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Embracing the Wickedness of Health Care

Essays on Reforms, Wicked Problems and Public Deliberation

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Julkaisun nimike

Terveydenhuollon pirulliset ongelmat: Esseitä reformeista, kompleksisuudesta ja kansalaisdeliberaatiosta

Tiivistelmä

Tutkimuksen tavoitteena on kehittää terveydenhuollon reformien toteuttamiseen ideaalimalli kompleksisuusajattelun ja erityisesti pirullisten ongelmien problematiikan (*wicked problems*) näkökulmasta. Tutkimuksen keskeinen väite on, että perinteinen mekanistinen käsitystapa terveydenhuollon uudistamisesta ei ole yksinään riittävä, eikä sovellu käytettäväksi sellaisenaan yhä kompleksisemmaksi muuttuvassa yhteiskunnassa.

Tutkimus koostuu kuudesta artikkelista ja yhteenveto-osiosta. Artikkeleissa rakennetaan alustava näkemys terveydenhuollon reformien ideaalimallista ja syvennetään ymmärrystä wicked-problematiikasta sekä erityisesti siitä, miksi terveydenhuollon reformit epäonnistuvat tavoitteissaan. Teoreettinen tarkastelu suuntautuu lisäksi moninaisälykkyyden (*co-intelligence*) ja deliberatiivisen demokratian merkityksiin terveydenhuollon pirullisten ongelmien käsittelyssä.

Artikkeleiden empiirinen aineisto koostuu terveydenhuollon reformien suunnittelijoiden haastatteluista, kansalaisille että kolmannen sektorin järjestöjen edustajille suunnatuista kyselyistä sekä terveydenhuollon reformeja käsittelevästä dokumenttiaineistoista. Väitöskirjan yhteenveto-osio syventää edelleen ymmärrystä tutkimuksen teemaan.

Tutkimus havainnollistaa terveydenhuoltoon liittyvää kompleksisuutta ja lisää tietoisuutta terveydenhuollon pirullisten ongelmien olemassaolosta. Tutkimuksessa luodaan terveydenhuollon reformeille ideaalimalli, joka toimii suunnannäyttäjänä tulevaisuuden terveydenhuollon reformeille. Mallia voidaan käyttää sekä tieteellisessä analyysissa, että myös konkreettisesti terveydenhuollon uudistamistyössä.

Asiasanat

Kompleksisuus, terveydenhuolto, hallinto, reformi, deliberatiivinen demokratia

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Abstract
The insufficiency of the mechanistic worldview in reforming a health care system is the fulcrum of this study. Acknowledging the complexity of the modern world, it can be stated that the mechanistic view alone is not sufficient. New ways of seeing and understanding are needed. This research provides an alternative view on the issue of reforming health care, by developing an ideal model for a health care reform from the perspective of complexity thinking and the concept of the wicked problem.

The study consists of a summary-part with six articles. In the articles a preliminary view of the ideal model for a health care reform is created. Also the understanding of the concept of the wicked problem, and the question of why health care reforms tend to fail in their objectives, is deepened. Additionally, the discussion is focused on the significance of co-intelligence and deliberative democracy in tackling wicked health care problems. The empirical data of the articles consists of interviews (of health care reform planners), two electronic surveys (to citizens and NGO representatives), and document material covering health care reforms. The objective of the summary-part of the study is not just to sum up the individual articles, but to further deepen the understanding of the researched topic.

As central contributions, the study illustrates the complexity of health care, increases the awareness of the existence of wicked health care problems and creates an ideal model for a health care reform; this is not to be used only in scientific analysis, but also in concretely reforming health care. The model functions as a trendsetter for future health care reforms.

Keywords
Complexity, health care, administration, reform, deliberative democracy

PREFACE

As I now reflect upon my path of becoming a researcher, I realize how much the theoretical framework of this research actually explains the process. It has indeed been a path characterized by emergence and self-organizing. Things haven't always gone as planned, and rather many surprises were encountered along the way. But now, here I am. In the end, what matters is how you embrace the unexpected.

Also, it must be said that this wasn't a solitary path. As the research of social issues takes place in a social world, and not in a closed research chamber, connectivity and interdependence in the process are natural. Thus, there are so many people who have had an influence on this research. Below I mention only a few by name, and my gratitude goes to all these people who have been involved in the process.

Firstly, I am deeply grateful to my supervisor Professor Pirkko Vartiainen. When she asked me to join the faculty four years ago, I didn't think twice before saying yes. In many ways she has been an ideal supervisor who has supported and inspired me throughout this process. Most importantly, as I am a person who gets excited easily, it has been essential to have a supervisor who is open to many different ideas and who similarly knows to intervene when a person gets too carried away.

I have also been lucky to have two highly distinguished professors of public administration as pre-examiners. Professor Markku Temmes and Professor Ismo Lumijärvi gave valuable comments on my research, for which I am very thankful.

During these four years of research I have received funding from many different sources. Thank you belongs to the Finnish Cultural Foundation, the National Post Graduate School in Social and Health Policy, Management and Economics (SOTKA), Nordiska Administrativa Förbundet (NAF), the Academy of Finland and the Hungarian Academy of Sciences.

Many academic journals, including one edited book, are part of this research; as platforms for publications. I am grateful to the editors of these journals and for all the constructive comments received from the peer-reviewers. Especially, I would like to thank Professor Jarmo Vakkuri, Professor Ted Becker and Dr. Michael Briand. Similarly I thank those individuals who agreed to be interviewed for my research and who answered to the two surveys implemented in this research. For ensuring the grammaticality of the research I thank Anna Martikainen.

I have been fortunate to work with a diverse group of people who share my enthusiasm for researching the many complexities of social and health care. I thus wish to thank the current and former colleagues in social and health management, members of the research group HYMY and the enthusiastic developers of the BoWer -network. For our almost daily coffee breaks for the past six years, filled with inspiring conversations, I thank my friends and colleagues Juha Lindell and Niklas Lundström. During my research exchange in Hungary I became friends with fellow researcher Katalin Érsek. Kata and I have shared many experiences as young researchers together and have supported each other on our chosen career paths. I am grateful for our friendship.

My deepest gratitude goes to my family. For my entire life, my parents Arja and Kalevi and my brothers Jarno and Tero have supported and encouraged me in whatever I chose to do with my life. My dear Nina came into my life, with a big impact, at the later stage of this research. As a friend once told me "Harri, life is more than just work and gym". With Nina, I have realized this to be true. Without her, finishing this long path wouldn't feel the same as it does now.

Vaasa, September 2010

Harri Raisio

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[2] Raisio H. (2008). Wicked-problematiikan käsitteellinen tarkastelu: Uusia näkökulmia terveydenhuollon johtamiseen (Conceptual examination of the concept of wicked problems: New perspectives to the health care leadership). *Premissi* 2: 1, 32–42.

[3] Raisio H. (2009). Pirulliset ongelmat terveydenhuollossa: Esimerkkeinä Kansallinen terveyshanke ja hoitotakuu-uudistus (Wicked problems in health care: National health reform and guarantee for care reform as examples). In J. Vakkuri (Ed). *Paras mahdollinen julkishallinto: Tehokkuuden monet tulkinnat* (Best possible public administration: Many interpretations of efficiency). Helsinki: Gaudeamus Helsinki University Press. 73–91.

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1 INTRODUCTION

It is tempting to assume that a health care system is a simple, a machine-like, entity. If a health care system is understood as such, the implications are evident. It would then be assumed to be operating as a machine, i.e. with routine, efficiency, reliability and predictability. Thus health care managers could organize, predict and control the operations of the system. Actually, if a health care system would be a machine, it would then be possible to contrive "an all embracing Theory of Management" (see Richardson 2008: 14). With this, managers would have an exact theoretical answer to basically every situation conceivable. Managing health care could then be considered to be just a problem of a technical nature. (Morgan 2006.) Even though this is an exaggerated example, this general worldview is explicit in many management theories. Classical management theory, e.g. Henri Fayol, and scientific management, e.g. Frederick Taylor, with their focus on rational planning and control, are obvious examples (Morgan 2006: 18, 22; Jones 2008: 437).

This preceding view of a clockwork universe has been criticized by many (e.g. Becker & Slaton 2000; Conklin 2005; Vartiainen 2008; Zimmerman, Lindberg & Plsek 2008). The critique, however, should not be seen as such which would strive to refute the management theories supporting this more technical view to management processes. Instead, as Morgan (2006: 8) in his seminal 'Images of Organization' has stated "There are no right or wrong theories in management in an absolute sense, for every theory illuminates and hides". With this he refers to the idea of theories as metaphors. The meaning of this is that basically every theory can be understood as based on some specific metaphor. The metaphor then guides us to see and to understand the objects of the theories in a certain way. The important point that Morgan (2006: 5) makes is that every metaphor, and thus theory, is partial. For example the metaphor of a machine can give insights about managing in certain stable conditions, such as in mass-production factories. But at the same time the metaphor is incomplete as it ignores other important factors such as the human aspects of managing. Also, as the turbulence of the world increases, the limitations of the machine metaphor become even more explicit (Morgan 2006: 31).

For example, in Finnish health care, the general situation can be considered to be highly turbulent. Notably, Finland has managed to develop an internationally acclaimed system, but contemporary challenges are significant. As Teperi, Porter, Vuorenkoski and Baron (2009: 20) write "Finland cannot rest on its laurels". With this they refer to the situation created by the growing challenges of the health care system, including the advances in medical science, the aging of the

population – affecting especially patient demographics and to the availability of health care professionals – and the increasing expectations and demands of the citizens. This turbulent situation makes reforming the Finnish health care system an imperative. More clearly, Finland is now in a situation where incremental improvements are not sufficient. More fundamental approaches are needed (Teperi et. al. 2009: 94).

If the health care system would be considered as a machine, this would make the reforming of a health care system quite a simple process of management and control. Issues wanted to be dealt with through these reforms could be approached in linear and reductionist ways. It would then be possible to solve issues such as scarce resources and the need for priority-setting in health care, and many others, just by planning hard enough. A few selected individuals would do the planning and then what is decided would be implemented with a top-down approach. Everything would go as was decided, and what would result is a problem solved. Similarly, a problem could be divided into sub-problems, and by solving these problems individually, the upper level problem would be, once again, solved. Even though these, again, are exaggerated examples, approaches such as these can be seen taking place in many health care reforms (see e.g. Mihályi 2008; Vartiainen 2005, 2008; Raisio 2009a, 2009b, 2009c).

Vartiainen (2005: 175) sees that the traditional approaches, such as the mechanistic approaches described above, dominate the planning and the implementation of Finnish health care reforms. For her, this is one of the main reasons why these reforms haven't usually accomplished their objectives. It seems that there is something more in the world than what the metaphor of the machine implies. Just as Morgan (2006) stated, the metaphors give insight but they also hide certain issues from the sight. Acknowledging the complexity of the modern world, it can be stated that the machine metaphor, alone, is not sufficient. New ways of seeing and understanding are needed.

This thought of the insufficiency of the machine metaphor in reforming health care systems is the fulcrum of this study. As an alternative metaphor, the metaphor of the wicked problem – which emphasizes the complexity, ambiguity and divergence of many social issues – is chosen (Rittel & Webber 1973; Harmon & Mayer 1986: 11–12). It is not asserted that this is the one and the only way to see health care systems[1], but as a metaphor it gives new insights into the important

[1] Morgan (2006), from the perspective of organizations, wields altogether the metaphors of machine, organism, brain, culture, political system, psychic prison, flux and transformation, and domination.

issue of a health care reform. It is, however, explicitly asserted that this metaphor of the wicked problem can be seen to be more suitable to the contemporary challenges of health care systems than the still dominant metaphor of a machine. When the focuses of health care reforms are thought of as wicked by their nature, the question arises of what are the implications to health care reformers. If the metaphor of a machine calls for a linear and a reductionistic approach, what would the approach be when looked at through the lens of wickedness? This issue is examined through six articles. The synthesis of these articles is presented in this summarizing part of the dissertation.

1.1 Objective of the study

If many of the problems of health care are began to be understood as wicked, i.e. highly complex, ambiguous and divergent issues, what are the implications? The objective of this study is to answer this question from the view point of health care reforms; to build an ideal model for a health care reform based on the metaphor of the wicked problem. The main research question then is:

> *If it is accepted that many of the health care issues are wicked by nature, what would an ideal model for a health care reform then look like?*

The more specified sub-questions that follow are:

> *What are health care reforms and why are they needed?*
>
> *What are the implications of problem wickedness to health care reformers?*

From the last question, one particular theoretical notion arises, raising two more sub-questions:

> *What are co-intelligence and deliberative democracy?*
>
> *What is the importance of these in reforming health care?*

From these research questions four different themes can be found: an ideal model for a health care reform, health care reform generally, the concept of wicked problems and complexity thinking, and the idea of co-intelligence and deliberative democracy. Six articles, chosen for this dissertation, focus on these particular themes. The division of how these themes are wielded in each article is presented in figure 1. As none of the articles wield all these themes, it is the objective of this summary to present such a synthesis. The formed synthesis is then not just a sum of the individual articles. Instead, the articles are seen as data for the synthesis.

The objective is to form a deeper understanding of the researched topic; a matured perspective.

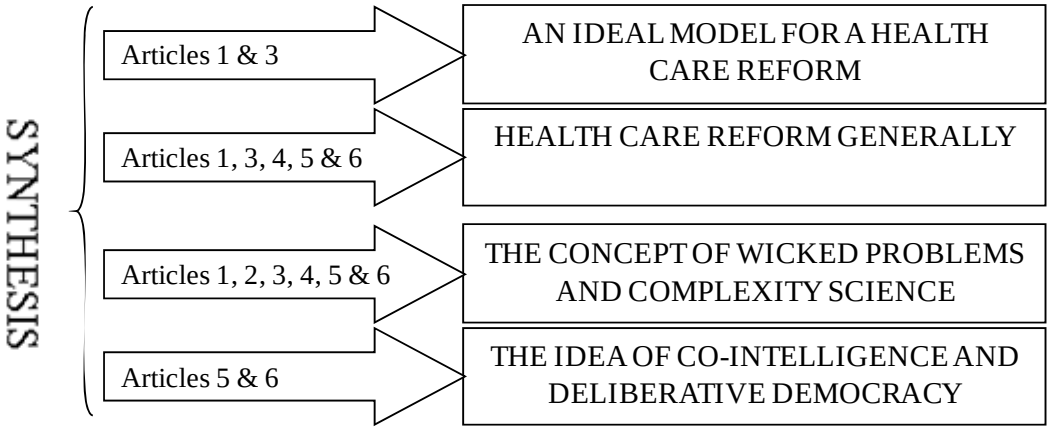

Figure 1. The relationship between the themes of the research, included articles and the emerging synthesis.

This study is to be understood as a general approach to reforming health care systems. The perspective, then, is strongly theoretical. However, two country specific empirical cases are used to test and to support this theoretical framework. The first case discusses Finnish National health reform and the "guarantee for care" reform within it (Raisio 2009a; 2009b). This reform complex was chosen as it was seen to be a good case to exemplify problem wickedness; firstly, because it can be considered to be the most fundamental and attention attractive Finnish health care reform of 2000s and, secondly, because reforms trying to cut down the waiting times, i.e. guarantee for care, are commonly considered as type examples of highly complex problems (see Raisio 2009a: 74; see also Kenis 2006). This case, and the Finnish context, was supplemented, or, better, carried on in Article 5 (Raisio 2010).

The second case wields the Hungarian health insurance reform (Raisio 2009c). The examination was not as fundamental as with the first case. The focus was on the process; not so much on the actual content of the reform. The author spent six months (08.09.2008–28.02.2009) on a research exchange in Hungary and during that time became familiar with the process of the health insurance reform. During that time the work on Article 5 – on public deliberation and co-intelligence – was underway. Then while learning about Hungarian health insurance reform, the tie-in between the fall of this reform and the lack of public deliberation was hypothesized. The author was invited to present a commentary address at the Finnish-Hungarian Health-economic Conference at the Corvinus University of Budapest on 5th of February 2009. In the commentary the hypothesized linkage was pre-

sented. The feedback was such that it was considered that an article needed to be written on the topic. Because of the author's experiences in Hungary and because there hasn't been a similar case with a health care reform in Finland – i.e. a reform process including wide riots, strikes and referendums leading finally to the cancelation of the whole national reform (see e.g. Mihályi 2008) – this forms a good case for this study to test and support the theoretical framework.[2]

1.2 Structure of the study

In the next chapter the articles included in this dissertation are presented. However, firstly an account is given on how the theme of the research came to be what it is. Also, the relation of the discipline of social and health management to the research theme is briefly discussed. The rest of Chapter 2 focuses on the individual articles; their objectives, methods and data. At this point neither the theoretical background nor the results of the articles are wielded.

The advanced theoretical framework is formed in Chapter 3. Also, some results of the articles are picked up here, but a thorough examination in the form of synthesis takes place in Chapter 4. Conclusions, contributions of the study, limitations and further studies are included. Additionally, the reprinted articles are to be found in the end of this summarizing part of the dissertation.

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[2] However, it must be acknowledged that Hungary is a transition country. Salminen and Temmes (2000: 8) understand transition as a reformation of the post-communist countries towards a market economy and liberal democracy. As a transition country the situation in Hungary then differs significantly from that of Finland, a developed welfare state. Thus the context and the possibilities for deliberative democracy cannot be directly likened in these two countries. In Finland public participation, for example, in the form of 'near democracy' is a common practice. In Hungary institutional mechanisms for public participation are still lacking. For example Jenei (2008: 60) writes that: "The democratic political system in Hungary is in the stage of a representative democracy now. I would add that a special version of representative democracy has been implemented in Hungary. In this version, the party leaders are supposed to be charismatic, and for the citizens, democracy means regular participation in the voting process. And nothing else!" Additionally, in Hungary the confidence and prestige towards political institutions and public institutions is declining rapidly. Jenei (2008: 66) strongly calls for the emergence of the civil society in Hungary.

2 ARTICLES, METHODS AND DATA

The author's research interests in the topic of this research initially originate from two different but interlaced sources. The first of these is an article written by Vartiainen (2005) entitled "Wicked health care issues: An analysis of Finnish and Swedish health care reforms". In the article Vartiainen examines selected Finnish and Swedish health care reforms and concludes that these reforms have had many shortcomings because of the unwillingness or incapability of the reform planners to see the wickedness intrinsic in health care. The reading of the article by Vartiainen raised questions that had arisen before; especially during the writing of the author's own master's thesis on the network approach to the integration of refugee children (Raisio 2006). The main stimulus born was the question that if it is so that many social issues are indeed wicked, why it is then that those in responsibility of tackling these issues do not see the true nature of the problem, and then act accordingly?

After the research interest in the theme of problem wickedness was raised, the author got a chance to join a research project covering a similar topic. The project "Public Sector Efficiency as an Ambiguous Problem" lasted for three years (2006-2008) and was funded by the Academy of Finland (see Vakkuri 2009). The premise in the project was the same as what is implied by problem wickedness, i.e. the limitedness of perfectly rational actions in public administration. After joining, the author's research interests became more focused. As health care was one of the focus areas of the research project, this became the path taken and the question raised was that if health care reformers are facing wicked problems, what does this imply to the processes and the contents of health care reforms.

An explicit steering factor has been the discipline of the researcher, i.e. social and health management. As a discipline, social and health management is a diverged section of general administrative science (see Salminen 1995: 23; Ollila 2006: 10). The difference lies mainly in the substance, i.e. in the focus of the research. The topics that general administrative science is interested in are, among others, public services, the relation of administration on democracy and citizens, organizing and managing, and bureaucracy (Salminen 2004: 10). This research positions centrally on the theme of reforming public services in the operational context of social and health management (cf. Laaksonen 2008: 22). Also, the citizen involvement perspective is highlighted strongly.

The source material of this study is diverse. In addition to research literature on public administration and social and health management, especially political science and psychology are represented. The approach, then, is interdisciplinary.

The language of this study is bilingual. As the topic of problem wickedness was rather uncharted in the research fields of Finnish public administration and social and health management, the first three articles, focusing on the basics of the concept of wicked problems, were thought to gain most when written in Finnish. As the latter three articles focus on more specified topics, these were seen, correspondingly, to be reasonable to be published in an international area; and therefore to be written in English. Similarly, to make this summarizing part of the study to be acceptable to a wider readership, it was chosen be written in English. Next, the articles included to this study are presented[3].

Article 1. Simple health care reforms called into question: With a view of creating an ideal model to the extensive health care reform

The research process on the first article (Raisio 2007) began in autumn 2006 (see Figure 2). In it, a tentative ideal model for a health care reform was created. The article had three objectives. The first objective was to cover the theoretical discussion about the definition of, and defining, a health care reform. The second objective was to construct a tentative ideal model – based on this chosen definition and on the other background theories – for a health care reform. The thought was that this ideal model could form a framework to which implemented health care reforms could be compared. Related to this, the third objective was to open up the discussion about the rapidly changing world and to assert that simple health care reforms won't be suitable to respond to the wicked problems health care reformers are facing today; thus the ideal model for an extensive health care reform.

This first article is theoretical in nature and can be considered to be closest to a synthesizing theoretical research (e.g. Kallio 2006: 533–534). In the article different theoretical perspectives were combined to form the tentative ideal model. Literature on health care reforms, concept of wicked problems, complexity thinking and intentional change theory were used. The main reason for choosing these different theoretical aspects was their mutual compatibility. Also, in the article, the emphasis of certain references to health care reforms were justified as works of distinguished researchers and results of wide research projects (Raisio 2007: 30).

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[3] Articles 1, 2, 4, 5 and 6 went through the traditional scientific review process. Article 3 was published in an edited book. Nevertheless, it went through a rigorous peer-review. The main reviewers were two professor level academics, i.e. the editor of the book and one other writer in the book chosen to be a reviewer. Additionally, other writers had the possibility to comment and, also, there was an open seminar where the papers of the book were presented and commented on.

The strong usage of theorizing about complexity was explained by referring to the limitations of traditional approaches to reform. Instead of considering complexity thinking just as a fad, it was asked in the article that if these 'new' theories of complexity are indeed useless, why the traditional approaches of reforming health care don't then generally succeed in their objectives (cf. Grobman 2005: 353). It was considered that the changes happening all around us in the contemporary world, and the ways administrators are regarding these changes, support the affiliation of complexity thinking to the issue of reforming health care (Raisio 2007: 31). This first article will be reflected upon especially in Chapter 3.1 where the understanding of the issue of health care reform is deepened, and in Chapter 4 where the tentative ideal model for the health care reform is 'updated' to equate the researcher's present perspective to the topic.

Figure 2. Timeframes of the articles

Article 2. Conceptual examination of the concept of wicked problems: New perspectives in health care leadership

The second article (Raisio 2008) took a deeper focus on one particular aspect of health care reform, i.e. the existence of wicked problems. As the assertion was that many of the health care issues have become wicked in nature, the question then arose of what these wicked problems are and what implications ensue. This article strived to introduce the concept of wicked problems more strongly than what had been done before in the research field of Finnish public administration and health care management. This objective was realized by first defining the concept of wicked problems more widely than in Article 1 before, and then by discussing the implications ensued from the perspective of public administration and especially from the perspective of health care management. Also, the concept of wicked problems was translated into Finnish. Finnish versions of the concepts already existed (e.g. Sotarauta 1996); however a different, and more proper, one was presented.

This article, similarly as Article 1, is theoretical in nature. As the concept of wicked problems is examined in the article in more detail, the article is closest to analytical theoretical research, i.e. research being more focused than synthesizing theoretical research (e.g. Kallio 2006: 533). The review of problem wickedness was based on the then existing research on the concept of wicked problems. At the time (see Figure 2) this literature was rather modest. Literature on complexity thinking was used to supplement the theoretical discussion. Chapter 3.2 builds on this particular article.

Article 3. Wicked problems in health care: National health reform and guarantee for care reform as examples

The third article (Raisio 2009a) is a straight continuation of Article 1. In it, wicked problems in health care were examined through the examples of Finnish National health reform and a guarantee for care reform within it. Firstly, the objective was to illustrate the ambiguity of many health care issues. The main objective was to test the ideal model for a health care reform, tentatively created in Article 1. The question was about the model's applicability in reforming health care.

The research approach taken was the one of a case study; or, to be more precise, an instrumental case study (see Stake 2008: 445; Eriksson & Koistinen 2005: 9–10). Finnish National health reform and a "guarantee for care" reform within it – for the reason explained in Chapter 1 – were chosen to test and to support, but also to advance the understanding of the theoretical framework of the article; especially the constructed ideal model. As data to examine the selected reforms, documentary information was gathered (see Yin 2003: 85-88). The data consisted mainly of official documents such as planning documents and research and follow-up reports. At that time, independent scientific research was still lacking. Also, the objectivity of the official documents was acknowledged; there existed suggestions about the over-positivity of the official reports (see Raisio 2009a: 74, 87).

A tentatively constructed ideal model for a health care reform was used as an analyzing framework, i.e. the information in the documents was categorized according to the features of the ideal model. For example, when the philosophical aspects of the planning were considered, issues related to the critical and challenging addresses were scanned from the documents. However, as it was clear that not everything came into sight from the official documents, some conclusions were difficult to make. This was one reason for the further study, i.e. to a gain deeper understanding through triangulation (e.g. Yin 2003: 97–99). The findings from Article 3 will be reflected upon, especially in Chapter 4.

Article 4. Health care reform planners and wicked problems: Is the wickedness of the problems taken seriously or is it even noticed at all?

The fourth article (Raisio 2009b) focused similarly on Finnish National health reform and a "guarantee for care" reform within it; and thus supplemented Article 3. In the third article it became clear that the results of the examined reforms weren't what were expected. The assertion was that the planners of the reforms did not focus enough on the complexity of the problems they tried to solve. Thus, Article 4 strived to answer the question of how the planners of the health care reforms saw the problems they were trying to solve. The objective was to get a better understanding of the issue of why health care reforms tend to fail.

Twelve interviews were made (see appendixes 1, 2 & 3). The interviewees consisted of people in high status positions, who in some way participated in the planning of the reforms under examination. The interviewees were selected so that they would present widely different perspectives on the theme of the article. There were representatives of the executive group of the National health reform, representatives of every planning work group of the National health reform, representatives of the so called 'queue -work group' – focusing specifically on the issue of guarantee for care – and representatives of the monitoring group of the National health reform. Also, third sector representatives were included as interviewees even though their role in the planning was only marginal. The potential of the third sector, however, is highly significant, so their voice is important to be heard; especially to gain a better understanding on the topic of the study. Some of these interviewees had multiple roles and a wider perspective on the subject (see Raisio 2009b: 478). Additionally, the interviewees consisted equally of men and women.

The focus of the article was specifically in the planning processes of the examined reforms. This was the choice because the role of the planning process was considered to be of major importance. Jalonen (2007) has also used this justification, from the perspective of decision making in municipalities: "…decision making is the acceptance of prepared propositions and the real power is used in the preparation of matters".

The interviews were conducted mainly at the workplaces of the interviewees. The average time for each interview was one hour, the longest being one and a half hours. The interviews were recorded and transcribed. The interview method was semi-structured thematic interview. The themes were clear and the questions were made according to these themes. The questions asked in the actual interviews depended on the answers and backgrounds of the interviewees. Not all the questions could be asked from all interviewees, i.e. the questions worked more as assistance

than as a strict structure to follow. Therefore, the interviews were conducted more like discussions than perfectly structured interviews. This way the individual voice of the interviewees came more clearly into view (e.g. Hirsjärvi & Hurme 2001).

The research analysis was theory originated content analysis (e.g. Tuomi & Sarajärvi 2002). Thus the analyzing framework was built from the themes of the article's theoretical background. Similar to a tree diagram, the main themes were identified from the theory and then divided into sub categories (see Gillham 2005: 139–140). The interview material was then divided into these different themes and categories. The results were illustrated using these particular themes. For example, the first analyzed theme was how the interviewees considered the complexity of the problems the examined reforms tried to solve. This theme was consequently divided into three categories depending on the perspectives of the interviewees (see Raisio 2009b: 483–484). The results from this interview study are illustrated especially in Chapter 4.

Article 5. Public as Policy Expert: Deliberative Democracy in the Context of Finnish Health Care Reforms and Policies.

In the fourth article, one particular view of wicked problems and health care reforms emerged. A part of the interviewees stated that the process of planning the examined reforms was more authoritarian than collaborative, i.e. for example third sector organizations weren't included enough in the planning and the patients were left out of the planning processes. This was seen as a major flaw. From these notions and from the background theories, the views of co-intelligence and deliberative democracy emerged. These became the author's dominant research interests.

The fifth article (Raisio 2010) then focused on the role of public deliberation in tackling wicked health care problems. There were three objectives in the article: to explain why the increase in public deliberation is needed, especially in the context of the Finnish welfare state; to describe the forms of public deliberation used in Finland; and to survey the views of representatives of Finnish patient and disability NGOs[4] and Finnish citizens about the possibilities for better public involvement.

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[4] Originally the objective was to compare the views of Finnish patient and disability NGO representatives to their counterparts in England (see appendix 4). However, because of the low response rate on the part of English NGO representatives, the examination in the article focused solely on the views of Finnish representatives.

On the last objective, two electronic surveys were carried out. The first survey was sent to 30 representatives of Finnish patient and disability NGOs (see Appendices 4 & 5). These formed a large part of Finnish patient and disability NGOs working on the national level. The response rate was average (63,3 %) as 19 representatives responded. Twelve of the respondents were executive directors or secretary generals of these national NGOs. The rest of the respondents varied, for example, from a chairperson to a development director. The respondents were quite evenly from major national NGOs – the largest having more than 100.000 members – and from small national illness specific NGOs with a few hundred members. Therefore, also the positions of the respondents were diverse. For example, a secretary – one respondent – was a significant actor in a small national organization with only a few paid employees.

Respondents were asked open questions using a qualitative electronic survey. The questions were about the role of NGOs and the patients, or clients, to influence the planning of health care reforms and policies in Finland. In the article, as the focus was on citizen involvement, questions about the role of citizens, or in this case patients and clients, were analyzed[5]. The responses were analyzed using theory originated content analysis, where the theoretical concepts are already known (Tuomi & Sarajärvi 2002). Therefore, instead of letting the empirical data dictate the content of the theoretical concepts, the empirical data was used to preliminarily test the suggestions already made in the article, i.e. about the importance of better public involvement. The analysis framework consisted of two main categories; the first one being about how the respondents saw the role of patients, or clients, to influence the planning of Finnish health care reforms and policies, and the second about the question if the role of patients, or clients, should be increased in this particular context.

The second electronic survey consisted of the views of the Finnish citizens themselves (see Appendices 6 & 7). 'E-Lomake' program was used; as it was also used in the NGO survey. Finland's Ministry of Justice supported the survey by agreeing to post information about it, with a link to the survey, on their website called Otakantaa (voice your opinion, see www.otakantaa.fi). As the idea of Otakantaa is to increase the possibilities of citizens to influence the societal decision making, it was an ideal location to ask citizens their views about the theme of this

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5 As the main assertion in the article was that citizens are experts in their own right, by being experts of the lived life, representatives of Finnish patient and disability NGOs were asked how they considered this to be from their point of view. These NGOs represent citizens who meet these wicked health care issues in the point of greatest impact, i.e. patients/clients. The main question was if NGOs acknowledge this expertise.

article. However, the Otakantaa-website is not well known in Finland. Therefore, 11 major national patient organizations were also asked to promote the questionnaire to their members. Ten of the organizations agreed to do this. Information about the questionnaire was then published on their websites, discussion platforms, internet magazines and journals.

It must be acknowledged that the common critique to electronic surveys applies (see e.g. Fontana & Frey 2008). Responses have then been biased to citizens who are more active than average citizens, and who have an internet connection and are able to use it. They visit these government or NGO websites, or read the NGO member journals. Also, they find the time to respond to the survey. This is an important factor as the opinions of the people who are passive or who do not have an internet connection, are very likely lacking. However, due to the cost issues of traditional surveys – and as the objective was not to gain a representative sample – an electronic survey was seen as an appropriate research approach.

Overall the survey got 153 responses. The background variables were such that women over-represented men (74 % to 26 %), that working age population over-represented the young and the elderly (89 % to 11 %), and that respondents with higher professional education, i.e. college, polytechnic or university education, over-represented respondents with lower professional education, or none at all (71 % to 29 %). Additional variables were occupational group and the place of residence. In occupational groups it was important to notice that especially the unemployed were under-represented (3 %). Additionally, in the place of residence, one province was highly over-represented (47 %) compared to other 19 provinces. This particular province was the capital area (Uusimaa). Therefore, in additional to the modest sample size, the background variables implied that the results cannot be generalized to the whole Finnish population. However, as the objective of the article was not to have generalized results, but to preliminarily survey the views of a small group of citizens on what they think about the questions presented in the article, the sample could be acknowledged as adequate for the purpose.

The electronic survey had both qualitative and quantitative questions. The quantitative questions which formed the main part of the survey were analyzed using descriptive analysis, i.e. the results were presented in simple percentage values. The qualitative questions were analyzed with content analysis. These questions were about different kinds of participation methods. Additionally there was space to write comments about the survey at the end. However, these questions about participation methods were discussed in another publication (Raisio 2009d), but because respondents wrote actively in the free space – about their willingness to

participate etc. – the comments related to the theme of the research were presented briefly. Finally, the background theories of the article make the foundation for Chapter 3.3. Findings are reflected in Chapter 4.

Article 6. Deliberating Together: Public Deliberation in the Context of the Hungarian Health Insurance Reform.

The sixth article (Raisio 2009c), as explained in Chapter 1, continued on the theme of the importance of the deliberative democracy and co-intelligence in reforming health care. The Hungarian health insurance reform, as a highly debated and ultimately failed reform, was considered to be an apt case to exemplify the issue. Based on document analysis, the objective of the article was to illustrate how public deliberation could have improved the process of reforming Hungarian health care.

The gathered documents consisted of the available English literature on the Hungarian health insurance reform. Additionally, the author's own perceptions gained during the six-month-research exchange in Hungary supplemented the literature. Because of the lingual dilemmas, the observations in the article were, however, presented mostly on a general level. Moreover, the focus was on the process of the reform; not on the content. Thus, first the process of the reform, i.e. "the rise and fall of the new health insurance act" (Mihályi 2008), was presented, after which it was analyzed according to the theoretical framework of the article. Chapter 4 reflects the findings of this article[6]. Lastly, a summary of all the above presented articles is presented in table 1.

[6] Additionally two more papers by the author et. al. (Raisio, Vartiainen, Ersek & Gulacsi 2009; Raisio, Valkama, Isosaari, Ollila & Vartiainen 2010) wield this particular theme of deliberative democracy and co-intelligence.

Table 1. Articles, research approaches and data

	CENTRAL THEME	**MAIN OBJECTIVE**	**DATA**	**RESEARCH APPROACH**
No1	Wicked problems and an ideal model for a health care reform	To construct a tentative ideal model for a health care reform.	Literature on health care reforms, concept of wicked problems, complexity thinking and intentional change theory	Synthesizing theoretical research
No2	Wicked problems in the context of public administration and health care management	To produce a wide review on the concept of wicked problems	Mainly existing research on the concept of wicked problems	Analytical theoretical research
No3	Continuation to Article no.1; a case study approach	To test the tentative ideal model for a health care reform	Mainly official documents such as planning documents and research and follow-up reports.	Document analysis
No4	Health care reform planners and wicked problems	To get a better understanding of the issue of why health care reforms tend to fail	Twelve semi-structured thematic interviews	Qualitative interview study
No5	The roles of co-intelligence and deliberative democracy in reforming health care	To survey the views of NGOs representatives and Finnish citizens about the possibilities for better public involvement.	Views of NGO representatives: 19 responses. Views of citizens: 153 responses	Two electronic surveys including both quantitative and qualitative elements
No6	Continuation to the theme of Article no.5; a case study approach	To illustrate how public deliberation could have improved the reform process of the selected case.	Available English literature on the Hungarian health insurance reform.	Document analysis

3 ADVANCED THEORETICAL FRAMEWORK

Later on, as a synthesis, an ideal model for a health care reform, from the perspective of problem wickedness is constructed. This takes place in Chapter 4. Firstly, the advanced theoretical framework is presented. As a foundation, in Chapter 3.1., the discussion concentrates on health care reforms more generally. 'Why reform?' and 'What reform?' are the questions asked. After this, in Chapter 3.2., the concept of wicked problems and its implications are examined. Also, this concept is affiliated to a wider conceptual framework, i.e. complexity thinking, in Chapters 3.2.5 and 3.2.6. The third theme consists of the idea of co-intelligence and deliberative democracy. These are discussed in Chapter 3.3. Some findings of the individual articles are presented within this theoretical framework. However, a more thorough discussion takes place in Chapter 4.

3.1 Health care reform – the foundation

3.1.1 Why?

Reforming health care has been a continuous trend; lasting the better half of the preceding century and still continuing as strong as ever. This can be seen clearly in the three overlapping generations of 20th century health care reforms, defined by WHO (2000; see also Frenk, Sepúlveda, Gómez-Dantés & Knaul 2003). The first generation of health reform formed the basis of national health care systems, for example, the National Health Service (NHS) in the UK in 1948. In developed countries these reforms took place mostly in the 1940s and 1950s, and later on in developing countries. For example, in the case of Finland, the hospital system got a major push forward in the 1950s and 1960s and the national health insurance scheme was introduced in 1963 (Vuorenkoski 2008: 21-27). However, because of the high costs generated by the hospital centrality of the care, these health care systems came soon under pressure to change their policies.

As a result, the second generation of reforms, promoting primary health care, was implemented. The objectives were to achieve affordable universal coverage (WHO 2000: 14) and more specifically, for example in the case of Mexico, to make the overly centralized health care systems more accessible by extending basic care more strongly to the rural and urban-poor populations (Frenk et. al. 2003). This imbalance between the focus on hospital care and on primary care was seen clearly in Finland. The percentages of total public health expenditure spending were 90% and 10%, respectively. The concentration of health care ser-

vices to urban areas was also noted. Therefore, in the beginning of 1970, Finland started to reform its health care system to be more primary care focused (Vuorenkoski 2008: 22).

The second generation of health care reform had its problems. One of the strongest critiques was the strong need-orientation of both the first-generation and second-generation reforms. (WHO 2000: 14–15). The third generation of health care reform took a more demand-oriented approach. Instead of concentrating mostly on presumed needs, the focus came to be more on perceived quality and responsiveness. Therefore, these reforms embraced solutions such as "separation of financing from the provision of services to stimulate competition and accountability; evaluation of health interventions with the goal of designing cost-effective benefit packages; programmes for the continuous improvements of quality of care; and increased participation of citizens in their care" (Frenk et. al. 2003: 1669). All these solutions can also be seen to be progressed in Finnish health care (see. e.g. Vuorenkoski 2008).

The strategies to reform health care are various. However, four main themes can be identified (WHO 1997, Salmela 1998). These have been defined to characterize the reforms of the 1990s, but can still be considered to be in fashion (see Hunter 2008a). The first theme has been about the changing roles of the state and the market in health care. Countries with a strong role of the state in health care sectors are reassessing the role of the state, and countries with a lesser role of the state in the health care sector are similarly reassessing the situation but from the opposite perspective. The second theme concerns decentralization. The view that centralized systems are inefficient, nonresponsive to changes in environment important to health and health care, and slow to change and to produce innovations make decentralization seem an attractive choice. Increasing the role of patients, by giving greater choice in selecting doctor and hospital, in actually participating in medical decision-making, or in allowing them to participate in local policy-making, forms the third theme. The final distinct strategy is to develop the role of public health. Awareness of the role of the public health has grown since, but still doesn't always get the attention it deserves (see e.g. Rimpelä 2004).

Reforming health care can be considered not only as a continuous process, but also as a natural one (Raisio 2007: 21–22). It is a dynamic process of development and evolution. In a positive meaning this means that reforms are implemented to improve the health care system and, more importantly, the health of the population (e.g. Seedhouse 1996a). Similarly, referring to Ackoff (1974: 28), reforming health care can be seen as a process of evolving with the changing world and as a vision of creating a desired future (see Raisio 2008: 35–36). However –

to be more concrete – the reasons for health care reforms can be perceived through two different sources; pressures coming outside and reasons existing inside the health care system (WHO 1997; Figueras, Saltman & Sakellarides 1998).

Macroeconomic realities, i.e. the condition of the overall national economy, form one of the most important pressures to reform health care (e.g. Salmela 1998). Given these pressures, it might be that regardless of how well the public health care system performs, it might face inevitable cost cuts (WHO 1997: 10; see also Raisio et.al. 2009). Pressure is then coming clearly from outside the health care system. Similarly, Pollitt and Bouckaert (2004: 32) point out a group of reasons not to be confined to any specific sector of society. This grouping consists of "chance events such as scandals, natural or man-made disasters, accidents and unpredictable tragedies such as shootings or epidemics". The influence of these isn't always so clear, but, nevertheless, it can be significant.

Peters (2001: 45–52) – from the viewpoint of administrative reforms – divides factors pushing to reform into three separate but partly reinforcing groups. These can be considered as general reasons to reform[7]; existing both within and beyond the health care system. The first group consists of administrative factors. Disappointment and success, both, paradoxically settle into this group. Firstly, disappointment in the results of previous reforms can lead to further reforms. Secondly, success can encourage governments to see how far they can go with the change. Also, rather than just a disappointment, reforms can produce unplanned outcomes and negative side-effects, i.e. perverse consequences, which need to be corrected with new waves of reforms. Additionally, the thinking that 'the grass is always greener on the other side of the fence' can beget further reforms; there are always alternative and maybe more attractive ways to reform.

The problems with the measurement of and limits to reform depict the second group; consisting of technical reasons (Peters 2001). Measurement causes difficulties because in practice it is highly difficult to measure what has been achieved with individual reforms. Also, it is at least as difficult to know the limits of how far it is possible to go with the reforms. To Peters (2001) the last group of factors driving reforms is perhaps the most important one. These political reasons include the paradox of quality; changes in parties and politics; running for office; the possibility of going too far; and organizational politics.

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[7] For an extensive list of external factors driving to reform, see Bovaird and Loffler (2009b: 16–18).

