3/1978, Department of Administrative Sciences, University of Tampere.

ERRATUM

Douglas A. Hibbs, Jr. and Henrik Jess Madsen: 'The Impact of Economic Performance on Electoral Support in Sweden, 1976–1978' pp. 33–50 in *Scandinavian Political Studies*, Vol. 4, No. 1, 1981.

The top line of Equation 4 (p. 37) should read:

$$P_t = P(Y_{it} = 1) = P(f(Z) + u_t > c)$$

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REFERENCES

- Ahlbäck, I. 1978. *Planeringen för folkhälsoarbetet: Teori och praxis inom folkhälso-planeringen*, Department of Public Administration, Åbo Academy (Masters thesis).
- Helander, V. 1979. *A liberal corporatist sub-system in action: The incomes policy system in Finland*, Occasional papers nr 1/1979, University of Turku, Institute of Sociology and Political Science.
- Isaksson, G.-E. 1980. *KTS-planering: Ideal och verklighet*, Department of Political Science, RESPO nr 45/1980, Åbo Academy.
- Kommittébetänkande. 1976. Utvecklandet av kommunplaneringen för koordinering av statens och kommunernas ekonomi- och verksamhetsplanering, *Kommittébetänkande*, 1976/58, Helsingfors.
- Landau, M. 1969. Redundancy, Rationality and the Problem of Duplication and Overlap, *Public Administration Review*, 4, 346–58.
- Ståhlberg, K. 1977. Byråkrati och närdemokrati: Två demokratiproblem inom den finländska kommunalförvaltningen, *Nordisk Administrativ Tidskrift* 3, 172–180.
- Ståhlberg, K. 1978a. *Politik och planering*, Stiftelsens för Åbo Akademi forskningsinstitut, Åbo.
- Ståhlberg, K. 1978b. Balans och obalans i kommunal planering, in Anckar, D. & Ståhlberg, K. (eds.) *Politik och förvaltning: 40 år statskunskap vid Åbo Akademi*, Stiftelsens för Åbo Akademi forskningsinstitut, Åbo.
- Ståhlberg, K. 1981. When, if ever, can be expect governmental planning to work: On premature programming of planning. In press.
- Vartola, J. 1978. *Administrative change, strategies of development and current problems in the central administration of the state of Finland*, Research reports 3/1978, Department of Administrative Sciences, University of Tampere.

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