

Local Governments and Health Services: How Can They Be Reconciled?

*Pekka Kettunen**

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The article discusses the concepts of centralisation and decentralisation in theory. There are various criteria that can be used to assess the advantages and disadvantages of decentralisation, and the paper will discuss these. In addition, empirical examples are presented. Next the article moves on to a case study of Finland. Finland has strong municipalities in the comparative European aspect, but there are problems, too. There are plenty of small municipalities which cannot carry all the responsibility by themselves; hence the national government would like to see more amalgamations. The final section discusses in more general terms how local autonomy can be combined with coordination, and which new options there are.

Keywords: local government, health services, Finland, centralisation, decentralisation

* Pekka Kettunen, PhD, Senior Lecturer, Abo Akademi University, Finland (viši predavač, Abo Akademy University, Finska, e-mail: pekka.kettunen@abo.fi)

1. Introduction

National politico-administrative systems tend to be more or less centralised. External relations, tax collecting, and legal institutions, to name but a few, always seem to be national-level activities, while welfare services are usually produced closer to the citizens (Dodds, 2013). In many other activities the criteria are not so obvious. It may be that the national or regional level is optimal, but other grounds can be stated as well. Hence the question of the division of labour, or the balance between centralising and decentralising, often remains a dilemma. The European Union has 28 members, and the degree of decentralisation varies a great deal between them. Strong municipalities are traditionally found in the north of Europe (Kuhlmann & Wollmann, 2014), while in the south of Europe the usually small municipalities carry out a less important role. A recent report comparing local government autonomy (Ladner et al., 2015) in Europe makes the following conclusions: “The Nordic countries – Finland, Iceland, Denmark, Sweden and Norway – consistently rank among the countries with the highest degree of autonomy together with Switzerland, Germany and Poland. This group is followed by Liechtenstein, Italy, Serbia, France, Bulgaria, Lithuania, Czech Republic, Austria and Estonia. Countries with a particularly low degree of local autonomy are Cyprus, Turkey, Malta, Moldavia, Georgia and Ireland.”

Decentralisation has a positive tone and, for example, the Council of Europe recommends the strengthening of the local level of government as a central value (Council of Europe, 2010). On the other hand, arguments in favour of centralisation mostly have to do with economy and coordination. It is argued that strong local governments may compete with each other and bring along excessive and overlapping service provision, as well as lead to an inefficient infrastructure and insufficient organisations to carry out welfare obligations. From the viewpoint of coordination the argument goes that certain societal functions need to be coordinated at the regional or national level to avoid fragmentation and, for example, NIMBY (“not in my back yard”) reactions when choosing sites for highways, airports, or nuclear power plants.

Local governments are close to the citizens and can adjust services according to their needs. In order to be capable of doing this, local governments may need to have a sufficient size and resources at hand. The choice may not be merely between small and large municipalities, but small municipalities can unite and form intermunicipal organisations in

order to compensate for their small size. From the viewpoint of democracy, it should be clear that decision-making close to the citizens is more democratic than decision-making which is remote from the citizens, but even this is not a straightforward question.

There are various criteria that can be used to assess the advantages and disadvantages of decentralisation, and the paper will discuss these. In addition, empirical examples are presented. It seems that there is a centralising process underway in Europe. The reasons deal with economics, globalisation, demographic changes, and changing values. On the other hand, local communities are still important for many in terms of giving identity, bringing the decision-makers close to the people, and enhancing social capital (Burns et al., 1994).

How then can local autonomy be combined with the needs of modern service production? The paper will tackle the question from the perspective of decentralisation, its definition, as well as the conditions supporting favourable cases of decentralisation. Health care is used as an example. Health care represents a professionally dominated service, which also, when it comes to hospitals, requires a certain level of centralisation. Still, one may discuss the choices between local-level health care and state-level health care, and the various combinations of the two. In Finland, for example, according to a recent reform agenda, hospital care will be restructured, i.e., centralised to the regional level. However, the question still remains of how the areas will solve the actual production of health care, and how a cost-effective system can be reached, which serves the citizens, too. Arguments in this reform will be used as an example of the centralisation vs decentralisation debate in the paper. The organisation of welfare services constitutes one aspect of the debate, a specific one. It can, however, be argued that service production is not an apolitical issue, but contains value considerations and political elements as well. Hence service organisation may reveal very fundamental issues about decentralisation.