Firstly, by opening channels for 'voice' on quality concerns – quality which actually might have been improved even though perceived otherwise – these issues become difficult for politicians to ignore. Also, obviously, when parties and politics change, also reform objectives may change (e.g. Hyyryläinen 1999: 83). This can be seen, for example, in the Hungarian health care reform where the change in health ministers and therefore also in the reform objectives has been spectacular (see Szócska, Réthelyi & Normand 2005; Raisio 2009c: 264). Thirdly it might be beneficial to continue reforms when running for office. As a result "administrative reform may simply have become what governments do" (Peters 2001: 51). Fourthly, it is possible to go too far with reforms which can lead to the 'rewinding' of implemented changes. Lastly, organizational politics, for example as some central agencies want to maintain or reclaim their dominance, can influence the continuation of reforms.

Acknowledging the factors presented above, the exterior pressures to reform health care can be roughly divided into political, ideological, social, historical, cultural and economic reasons (WHO 1997: 5–38; Figueras et.al. 1998: 1–4). Demographic and social pressures have their role to play in all of this. These include, among others, the aging of the population, technological developments, growing expectations of citizens and patients, political requirements – mentioned by Peters (2001) above – and influences coming from corporate management strategies, e.g. New Public Management (WHO 1997: 10–13).

Also, the public itself forms a distinct pressure to reform health care. According to Figueras et.al. (1998: 5), "health care services, like other human service systems, closely mirror the deeply rooted social and cultural expectations of the citizenry as a whole". With this they refer to questions such as if health care should be a collective good or a market commodity; or what should the role of the state be when it comes to health sector. The norms and values of the society have an influence on these central principles of the health care system and therefore, if the system and the values differ, pressures to reform increase.

Then there are pressures to reform surfacing specifically from the core of the health care system. Health challenges, such as the changing patterns of disease and the rising levels of chronic disease, call for change in how health care is organized (see e.g. Kanavos & McKee 1998). Pressure on health expenditure is also a significant factor. Demographic and social pressures covered above, such as the fast aging of the population, improved health technology, and the rising expectations and demands of population, are putting pressure on health expenditure (Salmela 1998). Lastly, the pressure to reform health care arises from structural and organizational challenges. These, among others, are limitations to maximize

health gain with the dominating health care system, rising inequities in health care, inadequate cost-effectiveness, inefficient health system performance, concerns with service quality and patient empowerment (WHO 1997: 36–38; Flood 1999: 1–3). All these factors create skepticism towards the approaches to health care systems, as they exist now, and form the final distinct force leading up to health care reform (Roberts, Hsiao, Berman & Reich 2004: 11–17).

Lastly – as it can be seen from the three overlapping generations of 20th century health care reforms – it can be asserted that health care reforms have an intrinsically episodic and cyclical character. This is caused by certain characteristics of health care systems. Roberts et. al. (2004; see also Vartiainen 2008: 47) name these to be the complexity of the health care system, its resistance to change and the diverse perspectives within it. To concretize, the initial reforms can, for example, cause perverse consequences, as stated above by Peters (2001), which, for one, lead to further reforms.

3.1.2 What?

Above, the pressures to reform health care, as well as general reform strategies to face those particular pressures were presented. But what in actual fact is a health care reform? It is clear that no final definition for a health care reform exists which is accepted by everyone (WHO 1997). It is not the objective of this study to develop either; only the framework for such a definition is suggested. We can start by examining the different kinds of changes in the public sector and in health care – those being actual reforms or not.

Firstly, a distinction can be made between incremental and comprehensive reforms (Fuchs & Emanuel 2005; see also Pollitt & Bouckaert 2004: 182–202), or similarly, between evolutionary and structural reforms (OECD 1994). Incremental and evolutionary reform, or rather change, is a continuous process of almost day-to-day change. These changes can be acknowledged to be not such an optimal way to achieve fundamental changes. But these are politically easier to implement. Reforms that achieve more radical changes, at a faster pace, can be called comprehensive or structural reforms. The stage for a radical health care reform is, however, more difficult to build than is the case with incremental and evolutionary changes. As Fuchs and Emanuel (2005) state, in the case of US health care, major reforms may need situations such as national health crises, depression, civil unrest, or even a war. Or it might just be that the people start to realize that the risks of contemporary health care systems are more critical than the risks embodied in proposed fundamental reforms.

Similarly, Ingraham (1997: 329–330) makes a division between the incremental model, the staged model, and the fresh start model of a reform. For her, these different reform models don't so much differentiate in the expectations created for governments, but more on the actual processes of the reforms. As the reforms of the incremental model are implemented to 'nudge' the existing base system to do new things, the reforms of the staged model and the fresh start model go further by addressing more fundamental issues and also by attempting to create new foundation conditions. The difference between the staged model and the fresh start model is, therefore, not in the fundamentality of the reforms, as both try to achieve it, but on the rapidity of the reform implementation. As the reform of the staged model is implemented, as the name suggests, in stages, the reform of the fresh start model is implemented more rapidly, as the case was in New Zealand. Ingraham (1997) points out, partially completing Fuchs' and Emanuel's (2005) view above, that even though the stage for incremental reform is easiest to achieve, as it requires the least political will, it can, after all, be the most political of these three models. This is because of the continuous tinkering of the system with small changes unable to achieve effective fundamental change.

Berman & Bossert (2000), as they also divide health care reforms into two distinctive groups, continue this polarization of reforms. They name these to be 'big R' and 'small R' reforms, the preceding being more strategic and fundamental and the latter more limited, partial and incremental. The divide is made through factors called 'control knobs', which will be introduced later more precisely. If only one of these control knobs is influenced by the reform, then it is a 'small R' reform. Those reforms which involve at least two control knobs can be considered to be 'big R' reforms. The important difference, then, is about the fundamentality of the health care reform.

Polarization can be done also by considering the purposefulness of reforms. In this case, the discussion is between the imposed reforms and purposeful reforms (Berman & Bossert 2000; DDM 2000). The idea behind this divide is that the concept of health care reform doesn't include all the changes taking place in the health care system. There are changes imposed by wide governmental initiatives, such as major state reforms, which can produce change in the health care system, but which cannot be considered to be health care reforms. According to Berman and Bossert (2000: 4) this distinction makes it possible to "evaluate health reforms on their own terms as purposeful means of achieving articulated goals". This is so because imposed reforms don't usually explicitly include a goal to improve the health system, even though improvements, or deterioration, may happen. As Berman and Bossert (2000: 4) continue "we should be cautious in calling

such changes ‘health sector reform’, since they may tell us little about purposeful programs of health system change”.

Seedhouse (1996a) continues by differentiating between the reforms of the public and private sectors. A private sector reform, such as reforming a commercial enterprise, is, maybe a bit aggravatingly, a straightforward business. The logic of the process is easy to see. Usually there is one single dominant purpose; maximizing profit. Reforming the public sector is more complex, as there hardly ever is one dominant overall purpose. Or it might be that the overall purpose is not clear and it is disputed. Often it can also be that these purposes conflict with each other, such as the case can be with cost-effectiveness and equity of services provided (e.g. Raisio et. al. 2009). This makes public sector reform a highly complex process (see Raisio 2009a; Raisio 2009c)

To continue, in health care reforms this complexity is even more immanent, as health care reforms have additional ‘unique’ aspects. Lundberg and Wang (2006: 46) wield these familiar aspects, which they name “the definition of equity, moral hazard and agency, asymmetric information and adverse selection, and other confounding factors”, however admitting that the same aspects can be seen in some form also in the other public sector reforms. In health care reforms these aspects are nonetheless more complex and confounding. One example of a slightly distinguishing feature is that compared to some other public goods and services, health care is only one influencing aspect to health. There are also many other aspects which need to be understood. Taking an example from Lundberg and Wang (2006: 46-48), the efforts to gain better health outcomes through health care reforms, implemented for example to construct clinics, may be futile, if the population doesn’t have access to clean water. The point is that “health care is not same as health”. Health is a result of many inter-related factors, which health care reforms need to take into account. Therefore it must be acknowledged that health care reforms don’t take place in isolation. As López-Acuña (2000: 4) states, health care reforms are often part of “Economic and Social Reforms, are affected by the course of Political Reforms and are closely intertwined with Public Sector Reforms”. This doesn’t however necessitate imposed reforms, as described above (see Berman & Bossert 2000:4). What is important is that health care reforms should acknowledge and work together with the other interrelated reforms in the public sphere.

Above, many different kinds of divisions are made. All of these describe changes but not all are necessarily reforms. Two aspects have been emphasized; fundamentality and purposefulness. The definitions of public sector reforms and health care reforms support the role of these two aspects. Firstly, Boyne, Farrell, Law,

Powell & Walker (2003: 3) define public management reforms as a "deliberate change in the arrangements for the design and delivery of public services". Similarly, Pollitt and Bouckaert (2004: 8) consider public management reform to consist of "deliberate changes to the structures and processes of public sector organizations with the objective of getting them (in some sense) to run better". Reform is then intentional, purposeful, change: it includes the element of planning. Secondly, for example, the definitions of health care reforms by Cassels (1995) and by Figueras, Saltman and Mossialos (1997) emphasize the fundamentality of reforms. Health sector reform is "concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented" (Cassels 1995: 331) and is "a sustained process which involves profound institutional and structural change, aiming at the attainment of a series of policy objectives and led by the government" (Figueras et.al. 1997: 16). These two definitions imply, implicitly, that just the redefinition of policy objectives is not enough: also institutional and structural changes are needed for reforms to succeed.

Bannink and Resodihardjo (2006) also include fundamentality and purposefulness in their definition of a reform. For Bannink and Resodihardjo (2006: 3), reform is "fundamental, intended, and enforced". For them, fundamentality means changes in structures or paradigms, or both. Intentionality is defined as a reform being "the result of conscious decision-making and planning processes" (Heyse, Lettinga & Groenleer 2006: 172). Enforcement brings in the third aspect of reform. It means that the reform has actually been put into force.

All these preceding divisions and definitions support the definition of health care reform chosen, in this study, as a foundation to build on. Health care reform is then a purposeful, fundamental and sustained change in health sector, a definition developed in the Data for Decision Making Project of Harvard University (Berman 1995: 15–17). To be more specific, fundamentality means a "substantial change, something more fundamental, complex, and extensive than just another new project or program". Sustainability means that "change must be more than just a one-time effort or sudden windfall – it must make a real difference in the way things work over time". Purposefulness means "clearly defined objectives, strategies for achieving those objectives, and effort to monitor change and modify strategies as needed". With the health sector it means "the totality of policies, programs, institutions, and actors that provide health care – organized efforts to treat and prevent disease". With change is meant a positive one. Finally it is emphasized that reform is a change that builds upon and improves what already exists. If health care would change its objective to provide something else than health and health care, the case would then be about a radical change, not health care reform. As Seedhouse (1996a: 3) defines it "any reform must aim to recon-

struct an existing structure or system in order to enable it to achieve its original end(s) in an improved way".

The purposefulness, fundamentality and sustainability of a health care reform will be examined next more specifically. However, from this point on the concept of purposefulness will be named differently. The concept of deliberativeness (e.g. Hartz-Karp 2007a) will replace the concept of purposefulness. It is seen that the concept of deliberativeness includes purposeful actions, e.g. clearly defined strategies, but goes a bit further with a stronger focus on the role of careful deliberation. This will become clearer, especially in Chapter 3.3.

Deliberativeness of a health care reform

If the deliberativeness of a health care reform would be just considered to be a process involving some sort of planning, it would be a far too simplistic picture. As the name suggests, deliberative reform includes a more holistic approach to the planning of health care reforms. Instead of purely logical and analytical process, the discussion is more about a contemplative process, i.e. a process based on deep serious thoughtfulness. To argue, because there is no one right way to reform and because a myriad of factors influence the reform process (e.g. Heyse, Lettinga & Groenleer 2006; Baumgartner 2006), the mechanistic approach isn't enough alone. However, as Heyse, Lettinga and Groenleer (2006: 185) write: "Precisely because there is no single path to reform, we should be optimistic about the possibilities of governments to carry through reform". To continue, precisely because of this, there not being a one right path forward, the analytical approach must be merged with the political and ethical approaches, that being a deliberative and contemplative overall approach to reform health care.

Firstly, health care reform is not only a technical process. The reform of health care will never get everybody's acceptance nor will rational arguments alone be able promote it (see Berman 1995). Therefore, it is as much a political process as a technical one (e.g. López-Acuña 2000). As aggregated by Brown (2006: 95), the analytics' role is mainly to begin the reform process. The rest of the process is guided by the "obscure logic of politics". The example often used is the failed US health care reform of President Clinton in the early 1990s. According to Hacker (2008) the greatest lessons from that particular failure is that "politics comes first". Therefore it doesn't matter how ideal the reform plan is technically, if it doesn't have the political support to be adopted (Roberts et. al. 2004). Also Figueras et.al. (1998) agree with this; health care reforms often focus on content, neglecting the actual of process of reforming. And as they continue, it is often the process of reforming, not the merit of the reform programme, which makes reforms fail. This can be hypothesized to have been the case, for example, with the

failing of the late Hungarian health insurance reform (see Raisio 2009c). Morone and Blumenthal (2008: 723), writing about how to achieve universal health care in the US, take this view a bit further by stating that sometimes the analysts need to be 'hushed': " Providing health care to the entire population never fits the economic program… the economic advisors have always counseled against reform… If you want health reform, hush the economists and plunge ahead. Rationalization and cost control will have to follow at a later day". Clearly, technical, political and ethical values interact with each other.

Roberts et. al. (2004) support this holistic approach to reforming health care. Narrow approaches, such as concentrating only on technical issues, only cause unintended consequences and difficulties. The reformer cannot ever fully understand the situations where reforms happen, but by concentrating equivalently on technical issues, political context and ethical choices, a deeper understanding is possible. It is clear that health care reforms cannot rely on technical issues alone, depicted by scientific data. As Roberts et. al. (2004) state, important issues, such as defining the priorities for health care reforms, inevitably involves ethics. But instead of a 'conflict', the real issue here is more like a 'symbiosis' of the technical, political, and ethical aspects of reform (see Raisio et. al. 2009). To gain political agreement, both ideals and ideas are needed. Ideas will be achieved with science, ideals with ethics. Ideas will increase the evidence baseness of reforms. Ideals will increase the integrity. They work in harmony. (Frenk & Gómes-Dantés 2009: 1406.)

Seedhouse (1996a; 1996b) also focuses on the balance between the logic and philosophies of health care reforms. For him the facts alone aren't enough. To gain depth in the understanding of health care reforms, philosophical questions need to be addressed. Therefore, the health care reform debate takes place on least on two overlapping levels. First, there are pragmatic questions, such as 'which services are cost effective?', and secondly, there are more philosophical questions, such as 'which services should be prioritized and on what grounds?'. There are also fundamental questions combining both philosophies and pragmatics such as 'what really is a health care system'? According to Seedhouse (1996b: 229) pragmatic questions often dominate the discussion about health care reforms. In proportion, philosophical issues are underappreciated or even ignored altogether, as it is thought that they don't provide the needed answers. But when health care reforms are planned, both the logical and philosophical perspectives are needed. How to reform something, if it isn't even known what it is, that is reformed?

Without philosophical thinking, the innovativeness of reforms is absent, or at least inadequate. In health care systems this can be seen, for example, in how the

health care system is defined. Without "philosophical theory of health" health care systems are defined by the "philosophical default" (Seedhouse 1996a: 10). Most often this would be the definition of a health care system as a medical system (see e.g. Hunter 2008b). Purely logical health care reforms would then just try to improve this existing system. If there would be more philosophical thinking in the background, the question could be more about how the reforms could improve the nation's health. The innovativeness of reforms would then be expanded substantially. A partial paradox referring to this issue can be seen clearly in health care. This is the 'paradox' of highly innovative health care technologies and therapies provided by static health care organizations (see Teperi et. al. 2009: 107). There exists a 'status quo' in the health care system which cannot be broken by logical thinking alone. However, as Roberts et. al. (2004) write, the pressures to reform health care, as stated above, don't only form a challenge but also an opportunity. An opportunity for breaking the 'status quo' exists because the crises resulting from pressures to reform can lead to openness to change and innovation.

As Stambolovic (2003) writes of an "epidemic of health care reforms" he refers in a significant manner to the preceding. According to him, most of health care reforms are based on "principles of social engineering", i.e. on purely logical thinking based on the mechanistic paradigm. As a result, reforms are implemented one after another while the status quo is maintained:

> *"Thus, health care experts, as engineers of reforms, are striving to change health systems while maintaining the status quo. They want to improve efficiency, effectiveness and equity, but at the same time they are reluctant to challenge the fundamentals so that they protect those dominant interests that have made health care systems the way they are…This is why engineers of health care reforms seeking to abandon the production of epidemics should change their role to that of a catalyst."* (Stambolovic 2003)

Fundamentality of a health care reform

Health care reform's fundamentality is a highly important issue. As Robinson (2008: 620) states: "The greatest challenge facing reformers is the complexity of the health care system and the interdependence of each piece on the others". This interdependence of the different parts of health care system makes it hard to implement reforms focusing on only one or a few parts of the system. Therefore, to be successful, the reform needs to consist of interdependent and mutually supporting approaches (Roberts et. al. 2004).

'Control knobs', defined originally by Hsiao (see e.g. Hsiao 2003), illustrate this issue of fundamentality of health care reform further. Control knobs are understood as something that can be adjusted by the actions of governments and which

have significant influences on a health care system's performance (Roberts et. al. 2004: 26). To be more concrete, these control knobs cover significant aspects of the health care system's structure and function. These 'five critical categories for health-system reform' are: financing, payment, organization, regulation and behavior (see Table 2 for a detailed description).

Table 2. Hsiao's 'control knobs' for fundamental reform (Roberts et. al. 2004: 26–28)

CONTROL KNOB	INCLUDES…
Financing	…mechanisms for raising money for health sector activities, such as taxes, insurance premiums and direct payment by patient; the design of the institutes which collect the money; and allocation of resources to alternative options.
Payment	…methods for transferring money to health-care providers, i.e. doctors, hospitals etc., such as fees, capitation and budgets.
Organization	…the mechanisms used to influence the mix of providers in health-care, their roles and functions, and how the providers operate internally. These typically include measures influencing competition, decentralization, and direct control of providers.
Regulation	…" the use of coercion by the state to alter the behavior of actors in the health system".
Behavior	…"efforts to influence how individuals act in relation to health and health care, including both patients and providers", such as mass media campaigns on smoking and using the medical society to influence physicians' behavior.

To continue, if the question is about a fundamental reform, then the use of more than one control knob is needed. For example, regulation alone can rarely achieve results without the complementary efforts of the other four approaches. The environment needs to be such that the regulation can be realistically followed. Also, just like changing the sides of a Rubik's Cube (see e.g. Robinson 2008), changing one of the control knobs influences the other control knobs. For example, the payment of physicians can influence their behavior. Not to be naïve, it must be strongly emphasized that there are, additionally to these five control knobs, a myriad of other factors influencing the process of health care reform. These might be issues that cannot be influenced by health care reforms, but, nevertheless, by trying to take these factors into consideration, reformers can better understand the confronted problems. (Roberts et. al. 2004: 29–30.)

To come back to 'small R' and 'big R' reforms, defined by Berman and Bossert (2000), the fundamentality of reforms is emphasized ever further. 'Small R' reforms aren't fundamental reforms. They focus on only one of the 'control knobs';

one part of the health care system; one part of the population; or one type of health care service. These reforms don't fundamentally transform the system. Of course, 'big R' reforms are usually made up of many 'small R' reforms. This doesn't, however, mean that many 'small R' reforms which are implemented independently of others, would together automatically equate with a fundamental 'big R' reform. Instead, 'Big R' reform consists of many interdependent and mutually supporting factors and as a whole it is more than just the sum of its parts. (Berman & Bossert 2000: 9.) Rhetorically, the fundamentality of health care reform doesn't just refer to the many different parts of the system that are reformed, but also to the essence that is 'born' from the sum of these reform actions.

Sustainability of a health care reform

Because of many reasons covered above, most reform efforts fail (Baumgartner 2006: 196). The more fundamental the implemented reform, the harder the process of reform becomes. Therefore many ideas for large-scale reforms stay just that; ideas. Reforms, however, are much more than just ideas, or fleeting changes (WHO 1997: 3). Reforms are changes which are sustained. As deliberativeness is the foundation for reform throughout its existence, and as the role of fundamentality has most of its strength in the planning and implementation phase of the reform, sustainability comes forward strongly, especially after the actual establishment of the reform. Sustained reform is much more than just enforced reform. As enforced reform, in the narrow definition, means that the reform has been implemented (see Bannink & Resodihardjo 2006: 3), sustainability refers to the phases which take place after the reform is already in place. So the starting point for the sustainability of reform is that the reform has already been 'enforced'.

Firstly, sustainability can be examined from the viewpoint of 'political sustainability'. With this Patashnik (2003: 207) means "the capacity of any public policy to maintain its stability, coherence, and integrity as time passes, achieving its basic promised goals amid the inevitable vicissitudes of politics". This is especially important when the question is about a 'general-interest reform'; a reform where special-interest benefits are decreased to gain more universal benefits, such as the US health care reform in the beginning of the 1990s. These reforms can be adopted, but their political durability is another, more difficult matter. A similar case can be considered to be with 'general-loss reforms' where basically a whole population is facing sacrifices, for example, in the form of introducing a visit fee for health care services (see Raisio 2009c) or when certain health care services are centralized so that the distance to the services lengthens remarkably (Raisio et. al. 2009).

There are many threats for reform to be dismantled politically. At the deepest level this can be understood that every reform has a chance to be reversed. Political decisions are never forever binding, as can be seen from Peters' (2001) political reason for reform, discussed above. For example in a 'general-interest' reform there is a strong pressure to reverse the reform, coming from those who lost their special-interests because of it. This all means that reform is not a static, 'one-shot', process. It is not just a noun, but more like a verb (see Berman 1995: 16). Reform is a "dynamic process in which forces seeking to maintain or protect a reform may be opposed by forces seeking to reverse or corrupt it". (Patashnik 2003: 210)

Century and Levy (2002; 2004) have a more holistic approach to sustainability. They have taken notice in their research that reforms go through three stages of development on their way towards sustainability. These are the establishment phase, the maturation phase, and the evolution phase. As the establishment phase focuses on the first stages of the reforms, such as introducing it and ensuring that it is working, and as the maturation phase tries to ensure that the reform is accepted and habitual, the evolution phase goes further by focusing on the reform's growth and improvement. There is a clear difference between reforms which are sustained and which are only maintained. Maintained reforms are those which have been established and accepted. The reform cannot, however, be stalled at maintenance. Maintenance is an essential part of sustainability, but to reach sustainability, reform needs to go further; it needs to evolve and adapt. Therefore Century and Levy (2004: 4) define sustainability to mean "the ability of a program to withstand shocks over time by maintaining core values and beliefs and using them to guide its adaptations to change".

This raises the question of how far a reform can evolve to no longer be the same reform. This is why Century and Levy (2002) emphasize in their definition the maintenance of the core intent and philosophy of the original reform. This has also been suggested earlier by Seedhouse (1996a). This doesn't need to be understood as a constraint. Almost unlimited evolution is still possible. For example, if a health care reform is implemented to produce more health, it stays as the same reform as long as it sustains this objective. The assumption is that the intent of health care indeed is to produce more health, and not just health, or sick, care, as the situation in reality might be more like (e.g. Rimpelä 2004; Raisio 2009a).

The aforementioned three aspects of a health care reform, i.e. deliberativeness, fundamentality and sustainability, emphasize the reform to be a learning process; a dynamic process of learning with time. This necessitates a long-term and holistic view of reforming a health care. Those in authority, however, tend to be fo-

cused more on the short-term results of reform. Instead of thinking about the future of coming generations, the thoughts of politicians can be, for example, on the next elections. (see Pollitt & Bouckaert 2004: 7-8, 18.) By concentrating only on the near future, the complexity embedded in the process of a health care reform stays hidden. This particular complexity, or rather wickedness, will be unfolded next.

3.2 The existence of wicked problems and the implications ensued

Rittel and Webber (1973: 156) assert that the achievements of the late centuries have been spectacular. This can be seen especially well in developed countries. The fall of devastating diseases, the construction of road networks and city structures with shelter for nearly everyone – including clean water, sanitary sewers, schools and hospitals – bear evidence for the assertion. However, Rittel and Webber (1973: 156) consider these to have been easy problems. The problems were easy to define and to understand, and therefore consensual.

Now that the foundations have been established, maturation and, more importantly, evolution are taking place[8]. At the same time, pluralism in societies is increasing. Where the problems of the pre-industrial society were solved in culturally homogenous societies and the problems of the industrial age already in more culturally diverse societies, the problems of the post-industrial age are taking place in societies far more diverse than ever before (Rittel & Webber 1973: 167; Raisio 2010). Dissensus is replacing consensus as the different values conflict with each other (Roberts 2000). Heterogeneous societies with diverse sets of values don't consent to solutions presented by technocrats as harmoniously as they once might have. Also health care reformers are facing this same challenge. When facing wicked problems, it is no longer possible to 'engineer' health care reforms, if it ever was. Problem 'wickedness' calls for much more than just any strictly drafted blue-print.

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[8] For example Finland has established an internationally acclaimed health care system, but as the contemporary challenges for health care are significant, Finland cannot stay in the status quo on its health care; maturation, and especially evolution of the system are needed (e.g. Teperi et. al. 2009).

3.2.1 Concept of wicked problem

To concretize the existence of different levels of problems, similarly to Kreuter, De Rosa, Howze & Baldwin (2004: 445), we can think these problems to exist on a continuum (see Figure 3). This divide is, however, partly factitious as the problems can move along the continuum (APS 2007). Over time, a simple problem can transform to be a highly complex problem. Regardless, it is practical to depict these problem levels as separate entities. From simple to more complex issues, these are ‘tame problems’, ‘messes’ and ‘wicked problems’.

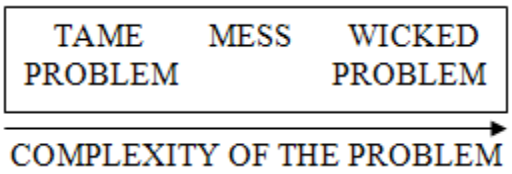

Figure 3. Three levels of problems

The simplest of problems are so-called ‘tame problems’. These are problems where it is clear what the problem is and how to solve it. As basically everyone agrees about the definitions of the problem and the solution, conflict is minimal. Tame problems can usually be solved in isolation from other problems. Also, it is possible to solve tame problems through specialization (King 1993). Repairing machines depicts a tame problem well. Repairers, through training and experience, easily identify the problem and routinely apply standard procedures to solve it (Roberts 2000: 1). However, they should not be directly assumed to be easy problems. They can be highly difficult to solve, but nevertheless, because of their technical nature, are still tame problems (Harmon & Mayer 1986: 9).

When the complexity of the problem increases so that one problem cannot be solved in isolation from others, are we dealing with messes (King 1993). Messes cannot be broken into parts and by solving the parts solve the whole problem, such as the case is with tamer problems. As messes have many interrelated parts, a more systemic approach is needed. Interactions between different parts need to be observed and also the understanding of how things done now interact with things happening later needs to be deepened. This calls for holistic thinking and interdisciplinary approaches. As long as there exists a consensus of how to solve the mess, these approaches are most suitable.

However, when there isn’t a shared and overriding outlook on the nature of the mess itself or about the proposed solutions, the problem transforms. When messes, complex but consensual issues, are interlocked with socio-political or moral-spiritual issues, they transform to be so-called ‘wicked problems’. To put

this into specific terms, tame problems are convergent. Agreement on the definitions of the problem and the solution come in due course. Also, when a shared understanding about the problem and the solution exists, a mess can be considered to be a convergent problem, too. Wicked problems, however, are divergent problems; highly complex problems with no consensual solutions in sight. Basically, to a wicked problem, there a solution acceptable by all does not exist. The more the problem is studied, the more the divergence increases. (see King 1993.)[9]

The divide between tame and wicked problems was originally done by "a pioneering theorist of design and planning" Horst W.J. Rittel (1930-1990) (see Churchman, Protzen and Webber 2007)[10]. His seminal treatise was 'Dilemmas in a General Theory of Planning´, published together with Melvin M. Webber in 1973. In the article, Rittel contrasted the tame problems of puzzle solving to the wicked problems of design and planning. To illustrate the difference, he highlighted ten distinct features of wicked problems (see Raisio 2008). These can furthermore be joined to constitute three themes: 1. 'Wicked problem cannot be solved for good', 2. 'Every wicked problem is essentially unique and a symptom of another problem' and 3. 'Every attempt to solve wicked problem counts significantly'. However, as there are degrees of wickedness, wicked problems don't have to include all the ten features to be considered wicked (Conklin 2005).

To begin with, the cause for a wicked problem can be understood in numerous ways (Rittel & Webber 1973: 166). Basically everyone who deals with a wicked problem has their own explanation for it. For example the cause for the lack of doctors in health centers can be understood in many ways, depending on who is asked (see e.g. Vartiainen 2008). For Rittel and Webber (1973) the analyst's world view is the strongest determining factor in this. If so, then basically endless number of explanations leads to an endless number of solutions, as the explanation of the cause determines the nature of the possible 'solution'. In the end, those whose explanation is chosen, have an upper-hand to choose the solution (Nie 2003).

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[9] Also, in this research, the focus is more on divergent than on convergent reasoning. Instead of striving to solve some specific bounded problem, a more innovative and creative thought process is applied, i.e. the objective is more about creating ideas than solutions (e.g. Uusitalo 1991: 22–23).

[10] Other notable academics working on the similar issues – especially on the limitedness of perfectly rational actions in public administration – have been Simon (1997) with his suggestion of 'bounded rationality', March and Olsen (1987) with their concept of 'ambiguity', Lindblom (1959) with his approach of 'muddling through' and Senge (1990) with his 'five disciplines'.

To continue, in tame problems there is a definite list of solutions and permissible operations, e.g. chess (Rittel & Webber 1973: 164). In wicked problems, e.g. tackling obesity, it is only a matter of infinite creativity to discover different 'solutions'. There is no list which would show all the possible 'solutions' or which would show the rules according to which the solution could be made and implemented. Therefore a wicked problem can be considered to be a scale problem (e.g. Wang 2002). It is simply far too enormous for anyone grasp it fully.

The preceding leads to the assertion that the definition of any given wicked problem is never perfect. In a tame problem it is possible to define the problem throughout. The defining of a tame problem is followed by the solution after which the solution is implemented. In wicked problems, a linear approach as such is not adequate (see e.g. Raisio 2009b: 490). As there is an endless number of possible 'solutions' to wicked problems and every idea for the 'solution' increases the understanding of the problem, the understanding of the wicked problem and its 'solution' evolve together interdependently, forever (Conklin 2005). As Rittel and Webber (1973: 162) state: "One cannot understand the problem without knowing about its context; one cannot meaningfully search for information without the orientation of a solution concept; one cannot first understand, then solve".

Metaphorically, trying to solve a wicked problem is like climbing Penrose stairs; an endless path. In a tame problem it is clear if the problem has been solved or not. It is similar to solving a puzzle. But for a wicked problem there is no 'stopping rule', as such (Rittel & Webber 1973: 162). Basically, wicked problems are missing a criterion which tells when the problem has been solved. In a wicked problem, because it is always possible to try to understand the problem more deeply, it is always possible to try to do better. In practice the work on a wicked problem stops for reasons external to the problem, such as running out of time, money, or patience. This can be considered to be one of the features of a wicked problem that forms the so-called circularity principle (see Vartiainen 2005; 2008). From the context of health care reforms Vartiainen (2008: 47) writes that reforms have the tendency to follow each other. The implemented reforms don't solve the problem, which is why new reforms follow. In wicked problems the circularity can be considered more often to resemble a vicious circle than a virtuous one (see Raisio 2009c: 264–265).

While scientists and engineers have the privilege to solve tame problems which have a right or a wrong answer, those facing wicked problems aren't as fortunate (Nie 2003). In wicked problems correct-or-false solutions don't exist; they are more like good-or bad solutions (Rittel and Webber 1973: 162). Every individual can judge the solutions from their own outlook and all of them are basically

equally right. For some the solution is good, for another bad, and maybe to someone else it's good enough. Also, similar to ameba, in a wicked problem the boundaries, shapes and explanations are vague, making it hard to know when the problem has been 'solved' (Pösö 2005: 4).

Making the finding of a correct answer for wicked problem even more impossible is the feature that there is no easy test to evaluate the solutions for a wicked problem (Rittel and Webber 1973: 163). The implemented solution will have such a 'waves of consequences' which will make comprehensive evaluation virtually impossible. These waves will continue through unbounded time having an influence on countless issues. As Weber and Khademian (2008: 337) write: "Similar to a stone dropped in the water, the ripples spread rapidly to have an impact on other issue areas". The full consequences cannot be evaluated until the waves have run out. At first, the issue might seem solved, the possible troubles unfolding only later on. Therefore all the evaluations of wicked problems are imperfect[11].

Together, all the features described above give good grounds to assert that wicked problems cannot be solved for good. Instead of solving wicked problems, the focus should be more on managing the challenges presented by wicked problems (Weber & Khademian 2008), or, better, on tackling wicked problems; not on solving the problems for good, but on minimizing negative effects and on maximizing the possible positive derivatives. This argument for the insolvability of wicked problems shouldn't be taken as a sign of cynicism or despair (Raisio 2008: 36). Instead, the acknowledgement of this feature of problem wickedness is a positive consent to the many complexities of the modern world; an opportunity, not a threat.

Making wicked problems more distinct is their uniqueness and the lack of natural problem level. Firstly, every wicked problem is in some way unique. There are similarities, but even the smallest of differences has the risk to override them. In tame problems there are rules according to which certain groups of problems can be solved, e.g. mathematical problems. On the contrary, wicked problems have to be approached as one-of-a-kind. Even though a certain wicked problem could look similar to another one, the same rules don't necessarily apply. Secondly, there is no natural level of a wicked problem. Basically any wicked problem can be considered to be a symptom of a higher level problem. The higher the problem

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[11] Also, for example Temmes (2004: 91) – on the evaluation of the impacts of the administrative reforms – has stated the difficulties in the evaluation processes. Acknowledging that reforms can have significant unexpected impacts, he calls for 'off-goals' type of evaluation which also strives to concentrate on these unforeseen consequences of the reforms.

level, the more difficult it is to be tackled. However, focusing on the lowest of problem levels is only an incremental approach, not quarantining an overall improvement, with even the possibility of making tackling higher level problems more difficult. (Rittel & Webber 1973: 164–165.)

Lastly, every attempt to solve wicked problem counts significantly, giving the planner no right to be wrong. With tame problems, scientists can experiment with solutions without much penalty. If the experiment fails, it can be done again and again, basically as long as there is money and time. With wicked problems things are different. Every attempt to tackle the problem leaves traces which cannot be undone. The point of no return is crossed. Things happen that are irreversible (e.g. Jentoft & Chuenpagdee 2009). With scientific experiments it is possible to start all over if it fails. With wicked problems, in the worst cases, the lives of millions of people are influenced and the situation isn't the same as before, making starting from the beginning impossible (see Raisio 2007: 32). Therefore, the immunity of scientists considering the solving of tame problems doesn't expand to include those individuals who try to tackle wicked problems:

> *"In the world of planning and wicked problems no such immunity is tolerated. Here the aim is not to find the truth, but to improve some characteristics of the world where people live. Planners are liable for the consequences of the actions they generate; the effects can matter a great deal to those people that are touched by those actions."* (Rittel & Webber 1973)

Levin, Cashore, Bernstein and Auld (2009; see also Lazarus 2009) have developed the concept of the wicked problem further by introducing the concept of 'super wicked problem'. They consider global warming to be such a problem and then define three additional features of wickedness to justify the 'super' prefix. These are 1. 'Time is running out'; 2. 'No central authority'; and 3. 'Those seeking to end the problem are also causing it'. 'Super wicked problem' is then an issue where the point of no return is even more explicit than what was described above. It is not just the case that tackling the wicked problem fails and the lives of numerous people are influenced. Instead the point is that the process might have gone too far and thus cannot be stopped or reversed anymore. The discussion isn't then so much about 'the point of no return' but more about 'the breaking point'. Also, as 'super wicked problems' are global and widely spread issues, there is no central authority that could match the wickedness of the problem (e.g. Lazarus 2009: 1161). As the third feature, 'super wicked problems' are basically caused by each and every of us, i.e. global warming where those trying to tackle the problem are also contributing to the creation of the problem (Levin et.al. 2009: 11). Considering these three features, the wickedness of the problem gets emphasized even more.

3.2.2 Problem wickedness as a fragmenting force

Conklin (2005: 3–4) clarifies the concept of the wicked problem using the concept of fragmentation. He juxtaposes fragmentation with collective intelligence, i.e. "the creativity and resourcefulness that a group or team can bring to a complex and novel problem". When a group of people have a socially shared cognition, collective intelligence is born naturally. Fragmentation involves forces which pull apart collective intelligence. A condition is created where incoherence, epistemic and axiological, instead of coherence, prevails.

Fragmentation includes three distinct forces; technical complexity, problem wickedness and social complexity. Technical complexity varies a lot between different problems, some including more technological aspects than others, but nevertheless it is one potential fragmentation force. It forms from different kinds of technologies involved with a wicked problem, interactions between these technologies and the pace of technological development. (Conklin 2005: 33–34.) In Finland, a distinct case of technical complexity is represented by the construction of the National Archive of Health Information. This is a large project striving most importantly to unite the many different health care information systems, in order to create one centralized place for all the information. At the moment there are a high number of different information systems, which has made the project far more complex than what was first expected. For example, because of the problems of compatibility, the transition period has been continuously extended. (e.g. MSAH 2009; Raisio 2009a: 88.)

Problem wickedness, as a fragmenting force, refers to the nature of the problem and the cognitive side of dealing with it (Conklin 2005: 5). van Bueren, Klijn and Koppenjan (2003: 193) call this 'cognitive uncertainty'. This is uncertainty which arises from a lack of knowledge or understanding about the problem and solution. Stoppelenburh and Vermaak (2009: 40) name this to be 'content complexity', meaning that wicked problems are so multidimensional, interrelated and ambiguous that gaining an understanding of them is a considerable challenge. Nie (2003: 308) continues by calling these issues 'wicked by nature'. The inherit nature and the context of the problem itself promises a conflict.

As problem wickedness is a property of the problem itself, the third fragmenting force, i.e. social complexity, is a property of the social network dealing with the problem (Conklin 2005). The extent of people involved and the diversity of the people constitute the social complexity. These people have, for example, a variety of worldviews, political agendas, educational and professional backgrounds, answerabilities, and cultural traditions, making social complexity within the wicked problem, in most cases, overwhelming (Weber & Khademian 2008). With

the same meaning, social complexity can be also called ‘process complexity’ (Stoppelenburh & Vermaak 2009: 40).

In policy networks, social complexity includes at least strategic uncertainty and institutional uncertainty (van Bueren, Klijn and Koppenjan 2003: 193–194). Strategic uncertainty arises from the existence of many different actors having their own perceptions of the problems and the solution, creating many different, even conflicting strategies. Institutional uncertainty develops from the existence of many different arenas where wicked problems are discussed. Many different levels of decision making, from local to global, can be included in tackling wicked problems. Therefore wicked problems are, in addition to being ‘wicked by nature’, also ‘wicked by design’, meaning that different actors, institutions and decision making processes render the problem even more wicked (Nie 2003: 309).

The forces of fragmentation create a condition known as ‘organizational pain’ (see Conklin 2005). This chronic condition exists in the background of different organizations, even on the level of societies. It appears in many forms, such as frustration, finger pointing and panic. This ‘pain’ may be thought of as natural and inevitable, making the very idea of trying to tackle a wicked problem in a novel way controversial. As a result, wicked problems will be ignored, business will continue as usual and the ‘pain’ endures. But when the fragmentation is brought to the light, the ‘pain’ can decrease. It is understood that the problem wickedness isn’t anybody’s fault. Instead of frustration, relief is felt. (Stoppelenburh & Vermaak 2009; see also Raisio 2009b: 491; Raisio 2009c: 266.)

As an antidote for fragmentation, Conklin (2005) calls for shared understanding and shared commitment, i.e. coherence. When fragmentation takes place, one may think that his or her understanding about the problem is the only right one and those who disagree can be thought to be lacking intellect and integrity (e.g. King 1993; Wang 2002). Shared understanding and shared commitment respond to fragmentation by generating a climate of coherence, where the ones tackling wicked problems try to achieve a shared meaning for the problem and shared commitment for achieving the planned goals. This doesn’t necessarily imply consensus (Conklin 2005: 42; Camillus 2008). Actually, the meaning of coherence is that the people involved become aware of and understand, or at least try to understand, each other’s positions and then, as a collective, engage in intelligent discussion and action to tackle the problem.

3.2.3 Confronting a wicked problem

The wickedness inherit in these highly ambiguous problems implies that a wicked problem cannot be tackled just by studying it (Conklin 2005). Studying the problem alone can be identified with procrastination. No matter how much the problem is studied, the full picture of the wicked problem will never be thorough. As Conklin (2005: 20) states: "Study alone leads to more study…". Similarly, Camillus (2008: 105) writes about learning through feedback (see also Raisio 2009a: 82). Feedback enables one to learn from the past. This is suitable when circumstances are stable and unsurprising, so that it is possible to perfect responses over time. With wicked problems, circumstances are, however, unstable and full of surprises making the faced problems dynamic. Therefore feedback on the problem at one certain period might not be any more relevant at some other moment in the future. In a way, every new moment during the basically endless span of a wicked problem is a challenge on its own.

Also, trying to tame a wicked problem is an unfeasible approach (see e.g. Raisio 2009b). According to Conklin (2005: 21–22) this is a natural way to approach the wicked character of these problems. He defines six ways of making the problem more manageable by simplifying it. The first, and the most common, approach is locking down the problem definition. Instead of trying to focus on the problem holistically, a sub-problem is addressed. This is the case for example when the obesity of children is tried to be solved by focusing on the more tractable problem of removing unhealthy food from school canteens (see APS 2007).

Taming the problem can also take place by asserting that the problem has been solved (Conklin 2005). Especially with strong authority it is possible to state, intentionally or ignorantly, that the approach to tackle the wicked problem has succeeded. For Roberts (2000: 4) authoritative strategies, as such, are 'taming strategies' in which the responsibility for the problem is given to someone or to a certain group of people. The positive side is that the complexity of problem solving is decreased and decisions are made faster. However, those with the authority can be wrong. The problem that was asserted to be solved might only have transformed. Yet, Grint (2005: 1473) points out problems which are highly complex, almost wicked, but which still are approachable by authoritative strategies. These are 'critical problems' where is no time to delay decisions, and where authority, in the form of commanding, is needed. In the case of an urgent crisis, such as a major traffic accident, those who are involved usually allow themselves to be commanded by those in command.

Thirdly, a wicked problem can be tamed with a measuring approach. For example, in health care there are specific objective parameters, such as waiting times,

by which to measure the success of the implemented solution. Then it can be asserted that when the waiting times have been decreased enough, the solution has been successful. The shortened waiting times, for example, in surgical procedures might, however, only have moved to increased waiting times of, for example, psychiatric care (see Raisio 2009a; 2009b). This is a form of 'cannibalism', i.e. some part of the health care system is prioritized at the expense of the others (Bruni, Laupacis, Levinson & Martin 2007; Raisio et. al. 2009). Similarly, when the focus is on the measurement of quantity, quality being only in a supporting role, many important details can be left unnoticed (e.g. Lumijärvi & Jylhäsaari 2000: 226–227). It might be that patients value as more important other issues than just fast access to care, e.g. the access to a personal doctor (see YTY 2006). Additionally, a wicked problem can be tried to be tamed by assuming it to be just the same kind of problem than those before and thus be approachable with similar approaches. (Conklin 2005.)

Just giving up, or waiting that time will take care of the problem, is also one taming approach (Conklin 2005). This is similar to the 'fire-fighting' approach described by Watson (2000: 17). It is hoped that the problem would go away with time, and if not, the problem would then be tried to be taken care when it becomes a real crisis. A result of the waiting and the lack of concern can be the problem only getting worse as time goes by. Lastly, a wicked problem can be tamed by giving only a few options from which to choose, e.g. to increase the amount of doctors, or let the people die.

Additionally, the creation of a highly thick regulatory environment can be considered as a sort of a taming strategy; especially in the form of "blame avoidance". This can take place, for example, when the central state is blamed for the problems of health care, to which the responses are increased regulations on the regional or local levels. Responsibility is then given to these levels, and if the regulations cannot be followed, the actors in these regional and local levels can be used as "scapegoats to blame, and to give the responsibility for difficult and unavoidable prioritizations." (Martinussen & Magnussen 2009: 48.) Waiting time regulations also fit well to this kind of a taming strategy. For example, in Article 4 (Raisio 2009b: 484, 490), it was perceived that resources cannot be made to be enough just by enacting a law that says the resources must be enough. One interviewee stated this strongly: "It is like the Russian army ordering that a soldier doesn't feel cold, so he doesn't need a greatcoat at all". Instead, if strong national regulations are made, it should also be made certain that they can be realistically followed (see Raisio 2009a: 82). Those on the top of the ladder shouldn't just create something and then let those below to survive alone (cf. Raisio 2007: 18).

Taming approaches, as described above, are only temporary solutions to wicked problems. But as temporary solutions, they have definite consequences. To illustrate this King (1993) uses the metaphor of bridge building: "The danger is not so much that we fail to build our bridges across the right rivers. Rather, the greater danger is that we destroy the materials we need to build our bridges across the right rivers". Every attempt to tame a wicked problem therefore has a possibility to make the problem harder to tackle (see also Raisio 2007: 32). But then, it is also possible to consider a tame problem as a mess or as wicked problem and thus complexify the problem needlessly (see Pösö 2005: 5).

Taming the problem and complexifying the problem both have their negative consequences. This makes identifying the true nature of the problem important. But only identifying the nature of the problem by itself is not enough, also movement from denial to acceptance is needed (Camillus 2008). Accepting the wickedness of the problem and the consequences that ensue makes it less likely that the problem will be tried to be tamed. Acceptance empowers those who are facing wicked problems to think holistically and instead of trying band-aid solutions, to strive for long-term outcomes (see Devaney & Spratt 2009). As denial maintains an approach of trying harder with more of the same, acceptance for one enables to see the problem from a different perspective; to try something novel (see Stoppelenburh & Vermaak 2009). Also, when acceptance of the nature of the problem increases, a shift happens, from blame - an indicator of fragmentation – to a deeper collective understanding about the problem and the solution (Conklin 2005).

Ultimately, trying to tame wicked problem highlights a 'wicked moral problem' (see Churchman 1967: 142). Trying to tame a wicked problem may firstly seem like the problem has been solved. In reality it might only have been 'silenced' for a moment. If it is intentionally asserted that the problem has been solved when it is not, deception takes place. If this deception is about a highly dangerous issue, it raises up a strong moral issue. When it is explicitly told what has taken place, the deception, in principle, might lessen. The question is, to what extent are those who are trying to tame a wicked problem responsible to inform about the failings of the implemented approach to those who are affected by the problems. Is it, for example, enough that the government informs citizens that the problem has partially failed or is it necessary to go further and try to attempt to deliberate together as a collective and gain a mutual understanding of the successes and failings of the implemented approach?

The taming approach can be identified with the so-called 'waterfall model' (see Conklin 2005: 8–9). This is a highly chronological approach, a management ap-

proach, of working with wicked problems. First the problem is defined. Then the data is gathered and analyzed after which the solution is formulated, implemented and evaluated. It is a top-down, linear and reductionist approach whose success is still a widely held common belief (e.g. Rith & Dubberly 2007: 74). Goals are clear and the outcomes can be easily measured, making this a technical approach deploying tried and tested processes where managers ask questions such as 'was the goal achieved?' (Grint 2005; Jentoft & Chuenpagdee 2009).

Similarly, the taming approach can be identified with the approaches of 'normal science'. Funtowicz and Ravetz (1994: 1883) define 'normal science', in the Kuhnian sense, as puzzle-solving exercises; routine scientific work. When there is a low epistemic uncertainly and no conflict of values, as is the case with tame problems, normal science is a suitable approach. Similar to the management approach, questions asked by scientists in this case are most often 'what is' and 'what if'. Also 'there ought to be' issues can be answered with normal science, as long as there is common acceptance and support. 'What ought to be' sort of questions, such as 'how to divide the scarce resources of health care', however, involve high uncertainty and are full of value conflicts making them ill suited for the routines of normal science (see e.g. Raisio et. al. 2009). These wicked issues need an approach of a 'post-normal science' (Batie 2008), such as the usage of the concept of wicked problems.

To make it clear, the objective here is not to assert that normal science and other traditional approaches are outdated and useless or that tackling wicked problems is more important than solving tamer ones. On the contrary, the important point here is that there is an appropriate approach to different kinds of problems, each important in their own way. Additionally, wicked problems can include tame subproblems which are solvable by traditional approaches. The matter isn't black and white. However, the objective here can be considered to be an argument to allocate more resources, and increase the focus, on wicked problems. (see e.g. Funtowicz & Ravetz 1994; Kreuter et. al. 2004; Batie 2008; Raisio 2007: 24.)

The post-normal science of Funtowicz and Ravetz (1994) and the 'jaggel-line model' of Conklin (2005) as well as the governance approach of Jentoft and Chuenpagdee (2009) and the leadership approach of Grint (2005), as an opposite of management approach[12] described above, all share a similar context (see also

[12] Bovaird and Löffler (2009a: 6) define public management as "an approach that uses managerial techniques (often originating in the private sector to increase the value for money achieved by public services". Respectively, public governance stands for "how an organisa-

Raisio 2007). They depict an opportunity driven approach for tackling wicked problems. Instead of a routine approach to solve tame problems, being a picture of already knowing or the equivalent of déjà vu, i.e. the waterfall-model, these approaches are more about learning[13] than knowing and more about something that has never happened than something that has taken place before (see Conklin 2005; Grint 2005). This makes planning blueprints to be basically like living documents (see Camillus 2008: 106). Within this view, every moment of planning can be considered as an opportunity to improve the understanding about the solution and about the problem. For those in authority it is, however, hard to admit not being the master of the situation and not knowing the right answers (Grint 2005). Asking questions and wandering all around with the issue is a natural, intelligent and creative, approach to learn about wicked problems; not a mark of incompetence (Conklin 2005: 12).

3.2.4 Wicked problem as a "problem of interaction"

An opportunity-driven, or nonlinear, approach to tackle wicked problems is essential. However, more fundamentally, tackling a wicked problem is "a problem of interaction" (see van Bueren, Klijn & Koppenjan 2003). Rith and Dubberly (2007: 73) clarifies this by pointing out fundamental ideas of Horst Rittel. As stated before, the definition of the wicked problem is subjective in the way that everyone can have an equally 'right' opinion about it. In other words, everyone holds 'some truth' in dealing with wicked problems (Roberts 2000: 13). Because of this diversity of subjective perspectives, there needs to be deliberation and argumentation about the issue to form coherence. This makes the process of tackling a wicked problem political. It is an argument and a deliberation.

As there are no single experts on wicked problems, the role of interaction is clear (see Ludwig 2001; Nie 2003; Kreuter et. al. 2004; Balint, Stewart, Desai & Walters 2006; Blackman et al. 2006; Batie 2008; Jentoft & Chuenpagdee 2009). True expertise can be achieved only through diversity. So compared to tame problems which can be "addressed primarily by experts with little or no involvement of stakeholders…" (Batie 2008: 1177), wicked problems "have no technical solution, it is not clear when they are solved, and have no right or wrong solution that

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tion works with its partners, stakeholders and networks to influence the outcomes of public policies".

[13] As Broussine (2009: 274) states: "There is a growing recognition that, in a complex and changing system, we need to see leadership and learning as simultaneous if not synonymous activities".

can be determined scientifically“ (Jentoft & Chuenpagdee 2009). These are questions where science, first of all, falls short.

Wicked issues are most often such that they cannot be made the responsibility of any one organization (e.g. APS 2007; Löffler 2009). As discussed before, for example, the responsibility for a healthy society cannot belong only to health care (see Hunter 2008a: 164). Diversity needs to be increased by working across organizational boundaries (Clarke & Stewart 2000). This approach strengthens holistic thinking. By including not only the most obvious stakeholders, as the case might be in linear thinking, the holistic view tries to grasp the big picture and observe the many interconnected linkages within wicked problems. Without a holistic approach, the contribution of many potentially important stakeholders might be neglected. Organizational networks (e.g. Goldsmith & Eggers 2004; Raisio 2006) and co-governance (e.g. Dingeldey 2009) have important roles.

The approach to tackle wicked problems doesn't only emphasize collaboration between diverse organizations. It can be seen that even more weight is given to the role of citizens. From the perspective of wicked problems there are two reasons for this. Firstly, by including the citizens, naturally, the diversity extends further. As the citizens are experts of lived life, they know the reality of the problems. Their contribution deepens the understanding of the problem and gives insight into the solutions (Clarke & Stewart 2000; Raisio 2010).[14] To illustrate this, citizens can then be considered to be in a co-researcher's role (Stoppelenburh & Vermaak 2009) or performing a function analogous of a peer-reviewer in traditional science (Funtowicz & Ravetz 1994). Additionally, the patients, especially the ones with chronic diseases, can be said to be the co-producers of care, i.e. experts of their own diseases (Teperi et. al. 2009).

Secondly, wicked problems call for changes in the way people behave (e.g. APS 2007). For example a healthy society is a commonly accepted societal objective, which cannot however be achieved without changes in the way people live: "The wicked issues by their nature will be enmeshed in established ways of life and patterns of thinking; they will only be resolved by changes in those ways of life and thought patterns" (Clarke & Stewart 2000: 378). Traditional levers, such as legislations and sanctions, alone are insufficient to gain sustained behavior changes (e.g. APS 2007). Basically this will take place only when the wicked

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[14] Morgan (2006: 208) writes about the metaphor of a "psychic prison". With this he refers to "the ways in which organizations and their members become trapped by constructions of reality that, at best, give an imperfect grasp on the world". Then, as the diversity extends and new insights increase, a chance to escape this "psychic prison" emerges (Morgan 2006: 235).

problems are widely understood, discussed and, most importantly, owned. And it is not only that legislation or regulation alone cannot achieve change in people, but this kind of top-down commanding would not be accepted to begin with without citizens accepting the proposed requirements or the sacrifices needed (Clarke and Stewart 2000). Then, when it comes to effective responses to social problems, they can be understood to be co-produced by the policy makers and by the citizens themselves (e.g. Harmon & Mayer 1986: 60–61).

The critique of top-down commanding in achieving behavior changes is supported by intentional change theory (ICT). For Boyatzis (2006: 610; see also Raisio 2009a) "it appears that most, if not all, sustainable behavioral change is intentional". This implies that the sustained change process is desired, i.e. it is wanted by the person, organization, nation etc. The important aspect in all of this is the ideal self, or, in the collective level, "collective, shared desired images of the future, shared hope, and shared sense of a group's identity and distinctiveness". These are forces that create, on a collective level, a shared vision driving towards sustainable behavioral change.

A wicked problem, as a problem of interaction, can then be tackled best with a collaborative, or better yet, a deliberative approach. As an opposite of authoritative and competitive approaches, the collaborative approach strives for a win-win situation. It is about creating a solution of 'enlarging the pie' for all. True collaboration is, however, hard to achieve. It can be that failing in other approaches is needed before the collaborative approach is given a chance. So even though the collaborative approach can be the most expensive of approaches, these costs need to be compared with the costs created by failings in other approaches tried before. (Roberts 2000; Durant & Legge 2006.)

3.2.5 A particular world view for wicked problems

To understand the features of wicked problems and the environment of health care reforms better, they can be affiliated to a wider conceptual framework (see Raisio 2008: 35). Such a framework is considered to be complexity science, i.e. the study of complex adaptive systems (CAS) (e.g. Klijn 2008: 314; Zimmerman, Lindberg & Plsek 2008). Complexity science is often called complexity theory. This is, however, partly misleading as it is not a unified theory (Cohen 1999: 375). It is more like a collection of different theories sharing the same kind of conceptual package (Begun, Zimmerman & Dooley 2003: 258). Mitleton-Kelly (2003) summarizes these as five different research trends: 1. complex adaptive systems, 2. dissipative structures, 3. autopoiesis, 4. chaos theory and 5. increasing return and path dependency.

Basically, complexity science can be seen, as there is a conceptual overlap of some level, as an extension of systems theory (e.g. Grobman 2005: 356). For example Mitleton-Kelly (2003) understands this in such a way that "complexity builds on and enriches systems theory by articulating additional characteristics of complex systems and by emphasizing their interrelationship and interdependence". From the perspective of wicked problems, there is, however, one especially important distinctive factor. Compared to system theory's emphasis on problem-solving, prediction and control, complexity science's focus is more on exploration and explanation (Phelan 1999: 238-239; Jalonen 2007: 60). So it could be asserted that as systems theory would make a suitable conceptual framework for tame problems and messes, wicked problems would fit better in the framework of complexity science.

Complexity science can be divided further, into three schools of thought. From the perspective of management science, Richardson and Cilliers (2001) name these to be reductionistic complexity science, soft complexity science and complexity thinking. These can be also called, respectively, the neo-reductionistic school, the metaphorical school and the critical pluralist school (Richardson 2008). For example, the view of Phelan (2001) can be classified within the reductionistic school. He has a very harsh view about what is complexity science and what is not. According to him, much of the work in complexity science has been pseudo-science instead of real science. This means that the symbols and methods of complexity science have been used to give only an illusion of science. Instead of supporting the holistic approach in complexity science, he writes about generative rules, i.e. "the rules that govern the interactions between lower-order elements that in the aggregate create emergent properties in higher-level systems" (Phelan 2001: 132).

Reductionistic complexity science strives to find these particular rules. It may, however, be disputed if this is what complexity science should be about for it is very similar to the objectives in the field of physics. This kind of a reductionistic effort to find the theory of everything, i.e. to find the general principles of complex systems, results as a loss in the richness of the reality and, in the end, is misrepresenting complexity science. In management, the theory of bureaucracy once strived to be such a theory. Regardless of its failures, the quest for an all-embracing theory is still strong. (Richardson & Cilliers 2001: 6.)

Soft complexity science can be seen as the other end of the continuum. As a powerful metaphorical tool it is the opposite of reductionistic and positivist complexity science. With this school of thought, the problem, however, is that the metaphors of complexity science are used without much, if any, criticism, i.e.

concepts are imported from other disciplines without considering the legitimacy of such actions. Complexity thinking represents the middle path. Thus, instead of focusing on what can be explained, as in reductionistic complexity science, the focus is more on what cannot be explained. Instead of taking the "anything goes" approach of soft complexity science, complexity thinking strives for a critical reflection. The focus of complexity thinking, as the exact understanding of reality is always incomplete, is on the limits of our knowledge. (Richardson 2008: 20–21.) Applying the words of Carl Jung (1875-1961) it could be said that an understanding of complexity does not give us any theories of everything, but it is a definite help, in as much as one can cope with a comprehensible unknowing (e.g. Raisio 2008: 51). As this study is clearly against the approach of reductionistic complexity science, and as more is wanted than just the metaphors, this study strives to adopt the approach of complexity thinking as a way to see the essence of complexity science.

Complexity thinking challenges the Newtonian worldview, i.e. the view of a clock-work universe (e.g. Grobman 2005: 355). Under this paradigm, the world is seen as deterministic and reductionistic; as a "really big machine" (Richardson 2008: 24). This means that it can be understood as a tame issue. It can be taken apart, and by studying the parts, the whole can be understood. Also, in this worldview, a clear causality of events and predictability of the future come true. This is a common worldview in public administration. For example, long-term planning includes the assumption of "an all-knowing planner" who is able to predict the future (Morçöl 2005: 299). Similarly, bureaucratic organizations follow the Newtonian worldview:

> *"The institutions of public administration are formed according to bureaucratic principles. The bureaucratic organization is expected to be deterministic and linear in its functioning. It is deterministic, because an order given by a superior in a hierarchy is expected to go down the ladders and implemented as intended (order is the cause, implementation the effect). It is linear, because a proportional relation is presumed to exist between the order and its implementation."*(Morçöl 2005: 299)

Within the paradigm of the Newtonian worldview, the world can be ontologically understood as a machine. Thus, epistemologically, it is possible to develop a scientific method with which it would be possible to know the world in every detail. Complexity thinking offers a challenging ontological premise. Instead of a machine, the world is seen more as an organic entity. As the ontology shifts, epistemological and methodological consequences are explicit. So as in the Newtonian worldview, where the unknowability of the universe is a result of flaws in the invented methods of control and prediction, i.e. epistemological limitation, in

the worldview of complexity thinking, the unknowability is more about the ontological premise, i.e. the reality is such that it is not even possible to finds such methods. (Morçöl 2005: 300; Richardson 2008: 24.)

The preceding can be clarified by referring to the philosophy of science expressed through the subjective-objective dimension of Burrell and Morgan (1979: 1–7). They divide this dimension into four assumptions about the nature of social science. The first assumption is about ontology; a debate between nominalism and realism. As the nominalist sees reality as produced by the individual cognition, the realist assumes reality to exist externally to the individual. The second assumption is about epistemological debate; a debate between anti-positivism and positivism. The positivist believes that it is possible to gather hard, real and objective knowledge about the social world. The researcher is in the role of an external observer. On the contrary, the anti-positivist understands knowledge as a softer and subjective kind of information. The social world is then considered a relativistic one.

Ontological and epistemological assumptions lead to the third debate; a debate between voluntarism and determinism in human nature. Determinism implies a mechanistic universe where the actions of human beings are determined, i.e. produced by the environment. Voluntarism, instead of seeing human beings as controlled by the environment, makes sense of them as the creators of their environments, i.e. as autonomous individuals. Lastly, these three preceding assumptions about the social world form two significantly different views to the methodological nature of social science. The nomothetic approach to social science resembles the approaches of natural science. Objective reality is assumed and quantitative methods are emphasized. The ideographic approach, on the other hand, emphasizes qualitative methods as a way of gathering subjective accounts of the social world. As the former focuses more on the general and universal, e.g. by trying to find some universal laws to the observed reality, the latter strives to gain an understanding about something that is unique and particular. (Burrell & Morgan 1979: 2–7.) Complexity thinking is positioned more clearly on the subjective side of the preceding subjective-objective dimension. Thus, the approaches applied are nominalistic ontology, anti-positivistic epistemology, the voluntarism of human nature, and ideographic methodology.

Basically what is taking place is that science is replacing its old metaphors. The metaphor of a clockwork universe is giving way to a more organic view of the universe. However, this doesn't imply that the old worldviews have been wrong. It is just stated that they have described situations that just don't take place anymore to the same extent as before. For example the Taylorian scientific manage-

ment, which saw the organization as a machine, was suitable for the societies of mass production (Leading edge 2001). Since that time, organizations have become such, which no longer fit the metaphor of a machine, e.g. service and network organizations. (Zimmerman, Lindberg & Plsek 2008: 43.) The limitations of the Newtonian worldview are starting to be recognized (Grobman 2005: 355); especially as the wickedness of many contemporary problems is becoming more explicit.

What is in the world, wicked problems included, that makes the Newtonian worldview insufficient? Mitleton-Kelly (2003) answers the question by defining the ten generic principles of complexity. They are self-organization, emergence, connectivity, interdependence, feedback, far from equilibrium, space of possibilities, co-evolution, historicity and time, and path-dependency. Using the literature of complexity thinking, these defining principles are presented briefly in Table 3. The principles will get slightly more detailed when discussing complex adaptive systems in the next chapter.

Table 3. The ten generic principles of complexity (Prigogine & Stengers 1984; Holland 1995; Kauffman 1995; Mittleton-Kelly 2003; Jalonen 2007)

Principles of connectivity and interdependence
These are the central characteristics of complex systems. Basically, there is connectivity and interdependence between the different actors and dimensions of a system, and also between the system and its environment. These cause complex behaviors to arise. This means that actions by individual actors within a system may affect, with varying impacts, other individuals within the same system, and in the environment. The higher the connectivity, usually the higher the interdependence. One actor in a system can then cause a wide perturbation on all the other related actors in the system and the environment.
Principle of co-evolution
As a consequence of connectivity and interdependence between a system and its environment, a system cannot evolve in isolation. The system is always part of a wider ecosystem consisting of other systems. Thus co-evolution takes place as the systems influence the other related systems within the wider ecosystem, and in turn are similarly influenced by the acts of others. What takes place is not an adaption to the environment, but rather co-evolution with all the other related systems within the ecosystem. The question is about reciprocal evolution, not about individual adaption.
Principles of far-from-equilibrium, and historicity and time
Through dissipative structures, complex systems exchange energy, matter or information with the environment, as the preceding principles imply. It might be that the system is in a state of balance, i.e. in status quo. But when external pressure is forced upon the system, it can be pushed far from equilibrium, to a state of imbalance. It is this state in which it is possible to create a new structure and order; to break the status quo. A bifurcation point emerges with alternative paths. This choice in the bifurcation point, i.e. the chosen path, will affect the future evolution of the system. Basically, it can be understood as a point of no return.

Principle of the space of possibilities
In a state of far-from-equilibrium, before the choice of the future path is made, a system is forced to explore different alternative paths in a space of possibilities. Exploration and experimenting in this space helps innovative alternative paths to emerge. Also, instead of trying to find a one right, or optimal, path, different possibilities are kept open and new possibilities are constantly scanned for.
Principle of feedback
The principles of connectivity and interdependency are based on feedback processes, negative and positive. Negative feedback processes strive to achieve balance, i.e. to maintain the status quo of the system. Positive feedback processes, on the other hand, strive for achieve change, i.e. to reinforce those issues that negative feedback processes often try to dampen. As in the state of far-from-equilibrium, the system is highly sensitive to external influences, positive feedback processes can achieve a nonlinear and cumulative positive feedback loop which causes new patterns and structures to emerge.
Principle of path dependency
Positive feedback processes can cause path dependency, i.e. a reinforcing trajectory in the system. This can be understood by considering technology developments. It is often that some technology starts to dominate the system. Depending on the possible negative feedback loops, positive feedback processes can make new paths in the system emerge. The followed path influences the whole system. In technology it is often so that through the developments in some technology, other technologies have to follow these particular developments, e.g. Windows. Thus the path dependency evolves.
Principles of self-organization and emergence
Connectivity, interdependency and feedback processes in a system create self-organization. It is a process which takes place spontaneously without any steering. This process includes emergency, i.e. a whole that is born in the process is more than just the sum of its individual parts. A new upper level order is created which cannot be understood by studying just the parts.

3.2.6 Complex adaptive systems

As stated above, complexity thinking can be understood as the study of complex adaptive systems (CAS). They can be found everywhere, even among ourselves. Some examples are: human immunity systems, ecosystems, public sector organizations, health care systems, cities, nations and so on. Zimmerman, Lindberg and Plsek (2008: 8) define CASs in the following way:

> *""Complex" implies diversity – a great number of connections between a wide variety of elements. "Adaptive" suggest the capacity to alter or change – the ability to learn from experience. A "system" is a set of connected or interdependent things. The "things" in a CAS are independent agents"*

Kelly (1994: 21-22) names these systems additionally as swarm systems or vivisystems. He defines four distinct features. Firstly, these systems have no imposed centralized control. Secondly, every agent in the system is autonomous. Thirdly, there is high connectivity between these agents. And fourthly, nonlinear causality

dominates actions in the systems. CAS, then, is a system which consists of a diverse set of interconnected and independent actors, who act on individual reactions, instead of being controlled by any central body, and which is able to adapt and learn. Some implications of CASs are presented next. These are about modeling and calculation, conflicts and surprises, change management and performance management, and democratic participation. Finally, some general implications of the management of CASs will be presented.

The generic principles of complexity, presented in Table 3, imply that creating models of CASs is essentially an impossible task. As CASs are open systems, whose boundaries aren't known, depicted by the diverse and interdependent nonlinear relationships, a model of such a system should include all these relationships in the system and in the environment, also including the interactions in the history of the system. This implies, as Cilliers (2000: 28) states, that "we will have to model life, the universe and everything", which, of course, is unmanageable. Also, the emergent properties of nonlinear interactions cannot be compressed, meaning that the model of a system, and its complexity, cannot be presented as simpler than the system itself, not at least if accurate models are wanted. Every model of a CAS would then be limited, as not everything could be included in the model. Something is always left out, which in the end could have a major effect on the system. Cilliers (2000: 30–31), however, clarifies that this incompressibility of CAS doesn't mean that modeling and calculation would be in vain. Instead, calculations should be done as they provide important information, even though not all the information. Also modeling is very useful, but in the end there is the need for interpretation and decision. Cilliers (2000: 28–30) announces the ethical nature of decisions based on these models and calculations. This means that choices have to be made, but they just "cannot be backed up scientifically or objectively".

Andrade, Plowman and Duchon (2008) and McDaniel, Jordan and Fleeman (2003) present the implications of complexity thinking on conflicts and surprises. They point out that the conventional view of conflicts and surprises is based on the Newtonian worldview, according to which if planned and controlled strongly enough, both could be avoided. Conflicts and surprises are in this worldview seen in a negative light. Complexity thinking, however, points out that these conflicts and surprises aren't happening, for example, just because of bad leadership or the lack of information. Instead, they can be seen as a result of the general principles of complexity thinking, and are, therefore, an inevitable and natural part of CASs. For example conflicts can be understood as the "natural occurrence of fluctuations that result as interdependent agents encounter information, make interpretations, and adapt to other agents' behaviors" (Andrade, Plowman & Duchon 2008:

27). As such, they are not bad or good by themselves. What is important is how they are considered. If the negative view is taken, the more the focus is on predicting the future and planning and controlling; conflicts and surprises are tried to be eliminated. What results is that the possibility to see them as opportunities is missed. For Andrade, Plowman and Duchon (2008: 24) this is a fool's errand. If, instead, conflicts and surprises would be seen in a positive light, as natural events in CASs, more creative, innovative and adaptive approaches could take place.

The implications of complexity thinking can also be considered in change management (Jones 2008) and in performance management (Leading Edge 2001). Firstly, if the organization is seen in a linear, i.e. in a Taylorian, way this implies that the aspired change is consequently tried to be achieved linearly. This linear assumption of change has, for example, the implications that the predictability of the system is assumed, that the change process is directed top-down and that the command and control approach is emphasized (e.g. Hunter 2008a: 56). Acknowledging the nature of CAS, the linear approach as such is unrealistic. Complexity thinking supports the nonlinear view to change management, which, for example, includes the assumption of unknowability and which supports wide interaction within the system and lets many different options for change emerge (Jones 2008).

From the perspective of complexity thinking, performance management also has one especially major problematic aspect. Performance management can be considered to follow the worldview of the clockwork universe. This is so because performance management, by giving independent targets for the individual parts of the system, often yields to reductionism. The problematic part is that the whole picture can be missed and the inward focus easily emphasized. The possibility, that by working together, the whole could achieve much more, could be then neglected as the individual parts concentrate on trying to achieve their own individual targets[15]. Instead of the reductionistic approach, complexity thinking would support the idea of setting a few high-level and system-wide targets. This approach could achieve more creativity within the system. (Leading Edge 2001.) Also, 'gaming' could decrease (e.g. Blum & Manning 2009: 51–52; see also Hunter 2008a: 27, 39; Raisio 2009b: 486).

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[15] Morgan (2006: 30) refers to this when writing about functional specialization: "Functional specialization is supposed to create a system of cooperation. Yet it often ends up creating a system of competition as individuals and departments compete for scarce resources or job positions higher up the hierarchy" (see also Lumijärvi & Jylhäsaari 2000: 228). As a result, it is the whole which suffers. The adverse effect can be, for example, that of 'gaming' (Blum & Manning 2009: 51–52).

Waganaar (2007: 17) uses complexity thinking to illustrate the superiority of participatory democratic arrangements to representative arrangements in dealing with CASs:

> *"Complexity makes system outcomes unpredictable and hard to control and, for this reason, defies such well-known policy strategies as coordination from the center, model building, and reduction of the problem to a limited number of controllable variables. It is argues that participatory and deliberative models of governance are more effective in harnessing complexity because they increase interaction within systems and thereby system diversity and creativity."*

This kind of nonreductionistic approach increases the level of connectivity within the system, which can take the system to the state of far-from-equilibrium, where it consequently may explore in the space of possibilities. As citizen participation in policy processes increases, the experiences of ordinary people combine with professional knowledge, resulting in a co-evolution process fostered by positive feedback loops. Professionals gain new insights in the complex policy issues and higher trust in the society emerges. Creativity within the system increases and new paths for the system may emerge. (Waganaar 2007.)

Generally, the implications of CASs to management are rather similar than those of wicked problems. This isn't surprising as wicked problems are part of the framework of complexity thinking. Richardson (2008: 25) defines four such implications. Firstly, CASs make problem-solving, by repeating previously used management approaches, problematic. It is very likely that the context has changed, similar to the saying "just because it looks like a nail, it doesn't mean you need a hammer". Secondly, as creativity increases with multiple perspectives, "decisions made by the many are often better than those made by a few". Thirdly, no matter how many perspectives there are, or how much time has been spent on planning and information gathering, the predictability of the decisions made is always incomplete. As modeling everything is unmanageable, decision makers need to make artificial boundaries. Viewing the issue through such boundaries very likely makes the decision makers miss something important which leads to the implication that "expect to be wrong (or at least not completely right)". Lastly, "flip-flopping is OK". This means that as the world is unpredictable and as the CASs evolve over time, opinions had and decisions made at some point in time may not be suitable at a later time. Thus, changing one's mind is not an indication of mistakes made, but more like a positive consent to the features of CASs.

3.3 Importance of creating co-intelligence via public deliberation

The concept of wicked problems and complexity thinking, by themselves, already produce many implications that health care reformers need to acknowledge. However, from these, one more theoretical construct emerges. Conklin (2005) referred to this when he wrote about shared understanding, shared commitment and coherence. van Bueren, Klijn & Koppenjan (2003) wrote about wicked problems as "a problem of interaction". Clarke and Stewart (2000) clearly emphasized the role of citizens in tackling wicked problems. Waganaar (2007) saw the prospect of participatory democracy in harnessing complexity. Many acknowledged that there are no single experts in wicked problems (e.g. Ludwig 2001; Nie 2003). Roberts (2004), among others, ushers the way towards the practices of deliberative democracy. The objective is to gather co-intelligence in order to tackle the wicked problems health care reformers are faced with.

3.3.1 The need for co-intelligence

Weick and Roberts (1993) write of the "collective mind" meaning "a pattern of heedful interrelations of actions in a social system". The idea is that dispositions toward heed have an influence on those actions which are supposed to construct interrelating in the system. This heedful interrelating can be understood as a collective mind. To clarify, the mind is actualized in behavior patterns. These patterns can vary from stupid to intelligent. The adverb "heedful", manifesting, for example, as critical, attentive, purposeful, caring and conscious performance, adds certain expectations for the essence of the mind, i.e. behaving in a certain, heedful, way. Contrary to habitual performance where each performance can be considered to be a replica of its predecessor, an outcome of continuous repetition and drills, heedful performance means a pattern of learning where each performance is basically unique, modified by its predecessors.

Actions to construct interrelating in the system consist of contributing, representing and subordinating. Contributing refers to the actions constructed by the actors in the system. With representing, the actors understand that the systems consist of joint actions. When subordinating, the actors interrelate their constructed actions in a system of connected actions. By contributing, representing and subordinating, a system, a collective mind, is formed which isn't about separate individuals, but about the process of interrelation in the activities done by these separate individuals. According to Weick and Roberts (1993, 365) the more

heedfully the interrelating in the system is done the more developed and more capable of intelligent action the collective mind will be.

Weick and Roberts (1993: 357) envision the importance of the collective mind especially in situations where almost continuous operational reliability is needed. The presumption is that as the collective mind, i.e. heedful interrelating, strengthens, the actors in the system begin to understand the complexity they are faced with better. Also the comprehension of unforeseen events grows and as a result the incidence of errors within the system decreases. On the contrary, when the collective mind weakens, i.e. when the interrelating breaks down or heed erodes, isolation within actors starts to develop, comprehension of problems lessens, the system starts to lose its form and interrelating becomes more and more difficult. The individual mind begins to replace the collective mind: "As people move toward individualism and fewer interconnections, the organization's mind is simplified and soon becomes indistinguishable from individual mind" (Weick & Roberts 1993: 378).

It can be generalized that the minds of a high-efficiency organization are simpler that those of high-reliability organizations (Weick & Roberts 1993: 376). For example, it can be considered that the collective mind of a surgery team, where mistakes are fatal, is highly evolved compared to some mass production factories. However, the expectation of Weick and Roberts (1993, 376) is that when heedful interrelations in high-efficiency organization is increased, for example, with total quality management, these organizations could begin to act more like high-reliability systems.

The preceding discussion can be examined in relation to the aforementioned three levels of problems. Firstly, success in solving tame problems can be achieved without the collective mind. As tame problems can be solved in isolation and with specialization, a basic habitual performance is enough. Messes, as more complicated problems, however, have many interrelated parts, meaning that interrelations between different parts need to be observed. This is a case for the collective mind[16]. The collective mind, alas, can only be fully useful as long as there is a consensus within the system. As the consensus lessens and the socio-political and moral-spiritual aspects within the issue increase, i.e. the problem becomes

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[16] Hakkarainen and Paavola (2006: 239) consider the collective mind as one example of 'collective expertise'. Koivunen (2005: 32) defines collective expertise as "an ongoing process and an ability to function together with other experts". The important element of this is the collective construction of the knowledge (see Hakkarainen & Paavola 2006).

wicked, the call for co-intelligence arises. To concretize, the collective mind is more about collectively intelligent oneness than wholeness (see e.g. Atlee 2008).

Before focusing on co-intelligence, its antecedent, i.e. collective intelligence, needs to be defined. Firstly, Hakkarainen (2003) defines collective intelligence as "processes of intelligent activity which are manifested more on the collective level than on the level of an individual actor". The working definition by the MIT Center for Collective Intelligence follows in the same fashion: "collective intelligence is groups of individuals doing things collectively that seem intelligent" (Malone 2008: 1)[17]. Zara (2004: 5) gives a slightly more imaginative definition by defining collective intelligence as "the capacity of an organization, a community, to ask questions and seek answers together". These three preceding definitions see collective intelligence as a process, action or a capacity. Instead, the definition by Lévy (1997: 13) emphasizes collective intelligence as a form; "a form of universally distributed intelligence". The universality in the definition is lucid: "No one knows everything, everyone knows something, all knowledge resides in humanity" (Levy 1997: 14). The important point to emphasize is that collective intelligence isn't just a collection of individual intelligences. Instead, what is born in collective intelligence is clearly more than the mere sum of intelligences of the individuals; emergence is taking place (Atlee 2003: xi).

As it is quite common sense to think that the results of a planning process are of a higher quality if diverse and numerous groups of people have been participating in it, the idea of collective intelligence can be considered to be like stating the obvious. But if one asks oneself if the planning processes are commonly really taking place in a way that takes collective intelligence into use, is it obvious? Actually, it might be that the use of collective intelligence isn't as self-evident as assumed. (Zara 2004: 5.)

More probable is that the modern planning processes are still using pyramidal collective intelligence; a form of collective intelligence which is based on hard-coded social architecture, top-down management, competition and standards and norms[18]. Pyramidal collective intelligence has had its undeniable successes before, but its flaw, however, is that it has problems to adapt to the complexities of the contemporary world. Instead of creativity, pyramidal collective intelligence

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[17] The focus of MIT Center for Collective Intelligence is especially on "Web enabled collective intelligence", e.g. Google and Wikipedia (Malone, Laubacher & Dellarocas 2009).

[18] For example Strandman (2009: 208) in her research found out that this kind of rational communication based on positivistic paradigm is still dominant in the communication of municipalities' strategies.

embraces competition, reductionist visions and constricting rules. (Noubel 2008: 225–226.)

Collective intelligence, instead of pyramidal collective intelligence, emphasizes unrestricted activity between people. However, this implies more than any normal collective communication, as it can just consist of an exchange of information. The question is more about collective reflection (Zara 2004) or generative dialogue (Atlee 2004) than merely about communication. With reflection and dialogue, i.e. "shared exploration towards greater understanding, connection and positive possibility" (Atlee 2003: 63), routine communication between people is replaced by a deeper form of collective intellectual activity; the information is not only exchanged, it is co-created.

Pyramidal collective intelligence has its attractions. Especially its authoritative nature is alluring to many administrators. Moving from pyramidal collective intelligence to genuine collective intelligence can be daunting, as it can be understood to imply a loss of authority. However, the use of wide reflection and dialogue in decision making doesn't mean the same as collective decision making. As Zara (2004: 6) states, it basically doesn't matter who in the end makes the final decision. What is important is the process leading to that decision. Collective intelligence helps the decision to emerge by enhancing thinking, cooperating, innovating and creating. It is, for those in authority, if they would decide to move away from the traditional pyramidal collective intelligence, unnecessary to fear that the power to make decisions would be taken away from them.

The study of collective intelligence is a new research field, and is still in its infancy. Therefore it is natural that opinions about it diverge to different extremes. For example Malone (2008, 4) states that it is too early to make any definite conclusion about collective intelligence and writes: "Sometimes collective intelligence is good; sometimes it isn't. Sometimes it works, and sometimes it doesn't." Similarly the idea of collective intelligence has raised many questions. Watkins (2008), for example, asks "how can humans at once be totally biased, manipulable thinkers and wise, sophisticated problem-solvers?" For her the answer can be found from the whole that the collective (i.e. the people) and the system (i.e. environment) together create. This she calls "a collectively intelligent system". The point is that as the intelligence embodied to the physical environment and the intelligence created by social interactions are joined together, the whole becomes such that a good decision can emerge.

Similarly, Atlee (2008: 9) writes of reflective collective intelligence and structural collective intelligence. With the former he refers to people developing, by thinking and acting together, such outcomes what they couldn't achieve alone. Struc-

tural collective intelligence, on the other hand, calls for the creation of such a system which supports and nourishes the creation of collective intelligence. So to come back to Malone's (2008: 4) statement about varying outcomes of collective intelligence, it can be tentatively asserted that by focusing on creating the system in such a way that it nourishes collective intelligence, the chance for collective intelligence to work better, and to be good, increases.

In the contemporary world, the idea of collective intelligence has significant implications. As collective technological and economic powers grow, the need for collective intelligence is strong. Collective unintelligence – i.e. a collective level phenomenon of people undermining each other or people incapable to relate to each other – and nuclear missiles and global financial markets make a bad combination (e.g. Atlee 2004: 101). Also, the world as a whole is getting more complex, heterogenic and dynamic, even turbulent. As a consequence, wicked problems are becoming more common. Most importantly, the separatisms and divides between people, the rich and poor, the healthy and sick etc., are increasing (Hartz-Karp 2007b; Raisio 2010). An extension to collective intelligence is needed. Intelligence needs to be combined with wisdom. This takes place in the definition of co-intelligence.

With co-intelligence, Tom Atlee implies more than just the intelligence of groups, i.e. collective intelligence. For Atlee (2008) co-intelligence includes, in addition to collective intelligence, at least multi-modal intelligence, collaborative intelligence, resonant intelligence, universal intelligence, and wisdom. From these six, the wisdom dimension comes forward strongly as an especially significant factor. With wisdom, the capacity to see the 'big picture' and to see further, becomes easier. We then see more than the "problems in front of our faces" (Atlee 2008: 7). Presumably, emergent evil consequences, such as the development of biological weapons (see Bella 2006), achieved by collective intelligence, can then be avoided (see Hakkarainen & Paavola 2006: 252–264; Briskin, Erikson, Callahan & Ott 2009: xiv, 7–8). A similar kind of a holistic approach is supported by Etheredge (2005: 297). He defines wisdom in public policy as "good judgment about important matters, especially embodying a genuine commitment to the well-being of individuals and to society as a whole". Finally, with the words of Senge (2009: vii) "wisdom is about connection, connection to one another and to a larger whole" (Briskin, Erikson, Callahan & Ott 2009).