The article first discusses the concepts of centralisation and decentralisation in theory, after which it moves on to a case study of Finland. Finland has strong municipalities in the comparative European aspect, but there are problems too. There are plenty of small municipalities which cannot carry all the responsibility by themselves; hence the national government would like to see more amalgamations. The final section discusses in more general terms how local autonomy can be combined with coordination, and which new options there are.

2. Arguments in Favour of and Against Decentralisation

Decentralisation can be defined as power handed over to the local level of government. On the other hand, one way is to make a distinction between different mechanisms of decentralisation: financial, organisational, and political (Robinson, 2007). In any case, decentralised politico-administrative systems have autonomy at the local level, the right to make decisions according to local preferences, and not merely implement orders given at the national level. Proponents of decentralisation base their assumptions on widely differing criteria, ranging from expected improvements in allocative efficiency, welfare, and equity through to increased participation, accountability, and responsiveness on the part of local authorities (Blair, 2000). Furthermore, Nemeč and Matejova (2014, p. 101) argue that the most essential arguments for decentralisation are primarily based on democracy-related arguments, which include both the idea of localism and the idea of public choice.

The most important arguments for territorial consolidation and limited decentralisation are connected with economic theories. According to these, not only economies of scale but also many other serious problems faced by small municipalities (including a lack of financing and employment opportunities for their inhabitants, a lack of technical infrastructure, difficult access to basic services, and a small population) limit their performance (Nemeč & Matejova 2014, p. 102).

Kuhlmann and Wollmann (2014, p. 135) present a summarised account of the advantages and disadvantages of decentralisation. They discuss these within the framework of six different issues: effectiveness, efficiency, horizontal coordination, vertical coordination, democratic control, and uniformity/equality. In each dimension decentralisation can lead to either advantages or disadvantages. For example, effectiveness can be improved through proximity to users, but at the same time insufficient specialisation may have an adverse effect on effectiveness. Likewise, democratic control can be improved by giving more influence to local inhabitants, but decentralisation may also lead to a susceptibility to corruption and loss of transparency (ibid., 135). In other words, the consequences of decentralisation are context-bound, not automatic.

The above argumentation suggests that decentralisation can lead to favourable democratic and economic consequences, but this is not necessarily the case. Decision-making in small communities can be dominated

by only a few political ideologies, and although they are close to the citizens, the service providers may not have sufficient skills to respond to all kinds of needs. In other words, there is not only one recipe for decentralisation – it is very much a matter of context. Decentralisation works if the circumstances are right, if particular rules of the game are in use, and if the actors follow the rules of the game.

Decentralisation may work better with regard to some policies than others, may require a certain type of local government structure, or depend on the dynamics of the system and the incentives of the actors. In addition, whether decentralisation is appreciated may be a question of values; for example, if regional equality (of services) is seen as important. Hence it is more a question of finding the right balance along a continuum, rather than making a mutually exclusive selection. The fact that all of the above characteristics can be either advantages or disadvantages make the assessment and design of power distribution difficult.

When does decentralisation not work? We have to see that it is not a panacea for all policies and secondly, that certain contextual conditions need to be fulfilled. A common argument for restricting the choices of local governments is coordination (Peters, 2007). Also, as the basic public choice literature argues, some issues have to be decided in concert (Laver, 1986). In any case, an airport, major highway, or factory may need to be located somewhere. The politico-administrative systems may also be more or less legalistic, and in the former case there may simply be a reluctance to transfer tasks to the regional and local level (Kuhlmann & Wollmann, 2014). There may also be historical and cultural explanations of country differences, for example, a long history of local governance enabling decentralisation of tasks. Nordic countries have traditionally had strong local autonomy, but the welfare state development, starting in the late 1960s, has added a strong central government factor to the picture as well (Pesonen & Riihinen, 2002).