Wisdom in co-intelligence can be illustrated by comparing it to individual wisdom. An individual, no matter how wise, is always finite in wisdom. As Atlee (2008: 108-109) states: "We are, alas, only one person, looking at the world from one place, one history, and one pattern of knowing. A community, on the other

hand, can see things through many eyes, many histories, and many ways of knowing." Therefore the differences in perspectives shouldn't be seen as threats but instead as possibilities for better understanding, creativity and, most importantly, wisdom (Atlee 2004: 99). The definition of co-intelligence is then clear: "the ability to generate or evoke creative responses and initiatives that integrate the diverse gifts of all for the benefit of all" (Atlee 2003: 3).

As discussed above, co-intelligence, by achieving a shared understanding and commitment in the whole society, plays a critical role in tackling wicked problems (see Conklin 2005). With co-intelligence it is possible to make choices that benefit everyone. As Hartz-Karp (2007b: 2, 8) states; co-intelligence can help us to be the best we can be. To her, there is a clear call for co-intelligence. In a world which has become so divided, the understanding of life situations and the opinions of others is more important than ever. People don't just think about their own selfish interests but instead also try to acknowledge the views of others. In the context of wicked problems, where blaming, dissensus and fragmentation prevails (Conklin 2005), this is highly important.

With the developments of technologies, especially the Internet, the capabilities of collective intelligence, and co-intelligence, can be seen to have increased remarkably (e.g. Malone 2008). It is then often presumed that the role of information and communication technologies needs to be emphasized when trying to create collective intelligence (see e.g. Brabham 2009).[19] However, face-to-face communication has always something that virtual communication cannot replicate[20]. For example, the belief of Atlee (2003: 167) is that to truly 'see' the others in the collective and to honor their perspectives, the real presence of one another is needed. Therefore virtual communication could be understood more like a supplementary to face-to-face communication, not as a replacement of it. For example, for some people face-to-face communication can be a very uncomfortable experience, making virtual reality a more pleasant setting for communication (e.g. Pearse 2008: 77). Nevertheless, the default should be to make the environment of face-to-face communication such which would make everyone feel comfortable to participate.

The preceding emphasizes co-intelligence as a capacity (Atlee 2003). As such, depending on the environment, it can unfold on many levels. If the environment is such that only the perspectives of a rare few, e.g. politicians, managers and scientists, are honored while the perspectives of others are brushed aside, the capacity

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[19] For example the Government 2.0 initiative emphasizes heavily the use of Web 2.0 applications in public governance (see e.g. Tapscott, Williams & Herman 2007).

[20] For more critique on electronic communication see e.g. Raisio 2009d.

of co-intelligence is highly limited (Hartz-Karp 2007b: 3–4). But as stated before, when tackling wicked problems, there are no experts. Only with wide-ranging diversity, especially including the voices of ordinary citizens, true expertise can be achieved. Co-intelligence, nurtured in an environment which allows it to blossom, can be considered to depict such true expertise to wicked problems. Next, the environment favorable to the growth of co-intelligence will be presented.

3.3.2 Public deliberation as a breeding ground for co-intelligence

It is asserted that the different manifestations of deliberative democracy form an ideal environment for co-intelligence to take place and thrive (e.g. Atlee 2003; Hartz-Karp 2007b). Basically this is a very old idea. Gutmann and Thompson (2004: 8–9) have written about the origins of deliberative democracy. They, as many others (see e.g. Gastil & Keith 2005; Fishkin 2009), trace its roots to ancient Athens and to its first defender, Aristotle. Compared to the prospects of experts deciding alone, Aristotle saw more value in the act of ordinary people debating and deciding together. However, the Athenian democracy Aristotle defended was flawed in a major way. The definition of a citizen was different than it is today, in developed countries. For example, women and slaves were excluded from participating in the forums of public deliberation.

Over time, many others have spoken for deliberative democracy. For example, the founding fathers of America supported it, though not in its full form. Basically, the Madisonian idea was that the people pick the deliberators, i.e. the elected representatives, but not be deliberators themselves (Friedman 2006: 2). Also John Stuart Mill and John Dewey, among others, have been seen to have an influence on the development of deliberative democracy. (Gutmann & Thompson 2004: 8-9.) A certain regard could be also given to Mary Parker Follet, ‘the prophet of management’, as she wrote highly encouragingly about public participation in managing and public administration (see Morse 2006). Then, close to the present day, the philosophers John Rawls and Jürgen Habermas began to develop these issues into a more précis form (e.g. Herne & Setälä 2005). However, the theory of deliberative democracy, as there are many different perspectives to it, cannot yet be considered as a unified theory (Geenens 2007: 357).

What is deliberative democracy?

First, deliberation can be understood as a process which “involves people who hold diverse perspectives talking together about public issues in such a way that they can all be heard and their views can contribute to a deeper shared understanding” (Atlee 2003: 167) and in which “people weigh competing arguments on

their merits" (Fishkin & Farrar 2005: 71) and which "always potentially leads to a transformation of preferences" (Cooke 2000: 948). Deliberative democracy can then be seen as "an association whose affairs are governed by the public deliberation of its members" (Cohen 1991) or as "a conception of democratic government that secures a central place for reasoned discussion in political life" (Cooke 2000: 948). Finally, participation in deliberative democracy refers to "a form of decision making in which citizens engage in discussion with decision makers to weigh the merits and problems of different alternative solutions in a specific matter of public concern". This definition by Grimes (2008: 3) promotes a view, not always common, of public deliberation where the citizens truly have an empowered role.

Gutmann and Thompson (2004: 3–7), in their definition of deliberative democracy, emphasize four different features of public deliberation. The most important of these for them is the requirement of reason-giving. The assertion is that citizens and their representatives both need to justify the decisions imposed upon others by giving reasons that should be accepted by others. Also, in additional to justifying the decisions, the reason-giving shows, as no one is forcing their will on another without reasoning, the mutual respect between different actors. Secondly, reasons given in deliberative democracy should be accessible to those concerned. This means that the reason-giving should be public, in two senses; deliberation itself should take place in public, not in privacy of any sort, and the reasons given should be such that people can understand them.

Thirdly, Gutmann and Thompson (2004: 5–6) propose that the processes of deliberative democracy should result in decisions which are binding, at least for some period of time. Then deliberation has concrete impacts, and is not just some beautiful idea. However, this process of deliberation isn't static. When the decision is made, the deliberation may come to a halt for a while, but at a later time it can continue again. As a fourth feature, deliberative democracy can then be considered to be made up of dynamic processes. Reason-giving doesn't just end when the decision is made. It is more like an open process. Gutmann and Thompson (2004: 6–7) see two reasons for this. Firstly, decision making is basically always imperfect. There is no guarantee that the decision and its justifications will endure the challenges of the coming future. Secondly, as the decisions, especially on wicked issues, are rarely consensual, the opposition may want to reverse or modify the decision. From these features a definition of deliberative democracy is generated, which sees it as a "a form of government in which free and equal citizens (and their representatives), justify decisions in a process in which they give one another reasons that are mutually acceptable and generally accessible, with the aim of reaching conclusions that are binding in the present on all citizens but open to challenge in the future".

Also the concept of 'deliberative governance'[21] has been used (see e.g. Hendriks 2009). If governance is understood, for example, as simply "collective decision-making in which government acts as one stakeholder among many" (Knight, Chigudu and Tandon 2002), the prefix 'deliberative' would add an imperative of deliberation to it. Deliberative governance can then be defined as "the application of deliberation and deliberative processes to the activities of governance" (Scott, Adams, Wechsler 2004: 13). Here, however, a position of not differentiating between these two concepts, i.e. deliberative democracy and deliberative governance, is taken. Firstly, the assertion is that such differentiation would only emphasize the reductionistic politics-administration dichotomy (e.g. Svara 1998). Secondly, the hypothesis is that the prefix 'deliberative' brings these two concepts closer together. To exaggerate, if it is thought that democracy implies partisan politics and governance for, more or less, technocratic administration, then it is the deliberation, as defined above, which brings them more together, and the result is societies with public deliberation as one of the central values. Basically the concepts of deliberative democracy and deliberative governance become one, and can be used interchangeably[22]. Deliberative governance ideally is what deliberative democracy, as a theory, stands for.

What deliberative democracy is not?

Firstly, deliberative democracy is not voting. Traditional voting is a purely private act, not public (Parkinson 2004). Also, in addition to voting, public deliberation cannot be achieved with polls or surveys (Tenbensel 2002; Ralston 2008) Even though, for example, with surveys it is easy to gather a large sample of answers, what lacks is the opportunity for dialogue and deliberation (Lenaghan 1999). Surveys present views of uninformed individuals. For example, health economics carry on this kind of approach, i.e. cost-utility analysis (e.g. Dolan &Tsuchiya 2005; see also Williams 2001, 2005; Raisio et. al. 2009).

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[21] Similarly, Denhardt and Denhardt (2007) write of 'New public service'. With this they refer to a form of governance which sees the public as citizens, instead of just as customers; which strives to discover public interest, instead of just the self-interests of individual citizens; which believes in citizen involvement, instead of just bureaucratic expertise or managerial entrepreneurship; which strives not only to create collective visions but also the co-production of the envisioned public services; which acknowledges the complex nature of accountability; which, instead of controlling or steering the society, aspires to achieve a shared form of leadership; and which in the end puts value on the people as such, not just on the productivity. For example, Lumijärvi (2009) sees the prospects of this model and thus envisions modern bureaucracies able to combine both high integrity and high performance.

[22] For reasons of clarity, the concept of deliberative democracy is used in this research.

The preceding approaches can be understood as aggregate approaches. With them, it is possible to collect existing preferences, i.e. raw opinions, of the citizens (Warren 2008: 69; Fishkin 2009: 14). The problem with approaches such as these is their quantitative and static character. Basically aggregate approaches create “static snapshots of public opinions” (Atlee 2004: 98) and are about "the numerical adding up of our individual opinions” (Atlee 2008: x-xi). But the problem is, as Atlee (2008: xi) states, that if we cannot understand some issues on our own, how could “adding all our individual incompre-hensions (sic) together” result in any better decisions? It is also possible that those who respond to polls and surveys, as they are uninformed about the issue, choose the option at random (Fishkin 2009: 2). For many this can appear as a better choice than to admit not to know or not to have any opinion about the issue. To go even further with this, it may be asked if these aggregate approaches produce even so much as the opinion of the people, or is it better to talk about the moods of the people (Sihvo & Uusitalo 1993).

Authentic public deliberation is not just any basic public meeting, as they can be dominated by individuals with specific interests in the issues under discussion and are usually participated mostly by those who are most likely to be impacted by the decisions made (Gregory, Hartz-Karp & Watson 2008). Also, basic public meetings do not achieve the reflection which is needed for deliberation to take place. The discussion is usually such which confines deliberation instead of generating it. The same is true with focus groups. They can be considered to be just extensions of surveys. The same can be said of public meetings, the time is too short to achieve deliberation (Rawlins 2005).

Compared to the preceding participation methods, public deliberation is essentially much more. Public deliberation is based on an open and fair public process which “envisages a dialogue between people from different backgrounds who exchange thoughts about the issue, offer up reasons why others might be persuaded by a course of action, reflect on the differences which emerge in the group and consider jointly what in the circumstances now revealed, might be said to be the course of action leading to the public good” (Davies, Wetherell, Barnett & Seymour-Smith 2005: 15). In the process of deliberation a reflective and mature public judgement develops (e.g. Button & Ryfe 2005). Instead of just ‘mirroring’ the opinions of the citizens, they are ‘filtered’ in deliberative processes so that ‘refined’ opinions, instead of ‘raw’ ones, can be elicited (Fishkin 2009: 14, 18). Additionally, compared to traditional forums of public participation, deliberative forums offer “safe public spaces”, instead of those of town meetings, for representative samples of citizens, instead of only those having special interests, to meet and to “truly discuss and listen to each other” (Fishkin 2009: 51). So as

those answering polls and surveys produce a reflection of the raw opinions of the public, public deliberation, taking place in a safe environment with many diverse participants, reflects more importantly the potential co-intelligence of the whole public (Atlee 2004).

It can then be said that deliberative democracy is not the same as participatory democracy, i.e. participation and deliberation are two different matters (e.g. Cohen 2009). As participatory democracy can be affiliated with the thinking of Jean-Jacques Rousseau, deliberative democracy goes better with the thinking of Jürgen Habermas. The former supports wide and direct participation to public decision making as the latter sees the importance of citizens addressing major public issues by reasoning together. Participatory democracy clearly calls for aggregative approaches. It is more about mass and direct participation than about deliberation in the form as it is defined above. (Cohen & Fung 2004: 23–24; Vitale 2006: 754.)

What follows is that as participatory democracy calls for wide and direct participation and deliberative democracy for more reasonable participation, which is hard to achieve with mass participation, these two forms of democracy are difficult to combine (see Cohen & Fung 2004: 27–28). By trying to improve public deliberation, the possibilities for public participation can decrease and, vice versa, as public participation is extended it may come at the cost of public deliberation. One major challenge of public deliberation is how to increase the scope of public deliberation so that the deliberation wouldn't be harmed in the process, i.e. how wide public participation could be achieved in a deliberative way. This challenge will be discussed in Chapter 3.3.3.

One more additional distinction needs to be made. This is the distinction between deliberative democracy and teledemocracy. Teledemocracy can be considered as "democracy at a distance" or "electronically mediated political talk" achieved commonly via information and communication technology. Basically it follows the tradition of representative democracy, symbolized by the aggregated individual preferences and competition and conflict of opinions and ideas. Differences between teledemocracy and deliberative democracy are then clear. For example, teledemocracy aspires to increase the quantity of public participation whereas deliberative democracy values quality as the true measure of public participation. Also, teledemocracy sees public opinion and citizen feedback as essential to good governance, whereas, for the proponents of deliberative democracy, aggregated opinions such as these cannot be considered to constitute a reasonable public

judgement. Deliberative democracy forms a distinct idea of democracy. (London 1995).[23]

Fishkin (2009: 33–43) defines five conditions for the high quality deliberative process. They are presented in Table 4. Similarly Herne and Setälä (2005: 176–179) consider six central features of deliberative democracy in its ideal form. Firstly, public deliberation should be about collective decision making, i.e. it has actual linkage to political decisions. Secondly, deliberative democracy is about inclusivity and equity, meaning that every citizen is given an equal possibility to present their opinions, which, as follows, will be evaluated equally by their merits. Thirdly, ideal public deliberation will be formed from a discussion which is public, evenly respectful, responsible, rational, objective and reasonable, i.e. deliberative. As a fourth feature, with deliberative democracy it is possible to decrease inconsistent arguments, flawed assumptions and unreasonable demands and as a resultant to change the preferences of the citizens. Finally, ideal public deliberation should not only increase the legitimacy of political processes and decisions among citizens but also the participants' understanding of complex societal problems, the societal sense of responsibility, and the ability for political participation.[24]

Different forms of deliberative democracy

The preceding ideals of deliberative democracy don't always take place in practice (Herne & Setälä 2005: 186). Basically different forms of deliberative democracy respond to these ideals in varying ways, some better than others. These different forms together can be called "citizen deliberative councils" (Atlee 2008: 169). There are, for example, national issues forums, participatory budgeting, 21st century town meetings, citizens' juries, planning cells, consensus conferences and deliberative polling. From these, citizens' juries, consensus conferences and deliberative polling, as these can be considered the most used practices of deliberative democracy (Herne & Setälä 2005: 176), will be outlined next. More detailed descriptions can be found elsewhere (e.g. Rowe & Frewer 2000; Fung 2003).

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[23] This parting of deliberative democracy and teledemocracy can be considered to be partly too strict. For example Keskinen and Kuosa (2006) see that teledemocracy – a term coined by Theodore Becker (see e.g. Becker & Slaton 2000) – or eDemocracy, includes deliberative methods, such as citizens' juries.

[24] Ideally, public deliberation would take place in an "ideal speech situation", defined by Jürgen Habermas (e.g. 1999), where everyone would have an equal possibility to participate in public discussion; where every participant could present their own views and arguments; and where it wouldn't be the power or the status of the participant that would count, but instead the merits of that argument (Edward 2007; Fishkin 2009).

Table 4. Five conditions for the high quality deliberative process (Fishkin 2009: 33–43)

CONDITION	DEFINITION
Information	"The extent to which participants are given access to reasonably accurate information that they believe to be relevant to the issue"
Substantive balance	"The extent to which arguments offered by one side or from one perspective are answered by considerations offered by those who hold other perspectives"
Diversity	"The extent to which the major positions in the public are represented by participants in the discussion"
Conscientiousness	"The extent to which participants sincerely weigh the merits of the arguments"
Equal consideration	"The extent to which arguments offered by all participants are considered on the merits regardless of which participants offer them"

The citizens' jury was invented by Ned Crosby in the USA in 1971. Since then, they have been implemented worldwide. In the UK alone, more than 200 citizens' juries have taken place (Parkinson 2004). Crosby and Nethercut (2005: 112-114) define seven important elements of citizens' juries. These can be summarized in the following way. In a citizens' jury a microcosm of the community, created by random-selection, comes together. Every participant is paid moderately for their participation. The size of the jury isn't too large. Twenty-four people are considered a maximum, which still enables good deliberation. The information given in the process of the jury is of high-quality. In this, the role of witnesses and questioning of witnesses is emphasized more than written information. Also, the deliberation is of high quality. The facilitator has a major role in ensuring this. Staff biases and outside manipulation are tried to be avoided. Similarly, a fair agenda and hearings are ensured, for example, by having an outside advisory committee. Finally, there needs to be sufficient time to study the issues, therefore making the typical citizens' juries last for five days. Additionally, the objective of the jury is to give a 'verdict' on which the jury members will vote in the end. Consensus isn't, therefore, a requisite. (Herne & Setälä 2005:180.)

Consensus conferences' origins are in the late 1980s Denmark. It was developed by the Danish Board of Technology. Even though the deliberation is similar to the previous example, the process of the Danish consensus conference, compared to the citizens' jury, is divided into two stages. First, the deliberators meet for two weekends where they preliminarily learn about the topic and the process of the

deliberation and where they also get to know each other. During this time, these deliberators, from ten to twenty-five individuals, develop the questions which are addressed in the consensus conference and also choose the coming presenters. As the actual deliberation, i.e. the second stage, takes four days, the consensus conference usually lasts a total of eight days. The first two days of the second stage comprises mostly of a panel of experts answering questions set earlier. On the two following days the writing of the conference report takes place. As a final act, the results of the consensus conference are presented publicly. (e.g. Hendriks 2005: 83–84.)

Both citizens' juries and consensus conferences have been criticized for not being statistically representative (Fishkin 2009: 81). But it could be asserted that the small size can also be an advantage; something that those deliberative practices with a higher number of participants cannot achieve. So-called 21st Century Town Meetings have even thousands of deliberators. These are usually one-time events which heavily utilize ICT. For example, the Town Meeting for the World Trade Center site planning included more than 4000 people deliberating under the same roof (Roberts 2004). However, Atlee (2004) criticizes mass participation exercises such as these for the lack of deliberation and therefore for the lack of breeding ground for co-intelligence.

Deliberative polling can be understood as a middle ground for mass participation on the one hand, and for small-group deliberation on the other. James S. Fishkin, the developer of deliberative polling, defines it in the following way: "a poll of citizens before and after they have had a chance to arrive at considered judgments based on information and exposure to the views of their fellow citizens" (Fishkin & Farrar 2005: 68). Deliberative polling uses random sampling[25] and with a large amount of participants – commonly from two hundred to five hundred – strives for both political equality and deliberation[26]. Even though the amount of participants in deliberative polling is much higher than in citizens' juries and consensus

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[25] The importance of random sampling and 'invitation only'-principle are emphasized. Thus using substitutes isn't desirable. Instead, the randomly selected individuals should be recruited with "the greatest effort possible". (Mansbridge 2010).

[26] However, random sampling can be critiqued as it may lead to a result where many people are excluded. This is the case, for example, when telephone surveys are used; those without telephones are automatically excluded. Thus Kashefi and Mort (2004) present another approach with their 'grounded citizens' jury'. The process of choosing the deliberators is then such that the steering committee contemplates on the recruitment profile, and then a professional recruiter talks with people on the streets and strives to find deliberators to fit the decided upon profile. The legitimacy of the deliberation isn't endangered: "The steering group decided whom they wanted to hear from and it is this fact that gives the jury its legitimacy, not some notional claim of representativeness" (Kashefi & Mort 2004: 294).

conferences, deliberation can be achieved via small group discussions (e.g. Herne & Setälä 2005: 181). Deliberative polling, however, as it commonly lasts for only one weekend, cannot be hypothetically considered to be a good breeding ground for co-intelligence as the other examples presented[27]. But it manages to show that citizens, after being informed about the issue and after hearing the perspectives of many other people, indeed do change their opinions (e.g. Fishkin 2009).

3.3.3 Prospects and challenges of deliberative democracy

The important question to ask is why the deliberation of elected representatives isn't enough. Why is there an additional need for the deliberation of the public? Let's think that deliberation in representative institutions, such as parliaments around the world, would indeed take place. This would be the ideal, for example, the founding fathers of America aspired for. Then with these representative deliberative institutions the 'tyranny of the majority' could be avoided (Fishkin 2009: 61). The assertion is that even democratic decisions can be bad ones, based on momentary passions, and people later on, after being more informed about the issues and having reflected more upon them, could regret the votes given. The deliberation of elected representatives would ideally then work as a filter for public opinion based on mass participation. In a Madisonian way, those who are elected would deliberate for the people and make the decisions best for the society (Fishkin 2009: 73).

This is what is aspired for. But when the party and electoral calculations intervene, the incentives for the elected representatives will be such that they can easily strive to react to the raw opinions of some select group, e.g. a political party (Fishkin 2009: 94). Also, the elected representatives often face a dilemma of if to follow the polls, for example, and be tempted by populist reasons (Blum & Manning 2009: 51) or to decide on what they think would be best for the society. Both of these choices lead to rough paths. First, if it is decided to follow the polls, representatives may be thought to be just 'weathervanes'; shifting with the public opinion. As public opinion can often be uninformed, this means that basically the blind would do the leading.

The flaw of uninformed mass public opinion is also its vulnerability to manipulation, or if taken to the context of wicked problems, to be tamed. This manipula-

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[27] However, Mansbridge (2010) defines deliberative polling as a 'gold standard' of deliberative practices. The reasons she recites are representativeness, balanced materials, policy links, the quality of space for reflection, and outcome measurement.

tion, or taming of the problem, is easier when the public is uninformed and disengaged. Then the volatile opinions of individuals can be taken advantage of. Also the information to citizens can be presented as 'true' facts without the possibility to hear other opinions. Similarly, some issues can be given higher visibility with more advertising. To go even further, the uninformed individual can even be presented misinformation. Finally, misleading can take place by priming some issue in such a way that it becomes highly attractive, smothering the other perspectives. (Fishkin 2009: 3–4.)

To continue, if elected representatives try to implement their informed will to a disagreeing public, no matter what the merits of the decision, the public can accuse the representatives of trying to decide on their own personal value judgments (Fishkin 2009: 74; Rawlins 2005; Raisio et. al. 2009). There is, however, a middle path. Instead of following the raw opinion of the public or deciding on their more informed but, nevertheless, more or less personal views, the elected representatives "can take account of what they think their constituents would think about an issue, once they were well informed and got the facts, heard the arguments on either side, and had a reasonable chance to ponder the issue" (Fishkin 2009: 74–75). Representatives can then resist the pressure to follow polls and instead follow the possible informed opinion of the public.

However, traditional representative democracy, being deliberative or not, always has many disadvantages, which, on the other hand, can be considered as the strengths of deliberative democracy. Firstly, electoral cycles hinder the possibility to achieve sustainable long-term development of public policies (see e.g. Raisio 2009c). Secondly, innovation and experimentation suffer as representatives attend to vested interests. Thirdly, as the public visibility and adversarial relations have an important standing in representative democracy, the style of speech can emphasize the other ways of communicating rather than that of deliberation. Lastly, because of the electoral context of representative democracy, intense and well-organized interests have easily more weight in policymaking than latent and unorganized interests, not to mention the common good. (Warren 2008: 54.) As Cohen and Fung (2004: 26) state, even at its best, traditional representative democracy is just a "fair bargaining among competing interests".

Additionally, Ferejohn (2008: 192, 211) points out some weak points of elected leaders. First, the ones elected to govern via elections can turn out to be, as opposite to ordinary people, "unusual people", i.e. "better, more able, or merely more ambitious leaders". Secondly, it can be that those who are elected become a professional class whose knowledge and interest don't match those of ordinary people. In the worst case, the principle of election and the competition it with-

holds can lead to a situation of ‘elective aristocracy’. This can be considered partly as the alienation of citizens from political decision making. As Setälä, Grönlund and Herne (2007) point out, for representative democracy to work, it is highly important that at least part of the public is sufficiently knowledgeable about the political decisions decided on. This knowledge makes it possible to oversee and also to challenge the decisions made by the elected representatives. Summing up all these preceding challenges of representative democracy to be deliberative, the conclusion is that the Madisonian ideal of deliberation *for the people* is in trouble. What is needed is deliberation *by the people*.

Even though it would be naive to think that self- and group-interests in politics could ever be dissolved with deliberative practices, they could be lessened and decisions could be made to be more reasoned. This could be achieved by framing the politics with considerations such as fairness, equality and the common good. Decisions wouldn’t just be the end products of power and interest. (Cohen & Fung 2004: 26.) Deliberative forms of democracy should, however, only be seen as complementary to traditional representative democracy. It isn’t meant that one approach would be replaced by the other (e.g. Warren 2008: 66).

Similarly, deliberative democracy can supplement the institutions of direct democracy. As the problem with direct democracy is that the chance to propose initiatives can be abused by special interests, as it is usually worthwhile to arouse or provoke discussion, deliberative democracy could make the process such that it would be more ‘deliberative’. Pressure groups, such as third sector organizations, usually have the disadvantage that they focus intensely on a single issue, and in the process forget the common good (Warren 2008: 53). So as Ferejohn (2008: 212) suggests, whenever an initiative is proposed, a deliberative process could be organized around it, with an objective to make the initiative an informed proposal. As the special interests couldn’t control the initiative fully anymore, the result could be a decrease in the abuse of initiative process by special interest. Also the initiatives could then become more likely to pass in a possible referendum, as they would be more attractive to the median voters and because they would be carefully deliberated so that the possible special interest of the proposers would have been lessened.

The practices of deliberative democracy can supplement both representative democracy and direct democracy. This can be considered as an important prospect of public deliberation. In Table 5, some other concrete purposes of deliberative practices are outlined. However, most importantly, public deliberation answers to the problem of separatism (see Fishkin & Farrar 2005). The problem with separatism is that you are unable to hear other people’s perspectives. Mary Parker Follett

uses the analogy of piano keys when stating that "value comes not in separateness, but in relating" (Morse 2006: 10). When we relate with many people from diverse backgrounds our understanding of the problem deepens. It is, therefore, not only about the quantity of the people, but more importantly about the diversity (Atlee 2008).

Table 5. Purposes of deliberative public engagement (Friedman 2006: 17–20)

1. Informing policy	Public's values, preferences and concerns help policy makers to make better decisions. When problems are close to citizens, they can give their own insights and then "offer critical pieces of the puzzle".
2. Legitimizing policy	When citizens engage authentically in decision making processes, it is easier to legitimize emerged outcomes.
3. Freeing a paralyzed policy process	Citizens' participation can help to remove political deadlocks.
4. Helping citizens move toward "public judgment" on specific issues	With deliberation, citizens can mature their opinions about the discussed issues. They then understand issues better. Also better recognition of political manipulation emerges.
5. Promoting a healthier democratic culture and more capable citizenry	Deliberative public engagement helps to strengthen democratic culture and practice. It gives new methods for democracy to happen.
6. Building community	With public deliberation it is possible to build stronger communities.
7. Catalyzing civic action	Deliberation in the best case precedes civic action. Deliberation creates more active citizens.

In the process of deliberation something happens that doesn't often take place within the normal lives of citizens. It might be that citizens indeed discuss important societal issues and politics, but as Fishkin (2009: 3) states, this discussion often takes place with people similar to them. And if there is a situation when people with different backgrounds and opinions meet and discuss, the topics more likely are something less controversial than political issues. Public deliberation makes possible a "moral discussion"; viewing the issues from the points of view of another, or "a kind of ideal role taking" (Fishkin 2009: 125). As a result, moral perception and empathy could be enhanced and morally better decisions achieved (Fouke 2009). Self-interests could be transcended and common good accentuated (see Murphy 2005)[28].

[28] If overstated, this can be seen as the classic ideal of deliberative democracy, where self-interests, negotiations and bargained compromises are excluded. Mansbridge, Bohman,

Wilson (2009: 22) illustrates social healing as one of the positive outcomes of deliberative practices. In her research about the deliberative forum dealing with the reconstruction of New Orleans, she noticed that more took place than just increases of social trust and social capital: "It helped residents re-member (sic) New Orleans in their hearts and minds. This was social healing: a moment of overcoming isolation and becoming whole". In the process, the collective identity of the community was begun to be re-established. Also, in a Millian way, models of deliberative democracy can be understood as "schools of public spirit" where the public can develop to be better citizens. Fishkin (2009) points to tentative empirical proofs which support the notion that with public deliberation the perspectives of citizens can truly change to focus more on the public good; to make decisions which benefit the whole (see Fishkin, He, Luskin & Siu 2010; see also Iredale, Longley, Thomas & Shaw 2006: 215; Guttman, Shalev, Kaplan, Abulafia, Bin-Nun, Goffer, Ben-Moshe, Tal, Shani & Lev 2008: 186). These all preceding prospects of public deliberation clearly point to the creation of co-intelligence.

As noticed, public deliberation has both instrumental value and expressive value. In the former, deliberative democracy is seen as an instrument with which good and justifiable decisions can be arrived at. The deliberation itself has no value, only the outcome which can be achieved matters. Expressive value, on the other hand, emphasizes the actual process of deliberation and the positive issues ensued, especially the moral significance of it. With the process of deliberation decision makers, by seeking the views of those influenced by the decisions, show respect to their fellow citizens[29]. The practical benefit of decision makers respecting the expressive value of deliberation is explicit: "If citizens perceive that their views are not being respected, they may seek to block otherwise good policies". (Gutmann & Thompson 2004: 21–23.) This will be discussed further in Chapter 3.3.4.

Chambers, Estlund, Føllesdal, Fung, Lafont, Manin & Martí (2010) however suggest a reformulation of this deliberative ideal by including constrained self-interest and certain types of negation to their formulation of "deliberative negation". The discussion is about non-coercive forms of deliberative negation, the opposite, for example, to democratic negations employing some kind of threats. The hypothesis is that if the self-interests of the deliberators aren't explored, then a form of common good may emerge that doesn't include all the individual perspectives. Thus, deliberative negation clarifies individual interests and preferences and lessens the risk that the common good of the more powerful dominates.

[29] The importance of the respect of others can be realized from Maslow's hierarchy of needs (see Maslow 1943). In the hierarchy, esteem is situated on the fourth level, only self-actualization above.

There are promising experiences with deliberative methods (e.g. Davies et.al. 2005; Setälä, Grönlund & Herne 2007; Fishkin 2009; Fishkin et.al. 2010)[30]. In health care related issues there have been trials of deliberation on many topics. For example, in the UK, a citizens' jury took place in a community suffering of significant health inequalities (Kashefi & Mort 2004). The jury was implemented to gain a better understanding of the needs of the whole community in order to be able to provide the needed primary care services for the population. The main question deliberated on was "What would improve the health and well being of residents of SWB (the South West Burnley)?". Twelve people were recruited to the jury, however, not through random sampling. As it was thought that random sampling would exclude many people, a different tactic was used. The process was such that the steering committee decided on the recruitment profile and then a professional recruiter, during many weeks, talked to the people of the community in order to find the jury matching the profile. The jury started with two preparatory evenings after which the actual five day deliberation took place. The deliberators were presented oral and written evidence from many different 'witnesses'. Additionally, four research projects were made and presented for the jury, e.g. a consultation of the local children. The jury ended with a final report, with over 80 recommendations. As one concrete result a health centre, "as a flagship both for active participation of community members on its management board... and also for tackling inequalities in access to healthcare", was established (Kashefi & Mort 2004: 298).

In New Zealand there has been a citizens' jury on the issue whether "New Zealand government should offer free mammography screening to all women aged 40-49 years" (Paul, Nicholls, Priest & McGee 2008). After a random-selection eleven 40 to 49 years old women gathered together, heard the evidence and deliberated on the issue. After the deliberation, ten of these women changed their mind to be against the issue. The reported main reason was that the deliberators became aware of the harms and low benefits of starting mammography screening at the age of 40.

In Israel, 132 randomly selected citizens deliberated on the issues of equity and rationing in health care, e.g. "whether people should be allowed to pay to ensure their choice of a doctor in publicly funded hospital" (Guttman et.al. 2008). All the deliberators participated in opening and closing sessions, but additionally the participants were divided into six regional groups which gathered together six times. They were provided written information and, as an interesting aspect, there was a

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[30] See Article 5 (Raisio 2010) for Finnish examples of deliberative democracy.

continuous presence of experts during the deliberations to be consulted when needed. Even though direct policy impacts didn't take place, the event was considered worthwhile by the deliberators, i.e. it was appreciated as such.

Priority setting has been one of the central themes in public deliberation on health care issues. For example in the UK, a local citizen jury comprised of 20 participants deliberated – during 11 meetings – on the question "What are the priorities of the citizens of Bristol for research into the provision of primary health and social care?" (Gooberman-Hill, Horwood & Calnan 2008). In Canada, 16 participants deliberated on the priority setting for health technology assessment (Menon & Stafinski 2008). In New Zealand, two citizens' juries, each consisting of 14 women with urinary incontinence, were carried out (Herbison, Hay-Smith, Paterson, Ellis & Wilson 2009). The main questions to deliberate on were "What can researchers study to make your life better?" and "What should we measure to see if your life is better?". The premise of the research was that the research questions defined by the researchers or by the funders of the research aren't necessary those which would be the most useful to the people facing the problems the research is focused on. This might be so in medical research, but also in wider health care research it would be advantageous to gather the informed opinion of the public on the priorities of health care research.

Additionally, Mitton, Smith, Peacock, Evoy and Abelson (2009) have made a wide review of public participation methods in health care priority setting. According to their research – including 175 articles – the perceived outcomes of deliberative engagement processes were perceived to be good in 78%, fair or poor in 13% and unclear in 9% of the articles. Compared to non-deliberative engagement processes, the perceived outcomes of deliberative practices were somewhat better.

Critical comments on deliberative democracy

Deliberative democracy has also aroused many critical comments (e.g. Sanders 1997; Price 2000; Young 2003). Lynn M. Sanders (1997) has voiced one of the strongest commentaries. She addresses the 'mutual respect' feature of public deliberation; deliberators consider each other as equals and deliberate by offering reasonable and morally justifiable arguments. This is the ideal, which, however, is difficult to live up to. The argument of Sanders (1997) is that there will always be those who speak more, are more persuasive and whose ideas count more than others. Similarly, there will always be people who speak less, are less likely to be listened to and whose ideas, no matter how reasoned and well presented, can easily be disregarded. Instead of mutual respect, public deliberation often seems to experience unequal participation and influence (see also Raisio et. al. 2010).

Referring to the preceding, if the deliberative practice is indeed such which would silence the voice of, for example, minorities, or be manipulative in some way, many conflicting opinions could possibly be neglected. This emphasizes the control and the design of the deliberation process and especially the importance of the role of the facilitators (see Kadlec & Friedman 2007). Basically, in the process of deliberation, the focus cannot be too consensus oriented. Consensus shouldn't be forced; not by facilitators and not by the more dominant deliberators. By cherishing the mutual respect between deliberators, the disagreements should also be constantly brought out. Karpowich and Mansbridge (2005: 348) call this "dynamic updating"; a process where "facilitators probe for possible conflicts as well as possible forms of cooperation and participants feel comfortable in exploring conflicts as well as in building bonds of solidarity, creating shared value, and finding unexpected points of congruence."[31] [32] This process can be helped, instead of just aspiring to achieve the 'common good', by trying to identify the 'common ground' (e.g. Mansbridge, Hartz-Karp, Amengual & Gastil 2006: 36–37). The latter can be understood as a more 'conflict friendly' objective to strive for.[33]

Thinking about one prospect of public deliberation presented above, that moral perception and empathy could be enhanced and morally better decisions achieved, from the perspective of health care rationing, Price (2000: 272) states a counter-argument. He points out the "tendency among juries to suppress by non-rational means the every-day moral language of health care evaluation and substitute for it a system of thought in which it can be deemed permissible to deny treatment to sick people". With non-rational means Price (2000: 274) means persuasion. Using the real-life example of a child who had been refused to be given a second bone marrow transplant by the authorities, he points out how in just four days a citizens' jury changed its moral position from sympathetic to the child to a more technocratic one, focused on effectiveness. This implies then, that in addition to the prospect of enhancing the moral discussion via public deliberation, there is

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31 Also see the reformulation of the deliberative ideal, i.e. "deliberative negation" by Mansbridge et.al. (2010).

32 In relevance to this, Zimmerman, Lindberg and Plsek (2008: 150-153) write about asking 'wicked questions'. These are paradoxical and 'hot' questions with no obvious answers. The objective of these questions is to get people to reveal their assumptions on the deliberated topic and thus to open up the deliberation further.

33 For example Airaksinen (2009: 193), in the context of administrative reform, highlights the role of genuine interaction, or deliberation – importantly including topics which are difficult and which may cause distress in the group – in achieving novelty and innovation in reform processes. If these processes are 'protected' from issues which may be troublesome and cause disturbance, as a result, reforming may become an incremental and fragmented process built from compromise solutions, leading in the worst case to decline or basically to status-quo.

also a danger of decreasing it. However, it isn't stated here that public deliberation should take place in issues as such, i.e. who gets the care and who doesn't. Instead of deliberating on the level of the individual patient, public deliberation should take place best on the programme level and/or the health system level (see e.g. McKie, Shrimpton, Hurworth, Bell & Richardson 2008).

Young (2003) highlights the challenges of deliberative democracy by juxtaposing deliberative democrats and activists – as ideal types – focusing more on the latter. From the viewpoint of an activist, the first challenge of deliberative democracy is about the exclusiveness of deliberative practices. As activists assert that that deliberations commonly take place behind closed doors by a selected few elites, there is a need for protests and other activist measures to get the opposing voices heard. However, as Young (2003: 109) states, this is also what deliberative democrats strive for: to create an open and inclusive setting for deliberative democracy to take place. On this issue, activists and deliberative democrats have a similar goal[34]. As a second challenge activists continue that bettering the formal inclusion to deliberation doesn't solve the problem. Their assertions is that if a society is formed by profound social and economic inequalities structural biases still remain, giving stronger possibilities to influence those more powerful and socially advantaged actors. For example, if most of the energy of the individual goes towards surviving from day to day, involvement on deliberative practices may seem just a distant idea (Young 2003: 110–111).

The constrained alternatives of deliberation form the third challenge for deliberative democracy. The assertion here is that because of the historical background and unjust structural inequality – which influence the choosing of the alternatives deliberated on – deliberative practices are constrained and thus activism is needed to highlight the other alternatives (Young 2003: 112–115). It can, however, be assumed that other forms of deliberative democracy are more prone to this challenge than others (see e.g. Ward, Norval, Landman & Pretty 2003). For example, deliberative polling can be considered restricted in the preceding way as the alternatives deliberated on are decided before the deliberation takes place, i.e. changes in opinions are calculated but the calculated issues are preset. Also, 'radical' alternatives which aren't considered as feasible within the current political process may be shunned (see Mansbridge 2010).

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[34] Fung (2005: 399) writes of 'deliberative activism', i.e. activism to achieve deliberative democracy: "I call this perspective deliberative activism because it holds that widespread inequality and failures of reciprocity can justify non-persuasive, even coercive, methods for the sake of deliberative goals".

Deliberative practices can be made more open to different alternatives, as for example, Ward et. al. (2003) propose with their model of an 'open citizens' jury'. However, an activist can still appeal to the influences of "common discourse which itself is a complex product of structural inequality" (Young 2003: 115). With this it is meant that the common discourse taking place in societies and thus in deliberative practices is deeply influenced by the predominant premises. As a consequence, alternative possibilities can stay hidden. Young (2003: 119) concludes that both activism and deliberative democracy are needed.

One challenge of deliberative practice is the "problem of scale" (Friedman 2006: 6), i.e. how to scale up public deliberation from the local level to consider major national and even international issues. Firstly, the important issue to take notice of within this challenge is the proportion of the costs of deliberation compared to the nature of the problem, i.e. when the problem is on such a level, is it actually justifiable to 'scale up' the deliberation?

Clearly, not every issue is in need of the deliberative approach. Mainly this is because of the time, resources and commitment required in the implementation of deliberative practices[35]. However, when thinking about these demanding sides of having public deliberation, it should also be kept in mind the costs of not having public deliberation (see Cookson & Dolan 1999; OECD 2001; Roberts 2004; Bruni et. al. 2007; Raisio 2009c). As stated earlier, sometimes it is necessary to fail in all the other methods, until the more collaborative approaches are embraced (Roberts 2000). This is highly costly and, because of path-dependency, irreversible. Alas, as the deliberative approaches are costly, there is a need to think carefully in which situations to use them. The main question then is; when is the problem 'hot' or wicked enough to justify the use of resources for public deliberation (Atlee 2004; Roberts 2004)?

Considering the preceding, issues having major long-term impacts and issues with wide concern and division deserve deliberative approaches more than others. (Gregory, Hartz-Karp & Watson 2008.) Similarly, according to Warren (2008: 66), public deliberation is suitable especially for two kinds of problems. The first of these is the traditional description of a wicked problem; a problem so complex and significant that wide public deliberation is needed. The second is a more concrete one; a problem which causes a conflict of interest in elected bodies. This means that some issues are such that those in authority are morally inept to decide

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[35] Pickard (1998: 243) in her critique on citizens' juries raises the point that the use of deliberative practices need to be thought over carefully. They are very expensive and might be implemented at the expense of the other participatory methods.

on by themselves. These can be considered, for example, to be issues such as electoral reform and a campaign finance law. If those in authority cannot be "judges in their own cases" there is a need for some other body to consider the issue. Judges with procedural expertise and academics or technical professionals with substantive expertise present one possibility. They have strong support, but in the end they can form just another kind of elite. As issues such as these often need trade-offs between different values, expertise is not enough. Therefore public deliberation offers something which is out of reach of the other models: "it can claim a right to base its recommendations on substantive value judgments and on relevant information from the community of experts". (Ferejohn 2008: 211.) Yankelovich (1995) continues that public deliberation is needed when an issue meets one or more of three criteria: the issue is significant to people's lives; there is a need for sacrifice; and special interests oppose the planned end result.

If an issue contains some features presented above, it could be stated that the implementation of deliberative practices is justified. Also, the more the features present, the more the deliberation should be 'scaled up'. So, basically, local issues could be handled with approaches such as citizens' juries. However, more wicked issues presume something like a 'multi-process approach', presented by Atlee (2004: 96-97), where different kinds of participation and deliberation methods are combined so that together in synergy they could produce something none of the methods could produce alone. Important in all of this is that deliberation, being on a local, national or international level, doesn't just take place within the actual deliberative forums. Instead there are, both internal deliberations and external deliberations (see e.g. Ferejohn 2008: 208–209)[36]. Within an internal deliberation, the participants deliberate only by themselves, as in external deliberation the process is exposed to the wider society. So the deliberation can start to resonate with the broader public (Fishkin 2009: 149). The ideal of Atlee (2004: 97) is that:

> *"Everyone is watching the activities of the most important councils unfold, and is talking about them. Stories of participants' engagement and change stimulate diverse members of the community to evolve towards the common good. Evocative ideas raised by the councils trigger conversations throughout the community and political action to push sensible solutions into policy. And out of such an engaged population, the next wave of council mem-*

[36] Hendriks (e.g. 2009: 175–176) distinguishes between two overlapping forms of deliberative theory, i.e. micro and macro. Basically micro deliberation refers to small scale deliberative forums emphasizing deliberation over participation as macro deliberation refers to wider – open and unstructured – deliberation in the public sphere. All these internal and external, and micro and macro deliberations can be considered to form the 'deliberative system' (see e.g. Mansbridge 2010).

> *bers is selected, creating a feedback loop through which the citizenry can watch itself evolve..."*

One more challenge is needed to be outlined, that being the one of sustainability. The sustainability of deliberative democracy needs more than just occasional experiments done mostly with the funding from foundations. As Wilson (2009: 20) writes, support from foundations can work by kick-starting public deliberation, but something more sustainable is needed. If they stay only "at the level of ad hoc or pilot projects", what may happen is fatigue from the part of the public, leading, for example, to apathy and protests. Wilson (2009: 22) suggests that deliberative practices should be embedded in the "institutional infrastructure of civic participation". She continues: "Deliberative democracy is not series of ad hoc events. It is a way of governance".

What follows is that governance should be made such which would evoke and sustain deliberative democracy. Governance practice of the current world view cannot, however, be seen to be as such. The elite – technocratic, political and administrative – still dominates while the opinions and demands of the citizens are neglected (see e.g. Hartz-Karp 2007b; Karttunen 2009). de Lancer Julnes (2006:178) states that neither the modern NPM (New Public Management) paradigm nor the traditional bureaucratic government support a world view endorsing a greater role for citizens. Firstly, the NPM paradigm might be too focused to see the public not as citizens, but as customers, and, therefore, sustaining a passive mode, and low level, of citizen participation, e.g. the use of surveys. Secondly, the traditional bureaucratic government strongly emphasizes technocratic and bureaucratic values which then impede the unfolding of democratic values supporting public participation and deliberation. The institutional arrangement should change so that the latter value group could emerge (e.g. Raisio et. al. 2009).

3.3.4 'Symbiosis' of technocratic and democratic values and 'a positive-sum game' of public administration and public deliberation

To emphasize, it is not suggested that, in reforming health care, technocratic values, such as efficiency, effectiveness, value-for-money and fast decision-making, should succumb, via increased use of public deliberation, to democratic values, such as transparency, equal opportunities, access to public services, fair procedures and especially citizen participation in decision making (Randma-Liiv 2008: 77). Neither is it asserted that public deliberation should replace managerial and expert, including political, decision making. Instead, what is called for is a 'symbiosis' of technocratic and democratic values with 'a positive-sum game' of public administration and public deliberation. This has been presented in detail in

Raisio et. al. (2009) and Raisio et. al. (2010), respectively. Figure 4 illustrates these two perspectives, which are outlined next.

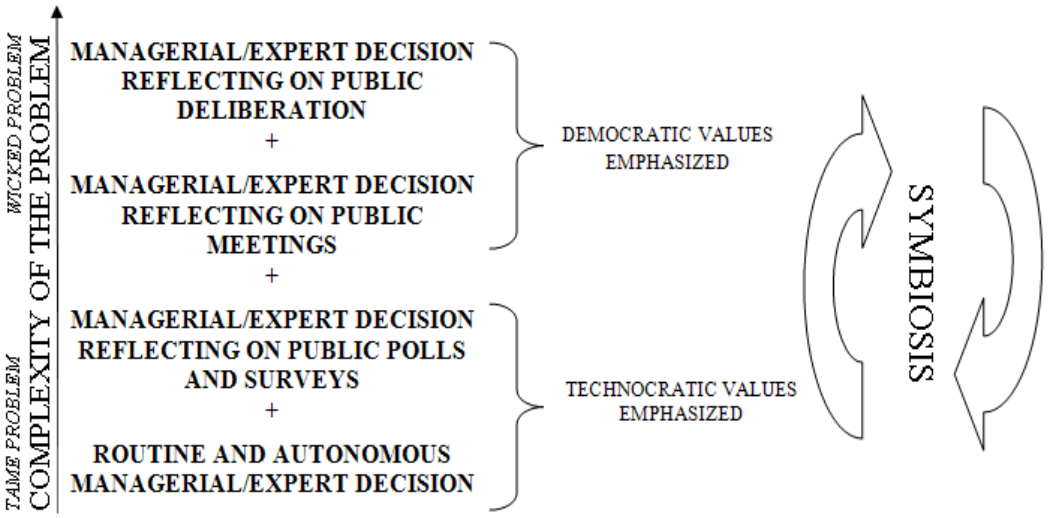

Figure 4. 'Symbiosis' of technocratic and democratic values and 'a positive-sum game' of public administration and public deliberation in relation to the complexity of the problem

Technocratic values and democratic values are two value groups which can easily contradict each other. When this happens, the likelihood is that technocratic values emerge as a winning side, not the other way around. For example, it can be considered that scarce resources easily steer decision makers to emphasize technocratic values at the expense of democratic ones (e.g. Randma-Liiv 2008). This shouldn't, however, be the way. Not at least as a default. Of course, there are some issues, such as tame problems, which can be tackled with approaches emphasizing technocratic values[37]. But the more complex the problem, the more emphasis there should be on democratic values. There are three suppositions to support this assertion.

Firstly, as wicked health care issues often call for sacrifices from the people, the need for the emphasized role of democratic values becomes strong. This refers to the assertion that when the people are part of the problem, they should also be part of the solution (e.g. Clarke & Stewart 2000). When the technocratic

[37] For example Harmon and Mayer (1986: 42) consider the values of efficiency, effectiveness and productivity to refer to the existence of tame rather than wicked problems. When problems are wicked, they continue, it is important to alter these value orientations. If technocratic values dominate it can be that "wicked problems are treated as though they are tame and the inevitable consequences ensue: The wicked problems remain or are replaced by new ones".

worldview dominates, it is usually so that the experts define the problems and, what follows, own the problems. It is then important that the citizens join in defining the problems, as then they can feel more strongly that they also own these problems (see Scutchfield, Hall & Ireson 2006). They have a strong responsibility as a collective to tackle it.

With a worldview also giving value to democratic values, and especially to deliberative democracy, people can come to see that they need to change their behavior and to accept that there is a real need to make sacrifices; to understand that it isn't correct to "hide behind the mantra of 'cutting waste, fraud, and abuse'" (Yankelovich 1995: 16). The will of the citizens is, indeed, often contradictory as at the same time they can demand high quality health care and low taxes (e.g. Warren 2008: 53). And as they are demanding more than it is possible to provide, or more than they are willing to pay, the need for sacrifices is explicit. Without public deliberation there is no real chance for citizens to contemplate on the tough choices included in sacrifice-making. The need to emphasize democratic values and especially public deliberation is then clear as it can help citizens to get a grip on reality and to understand and accept that improving health care services, without more fundamental changes, only has limited applicability (Yankelovich 1995).

Secondly, technocratic knowledge cannot speak on behalf of the public on the social values they hold. There is no legitimacy in this (Rawlins 2005). Knowledge based on technocratic evidence then needs social value judgments, based on the values and norms of the people themselves, to fill in the gap in legitimacy. To concretize, there exist scientific value judgments based on technocratic values and social value judgments based on democratic values. The role of the former is to interpret scientific and clinical data such as efficacy, clinical effectiveness and cost effectiveness. This is rightly the responsibility of the scientific experts. However, there also exist social value judgments which these experts, on their own, cannot make. These are, among others, about preferences and ethical principles. As they are about essential human values, then they should reflect the values of the whole collective; the current and future patients of health care systems and more generally the whole public; stakeholders via taxpaying. (Rawlins & Culyer 2004; NICE 2004; Rawlins 2005.)[38] It is only natural to think that citizens con-

[38] Coulter (2006) raises the point, through the UK example, of individual patient engagement succumbing to collective public involvement. The contradiction is between the active participants in collective action and the passive recipients of health care on the individual level. When increasing the focus on the collective level, this shouldn't be at the cost of individual patient empowerment.

tribute by paying taxes and therefore have a rightful say in how to spend the money (McBride & Korczak 2007).[39]

Thirdly, and most importantly, no matter how effective the decisions made would be, they sometimes cannot be implemented without the support of the public itself (see Raisio 2009c; Raisio et. al 2009). So basically a decision based on technocratic values could be a wise one, but, nevertheless, the people can complain as they do not understand the problem or the proposed solution. This isn't just about what decision would work well; at least as important is, that it works in a way that is acceptable to the citizens (Foresight 2007). Of course, it might be that in the end the public, after deliberation, could accept the decision without any changes to it. It does not mean that all has just been a waste of money. Instead, with the co-intelligence of the public it is possible to implement the suggested decisions with the support and the goodwill of the citizens (see Hartz-Karp 2007b) and as a result, the needless pain and frustration, often being a part of making tough choices, could be lessened (e.g. Conklin 2005; Raisio 2009c).

In tackling wicked problems there is a genuine need to concentrate more on the 'symbiosis' between these technocratic and democratic values. The argument is that in the case of wicked problems, there is 'not one without the other'. If there is focus mostly, or only, on technocratic values, the solution could be effective, but without public support it could lose its meaning as the people oppose it as they do not understand it. If there is a focus mostly on democratic values, the solution could be what people endorse, but without the knowledge of technocratic evidence, the results could be worse for everybody as the scarce resources are used ineffectively (e.g. Williams 2005; Raisio et.al. 2009).

'A positive-sum game' of public administration and public deliberation forms a similar case as the preceding 'symbiosis' of technocratic and democratic values. The idea is that it is the nature of the problem that defines the optimal level of collaboration between the administration and the public. The more complex the problem, the stronger the collaboration should be (Raisio et.al. 2010). However, the predominant view seems not to support this. Instead, what emerges - especial-

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[39] This discussion about technocratic knowledge and social values can be reflected with what Thacher (2009) calls "the experiential gap", meaning that public officials constantly "take actions that have implications for people whose experiences they do not share, and they must continually make laws that affect lives they have not lived." (see also Raisio 2010) When these decisions are done based on scientific understanding, and as there is no "direct experience to draw from" the risks of misconstruing the decisions may increase, e.g. public officials making decisions about public health care when they themselves only use private health care.

ly from Arnstein's (1969) illustration of public participation, i.e. the seminal 'ladder of citizen participation' - is a "zero-sum power struggle between government and citizens" (Cooper & Bryer 2007: 818). It is a competition for finite power between two sides, where opportunities for collaboration and shared decision making are nonexistent (Tritter & McCallum 2006). To concretize; when one gains power, the other one loses it. However, Cooper and Bryer (2007) and Tritter and McCallum (2006) state that instead of a zero-sum game, the act of increasing public participation in public administration is more like a 'positive-sum game'; a win-win situation of collaboration. Both sides gain, as through the process of public involvement, the government can gain increased trust and legitimacy with an image of being responsive and accountable, and the public can equally gain a stronger sense of community and empowerment with a sense of receiving more value for tax dollars (de Lancer Julnes 2005: 182).

If the assertion is that the nature of the problem defines the optimal level of collaboration between the administration and the public (e.g. Martin 2009: 284), there is a need to differentiate between these different levels. To begin with, Arnstein (1969: 217) and Thomas (1990), among others, have defined the levels of public participation. Arnstein's scale consists of eight levels, with each level representing a higher level of citizens' power to influence societal decision making. These are, from the bottom up, manipulation, therapy, informing, consultation, placation, partnership, delegated power and citizen control. Thomas (1990: 437), as a parallel to Arnstein's outlook, presents a similar scale of public participation, consisting of five levels, but from a managerial perspective (see Callahan 2006). On the first level, the manager makes decisions autonomously without any public involvement. Decision making on the second level is autonomous in a modified way, as the manager seeks information from segments of the public, for example via phone surveys, but decides alone whether to take the information into consideration. On the following level, the manager consults segments of the public and takes the reflections into account. Unitary public consultation, e.g. a large public hearing, is the approach of the fourth level. The approach of the last level is in the form of public decision, where the manager together with the public attempts to gain consensus on the solution.

Thinking about the levels of public participation presented above, and the entire preceding theoretical framework, the collaboration of administration and public can be divided into four different levels. Similar to Arnstein (1969) and Thomas (1990), the first level would be the most technocratic one; 'a routine and autonomous managerial/expert decision'. The problem dealt with would then be a tame one needing no input from the part of the public. Also the second level, i.e. 'a managerial/expert decision reflecting on public polls and surveys', as the op-

portunity for discussion is missing and the views presented are uninformed ones, is still a rather technocratic approach. Both these levels present approaches suitable for tamer problems.

'Managerial/expert decision reflecting on public meetings' forms the third level of collaboration. Democratic values are emphasized but with some weaknesses, such as the short time of the meetings and the dominance of the most interested citizens, as described earlier. In some situations, for example, in ones where there aren't many disagreements or passion, but where, nevertheless, the conversation with the citizens is appreciated, this could be a suitable level of collaboration. Also, these could be issues which affect only a small number of people. An example could be an area development taking place in a good spirit. The problem level is closest to that of a mess: it is clear what the problem is, there is a common goal, and it is acknowledged that a systemic problem-solving approach including many different parties is needed.

As an opposite to Arnstein (1969) and partially similar to Thomas (1990), the highest level of collaboration, 'managerial/expert decision reflecting on public deliberation', is not seen as an equivalent to citizen control. Those in authority still make the decision, but the decision reflects the 'public judgment' gained through authentic public deliberation. The idea is the one stated previously; the one who makes the decision is in the end irrelevant. What is important is the process leading to that decision (Zara 2006). When the issue is wicked, full of ambiguity, uncertainty and disagreements, this is the suitable level of collaboration[40]. On this level, technocratic and democratic values exist in symbiosis as the public administration and public deliberation form a positive-sum game. This is clearly a win-win situation and an opportunity for co-intelligence to take place and thrive.

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[40] This doesn't mean that the other forms of citizen participation are not used. On the contrary, when micro level deliberation starts to resonate with the broader public (e.g. Fishkin 2009: 149), the idea, or ideal, put forward is that the upper level of collaboration includes the lower levels, i.e. the macro level deliberation. Also, more coercive forms of democracy, such as voting, can be justified deliberatively. As Mansbridge et. al. (2010) argue, public deliberation should be seen as complementary – not antagonistic – to other non-deliberative democratic mechanisms.

4 AN EMERGING SYNTHESIS

The main question of this study was that *"if it is accepted that many of the health care issues are wicked by nature, what would an ideal model for a health care reform then look like?"*[41]. Next, as a synthesis, such an ideal model is presented. Also, the contributions and limitations of the study and further studies are explicated. First, however, it is necessary to clarify what is meant with an ideal model.

As was stated in Chapter 3.2.6., a health care system is a CAS and as such, cannot be modeled to perfection (see Cilliers 2000). Because of the diverse and interdependent nonlinear relationships, unknown boundaries, and emergent properties, these are systems which, if wanted to be modeled, would need a model as complex as the CAS itself. This is an unmanageable task as not everything can be taken into the model. It is humanly impossible. Thus, similar to Weber's ideal type construct[42], an ideal model of a health care reform is understood here as an abstraction of reality. Then, on no account, should it be assumed that a model defined to perfection is sought for. The objective of the study is not to model reality, but to contribute to the better understanding of it, by pointing out one particular way to perceive it.

The creation of the ideal model will be a process of synthesizing the results from the individual articles with the advanced theoretical framework presented above in Chapter 3. The process is such that the main results of the articles are presented beginning from Article 1 (Raisio 2007). Only Article 2 (Raisio 2008) is not wielded here as Chapter 3.2 builds on it, and has therefore been already examined throughout. The advanced theoretical framework is in 'dialogue' with the presented articles by analyzing and developing their results further. As a conclusion, the 'updated' ideal model for a health care reform, from the perspective of problem wickedness, is formed. Also, in Table 6, all the articles are once anew summarized.

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41 The sub-questions presented in Chapter 1.1 are only used as alleviating questions to structure this study. They won't be answered as such. However, more or less explicit answers are found throughout this study.

42 "An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct (Gedankenbild). In its conceptual purity, this mental construct (Gedankenbild) cannot be found empirically anywhere in reality. It is a utopia." (Weber 2007: 212)

Table 6. Theoretical framework, main data and main results of the included articles

	THEORETICAL FRAMEWORK	**MAIN DATA**	**MAIN RESULTS**
No1	An ideal model for a health care reform; Health care reform generally; The concept of wicked problems and complexity thinking	Literature on health care reforms, concept of wicked problems, complexity thinking and intentional change theory	From the perspective of problem wickedness, a tentative ideal model for a health care reform was created. Features, and interdependence, of purposefulness, fundamentality and sustainability of the reform – in relation to the complexity of the problem – were highlighted.
No2	The concept of wicked problems and complexity thinking	Mainly existing research on the concept of wicked problems	Through a review of relevant literature, the concept of wicked problems was introduced; especially in its relevancy to public administration and health care management
No3	Same as in Article No1	Mainly official documents such as planning documents and research and follow-up reports.	A tentative ideal model for a health care reform was tested. Examination showed that health care problems include many intangible and interdependent factors which the health care reformers need to take into account. It was concluded that the ideal model could work as a guideline in reforming health care.
No4	Health care reform generally; The concept of wicked problems and complexity thinking	Twelve semi-structured thematic interviews	The views of the health care reform planners, on the complexity of the problems they were trying to solve, were studied. As a main result it was noticed that even though the wickedness of the health care was in many cases acknowledged, the approaches chosen were those for tamer problems; i.e. the problems were tried to be tamed.
No5	Health care reform generally; The concept of wicked problems and complexity science; The idea of co-intelligence and deliberative democracy	Two electronic surveys: -Views of NGO representatives: 19 responses. -Views of citizens: 153 responses	Firstly, the wickedness of many health care problems, the importance of co-intelligence and the role of public deliberation were joined together. Secondly, it was suggested how deliberative democracy could aid in developing the future Finnish welfare state. Thirdly, the results from two electronic surveys – with positive implications to citizen involvement –were presented.

No6	Same as in Article No5	Available English literature on the Hungarian health insurance reform.	The hypothesized prospects of public deliberation in the context of Hungarian health insurance reform were portrayed. It was especially concluded that with public deliberation needless pain and frustration – crystal clear in the process of the examined reform – would have lessened.

Tentative ideal model for a health care reform (articles 1 & 3)

In Article 1 (Raisio 2007) an ideal model for a health care reform, from the perspective of problem wickedness, was tentatively constructed. It was based mainly on the concept of wicked problems, complexity thinking, intentional change theory (ICT) and previous theorizing on health care reforms. The foundation was the definition of a health care reform by the Data for Decision Making Project of Harvard University (Berman 1995: 15–17). What were emphasized then, were fundamentality, sustainability and purposefulness of the reform, wielded also in Chapter 3.1.2. These three elements of the ideal model were considered to be interdependent with each other. The assertion then was that the failure in just one of the elements can plunge the whole reform towards unravelling. Also, these three interdependent elements were positioned against the complexity of the problem. The more complex the problem, the more fundamental, sustainable and purposeful the reform should be. A graphical ideal model was presented (see Figure 5).

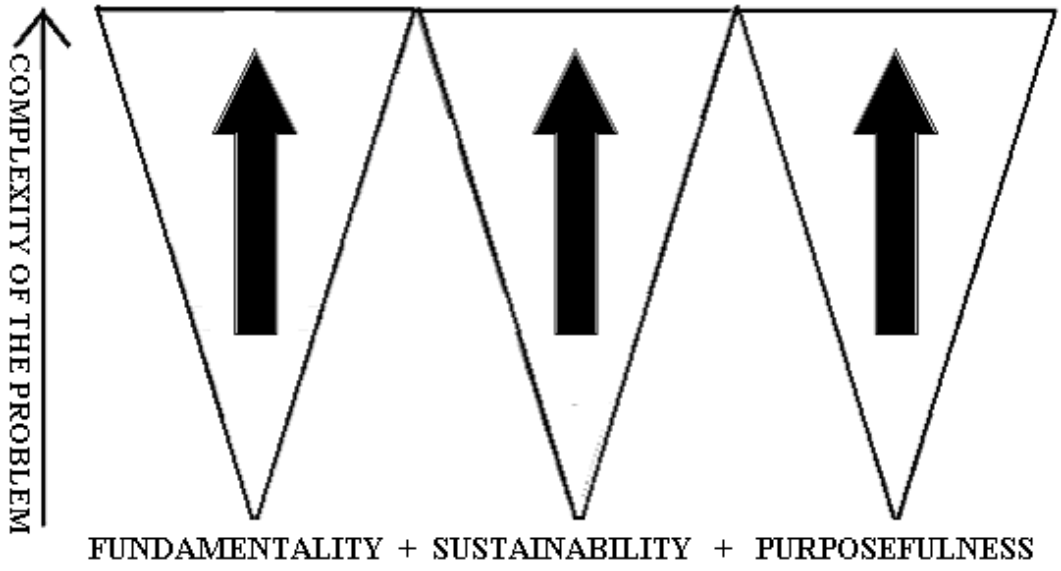

Figure 5. Tentative ideal model for a health care reform (Raisio 2007; 2009a)

The purposefulness of the reform was understood mainly as its rationality. It was then asserted that to be purposeful, the reform has to be planned, evidence-based

and wanted. It is then neither random nor enforced change. At this stage, Seedhouse's (1996a) five principles for rational health care reform and ICT were used as justifications. These principles emphasized the many-sided examination of the planned reform, such as the functions that are reformed, the overall purposes of these functions, the reasons for the current unsatisfactory performance and the ways that how these performance problems are tried to be influenced. The reform is more than just some random change; it is closely thought over. ICT points out that, in addition to rigorous planning, the reform has to be wanted (see Boyatzis 2006). The idea with this is that the wanted change can be achievable with a reform, but without the collective will to change, the process can be slow, cause unwanted results and needless pain, despair and frustrations, or not happen at all. Health care reform should then commence with a willful desire for people, organizations and even nations to change.

The fundamentality of the reform was wielded mainly through Hsiao's (2003) control knobs. The more knobs that are influenced the more fundamental the reform. The importance of this came from problem wickedness. These are problems which cannot be tackled, because of the interdependence of the different parts, just by influencing one part of the problem or by focusing only on the symptoms of the problem (see Churchman 1967). Therefore it was emphasized that when planning a health care reform, it is important to try to see the 'big picture'. Instead of linear and reductionistic thinking, the holistic approach of striving not to confine the scope of planning processes, but to acknowledge the importance of many diverse actors, actions and attitudes is necessitated.

Investing in the purposefulness and the fundamentality of the health care reform would be in vain if the reform would not be sustained. If the reform comes to be just a fleeting star, resources would be wasted. Three levels of sustainability were presented (see Century & Levy 2004). As health care systems are open and highly dynamic systems, the reform needs to raise high on sustainability. Just the levels of establishment and maturation are not enough. What is needed is evolution. Planned and implemented reforms are only part of the current world, and as the world is in constant change, problems don't stay solved (Ackoff 1974). Momentarily sustainability is not enough. Constant adaption and evolution to meet the demands of the changing environment is needed. The main assertion in Article 1 was that the planners of the health care reforms have a responsibility to acknowledge the complexity of many health care issues and the more clearly this complexity is perceived, the more weight should be given to the purposefulness, fundamentality and sustainability of the reform.

In Article 3 (Raisio 2009a), this tentative ideal model was developed further; especially on the element of purposefulness. Instead of just emphasizing the rationality of the reform, the philosophical aspects were raised. It was stated that the understanding the logic is not enough; also unbounded and critical philosophically rich contemplation is needed (cf. Seedhouse 1996a). With this philosophical aspect of reforming, space is given for creativity to flow and innovations to emerge. For example in health care, the sign of the lack of philosophical thinking is that some issues are taken for granted, e.g. the supreme role of health care organizations in achieving health (cf. Rimpelä 2004; Hunter 2008).

This philosophical viewpoint in reforming health care was raised strongly also in the advanced theoretical framework, in Chapter 3.1.2. Because it was wanted that the concept would be such that it would represent both the logical and the philosophical aspects of planning, the concept of purposefulness was replaced with the concept of deliberativeness. The deliberativeness of a health care reform was then defined as a contemplative process of reforming health care, i.e. a process based on deep serious thoughtfulness. Not only is it meant that an element of planning is included in the reform process, but more that instead of focusing only on logical and technical issues of the reform, it is as important that the focus is turned on the philosophical aspects, the political context and the ethical choices of reforming (e.g. Seedhouse 1996a; Roberts et. al. 2004). When these different issues are merged together a deliberative and contemplative overall approach to reform health care emerges. Health care reform can then be defined as *a deliberative, fundamental and sustainable – in relation to the perceived complexity of the problem – change in the health sector*.

Testing the tentative ideal model for a health care reform (articles 3 & 4)

In Article 3, the tentative ideal model was tested in the context of the Finnish National health reform, and the "guarantee for care reform" (GFC-reform) within it. The foundation for this wide reform was that the operational preconditions of health care and equal accessibility to care were having growing problems (see Raisio 2009a: 80–81). In 2001, the National health reform was set up to ensure care to every citizen regardless of their ability to pay for care. The reform had a highly wicked problem to tackle. A full account of the reform can be seen from Article 3. Here some main findings are highlighted.

When the National health reform was compared to the tentative ideal model of a health care reform, it was clear that the reform didn't raise high enough to face the complexity of the problem. Firstly, the deliberativeness of the reform was only moderate. Especially the GFC-reform didn't have the full acceptance of the health care field and, more importantly, the planning of the reform could be con-

sidered to be too bounded. Based on the official documents, it was noted in the article that the philosophical aspect of the planning processes stayed rather minor, i.e. the focus was more on questions of ‘what is’ and ‘what if’ than on the question of ‘what ought to be’ (cf. Funtowich & Ravetz 1994; Raisio et. al. 2009). As the focus was on the understanding of the logical side of the reform, the process was more pragmatic. As a result, many definitions of problems and solutions were taken as truisms of the predominant views. If the planning processes would have included more philosophical thinking and critical and challenging addresses on the health care system as it now is, a better understanding of the reform could have been achieved. This had severe implications on the fundamentality of the reform. Basically no matter how high the fundamentality, without a high level of deliberativeness, the means of the reform become bounded. For example, the National health reform was highly fundamental including basically all of Hsiao’s control knobs. Even though they would have all succeeded, as the logical discussion dominated the planning processes, the status quo would have very likely endured (cf. Teperi et. al. 2009).

Considering the preceding, in the planning process the Finnish National health reform can be considered as fundamental in a bounded way. Many different aspects of the health care system were taken into account. However, firstly, what was planned didn’t take place as such. For example, the plan to reform the structures of health care failed on most parts. The sustainability of the reform didn’t always achieve even the establishment phase. Secondly, what was planned didn't take in to account strongly enough the many interdependent and difficult to define aspects of the reform. When planning the GFC-reform this complexity was however briefly noted:

> *"When making regulations and laws, and planning development actions, it is not only the wholeness of the system that must be taken into account, but also the complexity and contradictory forces within it. Otherwise the 'side-effects' of the planned operations may build up to be more significant than the effects strived for."* (MSAH 2004: 19)

This perceived threat took place in the form of distortions. One of the clearest was the over-emphasized role of the GFC-reform. As a result, for example health promotion was overshadowed. The fear was, and still is, that this kind of progress would push Finnish health care more towards ‘sickness care’ than towards health care: "The discussion about the health reform implied that the objective was to improve the health of the Finns. Hands-on development work and also the in-

vestments seem however to concentrate on medical treatments" (Rimpelä 2004: 53; see also Hunter 2008a: 141)[43]. The growing problems of health care, however, are such which 'sickness care', alone, cannot tackle.

The conclusions made in Article 3 were sought to be verified in Article 4 (Raisio 2009b). In it, a total of 12 people, in high status positions, who participated at some level in the planning of the Finnish national health reform, and the GFC-reform, were interviewed. Basically the results of the article can be considered in such a way that the most of the interviewees acknowledged the complexity of the problems they were faced with, but as part of them necessitated approaches suitable for wicked problems, others instead strived to tame the problems at hand.

Thus part of the planners would have welcomed a more holistic and even big-bang styled reform. Especially GFC-reform was considered to be too pragmatic, bounded and linear. Also, it was seen that public health care was protecting its own turf and did not acknowledge the potentials of the whole nation. For example it was seen as regrettable that the patients were left out of the planning processes:

> *"This inventiveness of patients and the use of the resources of sick people are still exactly in zero. If we would include these sick people in planning the results would be totally different and less money would be spent."* (Raisio 2009b: 487)

A strong notion arose that Finnish health care is now in a situation where incremental reforms aren't enough. It was delineated that Finland has polarized into two different kinds of nations and that Finnish health care is already in crisis. It was strongly pointed out that, for example, those who have occupational health care are in an entirely different standing than those who do not. As one interviewee stated, the first time those who have the occupational health care face the truth is when they retire. What is happening now is basically that those who already have good care are given even more:

> *"…it is only going to get worse, it hasn't had an effect at least in a time period of a few years to that problem which is related to equal access to care and also to care, that what level of care one gets. Finland is polarizing to two different kinds of nations and that's just the way it is."* (Raisio 2009b: 489)

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[43] For example also Isosaari, Ollila & Vartiainen (2009: 256) in their research concluded that the GFC-reform sends a contradictory message: "the care and treatment of illnesses is given priority over motivating the responsibility of the public for their own health and healthy habits".

In Article 3, the critique was raised on the negative relationship between GFC-reform and health promotion. This viewpoint also came out strongly in the interviews of Article 4 (see Raisio 2009b: 485–486). The critical addresses stated that GFC-reform took the bottom away from health promotion:

> *"It is always that the sexy fields in health care like surgery and so on always beat, you know, these un-sexy fields like mental health and health promotion… It always happens, it is said, you know, that the sexy surgeons won…"* (Raisio 2009b: 485)

It was wondered that if primary health care and health promotion were thought to be the foundation of health care systems – as was written in the Government decision-in-Principle on securing the future of health care – then why so many resources were put towards activity that in the end mainly focused on specialist medical care, i.e. guarantee for care. It was believed that as there is not money for everything, those activities are done that can be measured (cf. Lumijärvi & Jylhäsaari 2000: 227); the GFC-reform measures the amount of provided services. One interviewee caricatured that:

> *"Now it is beneficial to leave health promotion out and wait for a man to get diabetes and then give him a new pancreas. And then we get a new produced service and everything works well within the law"* (Raisio 2009b: 485)

However, also contrary views emerged stating that health promotion got high visibility in National health reform. For example, it was the first topic in the memorandum which covered the development plan of the National health reform. Also, it was stated that just before the National health reform, the Health 2015-plan – concentrating on health promotion – was written up. So it was not necessary to create the same paper again. Yet, for example Rimpelä (2004: 85) has asserted that the Health 2015-plan and the National health reform were in no way in the same position in developing Finnish health care and policy. The basis for the Health 2015-plan, with, for example, lesser resources, were such that the assertion on the equivalence of these two programs was not valid.

Also those who tried to tame the problem, for the most part, understood the complexity, but nevertheless chose a limited scope. According to this view there was only a limited amount of time to make the plans and then carry on. It was seen that if the National health reform would have been expanded by including, for example, social care, it would have become too big to swallow. National health reform became a calculated shake-up of health services and mainly linear progression, quick identification of problems and very pragmatic actions were seen to be justified:

> *"…and I guess it was also thought if there is any reason to do the guarantee for care this simplified way, why not to the preventive care, but it wasn't our assignment. It was outside and that's just the way it was. It wasn't any health promotion guarantee."*(Raisio 2009b: 490)

> *"Maybe it must be thought so that every reform has its limits of what can be done, and in order to clear the queue it was necessary to focus so much force on it (i.e. GFC-reform), so that not everything was able to be done."* (Raisio 2009b: 489)

These results strongly support the conclusions made in article 3[44]. The view of those who chose the limited scope is alluring. Not everything can ever be taken into consideration, and at least something was attempted to be done. However, such a taming approach can cause a reform overload. This overload can have disadvantages such as "the displacement/distraction of time and energy from core tasks, the loss of staff morale and motivation, negative productivity consequences for other related work areas and the costs of remedying problems in reform design" (Blum & Manning 49–50). If every reform causes such disadvantages, and reforms follow each other at a fast pace, in the long run the consequences can be highly harmful. No wonder that Stambolovic (2003) writes of an "epidemic of health care reforms". As one of the interviewees (in Raisio 2009b) stated "that maybe not then the fifth project or sixth or tenth, but now we shall do something little differently, because these problems haven't vanished anywhere".

What can be understood with the preceding is a need and willingness to try something else than 'engineered' solutions to wicked health care problems. This something 'little different' could be offered by the opportunity driven approaches where every moment of planning can be considered as an opportunity to improve the understanding about the solution and about the problem (Conklin 2005). These are approaches such as the governance approach (see Jentoft & Chuenpagdee 2009) and the approaches based on the 'jaggel-line model' (see Conklin

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[44] Recent evaluations on the National health reform and the GFC-reform similarly present highly critical and parallel conclusions. It has been, for example, criticized that the central focus of the National health reform, i.e. the performance of primary health care, hasn't improved during the reform; more likely the prerequisites for improved performance have diminished (Tuomola et.al. 2008). Also it has been stated that the major flaw of the reform has been its boundedness. Examples are the topics of multi-channel financing system – an issue which was left outside the reform – and the follow-up treatments in the context of guarantee for care. In the latter issue the main dilemma was that the guarantee for care didn't include maximum times for the follow-up treatments. As the care doesn't often end with the procedure, e.g. a surgery, the implications are significant to the whole care process; for example, the effectiveness of the procedure can lessen. This has also influences on social care, as it takes part in follow-up treatments, e.g. rehabilitation. (National Audit Office of Finland 2008: 98.)

2005) and 'post-normal science' (see Funtowicz & Ravetz 1994). Nonlinearity, learning, questioning, collaboration and wandering-all-over are the keywords. Instead of being like a static object, health care reform is then considered more as a living entity (cf. Camillus 2008).

The importance of deliberating together (Articles 5 & 6)

Articles 5 and 6 (Raisio 2010; 2009c) implicitly continued the development of the ideal model for a health care reform. This was done by emphasizing the roles of deliberative democracy and co-intelligence in the planning of health care reforms. In other articles (Raisio 2007; 2008; 2009a; 2009b) the need for the collaborative approach in tackling wicked health care problems was already stated strongly. Articles 5 and 6 went further by highlighting the role of citizens[45].

The assertion in these two articles was that wicked health care problems necessitate a stronger public involvement than what is the case with tame problems and messes. In tame problems managerial approaches where standard procedures are applied routinely can be highly effective. The premise is that there exist few experts who, with training, experience and specialization, know the exact nature of the problem and also the solution and that the others agree with these experts. There is minimal conflict, i.e. the problem is convergent by nature (King 1993). The process is dominated by the habitual performance of experts (see Weick & Roberts 1993). As the experts know the problem and the solution and as there is no conflict about this, there is basically only a small, if none at all, need for stakeholder involvement.

Messes require a more deliberative approach than what is the case with tamer problems. Instead of being just a technocratic approach – as the issue is such which needs the contribution of many to achieve the common goal – increased need for collaboration is emphasized. This can be depicted through the concept of the collective mind which implies a process where actors construct actions in the health care system, understand that this system consists of joint actions and then interrelate their individual actions to this system of connected actions (Weick & Roberts 1993). These actors include, for example, different health care organizations, but also the citizens are part of this collective mind, or collective intelligent oneness.

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[45] Similarly, for example Temmes (2003) – from the perspective of administrative reforms – has considered the scarcity and narrowness of public discussion as one factor making the reforms fail. He sees that healthy public discussion could guide the reform processes and also provide the reformers with forceful feedback.

Instead of the habitual performance of a few experts or a collective mind formed on a common goal, wicked problems necessitate a highly deliberative approach. Many reasons have been stated for this. In the articles it was especially stated that problems of health care have become so complex, or wicked, that they can no longer be survived with simplistic measures. As problems which are depicted more notably as dissensual rather than consensual, deliberative democracy, and the co-intelligence created through it, are emphasized as remedies. With co-intelligence of the whole society many interrelated issues can be acknowledged better, the opinions of others will be identified more clearly and the understanding of and commitment to the wicked health care issues grows. Most importantly, separatism, strong in contemporary societies, could be lessened and society-wide coherence – as an opposite of fragmentation – could come true. Needless pain and frustration would be lessened (cf. Conklin 2005).

In Article 5 (Raisio 2010) this ideal of deliberative democracy and co-intelligence were considered in the context of Finnish health care reforms and policies. Firstly it was pondered on how the applications of deliberative democracy could transform the discussion on the future of the Finnish welfare state, and on its reforms and policies, to a more democratic and humane direction. It was for example expressed that the major problems of the Finnish welfare state have become highly wicked as consensus has been replaced with dissensus, a fairly homogenous society has become increasingly heterogeneous and humane values that were strong before, have gotten rival values. Especially the fulcrum of a welfare state, i.e. solidarity, has diminished[46]. Also the tension between the elite striving to develop the welfare state and the citizenry wanting to sustain it as it now is was highlighted. As a path forward it was suggested that public leaders – instead of following aggregate public opinion or deciding on their more informed but, nevertheless, more or less personal views – should make it possible for public deliberation to take place and then take into account the emerging post-deliberation public judgment, i.e. "the state of highly developed public opinion that exists once people have engaged an issue, considered it from all sides, understood the choices it leads to, and accepted the full consequences of the choices they make." (Yankelovich 1991: 6).

In Finland, the practices of deliberative democracy were considered to be few in number. Five practices of such, and an upcoming youth jury experiment, were presented in the article. Important pioneering on the practices of public delibera-

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[46] For example Hunter (2008a) writes strongly – from UK perspective – on how individualism and choice are competing and even replacing the values of collectivism and solidarity.

tion had nonetheless been done; however, not on the issues of Finnish health care. The issues deliberated on varied from the national level question of 'if the sixth nuclear plant should be built in Finland' to European and global level issues such as global warming. Even though these examples could be considered as good examples of deliberation in practice, as a negative remark it was noted that these examples didn't correspond fully with the ideal of deliberative democracy.

As the theorized prospects of public deliberation appeared as highly promising, with an electronic survey the views of Finnish citizens – on the topic of increased citizen involvement in the planning of health care reforms and policies – were asked. Do they want to increase their involvement on these wicked issues of health care? Do they see that they are capable of understanding issues which are often highly complex? Would they participate in a citizens' jury? As a result it was considered that the views of these citizens who responded to the survey (see Chapter 2) were in accordance to the theoretical background of the article. For example around 95 per cent of the respondents perceived the participation of the citizens in the preparation of health care reforms and policies as important or quite important. Not even one respondent saw this participation to be not important at all. Similarly 79 per cent of the respondents believed completely or somewhat that an individual citizen can comprehend the complex matters of health care. When it comes to the possible participation in a citizens' jury, almost 60 per cent of the respondents said 'yes' and 28 per cent 'maybe' for participating.