In *prima facie* decentralised countries, such as the Nordic countries, it is more a question of which services, or which kinds of service-related questions, are decided at the national level and which ones at the sub-national levels. What kind of criteria would then either support or discourage decentralisation? First, it depends on the municipalities and whether they have the capacity, resources, knowledge, and personnel to carry the responsibility. Secondly, there are economic concerns, i.e., what is an optimal service structure? Upper secondary schools (high schools) may not be available in every municipality and the national state may have means

(licenses) to restrict the founding of those. Primary schools, on the other hand, are usually found in all municipalities as closeness to services is seen as important. Some services demand greater centralisation than others, or at least on a wider scale. This is typically the case with hospital services or infrastructure arrangements, while social care and primary education are usually in the hands of local governments.

Thirdly, there is the related question of the fair distribution of services. Is it a national goal to have equal service provision in the different areas of a country, or is it accepted that some centralisation is necessary? Finally, the right to make decisions regarding both the structure and content of services may for the sake of coordination be centralised to the state level, but in Finland, for example, a large selection of services is taken care of by local governments. This may increase their commitment to service provision, not merely implementing state-level decisions.

The article next moves on to discuss the case of Finland. Finland belongs to the group of countries where local governments are strong. However, in recent years there has been increasing criticism of their role, and many welfare services are being centralised to the regional level.

3. Reforms of Health Care in Finland

Social and health services in Europe tend to vary considerably concerning who is in charge. It seems that in Europe the north is more prone to applying municipal amalgamations to reform the welfare state, while in the south the municipalities are smaller, have fewer tasks, and there is not such a need for them to merge (Heinelt & Bertrana, 2011; Kuhlmann & Wollmann, 2014). If municipalities have many tasks they should have enough resources to accomplish them. That then comes back to the financial capacity of the local level. One of the major motivations for amalgamation reforms is raising the quality of the services (Kuhlmann & Wollmann, 2014).

Scandinavian countries are fairly similar, but when we look at the details they also differ in many respects (Kettunen & Sandberg, 2014). Finland has not had a major territorial reform (like Denmark or Sweden have) and hence the share of small municipalities is high. Finland belongs to the North European type of local government profile, which implies large welfare state related tasks and a high degree of autonomy. The Finnish municipalities are in charge of a large share of the public expenses, and

of public sector employees (Pesonen & Riihinen, 2002). The size of the Finnish municipalities, however, varies significantly. The average size (in terms of inhabitants) is 17,100, but the median is just 6,000, and over one half of the 313 municipalities (in 2016) have fewer than 6,000 inhabitants. In order to cope with small size, the main strategy of the Finnish municipalities is cooperation. There are a number of laws explicitly requiring that municipalities build a consortium and manage the service in concert, such as central hospitals, or institutions for the disabled, while in other areas municipalities get together voluntarily to produce services. This is typical in the areas of culture and technical services. Intermunicipal cooperation, however, suffers from a number of problems as well. First, it can treat the members unequally. Secondly, it can be distant for the inhabitants. Thirdly, it can be rigid in decision-making (Pollitt, 2003; Teles & Kettunen, 2016). In addition to cooperation between municipalities there are such options as starting semi-private local enterprises, and purchasing the service from private companies.

Finland has traditionally had a mixed health care system. Hospitals were built in the late 1940s and 1950s using compulsory joint municipal organisations, and this has been the model of organising major hospitals ever since. Beyond this level (consisting of 20 central hospitals) there are minor hospitals in regions and major cities, and municipal or joint municipal health centres. In larger cities there are also private doctors and hospitals, whose use is supported by the state. Municipal health centres form the basis of the Finnish health system. Local authorities run currently about 160 health centres; 106 of these are municipal health centres, and the remaining belong to joint municipal authorities made up of several local authorities.

From the early 2000s this system has been questioned by the state level, both by politicians and bureaucrats. A combination of two things, the broad range of municipality tasks and the large number as well as the small size of municipalities, has dominated the political agenda in recent years. The fragmentation of the service sector and the existence of small units (health centres, schools, libraries, or fire brigades) has arisen as the central problem in the public sector.

What explains this rise in the second half of the millennium? The primary reason seems to be money. Health care costs are rising fast because the average age of the population is rising and because of advances in medical technology. Furthermore, the fragmentation is argued to cause both inefficiency and low quality of services, as many of the small units cannot offer specialised services or choice to their customers.

In 2006 the national government proposed a reform in order to increase the size of municipalities. The small size, connected to weak economy, was considered to be a problem. The reform was mostly rhetorical without compulsory means; however, municipalities were obliged to reorganise their social and health care so that each would serve at least 20,000 inhabitants. This led to amalgamations, but also to a number of ways the municipalities cooperated with each other to fulfil the requirements (Kettunen, 2008). In the years following the proposal the number of municipalities decreased, so that while in 2006 there were 431 municipalities, by 2014 their number had dropped to 317. However, in 2014 there were still about ten per cent of municipalities with fewer than 2,000 inhabitants and the structure of health care was very fragmented. There was a leap in the amalgamations from 2009 to 2013, thanks to government subsidies and encouragement.

The most recent reform, launched in the spring of 2015, took the form of dismantling social and health care from the municipal level of government. Instead this was supposed to be given to new regional governments. The regions would decide which services to use, and determine the demand on the basis of the service institutions.¹ The new regions are planned to start in 2019 and many things are still open. In any case the change is a radical one, and it would mean that the role of the municipalities will change radically. Social and health care currently constitutes the major share of local government budgets. The reform also implies that regions as politico-administrative actors will enter the scene in 2019. The reform represents a new era in the national government–local government relationship. The Finnish municipalities are among the most autonomous municipalities in Europe, but the reform strongly contradicts this. The reform has also led to heated opinions, and the local governments quite firmly resist the government's intervention in what they see as their internal affairs. The top-down reform also undermines the local governments' ability to make long-term plans and engage in strategic thinking, as they are uncertain about the future of social and welfare services. They have also criticised the government's economic agenda according to which reorganising may cut health care costs by about 3 billion euros. A second criticism points to the high transaction costs of the reform (Kuhlmann & Wollmann, 2014), and it has been stated that this is the largest administrative reform in Finland since the time of independence (1917).

¹ http://alueuudistus.fi/en/artikkeli/-/asset_publisher/1271139/sote-ja-maakuntauudistuksen-lakiluonnokset-lausunnot

4. Discussion

The paper began with the question: what is the optimal division of labour between state and local administration? Furthermore, the focus regarding the division of labour is on service provision, but other aspects can be included, too. The answer depends on the context, but on the policy in question as well. Returning now to the advantages and disadvantages of decentralisation, we can see how health policy fits into the picture. From the health sector's point of view, the main arguments for the reform are connected to efficiency and uniformity.

From the economic point of view, there are too many hospitals in Finland and centralisation would cut costs. Indeed, Finland is the last of the five Nordic countries to have health services in local government control (Kettunen & Sandberg, 2014). Gradually, however, the rise of health care related costs has given reason to reform the system. Because the local governments cannot, according to the reform, be trusted to make such decisions (which would render local hospitals unnecessary), the national government decided to take the big step of reorganising the whole of the social and health policy. The economic motivation is linked to a national-level program of reducing public debt. Second, but probably less important, is the uniformity criterion: to provide more or less equal services in the new region-led system from 2019. This line of argumentation has been important in the early phase of the reform, emphasising the competence of the local governments.

On the contrary, horizontal coordination and democracy were not widely acknowledged in the reform. Regarding the former, the reorganisation plan divides social and health services (to be coordinated at the regional level) from, for example, housing, leisure time, and cultural services, which may have a negative effect on the public health policy. Health care is not merely institutional, professionally-led care, but refers to creating a healthy environment and nourishing attitudes which support good health (WHO, 2011).

From a democratic viewpoint, the reform cannot be argued to be straightforwardly against democracy. The local governments' tasks are diminished and hence also the scope of issues decided at the local level. What is remarkable is that the Finnish reform is at the same time going to centralise the social services. This is defended by the need for the two sectors – the social and the health one – to be more highly integrated. On the other hand, the new regions will be based on elected councillors, so there will be a new channel for citizen influence.