Also from the qualitative answers of the citizens´ survey, the supporting views towards increased public involvement emerged. They were about the critique towards the planning of health care reforms and policies and about the distrust in the knowledge of decision makers. Respondents experienced, for example, that the decisions are made by a small number of insiders; that there is not enough communication about the planned reforms and policies; that the decision making is too cryptic and closed from the citizens; and that money is the determining decision making factor:

> *"...As an individual citizen, I experience possibilities to influence very small; budget, money and surplus are decisive. That is sad."* (Raisio 2010: 27)

> *"The only thing that I have is the experience about living as a disabled person through my life. As a survivor of polio, I have experienced one thing and another in health care through these years. Decision-makers and implementers don't know much about the reality."* (Raisio 2010: 27)

Additionally the views of representatives of Finnish patient and disability NGOs – representing citizens who meet wicked health care issues in the point of greatest

impact, i.e. patients/clients – were surveyed. Even though the role of NGOs in representing individual patients, or clients, came out strongly, they also acknowledged patients strongly as the experts of their own lives. It was seen that patients have information that the planners and decision makers do not have; that with improved involvement it would be possible to get a better commitment to the planning of health care reforms and policies; and that understanding the synergy of many interrelating reforms and complexes would become easier. In the process humane values would strengthen and technocratic ones lessen:

> *"For some reason, in health policy reforms, professional experts are also trusted as evaluators of patients' needs. Especially now as the economy is on top in every reform, the view of the patients is non-existent."* (Raisio 2010: 23)

> *"Patients have a lot of information and experiences that are often missed in reforms and decision-making."* (Raisio 2010: 24)

> *"With a participative attitude we could achieve commitment to the planning of reforms, policies and services. We could achieve dialogue with service-providers, financiers and service-users and we would strengthen the social capital. A participating service-user can create solutions together with professionals."* (Raisio 2010: 24)

In Article 6 (Raisio 2009c), the prospects of public deliberation were examined in the context of the Hungarian health insurance reform, i.e. a highly debated and ultimately failed reform including wide riots, strikes and referendums making the process of the reform painful and frustrating. This particular reform was then considered as a case book example of the failure to deliberate; and also of a wicked problem. An OECD report on Hungary described this wickedness embodied in the problem well:

> *"…fiscal conditions require a reduction in public spending. At the same time, the relatively poor overall health status, the relatively low current level of public spending on health, and the need for improving the overall performance of the health care system probably justify more resources. This conjuncture exerts pressure on the government (and other actors in the healthcare system) to improve efficiency. However, decreasing public expenditure is a constraint for addressing several key obstacles to efficiency and quality of care."* (OECD 2008.)

This was, however, only a hypothetical examination of how the practices of deliberative democracy could have improved the process of the Hungarian health insurance reform. Three points were made in the article. Firstly, it was pointed out that if public deliberation would have taken place citizens could have contemplated on the complex issues and then understood better the nature of the sug-

gested reform and the necessity to change. As public deliberation didn't take place, a strong resistance from the part of the citizens, among others, was created. As the President of Hungary stated it when declining to sign the law:

> *"I do not agree with this law, and therefore I will not sign it and promulgate it… First and foremost, no reform can hope to be successful unless it has the confidence of the citizens, who will have to pay the costs (…) I agree that the health care system must undergo reform. However, unless people trust and support a reform of this nature, it cannot succeed."* (Sólyom 2008)

Secondly, the dilemma of sustainability in improving Hungarian health care was pointed out. This was rather obvious as, for example, the health ministers and thus also important administrative positions were in constant change. As this kind of discontinuity in health care reforms and policies increases confusion, frustration and pain begin to extend further to the whole society. As a result, a political deadlock may emerge. It was then suggested that public deliberation could be used to free such a paralyzed policy process. With the co-intelligence of the public, it could be possible to implement health care reforms and policies with the support and goodwill of the citizens (cf. Hartz-Karp 2007b).

As a third point the situation of representative democracy in Hungary was highlighted. Expensive referendum initiatives had increased, which more fundamentally could be considered as a dilemma of Hungarian representative democracy. The suggestion was that deliberative democracy could promote a healthier democratic culture and more capable citizenry (cf. Friedman 2006) and thus supplement representative democracy. Also it was stated in the article that wide public deliberation could have provided more innovative approaches to reform and achieve a shared commitment to wicked health care problems. It wasn't, however, committed to say in the article that would the Hungarian health insurance reform been a good one or not. It could have been that with wide public deliberation the reform would have been sustained with the good will of the people, or maybe some new approaches could have emerged after the contemplation on these highly wicked issues. Whatever the final result would have been, in all likelihood the needless pain and frustration in the process of the Hungarian health insurance reform would have lessened.[47] Also, Figure 6 was presented in the article as a simplified process of surviving wicked health care problems.

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[47] Hungary already has at least one experience with deliberative democracy. In 2008 the institute of sociology and social policy of the Corvinus University of Budapest implemented a deliberative poll in the area of Kaposvár. A total of 108 randomly sampled inhabitants delibe-

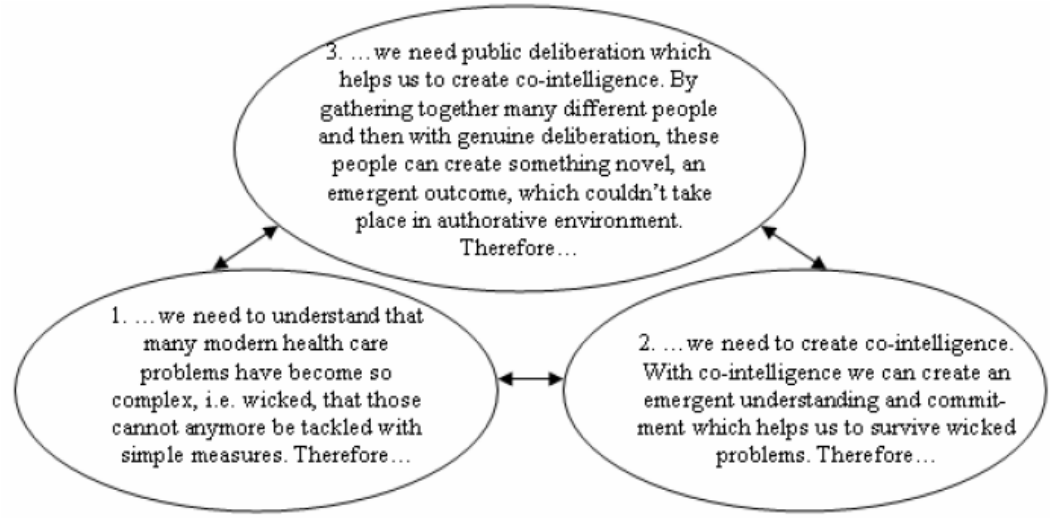

Figure 6. Simplified process of surviving wicked health care problems

If these results from these two articles are considered from the perspective of the ideal model for a health care reform, the implications are extensive. Deliberativeness, fundamentality and sustainability of a health care reform, and the interdependence between these three elements, all come clearer. Firstly, from the perspective of deliberativeness, it is important that democratic values are considered to be in symbiosis with more technocratic values, as was presented in Chapter 3.3.4. (see also Raisio et. al. 2009, 2010). This increases the contemplation on these wicked health care problems and a deeper understanding and commitment could be achieved. Also, as the diversity extends further the perceptual ability to see the interdependence of the many different pieces of health care system increases the positive influence on the fundamentality of the reform. On the sustainability of the health care reform, these issues have a major positive impact; especially on political sustainability, covered in Chapter 3.1.2.

4.1 Conclusion: An ideal model for a health care reform from the perspective of problem wickedness

In the introductory chapter it was stated that the lens through which we perceive the health care system – or the world more generally – influences our understand-

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rated then for two days on the topics of unemployment and job creation. (see Center for Deliberative Democracy 2008.)

ing of it. Whether we perceive it through the mechanistic lens or through one of wickedness, it is no trivial matter; the lens we choose directly defines the framework for future actions. In the context of health care reforms this means that whether we consider the health care system to be a machine or a complex adaptive system – as defined in Chapter 3.2.6. – has definite consequences on the whole process of reforming. In the view of the presented advanced theoretical framework and the included articles, the processes would be the following.

If the health care system is considered as a machine, the features of determinism and reductionism would prevail (cf. Richardson 2008). The predictability of the future and knowability of reality would be within the reach of health care reform planners. Morçöls' (2005: 299) notion of an "all-knowing planner" would be reality. In this worldview, the problems faced would be those which are tame in nature. These are problems best identified with mechanistic approaches of problem solving. Examples often used are puzzle solving and repairing a machine (e.g. Rittel & Webber 1973; Roberts 2000). As follows, health care reform would be understood as a solution to a puzzle or as a fix to a machine.

In relation to the definition of a health care reform presented above, i.e. deliberative, fundamental and sustainable – in relation to the perceived complexity of the problem – change in the health sector, the resultant portrayal on problem tameness is presented in Figure 7. Firstly, on deliberativeness, the approach is a highly technocratic and linear one. With technocratic it is meant that the values that dominate the process of the reform are technocratic ones and that those dominating the process are the technocratic elite. Thus the focus is on the values such as efficiency, effectiveness, value-for-money and fast decision making (cf. Randma-Liiv 2008), whereas the authority is situated with politicians, government officials, health care professionals and other selected experts. The explicit assumption is that due to the nature of the problem, these experts, by training, experience and specialization, are able to solve the problems faced with. As there is a low epistemic uncertainty and no conflict of values, the process of reform emphasizes the logical and technical issues of the reform and as determinism is assumed, what is planned, also takes place as such. Linearly, first it is defined what the problem is and then the solution is planned, e.g. it is found out what is wrong in the health care system and then according to that information, and without anymore returning to the definition of the problem, the solution is planned and implemented (cf. Rith and Dubberly 2007).

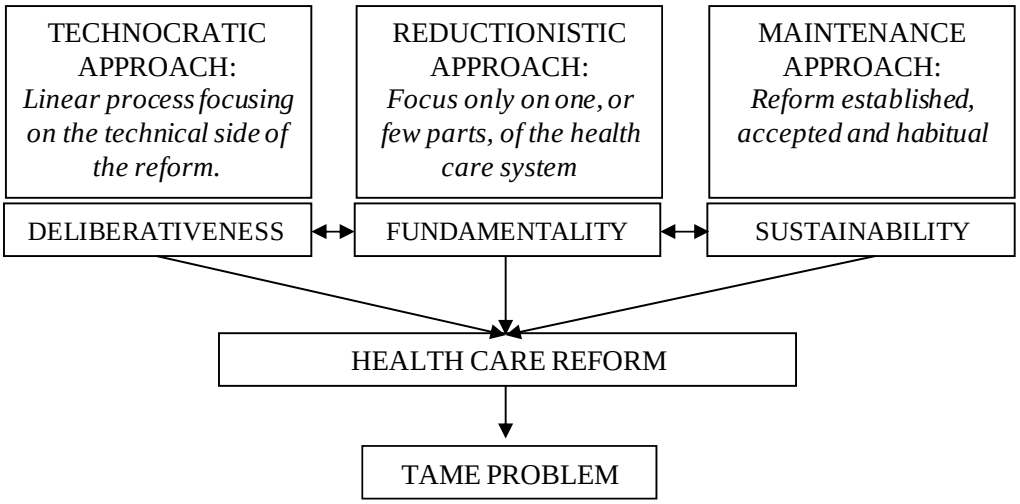

Figure 7. An ideal model for a health care reform from the perspective of problem tameness

Secondly, on fundamentality, the approach to reform is a highly reductionistic one. Considering Hsiao's control knobs, the problems of health care can be solved by focusing on one at a time (cf. Berman & Bossert 2000). For example, if a structural health care reform is pursued, the other aspects of reforming health care – such as financing and the behavior of the public – can be excluded. The problem can be solved by focusing on the structural aspects. Basically this means that problems such as the lack of doctors, long waiting times and the increasing demands of the citizens could be handled as individual issues without any coordination. To concretize, instead of focusing on the totality of the health care, the focus is on the individual parts of it.

Thirdly, on sustainability, the approach is about the maintenance of the health care reform. As a mechanistic worldview assumes a static health care system where problems stay solved (cf. Ackoff 1974) and as there exists the above mentioned low epistemic uncertainty with high consensus, the possibility for reform to dismantle politically or to ravel in other ways is faint. Health care reform is a 'one-shot' process (cf. Berman 1995). As the problem is solved, there is no need for reform to evolve and adapt. As a fix to a machine, it needs only to be maintained. Reform is then established, accepted and habitual (cf. Century & Levy 2002, 2004).

To change the angle on the problem complexity to a higher level – to a more complex level – problem messiness portrays a rather different picture than the problem tameness above. In tame problems coherence – epistemic and axiological – is assumed (cf. Conklin 2005). Axiological coherence, in the form of the collective mind formed on a common goal, takes place similarly in messes (cf. King

1993). However, in messes the epistemic incoherence is strong. This means that to gain epistemic coherence on messes, a more collaborative and systemic approach is needed than is the case with tame problems. If this is considered from the perspective of a health care reform, then the many interrelated parts of the health care system are acknowledged, interactions between different parts are observed and collaboration between stakeholders is increased. The problem isn't broken into parts, as the case might be with tame problems, but a systemic approach trying to see the whole picture of health care is taken into use.

Finally, if a health care system is considered as a CAS, the features of emergence, nonlinearity and holism would be prevailing (cf. Cilliers 2000). Health care is a system which consists of a diverse set of interconnected and independent actors, who act on individual reactions, instead of being controlled by any central body, and which is able to adapt and learn (cf. Kelly 1994; Zimmerman, Lindberg & Plsek 2008). These features would take the predictability of the future and knowability of reality out of the reach of health care reform planners. Not only cognitive uncertainty increases but also social complexity, i.e. strategic and institutional uncertainty (cf. van Bueren, Klijn & Koppenjan 2003). Problems become wicked by nature. These problems include highly controversial socio-political and moral-spiritual issues on which people have their own perceptions and strategies. Similarly, as there is no natural level on which to discuss them (cf. Rittel & Webber 1973), these are issues which overlap many different discussion arenas. As follows, health care reform would be understood as a CAS itself. An ideal model for a health care reform from the perspective of problem wickedness portrays as presented in Figure 8.

On deliberativeness the implications of problem wickedness are most confound, as has been presented above many times. On wicked problems, the deliberativeness of health care reforms comes to full scale. As the issues that health care reforms focus on are often highly controversial, a contemplative process of reforming health care is needed. The focus is then on the logical and technical issues of the reform and also on the philosophical, political and ethical aspects of the reform process. This can be considered as a symbiotic reform process between technocratic values and democratic values and 'a positive-sum game' of public administration and public deliberation, depicted in Chapter 3.3.4. Also, a nonlinear opportunity driven approach to reform is emphasized (cf. Conklin 2005).

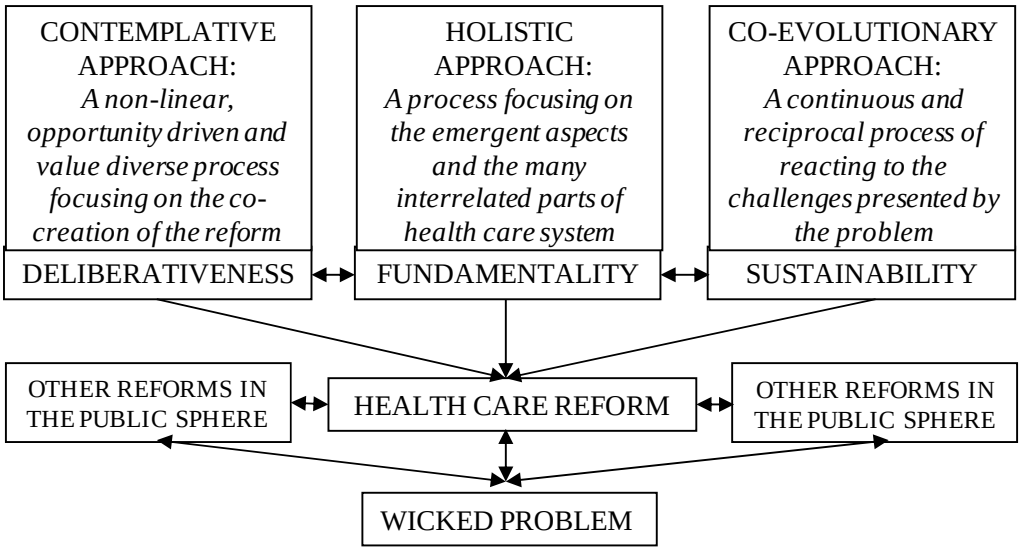

Figure 8. An ideal model for a health care reform from the perspective of problem wickedness

To concretize this, two aspects are highlighted. Firstly, as wicked health care issues are such which cannot be put on the responsibility of just a few selected experts, then the more wicked the problem, the more it should be an issue of the whole society. If health care reforms are planned, and implemented, solely by the experts, then these experts are the ones who own the problem and the solutions. However, if these processes would be more inclusive – including especially citizens – in the ideal case it would be the whole society which takes part in defining the problem and the solutions and thus owns them as a collective (cf. Scutchfield, Hall & Ireson 2006). Then in the process of the reform a society wide co-intelligence would be born (cf. Atlee 2003). In the most concrete sense this implies a creation of a new kind of solidarity – based on wide public deliberation – where a collective commitment and responsibility on these significant problems of our health care would be strong. A co-creation of future health care would take place.

Secondly, what is implied is that when planning a health care reform the definitions of the problem and the solutions shouldn't be nailed down too early. A chance should be given to the problem and the solution to develop together, without intervening prematurely. Of course at some moment the planning must be stopped for the time being and the action taken (e.g. Raisio 2007: 31). However, before that particular moment the approach should be that of learning and wandering all over from one issue to another (cf. Conklin 2005). This is about an exploration in the space of possibilities where the creativity and innovations prosper.

On the fundamentality of the health care reform, problem wickedness influences in a similar way as problem messiness, i.e. the focus is on the many interrelated parts of the health care system. Basically this means acknowledging the nature of CAS. Health care is a system depicted by the connectivity and interdependence between the different actors, and the other elements, within the system and in the environment. Also, the nature of the CAS implies that, in the wider environment, the health care sector is only one actor influencing the health of the population. Thus, other systems, and reforms within them, should be recognized, and instead of trying to compete with them, collaboration should be strived for. In this complex system of connected and interdependent actors even one actor can cause a wide perturbation on all the other related actors in the system and the environment (cf. Mittleton-Kelly 2003). Reform process, no matter how fundamental, is then always only partial. Emergent aspects cannot be planned for beforehand (cf. Cilliers 2000). The approach to reform needs to be a holistic one, trying to focus on the totality of the problem, but also acknowledging the inevitability of emergence and seeing this as an opportunity and a natural tendency instead of a threat and the fault of somebody (cf. APS 2007; Andrade, Plowman & Duchon 2008).

The significant issue in all of this is the relation of fundamentality of the health care reform to its deliberativeness (Raisio 2009a: 90). If the deliberativeness of the reform is on a low level, the means of the reform become bounded, i.e. it can be only fundamental in the sense of sustaining the status quo. When deliberativeness rises to a higher level and as the possibilities of the reform grow, an opportunity to break the status quo develops. Health care reform, instead of being boundedly fundamental, then becomes fundamental in an open and a creative way. However, none of this matters if the sustainability of the health care reform is forgotten.

As CASs and problem wickedness form an environment for health care reforms which is highly turbulent, the sustainability of the reform is under constant danger of unraveling. Most importantly, wicked problems don't get solved (Rittel & Webber 1973). Thus the focus is on reacting to the challenges presented by wicked problems (cf. Weber & Khademian 2008). This is a continuous process. The problem can transform its character as more information is gained and social complexity can increase, as, for example, political resistance increases (cf. Patashnic 2003). Just maintenance is not enough; evolution and adaption are needed (cf. Century & Levy 2004). More clearly, the approach is a co-evolutionary one, meaning that the reform evolves and adapts together with the problem and the wider system (cf. Mittleton-Kelly 2003). As the understanding of the health care system deepens, similarly the understanding, i.e. deliberativeness, of the reform

grows, and vice versa. It isn't just that reform reacts to the changes in the system; the process is reciprocal.

When the above constructed ideal models for a health care reform, based on problem tameness and on problem wickedness, are compared, a strong assertion is made about the importance on how the problem, the reform is focused on, is perceived. As Morgan (2006) writes, the chosen metaphor guides us to see and to understand in a certain way. This is illustrated in Figure 9, which represents the above constructed two ideal models of a health care reform (Figures 7 & 8) in relation to the previously created tentative construction of the ideal model (Figure 5). An explicit assumption is made here, that the metaphor of the wicked problem gives important insights into the issue of health care reform (e.g. Raisio 2009a, 2009b, 2009c).

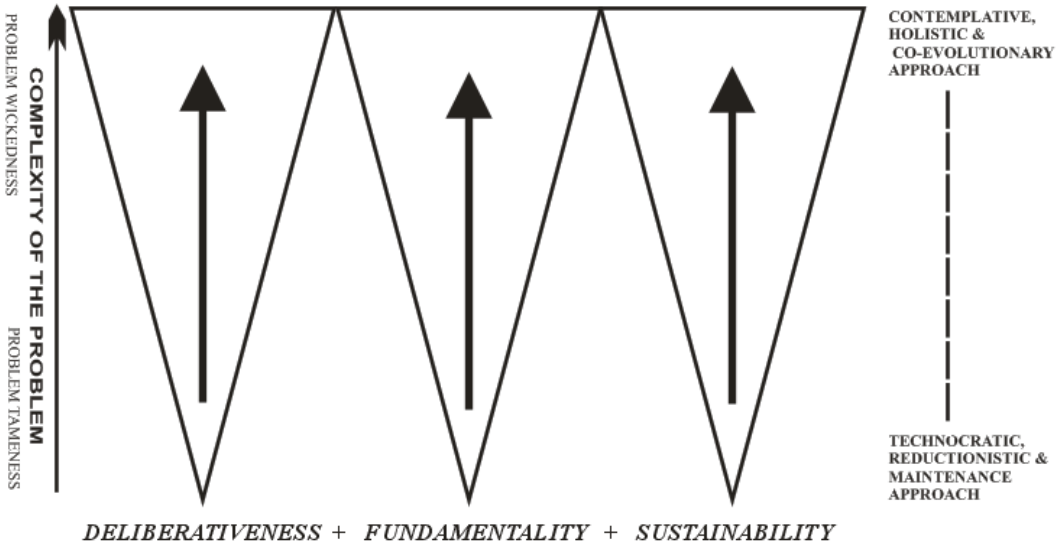

Figure 9. An ideal model for a health care reform in relation to the perceived complexity of the problem

4.2 Contributions of the study

The contributions that the study makes are considered from two different perspectives; the perspective of academics and the perspective of practitioners. From the perspective of the academic community, five main contributions can be found. Firstly, the study contributes to the research of the concept of wicked problems and complexity thinking on the research field of public administration, and espe-

cially in health care administration. This is true on the international level, but is more pronounced in the Finnish context. The concept of wicked problems and complexity thinking have been previously discussed in research literature by Finnish academics (e.g. Sotarauta 1996; Vartiainen 2005; Pösö 2005; Jalonen 2007; Vartiainen 2008; Kivelä 2010). However, as wide reviews focusing on the concept of wicked problems are missing, especially in the Finnish language, this research and the included articles strive to fill in this gap. Article 3 (Raisio 2008), focusing solely on problem wickedness and published in a Finnish journal focusing on health care management, is the main contributor on this issue.

Similarly, this study contributes by highlighting the ideas of collective intelligence, co-intelligence, and deliberative democracy in the research field of public administration and health care administration. In the Finnish context, the discussion of these subjects in these particular research fields is still rather minor. In other disciplines, the idea of collective intelligence is previously discussed especially in the research field of psychology (e.g. Hakkarainen 2003; Hakkarainen & Paavola 2006). The research on deliberative democracy is most developed in the research field of political science (e.g. Herne & Setälä 2005; Setälä, Grönlund & Herne 2007; Hokkanen 2008).

Atlee (2008: 12–13) points out that there exist many different research fields which, in one form or another, use the concepts of this study, e.g. problem wickedness, co-intelligence and public deliberation. There is a clear overlapping. As could be seen from the synthesis above, when these different fields are brought together, they complete each other, providing a clearer illustration of the reality than any of them could provide alone. As there hasn't so far been a study focusing on reforming health care, problem wickedness, complexity thinking, co-intelligence and public deliberation, each and every, the joining of these different research fields is the third contribution of this study.

The construction of the ideal model for a health care reform, from the perspective of problem wickedness (Figures 8 and 9), can be seen as the fourth, and a distinct, contribution. It can be used, for example, as a tool of comparison, i.e. to compare different health care reforms on how high they rise to meet the problem wickedness. Also, when evaluating individual health care reforms, the ideal model can work as an evaluation framework (e.g. Raisio 2009a), or as one perspective to base the evaluation on. Lastly, this study contributes to the academic discussion taking place on the shift of the administrative paradigm based on a positivistic Newtonian clockwork universe to a more complexity endorsing one (e.g. Jalonen 2007; Airaksinen 2009; Strandman 2009).

From the perspective of practitioners – in this case especially including the planners of health care reforms – three main contributions are to be found. Firstly this study contributes by raising awareness for wicked health care problems. When the practitioners acknowledge that problem wickedness is a reality – that wicked problems do exist – then the challenges this inflicts on the reform planners are better prepared for. As acknowledgement and acceptance increases, practitioners are empowered to try something new (cf. Devaney & Spratt 2009; Stoppelenburh & Vermaak 2009). It becomes less likely that the problem will be tried to be tamed. Much of the needless pain could then be lessened (see Raisio 2009b; 2009c). Also, relating to the preceding, this study strives to contribute to practitioners by opening a discussion of the importance, and the prospects, of co-intelligence and public deliberation.

As the most concrete contribution, this study offers the ideal model for a health care reform (Figures 8 and 9) as a tool to take advantage of by the health care reform planners[48]. However, it isn't suggested that the ideal model should be used precisely as such. The advantage could more likely come when the planners of the health care reforms would reflect on it when planning the reforms. The ideal model wouldn't work as a solution but more like a guide that ushers the way towards a more nonlinear, holistic and non-reductionist approach of reforming health care.

4.3 Limitations and further studies

Three central limitations of this study are elicited. Firstly, complexity thinking wielded in Chapters 3.2.5 and 3.2.6 could have benefited from a more thorough discussion. Now the risk is that the use of complexity science stayed more at the level of soft complexity science than at the level of complexity thinking (see Richardson & Cilliers 2001; Richardson 2008). However, as complexity science was presented mainly due to its role as a particular world view for wicked problems, its limited coverage can be seen as acceptable.

Also, the citizen survey carried out in Article 5 (Raisio 2010) can be considered as one of the limitations. Even though the electronic survey managed to gather 153 responses, this was below the expectation. Also, the background variables were such that generalizing wasn't possible. However, as the objective of the

[48] The created ideal model should not be restricted to reforming health care, but can be also reflected in the wider context of administrative reforms.

study was not to have generalized results, but to preliminarily survey the views of a small group of citizens on what they think about the questions presented in the article, the sample can be acknowledged as sufficient for the purpose.

The last central limitation is the mostly theoretical nature of the discussion on the prospects of public deliberation. A more critical approach using empirical evidence would have benefited this study. Now the discussion stayed mostly on an idealized level, even though critique was also raised. Partly this idealization can be justified by the nature of this research, i.e. creating an ideal model. The constructed model is a Weberian ideal type construction where public deliberation would work fully as was theorized. In reality this might, however, be a sort of a utopia. This and the other limitations presented above make a case for further studies.

Firstly, it would be interesting to form a more comprehensive account of Finnish health care reforms and then compare them to the created ideal model. Do all the reforms on a national level reflect a more mechanistic approach to reforming health care, or are more holistic, nonlinear and non-reductionistic examples to be found? Secondly, a more extensive citizen survey on the public's views on reforming health care would be informative. This could also be widened to include health care personnel, policy-makers and administrators. One interesting question could be that 'who should be the people who would deliberate and make decisions on the highly complex issues of health care?' For example, if there is a need – and there will be – to set priorities in health care, whose values and what values are those which should count (see Raisio et. al. 2009).

Most importantly – as deliberative approaches are still far from perfect and need plenty of research, development and experimentation (e.g. Davies et. al. 2005) – there is a need for an empirical testing of deliberative practices in Finnish health care. The theorized prospects of public deliberation and tentative empirical results clearly make this an imperative. Acknowledging the costs and difficulties in organizing such practices, the possible benefits are such that the researchers of health care management should seize this challenge and find out how public deliberation would work in the Finnish context. This is a challenge that the author of this study and colleagues of social and health management in University of Vaasa have taken to heart (see e.g. Vartiainen & Raisio 2009). A project to pilot deliberative practices on the issues of Finnish health care is already in the making. It will, indeed, be a substantial challenge, but the importance of it is a priority. One of the most esteemed theorists of deliberative democracy Professor Jane J. Mansbridge, from Harvard University, has strongly stated this:

> *"I strongly support this project. Our expanding capacities in health care and our inability (or lack of desire) to pay for them are world-wide problems of the greatest importance. You can make a contribution to the world as well as to Finland if you can orchestrate a good public deliberation on these issues. It will not, however, be easy."* (Mansbridge 2009, personal communication)

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APPENDICES

Appendix 1 Covering letter (article 4)

Arvoisa vastaanottaja,

Teen väitöskirjatutkimusta Vaasan yliopistossa sosiaali- ja terveyshallinnon oppiaineessa. Ohjaajanani on professori Pirkko Vartiainen. Tutkimukseni koskee terveydenhuollon ongelmia muuttuvassa maailmassa. Kompleksisuusajattelun avulla tarkoitukseni on luoda uudenlainen näkökulma terveydenhuollon kompleksisten ongelmien hallintaan. Erityisenä tarkastelun kohteena on Kansallinen terveyshanke ja sen sisällään pitämä hoitotakuu-uudistus.

Tutkimustani varten teen 15 korkealla tasolla vaikuttavan virkamiehen, poliitikon sekä järjestöedustajan asiantuntijahaastattelua. Toivon, että Te suostuisitte haastatteluun. Haastattelun teemat koskevat Kansallisen terveyshankkeen sekä erityisesti hoitotakuu-uudistuksen suunnittelua ja sen sisällään pitämää problematiikkaa. Ohessa on haastattelulomake kysymyksineen.

Otan Teihin yhteyttä marraskuun alussa puhelimitse, jotta voimme sopia haastattelusta.

Vaasassa 19. päivänä lokakuuta 2007.

Kunnioittavasti,

Harri Raisio

Hallintotieteiden maisteri

Vaasan yliopisto

Hallintotieteiden tiedekunta

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Appendix 2 Questionnaire (article 4)

HEALTH CARE REFORM PLANNERS AND WICKED PROBLEMS:
Is the wickedness of the problems taken seriously or is it even noticed at all?
(Artikkeliväitöskirjan 4. artikkeli, Alustava haastattelurunko. Kysymyksiä tarkennetaan haastattelun aikana kunkin haastateltavan taustan perusteella)

Wicked problematiikka on 1970-luvulla luotu suunnittelun kompleksisuutta problematisoiva käsitteistö
- kaksi keskeistä käsitettä: kesy ongelma (tame problem) ja pirullinen ongelma (wicked problem)
- kesyt ongelmat: helposti määriteltyjä ja ratkaistuja, käytännössä niitä samoja jokapäiväisiä ongelmia, joita me ratkomme onnistuneesti päivästä toiseen samalla rutiinilla kuin aina ennenkin.
- pirulliset ongelmat: erittäin vaikea määritellä ja käytännössä mahdoton ratkaista, ratkaisuihin ei ole olemassa mitään valmiita ohjeita.
- pirullisista ongelmista ei voi selviytyä yksinkertaisin ratkaisuin, suunnittelussa vallitsevien vakiintuneiden ajattelumallien muuttaminen tarpeen.

1. Kertokaa roolistanne hoitotakuu-uudistuksen/Kansallisen terveyshankkeen suunnittelussa?

2. Kuvailkaa suunnittelun etenemistä niin kuin itse näitte sen omasta roolistanne.

3. Oletteko tyytyväinen siihen kuinka hoitotakuu-uudistus/kansallinen terveyshanke on edennyt?

4. Mitkä ovat ne ongelmat joita hoitotakuu-uudistuksella/Kansallisella terveyshankkeella pyritään ratkaisemaan? Kuinka nämä ongelmat määriteltiin?

5. Jos katsotte kuviota 1, mihin kohtaan asettaisitte siinä ne ongelmat, joita pyritään ratkaisemaan Kansallisella terveyshankkeella ja hoitotakuu-uudistuksella?

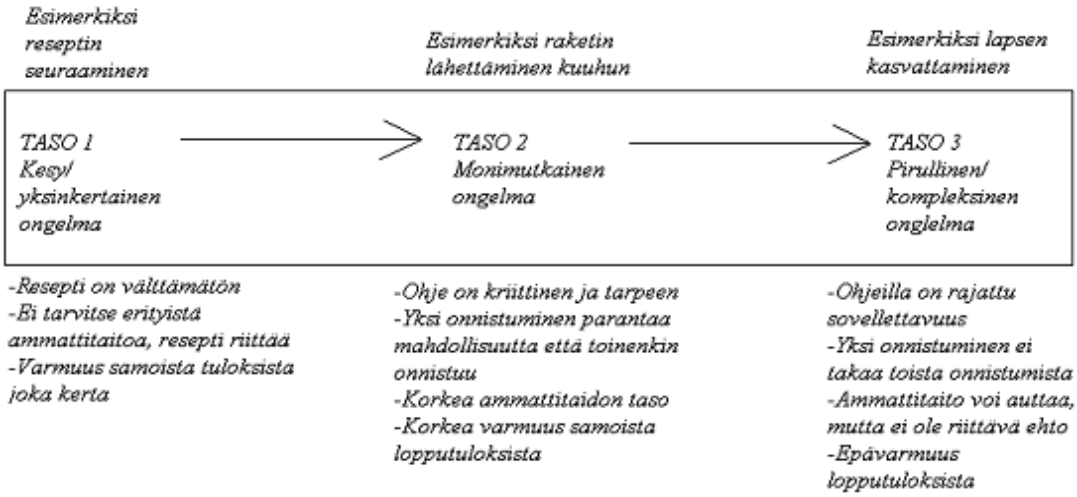
6. Kuinka kyseiset ongelmat vastaavat mielestänne taulukossa 1 esitettyjä pirullisen ongelman piirteitä?

7. Oliko suunnittelu epälineaarista vai lineaarista? Toisin sanoen palattiinko suunnittelussa sen edetessä ongelman määrittelyyn vai lyötiinkö ongelman määrittely lukkoon heti suunnittelun alussa?

8. Mietittiinkö suunnittelussa muita mahdollisia toimintatapoja kuin hoitotakuuta tai yleensäkään jonojen lyhentämistä ja hoidon saatavuuden parantamista fundamentaalisena keinona vaikuttaa ihmisten terveyteen? Oliko pääpainona siis vaikuttaminen terveydenhuoltoon sen perinteisessä mielessä vai mietittiinkö reformin toiminta-alueen laajentamista myös enemmän terveydenhuollon ulkopuolelle?

9. Mikä ”selviytymisstrategia” (kts. taulukko2) olisi lähimpänä Kansallisen terveyshankkeen/hoitotakuu-uudistuksen suunnittelua?

10. Otettiinko suunnittelussa huomioon terveydenhuollon ja sen ympäristön kompleksisuus? Katsottiinko asioita tarpeeksi kokonaisuuden kannalta?



Kuvio 1. Ongelmien kolme eri tasoa. (Glouberman 2006)

Taulukko 1. Pirullisten ongelmien keskeiset piirteet (Rittel & Webber 1973: 161–167).

1. ”Pirulliselle ongelmalle ei ole olemassa mitään lopullista ja täysin täsmällistä määritelmää”:
Ongelman ja ratkaisun määritteleminen on kytketty yhteen. Ratkaisun määrittäminen määrittää ongelman, joka määrittää taas uuden ratkaisun jne. Koska kaikkia ratkaisumahdollisuuksia ei ole mahdollista määritellä, ei pirullisen ongelman lopullinen määritelmä ole mahdollinen.
2. ”Pirullisella ongelmalla ei ole pysähtymisääntöä”:
Pirullisen ongelman ratkaiseminen ei ole mikään peli, joka loppuu ratkaisuun. Ei ole olemassa mitään pelin sääntöjä, jotka kertoisivat milloin ratkaisu on tapahtunut. Ratkaisuehdotuksia on mahdollista aina parantaa, joten suunnittelija pystyy käytännössä halutessaan ja resurssien riittäessä aina parempaan lopputulokseen.
3. ”Ratkaisut pirullisiin ongelmiin eivät ole oikeita tai vääriä, vaan hyviä tai huonoja”:
Koska lopullinen ratkaisu ei ole mahdollinen, mikään pirullisen ongelman ratkaisu ei ole koskaan oikea tai väärä. Sen sijaan ongelmien onnistuneisuus ilmenee ihmisten omista subjektiivisista käsityksistä. Joidenkin mielestä ratkaisu voi olla hyvä, joiden mielestä huono kun jotkut taas voivat pitää sitä tyydyttävänä.
4. ”Pirullisten ongelmien ratkaisujen arvioimiseen ei ole olemassa välitöntä ja täydellistä tapaa”:
Pirullisten ongelmien ratkaisujen vaikutusten jatkumo on ääretön, ajallisesti sekä tilallisesti. Kaikkia mahdollisia ratkaisun aiheuttamia vaikutuksia on mahdoton arvioida nopeasti tai saati sitten täydellisesti.
5. ”Jokainen ratkaisu pirulliseen ongelmaan on ainutkertainen toiminto; koska ei ole mahdollista oppia kokeilun ja virheen kautta, jokainen ratkaisuyritys merkitsee huomattavasti”:
Pirullisten ongelmien ratkaisuihin ei voi suhtautua kokeiluna. Sosiaaliset pirulliset ongelmat vaikuttavat ongelman laajuudesta riippuen lukemattomien ihmisten elämään. Jokainen ratkaisu vaikuttaa tällöin näiden ihmisten elämään ja jos ratkaisu epäonnistuu, ei sen vaikutuksia saa vain pyyhittyä pois. Lisäksi epäonnistumisten ratkaisuyritykset voivat vielä johtaa uusiin pirullisiin ongelmiin.

6. ”Pirullisilla ongelmilla ei ole laskettavissa olevaa (tai tyhjentävästi esitettyä) määrää mahdollisia ratkaisuja, eikä myöskään mitään hyvin määriteltyä listaa suunnitteluun sisällytettävistä sallituista toimintamalleista”:
Pirullisiin ongelmiin on käytännössä loputon määrä ratkaisuja. Se, että ratkaisua suunniteltaessa voitaisiin tällöin huomioida jokainen mahdollinen ratkaisutapa, on mahdotonta.
7. ”Jokainen pirullinen ongelma on luonteenomaisesti uniikki”:
Vaikka pirullisilla ongelmilla onkin yhtenäisiä piirteitä, niiden erityisyydet voivat kuitenkin tehdä nämä yhtenäisyydet lähes merkityksettömiksi
8. ”Jokaista pirullista ongelmaa voidaan pitää toisen ongelman oireena”:
Pirullisille ongelmille ei ole olemassa mitään luontaista tasoa. Alemman asteen ongelmien voidaan tällöin nähdä aina olevan osa ylemmällä tasolla olevaa ongelmaa. Oireiden ratkaisun sijaa paras vaihtoehto olisi tarttua varsinaiseen ylimmällä tasolla olevaan ongelmaan.
9. ”Pirullisen ongelman esittämät epäjohdonmukaisuudet voidaan selittää monin eri tavoin. Selityksen valinta määrittelee ongelman ratkaisun luonteen”:
Selittävien tekijöiden valinta määrittää ongelman ratkaisun luonteen. Selittävien tekijöiden valinta riippuu puolestaan monista tekijöistä. Esimerkiksi ihmisten omat aikomukset ja resurssit ratkaista ongelma vaikuttavat selittävien tekijöiden valintaan. Suunnittelijan maailmankuvalla on myös tärkeä merkitys epäjohdonmukaisuuksien selittämisessä.
10. ”Suunnittelijalla ei ole oikeutta olla väärässä”:
Ne jotka pyrkivät vaikuttamaan pirullisiin ongelmiin, vaikuttavat samalla lukuisten ihmisten elämään. Koska tarkoituksena ei ole löytää mitään äärimmäistä ratkaisua, vaan tarkoituksena on parantaa käsillä olevaa ongelmaa, ovat päättäjät ja suunnittelijat vastuussa tekemisistään.

Taulukko 2. Selviytymisstrategioita pirullisiin ongelmiin. (Mukaillen Roberts 2000: 3–7)

Strategia	**Käytettävissä silloin kun…**	**Käyttötarkoitus**	**Hyödyt**	**Haitat**
Autoritaarinen	Valta keskittynyt muutamalle.	”Kesyttämisstrategia”eli vähennetään konfliktia antamalla päätösvalta muutamalle asianomaiselle.	Vähentää ongelman kompleksisuutta, nopeuttaa ratkaisuprosessia ja tekee siitä vähemmän kiistanalaisen sekä mahdollisesti tekee ratkaisuprosessista ”asiantuntevamman” ja ”objektiivisemman”.	Valtaa hallussaan pitävät voivat olla väärässä. Heillä voi olla yksinään suppea näkemys asiasta. Vallan keskittyessä muutamalle, kansalaiset voivat loitontua yhä enemmän päätöksenteosta.
Kilpailuhenkinen	Valta laajasti jakautunutta. Kamppailua vallasta.	”Nollasummapeli”. Voittaja määrittelee ongelman ja valitsee ratkaisun.	Kannustaa uusien ideoiden etsintään ja pitää vallan liikkeellä.	Voi äärimmillään johtaa väkivaltaan. Kuluttaa resursseja, jotka voisi käyttää varsinaiseen päätöksentekoon.
Yhteistyöhenkinen	Valta laajasti jakautunutta. Ei kilpailua.	”Win-Win-tilanne”.Pyritään yhteistyön avulla ottamaan huomioon kaikkien etu.	Jakaa kustannukset, hyödyt ja riskit. ”Yhteistyössä on voimaa”.	Voi kasvattaa transaktiokustannuksia. Vaikeuttaa yksimielisyyteen pääsyä. Tarvitsee harjoittelua. Voi kasvavan erimielisyyden myötä vaikeuttaa päätöksen tekoa.