The political result represents a compromise between regional interests and those of the medical profession. For the latter an even more centralised model would be optimal, but for the politicians this would be too radical. Still, the model based on 18 regions is in many ways radical compared to earlier ones, but at the same time it is a compromise between the medical profession view and the regional political view. Out of the 18 regions only 12 will have comprehensive hospital services, which indicates the power of the professional view. The regions have the right to choose which services are used, both public and private, in providing social and health care. In other words, local governments have to compete with private providers. Some form of freedom of choice will also be introduced. Understandably, the local governments are not in favour of this proposal.

From the viewpoint of the local governments, the hospitals and health centres closest to the municipality are the important ones. From the medical point of view, it makes sense to have a service network which guarantees high-quality services. For a citizen needing the services, proximity is the most important concern. The health care reform has very much been a question of rational organisation. 'Rational' considered from the professional viewpoint refers to the kind of organisation which is sufficient in terms of providing the necessary services, which can mean that for rare operations one hospital is sufficient for a population of 5.6 million. Medical technology and highly specialised staff mean that there has to be some scale when organising the activity. This does not preclude a hierarchy of health care services, from simple everyday services to highly technical ones.

A contrary argument says that services need to be close to the citizens. Nothing prevents the health care system from providing services which are close to the citizens, by way of mobile services, for instance. However, their development has been lacking. This gap between the well-to-do and less well-to-do municipalities will probably grow in the future. In a nutshell, the Finnish debate is about the capability of the local governments to be in charge of health care. According to the government, the current system has led to a fragmentation of health services, overlap, and inefficiency. They thus proposed a centralisation of the system. The main argument is the professional one, reflecting the wishes and preferences of health professionals. In terms of party politics, the government parties were all committed to the proposals, although the local organisations of these parties did not necessarily agree.

For the local governments the most important value is self-governance, and the need to find solutions appropriate to the local circumstances.

How could the health care system be institutionalised while satisfying the various interests? Recently there has been talk of the place-based approach (Barca, 2009). This is a more normative concept implying that decisions ought to be made close to the citizens. The place-based argumentation states that local circumstances are not the same and hence development policies ought to acknowledge these differences. At the same time this approach proposes new ways of coordinating activities, emphasising coordination from below. In other words, it would be up to the national government to set goals and construct a framework within which the local governments would have a high level of autonomy. This model assumes that the performance of the municipalities would be based on indicators and measurement, and that the role of the inhabitants would be more important than it has been thus far. This approach would, in fact, bring the local governments closer to the model of the local community, as opposed to merely being a provider of national welfare services. Within this framework the municipalities would have more freedom and would primarily follow and serve the interests of the inhabitants.

Local government autonomy is not a dichotomous concept but a relative one. As Ladner et al. (2015) argue, strong autonomy indicates that the role of local governments in several policy areas is strong (defined as the extent of responsibility they have over the policy) and that local governments have a say in national politics through institutional channels of representation. Hence, rather than leaving the local governments without any responsibility in social and health care (unless the new regional actor decides in favour of this), the reformers could reconsider which tasks would be better suited to local responsibility and which tasks should be taken over by regional or national actors.

5. Conclusion

The preceding discussion suggests that shaping a health policy is strongly connected to economic arguments (economies of scale) and uniformity arguments emphasising equal access to high-quality services. Popular views are not seen to have such importance compared with professional (substance) and economic (high costs) arguments. Hence Finland has also taken a step towards an upper-level and a more state-level policy, after the health care system was run by the local government for a long while.

We can try to find an optimal politico-administrative structure, an optimal way of producing welfare services, but finding evidence for this can be difficult. As the preceding discussion shows, there are plenty of interests surrounding health policy, including the citizens, local government politicians and staff, professionals, national-level politicians and bureaucrats. Economists tend to calculate numeric values, while for political scientists democracy is often the most important criterion. Argumentation such as is given above always includes a power aspect as well (Goverde et al., 2000). The above analysis shows that arguments for decentralisation are numerous and partly contradictory. More recently there has been discussion about evidence, demanding that governments ought to be able to decide on the basis of firm, empirical evidence. The above delineation suggests that evidence is not easily applied in all cases. The question of health system design represents a complex and multi-faceted issue which cannot be decided only on the basis of, for instance, economy. In addition, designing ideal models and the reality do not always go well together. Local governments can be made responsible for the well-being of their inhabitants, and such is the practice in Northern Europe. However, if they are not able to shoulder the responsibility, the state has to intervene. Alternatively, the incentives of local governments have to be sufficient to enable dynamic development.

What makes this difficult is that local governments are not the same. Urban centres have much better chances to take responsibility than small rural municipalities. As Kuhlmann and Wollmann (2014) argue, North European municipalities are obliged to provide services and hence there is greater interest in their capacity, whereas in the south of Europe small municipalities do not have similar tasks. Drechsler (2013), on the other hand, proposes a radical view of democracy, emphasising local autonomy as the ultimate premise. In a similar way Bogason (2000, p. 3) argues that the model of evaluation based on generalised goals and command-control implementation is generally not suitable any more, as we need models that take diversity into account, crossing formal organisational boundaries, and developing an understanding for the problems of people such as field workers and clients. Returning to the pros and cons of decentralisation presented in the introduction, we can see that there are no definite answers in these. Local knowledge is hence a concept which feeds into the decentralisation discussion as well. Locally-blind programs do not take into consideration local specificities and serve mechanical, one-size-fits-all solutions. A good example of this is the Finnish local government reform, which was based on one kind of problem identification and a failure

to see variation. After all, public policy-making is not making decisions in a vacuum but in concert with several actors (Hoppe, 2011). All in all, the debate also tells us something about the characteristics of modern society, where unified structures and coordination rise to the forefront. However, health care services are not merely a professional issue, but have a political nature, too. At worst, the meaning of “local responsibility for the well-being of the inhabitants” (Local Government Act 2015) becomes eroded. Health care reform also seems to pave the way for territorial reform in general. For the national government the best solution would be a unified local government structure with strong and viable municipalities. For now, the dilemma remains.

However, coordinating local activities in a different way and letting the local governments take greater responsibility for the inhabitants is not easy to achieve. Local governments need enough resources and power to comply with the requirements. The national and local government ought to play together, not compete with each other.

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LOCAL GOVERNMENTS AND HEALTH SERVICES: HOW CAN THEY BE RECONCILED?

Summary

The article discusses the concepts of centralisation and decentralisation in theory. There are various criteria that can be used to assess the advantages and disadvantages of decentralisation, and the paper will discuss these. In addition, empirical examples are presented. Next the article moves on to a case study of Finland. Finland has strong municipalities in the comparative European aspect, but there are problems too. There are plenty of small municipalities which cannot carry all the responsibility by themselves; hence the national government would like to see more amalgamations. The final section discusses in more general terms how local autonomy can be combined with coordination and which new options there are. Coordinating local activities in a different way and letting the local governments take greater responsibility for the inhabitants is not easy to achieve. Local governments need enough resources and power to comply with the requirements. The national and local government ought to play together, not compete with each other.

Keywords: Local government, health services, Finland, centralisation, decentralisation

LOKALNA SAMOUPRAVA I ZDRAVSTVENE USLUGE: KAKO IH MOŽEMO USKLADITI?

Sažetak

U radu se raspravlja o pojmovima centralizacije i decentralizacije u teorijskom smislu. Prednosti i nedostatke decentralizacije moguće je procijeniti primjenom različitih kriterija, što se u radu i čini, te se navode empirijski dokazi. Slijedi studija slučaja Finske, čije su općine snažne u usporedbi s ostalim europskim zemljama, no ipak postoje određeni problemi. Državna vlast želi veći broj spajanja jer mnogo malih općina ne može snositi svu odgovornost i teret lokalnih službi. Rad završava raspravom o mogućnostima kombiniranja lokalne autonomije i koordinacije te se predlažu neke nove mogućnosti. Nije lako postići drugačiji način koordinacije lokalnih aktivnosti te dopustiti da lokalne vlasti preuzmu veću odgovornost za građane. Lokalnoj su samoupravi potrebna

određena sredstva i ovlasti kako bi mogla udovoljiti zahtjevima. Državne i lokalne vlasti ne bi se smjele natjecati, već bi morale surađivati.

Ključne riječi: lokalna samouprava, zdravstvene usluge, Finska, centralizacija, decentralizacija