Appendix 3 Interviewees (article 4)

– Ilkka Vass, Helsinki, 5.11.2007
  Executive director, SYKE ry
– Markku Lehto, Helsinki, 6.11.2007
  Former Chief Secretary, Ministry of social affairs and health
– Mats Brommels, Helsinki, 7.11.2007
  Professor, University of Helsinki,
– Kaarina Laine-Häikiö, Helsinki, 8.11.2007
  Executive director, Finnish Rheumatism Association
– Jussi Huttunen, Helsinki, 8.11.2007
  Senior Advisor, Sitra (former Chief Executive of Public Health Institute)
– Marja-Liisa Partanen, Helsinki, 9.11.2007
  Governmental Counselor, Ministry of social affairs and health
– Marjukka Mäkelä, Helsinki, 9.11.2007
  Research professor, Finohta
– Helena Hiila, Helsinki, 9.11.2007
  Chief executive, The Family Federation
– Sirkka Kukkola, Riihimäki, 15.11.2007
  Chief charge nurse, Health centre of Riihimäki
– Hannele Kalske, Helsinki, 16.11.2007
  Chief Executive, Rheumatism Foundation hospital
– Markku Sirviö, Vaasa, 20.11.2007
  Leading chief physician, city of Vaasa
– Matti Uusitupa, Kuopio, 23.11.2007
  Rector, University of Kuopio

Appendix 4 Covering letter of the questionnaire for NGO representatives (article 5)

Arvoisa vastaanottaja,

Teen väitöskirjatutkimusta Vaasan yliopistossa sosiaali- ja terveyshallintotieteen oppiaineessa. Ohjaajanani on professori Pirkko Vartiainen. Tutkimukseni koskee terveydenhuollon ongelmia muuttuvassa maailmassa. Kompleksisuusajattelun avulla tarkoitukseni on luoda uudenlainen näkökulma terveydenhuollon kompleksisten ongelmien ymmärtämiseen. Yhtenä tarkastelun kohteena on kansalaisten osallistuminen terveydenhuollon politiikkojen ja reformien suunnitteluun. Artikkeliväitöskirjani viimeinen artikkeli perehtyy tähän kysymykseen kolmannen sektorin järjestöjen näkökulmasta. Tarkoituksena on vertailla Suomen ja Englannin potilasjärjestöjen edustajien näkökulmia sekä tarkastella niitä yleisesti suhteessa taustateorioihin.

Tutkimustani varten olen valinnut kolmekymmentä (30) kolmannen sektorin järjestöä Suomesta että Englannista. Käytän tutkimuksessani elektronista kyselylomaketta. Se pitää sisällään neljä avointa kysymystä. Toivon, että Te suostuisitte ystävällisesti osallistumaan tutkimukseeni täyttämällä oheisen kyselylomakkeen. Tutkimus toteutetaan niin, että tutkimukseen osallistuvat järjestöt jäävät anonyymeiksi. Tarkemmat ohjeet löytyvät itse lomakkeesta. Kyselylomake avautuu painamalla seuraavaa linkkiä http://forms.uwasa.fi/lomakkeet/426/lomake.html

Jos Teillä herää jotain kysyttävää tutkimuksesta tai Teille tulee ongelmia kyselylomakkeen kanssa, olkaa hyvä ja ottakaa yhteyttä tutkijaan. Kiitos jo etukäteen.

Kunnioittavasti,
Harri Raisio
Hallintotieteiden maisteri, tutkijakoulutettava
Sosiaali- ja terveyshallintotiede
Hallintotieteiden tiedekunta
Vaasan yliopisto
Puh. (06) 324 8407, 040-706 2046
E-mail: harri.raisio@uwasa.fi

Appendix 5 Questionnaire for NGO representatives (article 5)

Olkaa hyvä ja täyttäkää taustatiedot ja vastatkaa kuhunkin neljään kysymykseen. Lopuksi voitte halutessanne kirjoittaa yleisiä kommentteja. Vastatkaa mielellään viimeistään 11.4.2008. Kiitos.

Organisaationne:

Asemanne organisaatiossa:

Kolmannen sektorin organisaation rooli:

1. Kuinka vahvaksi näette roolinne kolmannen sektorin organisaationa vaikuttaa terveydenhuollon reformien ja politiikkojen suunnitteluun Suomessa? Perustelkaa näkemyksenne.

2. Tulisiko tätä kyseistä roolia vahvistaa? Eli haluaisitteko vaikuttaa enemmän terveydenhuollon reformien ja politiikkojen suunnitteluun Suomessa? Miten ja miksi?

Potilaan (tai asiakkaan) rooli:

3. Kuinka vahvaksi näette itse potilaiden (tai asiakkaiden) roolin vaikuttaa terveydenhuollon reformien ja politiikkojen suunnitteluun Suomessa? Perustelkaa näkemyksenne.

4. Tulisiko potilaiden (tai asiakkaiden) roolia terveydenhuollon reformien ja politiikkojen suunnittelussa vahvistaa Suomessa? Miksi ja miten?

Vapaa tila kommentteja varten:

Appendix 6 Covering letter of the citizens survey (article 5)

Arvoisa tutkimukseen osallistuja,

Teen parhaillaan väitöskirjatutkimusta, jonka yhtenä aihealueena on kansalaisten osallistuminen terveydenhuollon uudistusten (esim. hoitotakuu-uudistus) ja terveys-politiikan (esim. terveyden edistämisen politiikkaohjelma) suunnitteluun Tutkimus tapahtuu Vaasan yliopistossa ja on osa HYMY-tutkimusryhmän toimintaa (kts. linkki alla). Tarkoituksena on selvittää kansalaisten halua ja mahdollisuuksia osallistua terveydenhuollon kehittämisen suunnitteluun. Tulosten avulla on mahdollista luoda pohjaa tuleville kansalaisten osallisuutta lisääville hankkeille kuten esimerkiksi kansalaisraadeille. Lisäksi tulokset mahdollistavat otakantaa.fi verkkosivuston kehittämisen. Mielipiteenne on siis erittäin arvokasta tietoa.

Kyselyyn vastaavien henkilöiden yksityisyyden suoja taataan täydellisesti. Osallistujien henkilöllisyys ei paljastu missään tilanteessa, joten yksittäinen vastaaja pysyy anonyymina. Tutkimuksen tulokset tullaan julkaisemaan englanninkielisenä artikkelina sekä lopulta osana väitöskirjatutkimustani.

Pyydän Teitä täyttämään elektronisen kyselylomakkeen. Lomake sisältää taustatiedot, seitsemän monivalintakysymystä sekä yhden avoimen kysymyksen. Kyselyyn vastaaminen ei vie paljoa aikaa, mutta toivoisin Teidän pohtivan tarkkaan kyselyn kysymyksiä ja halutessanne vielä kirjoittamaan perustelut näkemyksillenne niille määriteltyyn tilaan. Kyselyyn pääsette tästä linkistä. Lisätietoja tutkimuksesta saa alla olevista yhteystiedoista.

Yhteistyöstä etukäteen kiittäen
Harri Raisio
Hallintotieteiden maisteri, tutkijakoulutettava
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Hallintotieteiden tiedekunta
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E-mail: harri.raisio@uwasa.fi
Tietoa tutkijasta:
http://www.uwasa.fi/sotehallinto/henkilokunta/raisio/
Tietoa HYMY-tutkimusryhmästä:
http://www.uwasa.fi/tutkimus/tutkimusryhmat/hymy/

Appendix 7 Questionnaire of the citizens survey (article 5)

Täytä taustatiedot ja vastaa alla oleviin monivalintakysymyksiin sekä halutessasi perustele näkemyksesi kysymysten alla oleviin avoimiin kohtiin.

Ikä

Sukupuoli

Ammatillinen koulutus

Ammattiryhmä

Asuinpaikka

1. Millaiseksi koette mahdollisuutenne yksittäisenä kansalaisena vaikuttaa terveydenhuollon hankkeiden ja terveyspolitiikan (kts. kuvaus 1 lomakkeen alaosasta[49]) valmisteluun? (Vahvaksi, melko vahvaksi, ei osaa sanoa, melko heikoksi, heikoksi)

2. Haluaisitteko vaikuttaa vahvemmin terveydenhuollon hankkeiden ja terveyspolitiikan valmisteluun? (Kyllä, ehkä, ei)

3. Kuinka tärkeänä pidätte kansalaisten osallistumista terveydenhuollon hankkeiden ja terveyspolitiikan valmisteluun? (Tärkeänä, melko tärkeänä, ei osaa sanoa, ei lainkaan tärkeänä, ei lainkaan tärkeänä)

4. Uskotteko, että yksittäisellä kansalaisella on valmiuksia ymmärtää terveydenhuollon hankkeiden ja terveyspolitiikan kohteina olevia monimutkaisia asioita (esim. terveydenhuollon rakenteita)? (Uskon täysin, uskon jonkin verran, ei osaa sanoa, en usko juurikaan, en usko lainkaan)

5. Oletteko osallistunut otakantaa.fi (kts. kuvaus 2 lomakkeen alaosasta[50]) keskusteluihin? (Kyllä, ei)

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[49] Tässä tutkimuksessa terveydenhuollon hankkeilla ja terveyspolitiikalla tarkoitetaan sosiaali- ja terveysministeriössä tehtyjä ja tekeillä olevia kansallisia kehittämishankkeita sekä ohjelmia. Näitä ovat esimerkiksi terveyden edistämisen politiikkaohjelma, terveys 2015-kansanterveysohjelma, kansallinen terveyshanke ja hoitotakuu-uudistus sekä kunta- ja palvelurakenneuudistus (PARAS).

[50] "Otakantaa.fi on valtionhallinnon sähköinen kansalaisfoorumi, jolla kansalaiset voivat kommentoida hallinnossa käynnistyviä tai käynnissä olevia hankkeita, lainsäädäntöuudistuksia tai muita hallinnon ajankohtaisten toimenpiteiden valmistelua. Otakantaa.fi:n päämääränä on saada hallinnon hanke- ja valmistelutyöhön kansalaisten näkemyksiä, asiantuntemusta ja mie-

6. Koetteko, että osallistumalla otakantaa.fi keskusteluihin kansalaisten on mahdollista vaikuttaa terveydenhuollon hankkeiden ja terveyspolitiikan valmisteluun? (Vahvasti, melko vahvasti, ei osaa sanoa, en juuri lainkaan, en lainkaan)

7. Mitä muita sähköisiä toimitapoja haluaisitte käyttää oman mielipiteenne julkituomiseen hallinnossa valmisteltaviin hankkeisiin?

8. Osallistuisitteko kansalaisraatiin (kts. kuvaus 3 lomakkeen alaosasta[51])? (Kyllä, ehkä, en)

9. Millaisin muin tavoin haluaisitte osallistua terveydenhuollon hankkeiden ja terveyspolitiikan suunnitteluun?

10. Vapaa tila kommentteja varten

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lipiteitä. Samalla halutaan lisätä kansalaisten ja hallinnon välistä vuorovaikutusta ja parantaa hankevalmistelun laatua." www.otakantaa.fi

51 Kansalaisraadissa kutsutaan kokoon kansalaisista valittu raati. Raati voi käsitellä esimerkiksi paikkakunnalla esiintyvää ongelmaa, mutta myös laajempaa valtakunnallista ongelmaa. "Raati keskustelee, selvittää taustoja, hankkii faktaa ja kuulee asiantuntijoita, tuottaa omaa näkemyksellistä tietoa ongelmasta ja tekee päätösehdotuksia, jotka sitten käsitellään edustuksellisen demokratian prosesseissa kyseisellä paikkakunnalla" (Keskinen, A. & Kuosa, T. 2004 Uusi aikakausi vaatii uudenlaista demokratiaa. FUTURA 2. Helsinki.) tai kyseessä ollessa valtakunnallinen ongelma, valtakunnan tasolla. Raati kestää yleensä neljästä viiteen päivään ja raatiin valitaan keskimäärin 18-24 osallistujaa. Raatiin osallistujat valitaan vapaaehtoisista siten, että raadista tulee mahdollisimman hyvin koko yhteiskuntaa edustava. Lisäksi raatiin osallistumisesta maksetaan pieni korvaus. (The Jefferson Center 2004. Citizens jury handbook.)

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Yksinkertaiset terveydenhuollon reformit kyseenalaistettuina:

Tarkoituksena luoda ideaalimalli laajalle terveydenhuollon reformille

Harri Raisio

Artikkeli on toteutettu Suomen Akatemian sekä tutkijakoulu SOTKA:n rahoituksen turvin. Kiitos heille siitä.

ABSTRACT

The world is changing and we change with it. The changing world is full of very complex problems; problems that are even so beyond basic complexity that they can be called wicked. So what we are facing now are wicked problems instead of simple problems. That is a fact we need to understand for simple solutions don't fit to complex problems. If we however try to solve these problems with simple and wrong solutions the results can be something else than what we expected. And not in a positive way.

Modern health problems can be also understood as wicked problems. Health is a very wide concept. It is more than just what the basic health care can offer. We all have a role in it. So can we say that problems that affect our health directly and also indirectly shouldn't be solved just inside the health care? In this article it will be proposed that the concept of health care should be widened to include also all those others sectors of our society, not just the basic health sector as we now know it.

To be more effective the modern health care reforms facing very complex problems should be as purposeful, fundamental and sustainable as possible. Reforms should start with an intention. They should be widely planned and implemented. And just the implementation isn't enough. Reforms should also be kept in watch constantly and if there is need to change then the change should be done. One cannot just create something, and then leave it to survive alone.

JOHDANTO

Maailma muuttuu ja me muutumme sen mukana. Voimme muuttua sattumanvaraisesti tai sitten tarkoituksellisesti. Käytännössä muutos on kuitenkin toimivinta silloin, kun se ei ole pelkkää sattumaa, vaan sen sijaan juurikin tarkoituksellista muutosta (esim. Boyatzis 2006). Reformoiminen on yksi tarkoituksellisen muutoksen toteutustapa. Siitä kertoo esimerkiksi se, että viime vuosikymmeninä maailmalla ja myös Suomessa on toteutettu monia merkittäviä julkisen sektorin reformeja. Yhtenä tällaisena reformiryhmänä ja tämänkin tutkimuspaperin aiheena ovat terveydenhuollon reformit. Terveydenhuollon reformeilla on pyritty maailmanlaajuisesti vastaamaan kyseisen sektorin epäkohtiin. Yhtenä tällaisena epäkohtana on esimerkiksi ollut terveydenhuollon kustannusten jatkuva kasvu (STM 1995, 1-3). Samalla kun kasvavia kustannuksia on pyritty saamaan kuriin, on huomio kiinnittynyt myös palveluiden tasapuolisen saatavuuden säilyttämiseen (WHO 1997, 1). Reformit ovat tällöin pyrkineet vastaamaan vaikeaan ongelmaan yrittäessään rajoittaa kustannusten kasvua pyrkien kuitenkin säilyttämään samalla myös palveluiden tasa-arvoisen saatavuuden.

Samoin kuin ongelmat, joita reformeilla on pyritty korjaamaan, ovat myös itse reformitkin olleet erittäin moninaisia. Voidaan esimerkiksi havaita, että kun osa terveydenhuollon reformeista on ottanut tavoitteekseen merkittävät rakenteelliset muutokset, ovat toiset reformit

puolestaan tyytyneet vain suppeisiin inkrementaalisiin kehityspolkuihin. Esimerkiksi Verheijan (1998, 4-5) on jakanut julkisen hallinnon reformit kolmeen eri ryhmään: radikaaleihin, inkrementaalisiin sekä maltillisiin managerialistisiin reformeihin. OECD:n (1994, 15-35) raportissa seitsemäntoista OECD:n maan terveydenhuollon reformit on jaettu puolestaan evolutionaarisiin ja strukturaalisiin reformeihin. Strukturaalisilla ja radikaaleilla reformeilla tarkoitetaan pääasiassa fundamentaalisia ja jopa big-bang tyylisiä laajoja rakenteellisia reformeja. Inkrementaaliset ja evolutionaariset reformit tai pikemminkin muutokset pitävät sisällään puolestaan enemmänkin hitaasti kehittävää jokapäiväistä ja ei niin perin pohjin suunniteltua muutosta. (WHO 1997, 2-3.) Reformien jaottelussa on kuitenkin havaittavissa pientä sattumanvaraisuutta, jolloin reformeille annetaan erilaisia määritelmiä eri tahoilla (esim. OECD 1994, 14). Mikä loppujen lopuksi oikeuttaa tällaisen reformien moninaisuuden? Pyrkiikö kukin reformi ratkaisemaan erilaisia ongelmia, vai yritetäänkö erilaisilla ratkaisutavoilla saada ratkaisua vain yhteen laajaan ongelmaan? Reformien toteutukselle ei myöskään ole näkymässä loppua. Onko reformeissa tällöin jotain vikaa, vai onko reformien toteutus vain luontaista toimintaa nykymaailmassa?

Edellä olevat kysymykset ovat aiheellisia, koska ongelmat joihin reformeilla tulisi vastata, ovat erittäin haastavia. Tällöin jos näihin ongelmiin lähdettäisiin vastaamaan uudistuksilla, jotka eivät todellisuudessa vastaisikaan sitä mitä reformien tulisi käytännössä olla, ei näihin ongelmiin todennäköisesti saataisi haluttuja ratkaisuja. Reformien luonteen tulisi siis vastata itse ongelmien monimutkaisuutta. Usein reformeja kuitenkin toteutetaan ilman, että ymmärrettäisiin logiikka ja filosofia terveydenhuollon reformien taustalta. Esimerkiksi Seedhouse (1996b, 233) näkee, että ilman tätä ymmärrystä toteutettu reformi ei voisi toimia.

Tässä artikkelissa puhutaan uudistuksista, muutoksista sekä reformeista. Nämä käsitteet erotetaan toisistaan siten, että reformit nähdään uudistuksiksi ja muutoksiksi, mutta kaikki uudistukset ja muutokset eivät kuitenkaan ole välttämättä reformeja. Ideaalinen reformi on jotakin paljon laajempaa. Uudistus ja muutos nähdään käytännössä synonyymeiksi, mutta kuitenkin sillä erotuksella, että uudistuksen pitäessä sisällään suunnittelua, voi muutos tapahtua myös ilman tätä suunnittelun mukanaan tuomaa tarkoituksellisuutta.

Tämä artikkeli rakentuu muun muassa terveydenhuollon reformin määritelmää sekä määrittelemistä koskevan teoreettisen käsittelyn ympärille. Aikaisempien tutkimusten perusteella pyritään saamaan selvyys erityisesti laajasti nähdyn terveydenhuollon reformin määritelmästä. Lisäksi tavoitteena on rakentaa kyseisen määritelmän ympärille ideaalimalli, johon terveyssektorin uudistuksia voisi vertailla. Kyseistä viitekehikkoa pystyisi käyttämään esimerkiksi tutkimusvälineenä reformien laajamittaisessa arvioinnissa sekä se toimisi myös apuna reformien suunnittelussa että toteutuksessa. Ideaalimallin jäädessä tässä vaiheessa vielä ilman empiiristä testausta, jää se toistaiseksi vain teorian tasolle.

Artikkeli pyrkii avaamaan myös keskustelua muuttuvasta maailmasta. Vanhat ja yksinkertaiset ratkaisut eivät enää toimi monimutkaisiin kansallisiin sekä yleismaailmallisiin ongelmiin. Pääosin ratkaisut näihin kyseisiin erittäin kompleksisiin ongelmiin ovat vielä tänäkin päivänä juurikin yksinkertaisia. Ne voivat tuottaa lyhyt aikaisesti voittoa, mutta pidemmällä tähtäimellä tilanne voi muuttua tappion puolelle (Ackoff 1974, 28). Yhdeksi esimerkiksi yksinkertaisista ja vääristä ratkaisuista voidaan pienin varauksin nähdä hoitotakuu-uudistus. Se on ollut lyhytaikaisesti hyvinkin tuottelias uudistus, mutta jo nyt on nähtävissä tilanteen muuttuminen potilasjonojen vähitellen lähtiessä takaisin kasvuun. Hoitotakuun voidaan nähdä myös aiheuttaneen lisää ongelmia esimerkiksi henkilökunnan työmotivaation laskun vuoksi. Monimutkaisia ongelmia ei pystytä ratkaisemaan hoitotakuun kaltaisilla yksinkertaisilla ratkaisuilla. Päätavoitteenaan tällä artikkelilla on tällöin laajan terveydenhuollon reformin ideaalimallin rakentamisen kautta pyrkiä osoittamaan, etteivät yksinkertaiset terveydenhuollon reformit olisi enää päteviä vastaamaan laajoihin meidän kaikkien terveyteemme suorasti ja epäsuorasti liittyviin ongelmiin.

ONKO TERVEYDENHUOLTO YHTÄ KUIN TERVEYS?

Terveydenhuollolla on ilmeisen tärkeä rooli yhteiskunnan terveydentilan ylläpitämisessä sekä kehittämisessä. Tätä terveydenhuollon asemaa ei

sinänsä juuri kukaan kiistä. Tässä luvussa kyseinen asema kuitenkin kyseenalaistetaan ainakin hetkeksi. Kyseenalaistaminen tapahtuu kysymällä, että onko tämä kyseinen rooli kuitenkaan ihan niin tärkeä, että terveydenhuollon voitaisiin nähdä toimivan terveyden saralla yksinään kaikkien muiden yhteiskunnallisten sektoreiden puolesta. Vai onko niin, että kaikki yhteiskuntamme osa-alueet toimivat yhdessä meidän kaikkien yhteisen terveyden puolesta. Eli jos haluamme parantaa terveydentilaamme, niin riittääkö pelkkä terveydenhuollon reformoiminen, vai pitääkö reformointia pyrkiä toteuttamaan mahdollisimman laajasti myös itse terveydenhuollon ulkopuolellakin?

Meistä jokainen ymmärtää sen, että terveydenhuolto ei sanan varsinaisessa merkityksessä tarkoita samaa kuin terveys[1]. Ihmisten terveyteen vaikuttavat monet asiat ja terveydenhuollolla on toki tärkeä rooli, mutta loppujen lopuksi pelkkä terveydenhuolto ei pysty takaamaan kansalaisten hyvää terveyttä. Tämän vuoksi Lundberg ja Wang (2006, 26) määrittelevät sen näkökulman, että terveydenhuollon kulutus on vain yksi osuus terveyden tuotannossa, yhdeksi piirteeksi joka erottaa terveydenhuollon muista julkisista palveluista. Lundberg ja Wang painottavat sitä, että tutkittaessa terveydenhuollon reformien vaikutuksia terveyteen ja hyvinvointiin, tulisi tällöin ymmärtää myös näiden yllättävien tekijöiden kuten esimerkiksi elämäntapojen, ravitsemuksen sekä infrastruktuurin vaikutus. Tämä terveydenhuollolle erityinen piirre tekee tällöin terveydenhuollosta ei-niin-erityisen. Kansalaisten terveydestä huolehtiminen on kaikkien vastuulla, jolloin terveydenhuolto ei saisi ottaa itselleen määräävää roolia.

Myös Ljubljanan peruskirja terveydenhuollon uudistamisesta (1996) muistuttaa, että pelkästään terveydenhuolto ei yksinään vaikuta ihmisten hyvinvointiin. Tämän vuoksi kyseisessä julistuksessa nähdäänkin tarpeen hahmottaa tämä eri sektoreiden välinen yhteys keskeiseksi terveydenhuollon reformien piirteeksi. Lisäksi Ackoffkin (1974, 160) toteaa, että ”terveys riippuu kaikista elämän osa-alueista eli siten kaikista yhteiskunnan ja ympäristön osa-alueista”. Myös OECD:n (1995, 13, 59, 62) julkaisussa muistutetaan siitä, että terveydentilasta puhuttaessa huomio tulisi kiinnittää pelkkää terveydenhuoltoa laajemmalle. Tämä siksi, että ensinnäkin terveydenhuollon kulutuksen lisääminen ei välttämättä kasvata kokonaisterveystasoa halutulla tavalla ja toisekseen koska ihmisten terveyteen vaikuttavat monet muutkin tekijät kuin pelkkä terveydenhuolto[2]. Valtioiden tulisi tällöin huomioida se, että ne voisivat mahdollisesti saada aikaiseksi parempia tuloksia, jos ne jakaisivat resursseja laajemmin eri tekijöiden kesken sen sijaan, että suurin osa resursseista kiinnitettäisiin terveydenhuoltoon. ”Tarpeeton” kulutus terveydenhuoltoon resurssien ollessa rajalliset voi merkitä myös sitä, että silloin muut ja ehkä myös varsinaiset ongelmat jäävät ratkaisematta, koska varoja ei riitä enää niiden huomioimiseen.

Tulisiko terveydentilan nostamiseen suuntautuvat reformit suuntautua tällöin pelkkään terveydenhuoltoon vai sen sijaan sitä selvästi laajemmalle alueelle? Alustavasti voidaan vastata, että reformit voivat suuntautua näistä molempiin. Jos terveydenhuollossa on esimerkiksi joitakin helppoja ongelmia, joihin voidaan vaikuttaa yksinkertaisilla terveydenhuollon reformeilla, on se tällöin suotavaa. Mutta jos ongelmat ovat kompleksisimpia, tulisi tällöin lähteä etsimään ongelmia selvästi laajemmalla viitekehyksellä. Tässä artikkelissa tuodaan julki ajatus, jonka mukaan kansalliset sekä myös yleismaailmalliset terveyteen ja siten terveydenhuoltoon liittyvät ongelmat ovat kasvaneet mittasuhteissa niin kompleksisiksi, ettei niitä ole enää mahdollista ratkaista yksinkertaisilla terveydenhuollon reformeilla. Siksi terveydenhuollon reformin määritelmän tulee laajentua pelkän terveydenhuollon ulkopuolelle. Tulevaisuudessa voisimme pohtia myös sitä, että olisiko ”terveysreformin” käsite parempi kuvaamaan laajoja terveydenhuollon reformeja kuin terveydenhuollon reformin käsite.

MIKSI YLIPÄÄNSÄ REFORMOIDA?

Ackoff (1974, 22-31) jakaa ihmiset neljään eri tyyppiin pääosin heidän tulevaisuuden näkemystensä perusteella. Jos me uskoisimme, että asiat ovat nyt hyvin, eikä niitä tarvitsisi muuttaa, tekisi uskomuksemme meistä epäaktivisteja. Tällöin paitsi emme haluaisi muutoksia, pyrkisimme me myös kaikin mahdollisin tavoin estämään näkyvissä olevat muutokset. Jos puolestaan uskoisimme, että kaikki oli paremmin aikaisemmin ja haluaisimme siten palauttaa asiat siihen malliin, missä ne olivat aikaisemmin, olisimme me silloin

reaktivisteja. Kolmantena ihmistyyppinä, eli preaktivisteina uskomuksemme tulevaisuuteen olisi jo melko vahva. Uskoessamme, että parempi tulevaisuus olisi mahdollinen, tekisimme me tällöin kaikkemme ennustaaksemme tulevaisuutta ja valmistautuaksemme siihen. Jos puolestaan ajattelisimme, että parempi tulevaisuus olisi ehdottomasti mahdollista, ja että me pystyisimme vaikuttamaan siihen ja muokkaamaan omaa kohtaloamme, olisimme me silloin interaktivisteja. Interaktivisteina emme vain pyrkisi valmistautumaan tulevaisuutta varten saati sitten vain ennustamaan sitä, vaan pyrkisimme muokkaamaan siitä sellaisen kuin me siitä itse haluamme. Interaktivistien näkemysten kaltainen usko parempaan tulevaisuuteen on tällöin yksi syy reformien toteuttamiselle.

Maailmalla toteutettujen reformien suuresta määrästä huolimatta voidaan nähdä, että toteutettavien reformien määrä tuskin koskaan tulee ainakaan merkittävästi tippumaan. Tutkiessaan hallinnon reformien toteuttamisen jatkuvuutta Euroopan maissa, Peters (2001) on jakanut syyt tähän jatkuvuuteen kolmeen eri luokkaan; hallinnollisiin syihin, teknisiin syihin sekä poliittisiin syihin. Kyseiset syyt ovat esitettynä tiivistetysti taulukossa 1.

On vielä tarpeen muistaa se tosiasia, että kaikki ongelmia aiheuttavat olosuhteet eivät suinkaan ole täysin hallitusten kontrollissa (OECD 1992, 16). Hallitusten on esimerkiksi mahdoton vaikuttaa ihmisten ikääntymiseen ja lisäksi niiden on erittäin hankala puuttua kansalaisten kasvaviin odotuksiin ja teknologian kasvuun sekä muun muassa biologisista syistä johtuviin terveyseroihin ihmisten keskuudessa. Vaikka olosuhteita ei pystykään muuttamaan, pitää niiden kanssa kuitenkin oppia elämään. Mukautuminen muutokseen on tällöin välttämätöntä. Charles Darwinin (1809-1882) tapaan voimmekin ajatella, ettei ihmisten älykkyys saati sitten voimakkuus tee meistä vielä selviytyä, vaan sen sijaan se on kykymme mukautua muutokseen, joka auttaa meitä selviytymään ajanjaksosta toiseen. Peter-

Taulukko 1. Syitä reformien jatkuvuudelle. (Mukaillen Peters 2001, 45-51)

LUOKKA	SYY	KUVAUS
Hallinnolliset syyt	*Pettymys lopputuloksiin*	Liian kovat tavoitteet -> vaikea saavuttaa -> pettymys lopputuloksiin -> uusi reformi.
	Reformin onnistuneisuus	Halutaan nähdä kuinka pitkälle muutosta voidaan viedä. ”Ahnehditaan liikaa”.
	Vääristyneet lopputulokset	Reformit ovat tuottaneet lopputuloksia, jotka ovat jotain aivan muuta kuin mitä oli tavoitteena.
	”Ruoho on vihreämpää toisella puolella aitaa”	Uskotaan, että on olemassa jokin ideaalimalli, jonka tavoittelu ei koskaan pääty.
Tekniset syyt	*Mittaukselliset ongelmat*	Kuinka tulisi mitata oikein reformien aikaansaannokset?
	Rajojen löytämisen ongelma	Kuinka määritellä se raja, jonka yli reformia ei voi enää viedä?
Poliittiset syyt	*Laadun paradoksi*	Yrittäessään parantaa palvelujen laatua, voivat uudistukset saada näkyviksi uusia laatuun liittyviä epäkohtia.
	Muutokset puolueissa ja ideologioissa	Jos puolueet tai ideologiat muuttuvat, tällöin muuttuvat myös todennäköisesti asetetut tavoitteet.
	Puolueiden halu pitää valta itsellään	Poliitikot hyötyvät reformien toteuttamisesta. Reformit ovat niin sanotusti ”mediaseksikkäitä”.
	Liian pitkälle meneminen	Menty reformien toteuttamisessa liian pitkälle, jolloin uusien reformien kautta yritetään palata takaisinpäin.
	Organisatorinen politiikka	Organisaatioiden poliittiset konfliktit toimivat ”ruutitynnyrinä” uusille reformeille.

sin (2001) määrittelemiin reformien jatkuvuuden syihin, eli hallinnollisiin, teknisiin sekä poliittisiin syihin, voidaan lisätä tällöin vielä käytännöllisten syiden joukko. Reformien tulee jatkua, koska maailmakin muuttuu jatkuvasti. Reformoiminen on tällöin välttämätöntä.

Vaikka reformoiminen onkin käytännössä edellä mainitulla tavalla välttämätöntä, ei se tarkoita sitä, että siihen voisi suhtautua varomattomasti. Esimerkiksi Maynardkin (2005) muistuttaa vielä, että terveydenhuollon reformien toteuttaminen pelkkänä ”sosiaalisena kokeiluna” esimerkiksi ilman evaluointia olisi paitsi epäeettistä, olisi kyseisten reformien mahdollista tuottaa kansalaisten terveydelle haittaa yhtälailla kuin muutkin huonosti suunnitellut terveydenhuollon palvelut. Maynard yhdistää tässä vakavuusasteeltaan samaan luokkaan huonosti toteutuneet lääkäripalvelut kuin vastaavalla tavalla epäonnistuneet terveydenhuollon reformitkin. On vaikea väittää Maynardin olevan tässä väärässä, sillä vaikka terveydenhuollon reformin epäonnistumisen vaikutukset eivät heti näkyisikään, on niillä kuitenkin yhtä tuhoisat vaikutukset kuin esimerkiksi lääkärien aiheuttamilla hoitovirheillä. Erona on se, että terveydenhuollon reformien epäonnistumisien vaikutuksia on vaikea hahmottaa. Se ei kuitenkaan vähennä yhtään kyseisten vaikutusten olemassaolon todellisuutta. Maynard toteaakin, että käytännössä huonosti suunnitellut terveydenhuollon reformit voivat vaarantaa meidän kaikkien terveyden.

Reformoimisen välttämättömyyttä vahvistaa esimerkiksi d’Intignanon (1995, 211-213) esittämät kolme keskeistä tulevaan terveydenhuoltoon vaikuttavaa tekijää, joihin meidän tulee vastata. Kyseiset tekijät liittyvät ihmisten elämänkiertokulkuun lähtien liikkeelle lisääntymisestä ja syntyvyydestä päätyen aikuisiän akuuteista sairauksista aina rappeutumiseen ja kuolemaan asti. Ensinnäkin lisääntymiseen ja syntyvyyteen liittyy syntyvien lasten vähentyvä määrä sekä naisten synnytysiän jatkuva nousu. Vaikka lasten syntymisen väheneminen osaltaan vähentää kustannuksia, tulevat naisten korkeasta synnytysiästä johtuvat ongelmat esimerkiksi hedelmöityshoitojen muodossa kuitenkin lisäämään osaltaan terveydenhuollon kustannuksia. Toisekseen vaikka aikuisiän varsinaiset akuutit sairaudet voivatkin olla vähenemässä, ei terveydenhuolto tule tulevaisuudessa pääsemään kuitenkaan helpolla. Esimerkiksi vapaaehtoiseen riskiin liittyvien sairauksien määrä tulee kasvamaan. Lisäksi vanhusväestö tulee lisääntymään merkittävästi, joka puolestaan lisää esimerkiksi erittäin kallista saattohoitoa. Kysymykset liittyen edellä mainittuihin tekijöihin herättävät monia kysymyksiä, joihin tulevien terveydenhuollon reformien tulisi onnistuneesti vastata. Vaikka terveydenhuollon tila tällä hetkellä olisikin kohtuullisella tasolla, ei meidän tulisi elää vain tässä päivässä vaan sen sijaa alkaa päämäärätietoisesti tähytä kohti tulevaisuutta ja muuttuvaa maailmaa.

MAAILMA MUUTTUU JA ME MUUTUMME SEN MUKANA

Ongelmat eivät ole enää samoja mitä ne aikaisemmin ovat olleet. Helpot ongelmat ovat kehittyneet luontaisen evoluution myötä erittäin kompleksisiksi. Tämä tarkoittaa sitä, että elämisen perusteet on käytännössä jo rakennettu eli ne ongelmat, jotka vaikuttavat perustavanlaatuisesti elämiimme, on jo ratkaistu. Kehittyneissä maissa ihmisillä on siis pääasiassa paikka jossa elää, ruokaa tarpeeksi, mahdollisuus saada terveydenhuoltoa ja kouluttautua sekä tehdä töitä. Suurin osa yksinkertaisista ongelmista on tällöin jo ratkaistu. Tutkijat ovat kehittäneet lääkkeet moniin tappaviin sairauksiin, insinöörit ovat rakentaneet kaupunkistruktuurit ja yhteiskuntatieteilijät ovat suunnitelleet perustasolla toimivan terveydenhuollon. Näiden peruskysymysten ratkaiseminen on kuitenkin johtanut siihen, että ongelmat ovat monimutkaistuneet. Ihmiset ovat tulleet vaativimmiksi, eikä pelkkä perusteiden luominen elämälle enää riitä ihmisten vaatiessa nopeampaa ja toimivampaa terveydenhuoltoa, työpaikkoja jokaiselle ja esimerkiksi parempaa koulutusta. (Rittel & Webber 1973, 156) Ongelmat joutuvat tällöin kehittymään olosuhteiden ja varsinkin ihmisten vaatimusten muuttumisen myötä.

Aikaisemmin kun ongelmat olivat vielä perustavanlaatuisia, oli asiantuntijoiden työ käytännössä melko suoraviivaista. Tällöin asiantuntijat ratkaisivat ongelmia, jotka oli mahdollista ratkaista lineaarisin ratkaisutavoin. Ongelmien monimutkaistumisen myötä, pelkät lineaariset ratkaisutavat eivät kuitenkaan enää riitä. Varsinkin ”sosiaaliset ongelmat” ovat helppojen ongelmien vähenemisen myötä kasvaneet erittäin kompleksiksi. (Rittell & Webber 1973, 160) Rittell ja Webber (1973) puhuvat tällöin wicked problema-

tiikan mukaisista pirullisista[3] sekä kesyistä ongelmista (wicked & tame problem).

Kesyt ongelmat ovat määriteltävissä pirullisten ongelmien vastakohdiksi, sillä ne ovat useimmiten helposti määriteltyjä ja helposti ratkaistuja. Esimerkiksi tietynlainen matemaattinen tehtävä voi olla tällainen kesy ongelma. Pirulliset ongelmat ovat puolestaan vaikeasti määriteltävissä eikä niihin ole olemassa mitään helposti löydettävissä olevaa ratkaisua. (Clarke & Stewart 2000, 377-378.) Tällainen pirullinen ongelma olisi esimerkiksi tavoite lisätä terveydenhuollon tehokkuutta ilman, että palvelujen saatavuuden tasa-arvoisuus huononisi.

Terveydenhuollon reformienkin kohteena on tällöin lähes poikkeuksetta pirullisia ongelmia, sillä vain todella harva reformi kykenee ratkaisemaan kohdeongelmansa tavallisin lineaarisin ratkaisukeinoin. Sen sijaan reformit tarvitsevat onnistuakseen erittäin monipuolista ja laajaa eri osapuolet huomioon ottavaa suunnittelua (Rittel & Webber 1973, 160). Yksinkertaisten terveydenhuollon reformien tulee tällöin muuttua huomattavasti nykyistä laajemmiksi. Seuraavassa luvussa pyritäänkin rakentamaan ideaalimalli laajemmalle terveydenhuollon reformille. Kyseisen mallin toivotaan toimivan airuena asennemuutokselle reformien suunnittelun suhteen. Pirullisten ongelmien erilaisten piirteet tulevat myös vielä tarkentumaan samassa yhteydessä.

TERVEYDENHUOLLON REFORMIN IDEAALIMALLI

Esimerkiksi Cassels ja Janovsky (1996, lainaus artikkelista Berman & Bossert 2000) näkevät, ettei terveydenhuollon reformin käsite välttämättä tarvitsisi mitään yksittäistä universaalia määritelmää. Muun muassa reformien evaluoinnin lisääntymisen myötä kyseinen näkemys on kuitenkin muuttunut ja nykyään nähdäänkin tärkeäksi reformien tarkka määrittely. Edelleenkään ei kuitenkaan nähdä niinkään tarpeelliseksi kaikenkattavaa määritelmää, vaan enemmänkin painotetaan reformien yksilöllistä luonnetta. Reformit tulisi siis käytännössä määritellä tapauskohtaisesti sen sijaan, että ne nähtäisiin yhtenä homogeenisenä tapauksena. (esim. Figueras, Saltman & Mossialos 1997, 6) Tästä huolimatta tarvitaan kuitenkin myös terveydenhuollon reformin yläkäsitettä, johon yksittäistä reformia voitaisiin verrata. Muutoin on vaarana, että yksittäinen reformi onkin jotain muuta kuin mitä terveydenhuollon reformin tulisi ideaalisimmin olla.

Tieteellinen kirjallisuus julkisen hallinnon reformeista on kattavaa. Nähtävissä on kuitenkin, että reformeja käsitellään usein ilman tarkempaa määrittelyä siitä, mitä reformin käsite todellisuudessa pitää sisällään. Terveydenhuollon reformista ei siis ole olemassa mitään kaikenkattavaa ja kaikkien hyväksymää määritelmää. On esimerkiksi nähty, että poliittisilla päättäjillä olisi suuri houkutus nimetä pienetkin muutokset terveydenhuollon sektorilla reformeiksi vain korostaakseen niiden vaikutusta. (WHO 1997, 2.)

Reformeja ei kuitenkaan tulisi määritellä edellä mainitulla ”poliittisella” tavalla. Uudistuksia on monenlaisia, eivätkä kaikki niistä suinkaan ole luettavissa edes suppean määritelmän mukaisiksi terveydenhuollon reformeiksi. Terveydenhuollon reformeille ja reformeille yleensäkin on löydettävissä monia erilaisia määritelmiä. Esimerkiksi WHO (1997, 2) määrittelee reformin ”valtion hallinnon johtamana jatkuvana ja perusteellisena eksplisiittisten poliittisten tavoitteiden saavuttamiseen pyrkivänä institutionaalista ja rakenteellista muutosta aiheuttavana prosessina”. Boyne, Farrell, Law, Powell ja Walker (2003, 3-4) näkevät reformin puolestaan ”tarkoituksellisiksi muutokseksi järjestelyissä julkisen sektorin palveluiden suunnitteluksi ja jakeluksi”. Terveydenhuollon reformi on määritelty myös DDM:n (Harvardin yliopisto, Data for Decision Making Project) tavoin ”vakaaksi, tarkoituksellisiksi ja fundamentaaliseksi muutokseksi” (Berman 1995). WHO (1997, 3) on tiivistänyt terveydenhuollon reformin keskeiset piirteet seuraavaan taulukkoon 2.

Taulukossa esitetyt piirteet tulevat vielä tarkentumaan myöhemmin tässä paperissa tarkasteltaessa erilaisia kriteereitä terveydenhuollon reformeille. Jo tässä vaiheessa on kuitenkin nähtävissä, että terveydenhuollon reformit ja julkisen sektorin reformit on yleisesti määritelty samoin tavoin. Olisiko kuitenkin tarpeen tehdä ero näiden kahden eri käsitteen välillä? Esimerkiksi Lundberg ja Wang (2006, 40) toteavat, että vaikkakin muutamat terveydenhuollon reformien ominaiset piirteet näkyvät mahdollisesti jollakin tapaa myös muissakin julkisen sektorin reformeissa, ovat nämä piirteet terveydenhuollon reformeissa kuitenkin kompleksisempia ja hämmentävimpiä kuin muualla. Tässä artikkelissa kuitenkin ehdotetaan wicked problematiikkaan vedoten, että

Taulukko 2. Terveydenhuollon reformin keskeiset piirteet. (WHO 1997, 3)

PROSESSI:
- Pikemminkin rakenteellinen kuin inkrementaalinen tai evolutionaarinen muutos
- Pikemminkin poliittisten tavoitteiden muutosta seuraava institutionaalinen muutos kuin pelkästään yksistään tavoitteiden uudelleenmäärittely
- Pikemminkin tarkoituksellinen kuin sattumanvarainen
- Pikemminkin vakaa ja pitkäkestoinen kuin hetkellinen muutos
- Poliittinen ylhäältä alaspäin johdettu prosessi
SISÄLTÖ:
- Keinovalikoiman monipuolisuus
- Terveydenhuollon systeemien piirteiden maakohtainen vaikutus

kyseisen keinotekoisen rajan määritteleminen on turhaa ja jopa haitallista. Yleismaailmalliset ongelmat, jotka ovat tänä päivänä huomiomme keskipisteessä, pitävät sisällään lukuisia eri sektoreita. Terveydenhuolto on vain osana näitä ongelmia, joten sille ei sinänsä tulisi antaa mitään erityistä asemaa. Ei ole mahdollista väittää, että esimerkiksi asianmukaisen hoidon saaminen olisi yhtään sen kompleksisempaa kuin rasismin tai rikollisuuden kitkeminen. Perusteet ovat tällöin kaikilla laajoilla reformeilla samat. Tässä artikkelissa käytettäväksi esimerkiksi on kuitenkin otettu juuri terveyteen liittyvä teema, joten sen vuoksi tarkastelu on terveyskeskittynyttä.

Tarkoituksena ei ole myöskään suoranaisesti väittää, että terveydenhuollon reformin laajan määritelmän käyttäminen olisi yhtään sen tärkeämpää kuin suppeankaan. Esimerkiksi Mason ja Mitroff (1981, 31) muistuttavat, etteivät kyseiseen laajaan määritelmään liittyvät pirulliset ongelmat ole kuitenkaan käytännössä sen tärkeämpiä kuin suppeaan määritelmään liittyvät yksinkertaisetkaan ongelmat. Molemmat ongelmat ovat sen sijaan luontainen osa ympäristöämme. Muutosta pääasiassa kuvaavat pirulliset ongelmat ja pysyvyyttä edustavat yksinkertaiset ongelmat ovat tällöin toisiaan täydentäviä osaalueita. Käytännössä voidaan kuitenkin nähdä, että jatkuva muutos on olennaista ihmiskunnan selviytymisen kannalta, jolloin pirullisten ongelmien käsittely on kesyihin ongelmiin nähden etusijalla.

Artikkelin taustalla olevat teoriat tukevat edellä esitetyn DDM:n terveydenhuollon reformin määritelmän valintaa kuvaamaan laajaa terveydenhuollon reformia. Määritelmä sopii luontaisesti myös muillekin laajoille reformeille. Yleisesti ottaen erittäin monimutkaisiin ongelmiin vastaavien reformien tulisi tällöin olla fundamentaalisia, vakaita sekä tarkoituksellisia. Ensinnäkin kompleksisuustieteet[4] ja erityisesti niiden sisällään pitämä wicked problematiikka tukevat varsinkin reformien fundamentaalisuutta. Fundamentaalisuuden tulisi koskea reformin implementaatiota, vaikuttavuutta sekä myös suunnittelua. Reformin suunnittelussa olisi tällöin mukana mahdollisimman monia eri toimijoita ja se toteutettaisiin mahdollisimman laajasti. Lisäksi reformien tulee olla tarkoituksellisia. Esimerkiksi tarkoituksellisen muutoksen teorian (intentional change theory, tästä lähin ICT) mukaan muutos ei ole useimmiten jatkuvaa ilman tätä tarkoituksellisuutta (esim. Boyatzis 2006). Muutosta tulisi haluta ja siihen tulisi tietoisesti pyrkiä, jotta se olisi jatkuvaa. Lopuksi reformien tulisi olla myös vakaita. Se ei riitä, että reformi toteutetaan, vaan sitä pitää myös jatkuvasti muokata vastaamaan ympäristön muuttuvia haasteita. Viisas ongelmanratkaisija ei ole tällöin se joka ratkaisee ongelman, vaan se joka ratkaisee ongelman ja sen lisäksi valvoo tehtyä ratkaisua jatkuvasti ja on valmis muokkaamaan sitä tarpeen mukaan. (Ackoff 1978, 189.)

On mahdollista havaita, että ”reformiteoriat”, kompleksisuustieteet sekä ICT sopivat yhteen kuin palapelin palat ja tällöin niiden yhdistelmä tukee myös valitun määritelmän valintaa. Tämän

eri ”teorioiden” yhteensopivuuden voi havaita esimerkiksi seuraavasta valitun määritelmän mukaisesta yksittäisten osatekijöiden tarkastelusta. Kyseiset tarkastelut tulevat pohjautumaan vielä tässä vaiheessa pääasiassa ”reformiteorioihin” kompleksisuustieteiden ja ICT:n jäädessä pääosin vain täydentävään asemaan. Myöhemmissä julkaisuissa tarkastelu tulee kuitenkin täydentymään laajemmin myös kompleksisuustieteiden sekä ICT:n osalta.

Tarkoituksellisuus

DDM:n ehdottamassa terveydenhuollon reformin määritelmässä reformin tarkoituksellisuudella pyritään tarkoittamaan sitä, että reformien tulisi rakentua rationaalisella tavalla eli reformien tulisi tällöin perustua suunniteltuun ja näyttöön perustuvaan prosessiin. (Berman ja Bossert 2000, 2-3). Reformia ei tällöin kuvaa sattumanvaraisuus, vaan sen sijaan juuri tarkoin harkittu tarkoituksellisuus (esim. WHO 1997, 3).

Jos tarkoituksellisuudella tarkoitetaan reformin taustalla olevaa laajaa suunnittelua, niin kuinka tätä suunnittelun toteutumista voitaisiin arvioida tai mitata? Määritellessään viittä ehtoa rationaaliselle reformille, on Seedhouse (1996a) osaltaan jo vastannut tähän kysymykseen. Seedhouse (emt. 2-3) on rakentanut viidestä olennaisesta ehdosta rationaaliselle reformille koostuvan kriteeristön, jota voidaan harkita käytettävän juuri tähän reformien tarkoituksellisuuden määrittelyyn. Vaikka Seedhouse käsitteleekin kirjoituksessaan pääasiassa terveydenhuollon reformeja, tarkoittaa hän ehtoja käytettäviksi kuitenkin kaikenlaisiin reformeihin. Määrittelemiensä viiden ehdon yläpuolella hän asettaa ajatuksen, että ”jokaisen reformin tulisi tähdätä jo olemassa olevan rakenteen tai systeemin uudelleenrakentamiseen mahdollistaakseen alkuperäisten tavoitteiden saavuttamisen entistä kehittyneemmällä tavalla”. Seedhousen viisi ehtoa perustuvat tähän kyseiseen ajatukseen. Ehdot on esiteltynä taulukossa 3.

Yhdenkään Seedhousen (1996a) toimittamassa kirjassa kuvatun projektin suhteen edellä mainitut ehdot eivät kuitenkaan täysin toteudu. Samalla kun hän toteaa, että ehkä kyse on vain akateemisen filosofin liian kovista vaatimuksista, tukee Seedhouse kuitenkin omia päätelmiään rationaalisen reformin ehdoista. Hän kirjoittaakin, että ”jos kerran reformin ehdot eivät toteudu, on tällöin terveydenhuollon reformeja kokeile-

Taulukko 3. Viisi ehtoa rationaaliselle terveydenhuollon reformille. (Seedhouse 1996a, 2-11.)

EHTO	KYSYMYS REFORMOIJALLE
1. Reformoitavan toiminnan kohde tulee määritellä.	- Mikä on se toiminnan kohde joka tullaan reformoimaan?
2. Alun perin halutut määritellyn toiminnan kokonaispäämäärät tulee olla tiedossa.	- Mitkä ovat alun perin halutut kokonaispäämäärät määritellylle toiminnalle?
3. Tulee olla selvää miksi olemassa oleva järjestely: a) ei ole saavuttamassa haluttuja kokonaispäämääriä b) saavuttaa halutut kokonaispäämäärät, mutta haittojen x, y ja z... kanssa (jotka pitää myös määritellä).	- Miksi voimassa oleva järjestely: a) ei ole saavuttamassa haluttuja päämääriä b) saavuttaa päämäärät ei-haluttujen ja tarpeettomien kustannusten x, y ja z kanssa?
4. 3a:n ja 3b:n ratkaisemiseen tarkoitetut strategiat tulee olla tiedossa sekä mahdollisia. Tulee olla selvää miten tarkoitetut reformit tulevat varmistamaan sen, että kokonaispäämäärät tultaisiin saavuttamaan paremmin.	- Miten kysymyksiin 3a ja 3b aiotaan vaikuttaa?
5. Alun perin halututtuja kokonaispäämääriä ei saisi hylätä.	(Tämän toteuttaminen ei olisi enää reformi vaan sen sijaan radikaali muutos; esimerkiksi polkupyöriä valmistava yritys alkaisi valmistaa autoja.)

vien maiden kansalaisilla oikeus kysyä, että mitä oikein ollaan toteuttamassa, sillä (siltä osin, että ehdot eivät täyty) reformi se ei ainakaan ole" (Seedhouse 1996a, 11). Seedhouse ehdottaa myös, että jos toteutettavan reformin suhteen ehdot eivät tulisi todennäköisesti täyttymään, olisi tällöin parasta miettiä uudelleen koko projektin toteuttamista.

Seedhousen ehdot antavat hyvät lähtökohdat reformien tarkoituksellisuuden arvioimiselle. Ehtoja on mahdollista kuitenkin täydentää vielä ICT:n sekä kompleksisuustieteiden kautta. Ensinnäkin ICT:hän on erittäin läheisessä suhteessa kompleksisuustieteisiin, sillä se on jo itsessään kompleksinen systeemi (Boyatzis 2006, 608). ICT on tällöin määritellyt itseään monilla kompleksisuustieteissä esitetyillä periaatteilla. Boyatzis (2006, 619) on kuvannut tarkoituksellisuuden asemaa muutoksen onnistumisen kannalta seuraavasti: "Ihmiset muuttuvat. Ihmiset muuttuvat halutuilla tavoilla, mutta eivät ilman tarkoituksellista pyrkimystä. Ryhmät, organisaatiot, yhteisöt ja jopa maat voivat muuttua halutuilla tavoilla. Mutta edelleenkin, ilman tarkoituksellista pyrkimystä muutokset ovat hitaita, niiden lopputulokset päätyvät huonoihin tahattomiin seurauksiin verrattuna siihen mitä oli haluttu ja ne herättävät jaettua epätoivoa tulevaisuudesta ja heikentävät ihmisten mielialaa."

"Tarkoituksellinen muutos on haluttua, tarkkaan harkittua ja vuorottelevaa" (Howard 2006, 660). Sillä ei tarkoiteta muutosta, joka ei olisi vapaaehtoista (Dyck, Caron & Aron 2006, 672). Tarkoituksellinen muutos edellyttää tällöin tietoista valintaa. Boyatzis (2006, 609-610) perustelee tarkoituksellisuuden merkitystä muutoksen vakauden kannalta muun muassa tarkastelemalla tutkimuksia aikuisten ihmisten oppimisprosesseista. Näiden tutkimusten mukaan muutos on säilyvää usein ainoastaan silloin kun oppiminen on tarkoituksellista. Näkemys perustuu siihen, että ilman tarkoituksellisuutta ihmiset voivat teeskennellä kuuntelevansa ja oppivansa kuitenkin unohtaen kaiken sen opetuksen päätyttyä. Muutoksen tekee tällöin mahdolliseksi vain ihmisten halu tietoisesti oppia ja muuttua. Esimerkiksi Dyck, Caron ja Aron (2006) käsittelevät tätä näkemystä vaikeasti sairaiden aikuisten näkökulmasta. Heidän mukaan se, että nämä potilaat haluaisivat itse tietoisesti ja harkitusti tavoitella ideaali-minäänsä, toisi heille toivoa tulevaisuudesta ja opettaisi heitä muun muassa ottamaan enemmän itse vastuuta hoidostaan. Painotus on juuri siinä, että kyseisen muutoksen pitäisi olla tarkoituksellista sekä potilaan, että häntä hoitava organisaation osalta.

Laajan terveydenhuollon reformin ideaalimallin piirteitä voidaan laajentaa tarkoituksellisuuden osalta ICT:n pohjalta. Paitsi, että reformi olisi Seedmanin ehtojen mukaisesti tarkkaan suunniteltua, tulisi sen olla myös haluttua. Reformin toteutuksen tulisi tällöin lähteä liikkeelle tietoisesta ihmisten, organisaatioiden ja jopa valtioiden halusta muuttua.

Fundamentaalisuus

Hsiao (esim. 2003, 5) määrittelee viisi "ohjaussäädintä" (control knobs), joihin vaikuttamalla hallitukset voivat saada aikaan merkittäviä lopputuloksia toteuttamilleen reformeille. Nämä viisi ohjaussäädintä ovat rahoitus, maksut, terveydenhuollon jakelun makro-organisaatio, säännöstely ja vakuuttelu. Esimerkiksi Berman ja Bossert (2000) määrittelevät terveydenhuollon reformin fundamentalistisuuden juuri näiden Hsiaon ohjaussäätimien avulla. Reformeja jotka koskevat vähintään kahta ohjaussäädintä, Berman ja Bossert nimittävät "iso-r" (big-r) reformeiksi. "Pieni-r" (little-r") reformit koskettaisivat puolestaan vain yhtä Hsiaon määrittelemää ohjaussäädintä. Tällöin reformit, jotka eivät koskisi edes yhtä tällaista ohjaussäädintä, eivät olisi luettavissa määritelmän mukaisiksi terveydenhuollon reformeiksi. Terveydenhuollon reformin fundamentaalisuudella tarkoitetaan tällöin reformin toteutuksen laajuutta, eli sitä kuinka moneen eri osa-alueeseen reformi vaikuttaa. Mitä enemmän vaikutuksen kohteena olevia osa-alueita, sitä fundamentaalisemmasta reformista on kyse.

Berman ja Bossert (2000, 4) ehdottavat, että "iso-r" reformit määriteltäisiin strategisiksi ja "pieni-r" reformit puolestaan inkrementaalisiksi. Tarkoituksellisuuden suhteen he puolestaan näkevät nämä inkrementaalisiksi määritellyt reformit merkittävämmiksi kuin strategiset reformit. Tämä siksi, että jälkimmäiset reformit johtuvat usein yhteiskunnallisista kriiseistä, jolloin reformeilla voi olla kiire toteutua, eikä niitä tällöin välttämättä ehditä suunnitella tarpeeksi. Tämä on ollut yleistä varsinkin kehittyvissä maissa. Lisäksi Berman ja Bossert (emt. 9) huomauttavat, että "iso-r" reformi voi koostua myös useasta pienem-

mästä reformista. Tällöin ”iso-r” reformi ei kuitenkaan saisi olla vain osiensa summa. Taulukossa 4 esitetään lyhyesti Hsiaon ohjaussäätimet.

Hsiaon ohjaussäätimien kautta pystytään kuvaamaan hyvin sitä, kuinka fundamentaalinen reformin toteutus on eli kuinka laajoin keinoin reformia lähdetään toteuttamaan. Näiden ohjaussäätimien kautta ei kuitenkaan pystytä vastaamaan siihen, että kuinka fundamentaalisesti reformin idealistiset tavoitteet toteutuvat käytännössä.

PAHO:n (Pan American Health Organization) jäsenhallitukset ovat määritelleet viisi terveydenhuollon reformeja ohjaavaa periaatetta, jotka auttavat tuomaan näkyviin myös terveydenhuollon reformin toteutumisen fundamentaalisuuden. Näiden ohjausperiaatteiden tarkoituksena on määritellä reformien suunta niille määriteltyjen tavoitteiden näkökulmasta. Ideaalinen reformi olisi tällöin sellainen, joka reformin loputtua olisi parantanut jokaista viittä ohjausperiaatetta ja vältettävä reformi puolestaan sellainen joka toimisi näitä ohjausperiaatteita vastaan. Nämä kyseiset ohjausperiaatteet ovat oikeudenmukaisuus, laatu, tehokkuus, vakaus sekä sosiaalinen osallistuminen. (López-Acuña 2000, 1, 5.) Ohjausperiaatteiden sisältö selitetään lyhyesti taulukossa 5.

Hsiaon ohjaussäätimet sekä PAHO:n jäsenhallitusten määrittelemät viisi ohjaavaa periaatetta antavat hyvän pohjan laajan terveydenhuollon reformin ideaalimallille fundamentaalisuuden näkökulmasta. Reformien tulee tällöin olla toteutukseltaan sekä vaikutuksiltaan mahdollisimman laajoja. Tälle ajatukselle saadaan tukea myös kompleksisuustieteistä ja erityisesti wicked problematiikasta. Ensinnäkin Ackoff (1978, 118) muistuttaa, että monimutkaisiin ongelmiin on vain harvoin niin helppoja ratkaisuja, että ongelmat voitaisiin ratkaista vain yhtä osatekijää muuttamalla. Hän puhuu tällöin eri osatekijöiden välisistä kausaalisista suhteista. Vaikka näitä suhteita onkin usein vaikea havaita, ovat ne kuitenkin joka tapauksessa olemassa. Niiden havaitseminen on oleellista erittäin kompleksisten ongelmien ratkaisuissa, jolloin vaikeuksista huolimatta eri tekijöiden välisten kausaalisten suhteiden löytäminen on erittäin tärkeää.

Myös Churchman (1967, 141-142) huomauttaa, ettei pirullista ongelmaa voida ratkaista valit-

Taulukko 4. Hsiaon ohjaussäätimet (Hsiao 2003, 9-19)

OHJAUSSÄÄDIN	**SELITYS**
1.Rahoitus	Viittaa tapaan jolla raha pannaan liikkeelle ja käytetään. Pitää sisällään rahoituskeinot, rahoituksen jakamisen, säännöstelyn ja institutionaaliset sopimukset rahoituksesta.
2. Terveydenhuollon jakelun makro-organisaatio	Viittaa siihen rakenteeseen, jonka vastuulla on terveydenhuollon järjestäminen. Pitää sisällään kilpailun, desentralisaation, integraation ja omistussuhteet.
3. Maksut	Viittaa tapoihin, joilla rahoitus maksetaan yksilöille ja organisaatioille. Pitää sisällään kannustinpalkkiot kuluttajille sekä tuottajille.
4. Säännökset	Viittaa hallituksen tapaan käyttää pakkovaltaa määrätäkseen pakotteita yksilöille ja organisaatiolle. Pitää sisällään muun muassa lait, tutkinnot ja ohjesäännöt.
5. Vakuuttelu	Viittaa tapaan vaikuttaa ihmisten uskomuksiin, odotuksiin, elämäntapoihin ja mieltymyksiin mainostamisen, koulutuksen ja informaation levittämisessä.

Taulukko 5. PAHO:n jäsenhallitusten määrittelemät viisi ”ohjaavaa periaatetta” (López-Acuña 2000, 7-8)

OHJAUSPERIAATE	SELITYS
1. Oikeudenmukaisuus	Ovatko terveydenhuollon reformit johtaneet (oikeudenmukaisuuden) kehitykseen kattavuudessa, resurssien jakelussa, hoitoon pääsyssä ja resurssien käytössä?
2. Vaikuttavuus ja laatu	Ovatko terveydenhuollon reformit johtaneet parannuksiin teknisessä laadussa, koetussa laadussa, terveydentilassa ja kuolleisuudessa?
3. Tehokkuus	Ovatko terveydenhuollon reformit johtaneet (tehokkuuden) kehitykseen resurssien käytössä ja hallinnoinnissa?
4. Vakaus	Ovatko terveydenhuollon reformit parantaneet muun muassa hoidon tuottajien legitimiteettiä ja hyväksyttävyyttä?
5. Sosiaalinen osallistuminen	Ovatko terveydenhuollon reformit parantaneet sosiaalista osallistumista ja hallintaa terveydenhuollossa?

semalla kokonaisongelmasta vain tietty osa-alue. Kyseinen ratkaisutapa voi ehkä ”taltuttaa pirullisen ongelman murinan”, mutta se johtaa kuitenkin vain siihen, että ”pirullinen ongelma ei enää näytä hampaitaan ennen kuin se puree”. Tällöin syntyy helposti harhaluulo, että ongelma on ratkaistu, mitä se ei kuitenkaan tosiasiassa ole. Tämä johtaa taas siihen, että pirullinen ongelma yllättää ihmiset ilmestymällä kuin salama kirkkaalta taivaalta. Laajoja sosiaalisia ongelmia on myös hankala ratkaista pyrkimällä vaikuttamaan pelkästään ongelman oireisiin. Sen sijaan tulisi vaikuttaa itse varsinaiseen ongelmaan. (Ackoff 1978, 116) Esimerkiksi jos epäterveellisille ruokavalmisteille asetettaisiin suurempi arvonlisävero kuin terveellisille, olisi se vaikuttamista juuri ongelman, eli ihmisten lisääntyvän ylipainoisuuden, oireisiin. Ratkaisun tulisi kuitenkin sen sijaan kohdistua itse ongelmaan, eli siihen miksi ihmiset eivät pidä huolta terveydestään. Lisäksi Clarke ja Stewart (2000, 378-379) ovat sitä mieltä, että pirulliset ongelmat ovat niin laajalla levinneitä kokonaisuuksia, ettei niitä pystyttäisi ratkomaan pelkästään tyypillisin hallinnollisin toimenpitein kuten esimerkiksi lainsäädännön ja säätelyn avulla. He toteavat asian laidan lyhyesti seuraavalla tavalla: ”pirulliset ongelmat ovat luonteeltaan kietoutuneita vakiintuneisiin tapoihin elää sekä ajattelumalleja; ne voidaan selvittää vain muuttamalla näitä vakiintuneita tapoja ja ajattelumalleja”.

Kompleksisuusajattelun myötä fundamentaalisuuden piirre laajoissa terveydenhuollon reformeissa laajenee pelkän toteutuksen ja vaikuttavuuden ulkopuolelle. Tällöin paitsi toteutus ja vaikuttavuus olisivat mahdollisimman laajoja, myös itse suunnittelun pitäisi olla fundamentaalisuudeltaan erittäin mittavaa. Clarke ja Stewart (2000) tuovat julki tätä ajattelumallia. Ensinnäkin he painottavat sitä, että pirullisten ongelmien selvittäminen vaatii lineaarisen tai vaillinaisen ajattelun sijasta holistista ajattelua. Tällöin holistisella ajattelulla tarkoitetaan ajattelumallia, joka pystyisi pitämään sisällään monien eri toimien, tapojen, käytösten ja asenteiden vuorovaikutuksen. Clarken ja Stewartin (2000, 379) sanoin kyseisen ajattelutavan tarkoituksena olisi nähdä niin sanottu ”big picture”, joka vähentäisi mahdollisuutta siihen, että jotkin pirullisten ongelmien selvittämisen kannalta oleelliset asiat jäisivät

pimentoon. Päättäjien tulisi siis yrittää välttää kiusausta rajoittaa käsittelyalueen laajuutta.

Toisekseen Clarken ja Stewartin (2000, 380-383) mukaan pirullisten ongelmien selvittämisen kannalta olisi tärkeää ajatella ja työskennellä ylitse organisaatioiden sisäisten että ulkoisten rajojen. Tässäkin tapauksessa painotetaan holistista ajattelua, joka mahdollistaa monien eri asianomaisten ottamisen huomioon. Esimerkiksi tästä käy hyvin terveydenhuolto. Jos valtionhallinto yrittää ratkaista laajoja terveyteen liittyviä ongelmia, joutuu se tällöin ottamaan päätöksentekoon mukaan lukuisia eri toimijoita. Pelkästään terveydenhuollon organisaatiot eivät välitä terveyttä.

Kolmanneksi Clarke ja Stewart (2000, 383-384) kirjoittavat kansalaisten sisällyttämisestä pirullisten ongelmien ratkaisuprosesseihin. Kansalaisten mukaan ottamisen tärkeyttä selittää kaksi asiaa. Ensinnäkin koska pirullisia ongelmia on erittäin vaikea ymmärtää ja koska eri ihmisillä on niistä usein eri käsityksiä, merkitsee useampien ihmisten mukaan ottaminen erilaisten näkökulmien lisääntymistä ja tällöin pirullisten ongelmien syvempää ymmärtämistä. Lisäksi voidaan nähdä, että kansalaisten mukaan ottaminen selvitysprosessiin on erityisen tärkeää, koska heillä on usein ensikäden tietoa eli omakohtaisia kokemuksia pirullisten ongelmien ilmentymisistä. Toisekseen Clarke ja Stewart (2000, 384) näkevät, että koska pirullisten ongelmien selvittäminen vaatii usein muutoksia kansalaisten käytöksessä, on näiden muutosten aikaansaaminen helpompaa kansalaisten ollessa itse mukana keskusteluissa ja päätösten hyväksynnässä. Clarke ja Stewart (2000, 379) painottavatkin pirullisten ongelmien ratkaisussa hallinnollista tyyliä, joka ”oppisi ihmisistä ja työskentelisi ihmisten kanssa”. Toisin sanoen reformit tulisi toteuttaa ihmisten kanssa sen sijaan, että ne toteutettaisiin ihmisiä varten.

Reformin fundamentaalisuuteen liittyy myös moraalinen petoksen periaate: ”Se joka yrittää kesyttää osan pirullisesta ongelmasta, mutta ei kokonaisuutta, on moraalisesti väärässä”. (Churchman 1967, 142) Voidaan nähdä, että jos kyseinen kesyttäminen tapahtuu tietoisesti eli kyseinen toimija tietää ratkaisun olevan väärä ja on tietoinen ratkaisun aiheuttamista mahdollisista negatiivisista vaikutuksista, on paitsi itse ongelma pirullinen, jakaa myös toimija tämän pirullisuuden määritelmän sen eettisessä merkityksessä vaikkakin sitten vain lievästi. On tarpeen kuitenkin välttää ylilyöntejä pitäen mielessä se, että poliittiset päätökset ovat usein erittäin vaikeita ja tuskallisia. Joskus on vain käytännössä pakko tehdä päätöksiä, jotka auttaessa monia voivat aiheuttaa kuitenkin monille muille ihmisille harmia. Näiden päätösten teko ei kuitenkaan tee ihmisestä pirullista. (Benn 1985, 801.)

Vakaus

Vakaudella DDM:n terveydenhuollon reformin määritelmässä pyritään tarkoittamaan sitä, ettei reformi tulisi olemaan vain pelkkä lyhytkestoinen toteuttamaton ajatus tai niin sanotusti vain kertalaukauksena toteutunut uudistus ilman pysyviä vaikutuksia, vaan sen sijaan toteutettu pitkäkestoinen ja vakaa uudistus (Berman ja Bossert 2000, 2-3). Fundamentaalisuuden ja tarkoituksellisuuden ohella vakaushan on keskeinen osa reformin määritelmää tai ehkä jopa kaikista keskeisin. Voidaankin pohtia, miten kävisi uudistusten rationaalisuuden, jos ne jäisivät vain lyhytkestoisiksi muutoksiksi vailla minkäänlaista tulevaisuutta? Reformien toteutus vaatii kuitenkin paljon aikaa ja resursseja, joten jos uudistus jää vain hetkelliseksi ilmiöksi tai jopa pelkäksi ajatukseksi, voitaisiin sitä siinä tapauksessa pitää epäonnistuneena, sen jättäessä täyttämättä reformeille asetettuja vaatimuksia. (Century & Levy 2004, 18.)

Milloin reformin voidaan sitten nähdä olevan vakaa? Amerikkalainen laaja RSR-projekti (the Researching the Sustainability of Reform) on osaltaan onnistunut vastaamaan tähän kysymykseen tutkiessaan sitä, että kuinka koulutussektorille tehtyjä muutoksia voitaisiin ylläpitää ja että kuinka reformeja voitaisiin kannustaa jatkumaan. Ensinnäkin RSR-projekti osoitti sen, että pelkkä uudistuksen ylläpito ei sinänsä tarkoita vielä sitä, että uudistus olisi vakaa. Se, että uudistuksen peruselementit olisivat toteutuneet ja että niitä jopa pystyttäisiin ylläpitämään, ei sinänsä tee uudistuksesta vakaata. Siinä missä RSR-projektin tutkima koulutussektori on kompleksinen ja jossa olosuhteet muuttuvat jatkuvasti, voidaan terveydenhuollon sektorilla nähdä näiden piirteiden korostuvan vielä entisestään. Se, että uudistusta ylläpidetään, ei näissä olosuhteissa ole riittävää vaan uudistuksen tulee myös kehittyä näiden olosuhdemuutosten myötä. Tämän

vuoksi RSR-projekti määritteleekin vakauden tarkoittamaan ”projektin (tässä tapauksessa reformin) kykyä säilyttää perus uskomuksensa ja arvonsa ja käyttää niitä hyväkseen sopeutuessaan muutoksiin ja ympäristön paineisiin”. (Century & Levy 2004, 4-5.)

Käyttämällä hyväksi RSR-projektin laajaa tutkimusta, voidaan vakaudelle antaa tällöin tietyt ehdot. Vakaudella olisi tällöin kolme eri tasoa ja mitä korkeammalla tasolla reformi tässä suhteessa olisi, sitä vakaampi reformi olisi. Nämä tasot ovat perustaminen, kypsyminen ja kehittyminen. Kyseisten tasojen yläpuolella on ajatus, että vakaus ei ole vain pelkkää muutoksen ylläpitoa vaan myös adaptaatiota muutoksiin ja ympäristön paineisiin. (Century & Levy 2004, 4-6). Tasot esitetään taulukossa 6.

Kompleksisuustieteiden näkökulmat tukevat edellä esitettyä vakauden määritelmää. Jos ennen uskottiin, että ongelmiin olisi mahdollista löytää jokin perimmäinen ja lopullinen ratkaisu, on tilanne tänä päivänä eri. Systeemiajalla on havahduttu siihen, että maailma on suljetun systeemin sijaan avoin ja dynaaminen, jolloin myös ongelmat ja niiden ratkaisut ovat vain osa sen hetkistä maailmaa. Koska ongelmat ja ratkaisut ovat tällöin jatkuvassa liikkeessä, on niiden käsittely jatkuva prosessi. Ongelmat eivät pysy ratkaistuna, joten pelkkä hetkittäinen vakaus ongelman ratkaisun suhteen ei vielä ole lopullinen ratkaisu. Tällöin on tarpeen jatkuvasti seurata tilannetta ja muokata suunnitelmia olosuhteiden muuttuessa. (Ackoff 1974, 31-33.) Tämän vuoksi RSR-projektin määritelmistä tasoista erityisesti kolmas taso on ehdottaman tärkeä. Eli kuten Ackoff (1974, 33) toteaa: ”Mikään ongelma ei ole koskaan lopullisesti ratkaistu. Tämän vuoksi ratkaisut tarvitsevat kontrollia; jatkuvaa ylläpitoa ja kehittämistä”.

VOIDAANKO YKSINKERTAISET TERVEYDENHUOLLON REFORMIT KYSEENALAISTAA?

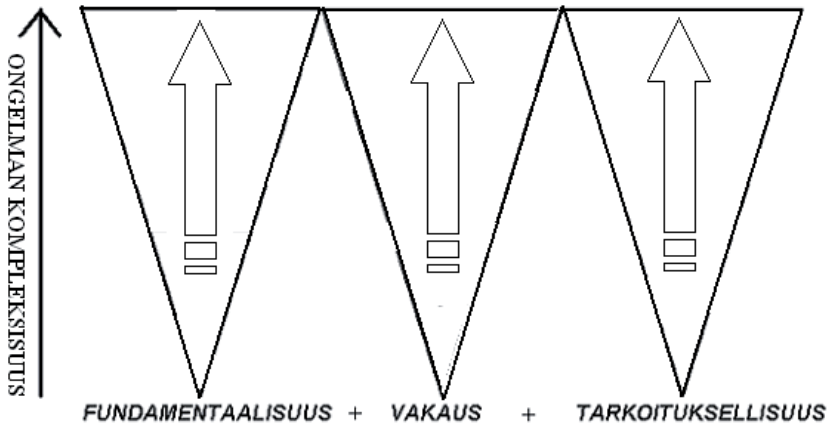
Edellä on luotu ideaalimalli laajalle terveydenhuollon reformille. Vastatakseen nykyajan erittäin kompleksisiin ongelmiin, tulee reformin olla tällöin mahdollisimman tarkoituksellinen, fundamentaalinen sekä vakaa. Ongelman kompleksisuuden kasvaessa, kasvaa myös näiden kolmen eri tekijän painoarvo. Kyseinen näkökulma on esitettynä kuviossa 1. Kuvion mukaisesti reformin tarkoituksellisuus, fundamentaalisuus sekä vakaus ovat kiinteässä vuorovaikutussuhteessa toistensa kanssa. Jos jokin näistä osatekijöistä epäonnistuu, on tällöin suurena vaarana myös koko reformin epäonnistuminen.

Kuinka oikeutettu rakennettu ideaalimalli loppujen lopuksi on? Ensinnäkin tähän kriteeristöön valittiin Seedmanin ehdot, Hsiaon ohjaussäätimet, PAHO:n ohjausperiaatteet sekä RSR-projektin määrittelemät vakauden kolme tasoa. Näiden eri määritelmien valintaa selittävät osaltaan jo niiden järkevyys niissä itsessään. Tämän loogisuuden näkökulman lisäksi selittävänä tekijänä valintoja tehdessä oli myös tarkasteltavien käsitteiden määritelmien ja kriteeristöjen suppeus varsinkin terveydenhuollon reformien näkökulmasta. Määritelmät ovat myös ansioituneiden tutkijoiden ja laajojen tieteellisten projektien tulosta, joka osaltaan lisää tässä artikkelissa tehtyjen valintojen oikeutusta. Myös kompleksisuustieteiden sekä ICS:n näkökulmat tukevat tässä artikkelissa tehtyjä valintoja.

Entä mikä puolestaan oikeuttaa kompleksisuustieteiden sekä ICS:n valinnan. Voidaan esimerkiksi kysyä, että ovatko nämä kompleksisuustieteet ja ICS vain ohimeneviä muoti-ilmi-

Taulukko 6. RSR-projektin määrittelemät vakauden kolme tasoa (Century & Levy 2002, 3)

VAKAUDEN TASO	SELITYS
Taso 1. Perustaminen	Reformi on käyttöönotettu, perus elementit ovat vakiintuneet ja toiminta on tehokasta ja odotettua.
Taso 2. Kypsyminen	Reformi on laajasti hyväksytty ja toteutus on piintynyttä.
Taso 3. Kehittäminen	Reformi keskittyy kasvuun ja kehitykseen. Tartutaan muutoksiin ja pyritään saamaan parempi ymmärrys reformista.



Kuvio 1. Terveydenhuollon reformin ideaalimalli ongelmien kompleksisuuden mukaan.

öitä. Onko niiden varaan tällöin turha laittaa näinkin paljon painoarvoa? Esimerkiksi Grobman (2005, 353) kyseenalaistaa myöntävän vastauksen tähän kysymykseen. Hän kysyykin sen sijaan, että jos nämä teoriat ovat kerran täysin turhia ja tavanomaiset teoriat sen sijaan niin erinomaisia, niin minkä vuoksi nykyiset ratkaisumallit eivät sitten tuota toimivia ratkaisuja. Eli jos vallitsevien teorioiden mukaan tulevaisuutta kerran voidaan nähtävästi ennustaa, niin miksi tämä ennustaminen ei sitten tuota tulosta. Voi toki olla, etteivät kompleksisuustieteet eikä myöskään ICS saa aikaa sen parempia tuloksia, mutta ainakin vielä tässä vaiheessa kaikkialla ympäristössämme tapahtuvat muutokset ja niihin suhtautuminen tukevat näiden ”uusien” teorioiden käyttöönottoa.

Seedmania (1997a) lainaten voidaan myös kysyä, että onko esitetty ideaalimalli vain nuoren aloittelevan tutkijan idealistinen päähänpinttymä. Onko tätä ideaalimallia edes mahdollista toteuttaa kun otetaan huomioon esimerkiksi poliittiset ja taloudelliset rajoitukset? Vaikka ideaalimalli voisikin olla rationaalisin malli terveydenhuollon reformille, tulee toki tiedostaa sen rajoitukset. Simonin ”rajoitetun rationaalisuuden” käsitteen mukaan suunnittelu ja päätöksenteko perustuvat rajoitettuun tietoon ja tiedonkäsittelyyn (esim. Hanoch & Rice 2006). Kaikkia mahdollisuuksia on mahdoton ottaa huomioon, mutta se ei kuitenkaan tarkoita liian hätäistä rajojen asettamista. Hatchuel (2001) puhuu tällöin ”laajenevasta rationaalisuudesta”. ”Laajeneva rationaalisuus” tulee esille erityisesti suunnittelussa, jossa erilaisia suunnittelumahdollisuuksia on ääretön määrä. Käytännössä ”laajenevan rationaalisuuden” voidaan nähdä tarkoittavan sitä, ettei se sulje pois mitään vaihtoehtoja rajoitetun rationaalisuuden tapaan. Suunnittelun alkuvaiheessa kaikki eri suunnittelupolut olisivat siinä mielessä vielä avoinna (Hatchuel & Weil 2002, 16-17). Rajoitettu rationaalisuus puuttuu suunnitteluprosessiin aikanaan, mutta ainakin suunnittelun alkuvaiheessa kaikki mahdolliset vaihtoehdot pitäisi pitää mahdollisina, tuntuivat se sitten kuinka mahdottomilta tahansa. Eli kuten esimerkiksi Van Wyk (2003, 6) on todennut, me emme suinkaan tarvitse mitään guruja, jotka kertovat kuinka erittäin monimutkaisia ongelmia ratkaistaan. Sen sijaan tarvitsemme oppaita, jota opastavat meidän uudenlaiseen ajatteluun. Tämä ideaalimalli pyrkii toimimaan tällaisena oppaana.

Voidaanko tämän artikkelin perusteella yksinkertaiset terveydenhuollon reformit kyseenalaistaa? Onko niin, että tänä päivänä toteutetut terveydenhuollon reformit ja myös muutkin reformit ovat suunnittelultaan, toteutuksiltaan ja vaikutuksiltaan riittämättömiä vastaamaan tämän päivän ja erityisesti tulevaisuuden haasteisiin. Ensinnäkin mainittakoon se, että yksinkertaisia terveydenhuollon reformeja ei sinänsä voida kiistää. Niilläkin on oma tärkeä tehtävänsä yksinkertaisten terveydenhuollon ongelmien ratkaisuissa. Monimutkaisia terveydenhuollon ongelmia ei niillä kuitenkaan erittäin todennäköisesti pystytä ratkaisemaan. Toisekseen myönnettäköön, että tässä

artikkelissa ei vielä pystytä tätä väitettä todistamaan. Todistus vaatisi laajaa terveydenhuollon reformien tarkastelua ja siihen ei tässä vaiheessa ole vielä mahdollisuuksia[5]. Tulevan tutkimuksen aiheena tulee kuitenkin olemaan laaja viime vuosikymmenien aikana toteutettujen terveydenhuollon reformien arviointi. Hypoteesina on tällöin se, että kyseiset reformit eivät ole saaneet aikaan haluttuja saati sitten tarvittavia lopputuloksia. Tämän hypoteesin osoittautuessa todeksi, syinä reformien epäonnistumiseen olisi silloin erittäin todennäköisesti reformien kohteena olevien ongelmien näkeminen yksinkertaisina ja siten yksinkertaisten ratkaisujen toteuttaminen.

LOPUKSI

Tunnettu yhdysvaltalainen sosiaalikriitikko H. L. Mencken (1880-1956) on kirjoittanut; ”Jokaiseen kompleksiseen ongelmaan on olemassa ratkaisu, joka on yksinkertainen, viehättävä ja väärä”. Tämän päivän sosiaaliset ongelmat, koskivat ne sitten ihmisten terveyttä tai esimerkiksi turvallisuutta, ovat erittäin kompleksia. Menckenin ajatusten mukaisesti yksinkertaiset ratkaisut näihin ongelmiin ovat hyvin todennäköisesti vääriä. Vääriä, koska ne eivät ratkaise ongelmaa. Vääriä, koska ne voivat aiheuttaa vain lisää ongelmia. Vääriä, koska ne voivat myöhemmin estää oikeiden ratkaisujen toteuttamisen. ”Vaarana ei ole niinkään se, että epäonnistuisimme rakentamaan siltoja oikeiden jokien yli. Ennemminkin suurin vaara on siinä, että me tuhoaisimme sen materiaalin mitä tarvitaan siltojen rakentamiseen oikeiden jokien yli” (King 1993, 106).

Meidän tulee rakentaa siltoja oikeiden jokien yli, sillä tekemämme ratkaisut tulevat vaikuttamaan miljoonien ihmisten elämään, eikä meillä ole tällöin varaa epäonnistua näissä ratkaisuissa. Vastuu on tällöin meillä kaikilla, mutta eritoten reformien suunnittelijoilla. Reformien suunnittelijoiden pitää ymmärtää käsillä olevien ongelmien kompleksisuus. Se on erittäin tärkeä lähtökohta onnistuneelle ratkaisuprosessille. Reformoijien pitää myös ottaa huomioon reformien suhde ongelmien kompleksisuuteen. Mitä suurempi ongelmien kompleksisuus, sitä suurempi painoarvo reformien tarkoituksellisuudelle, fundamentaalisuudelle sekä vakaudelle tulisi antaa.

Tämä artikkeli pyrkii kontribuutiollaan herättämään keskustelua muuttuvasta maailmasta ja sen mukana muuttuvista ongelmista. Suoranaisesti artikkeli luo myös viitekehyksen laajan terveydenhuollon reformin ideaalimallille. Ideaalimalli on tässä vaiheessa vielä osittain vajaa, ja sitä tullaankin vielä myöhemmissä julkaisuissa laajentamaan varsinkin kompleksisuustieteiden sekä tarkoituksellisen muutoksen teorian kautta. Tässäkin vaiheessa kyseisen malli voi kuitenkin toimia jo suunnannäyttäjänä tuleville reformeille. Toivottavaa olisi ainakin se, että tässä artikkelissa rakennettu terveydenhuollon reformin ideaalimalli saisi ihmiset näkemään asioita avarammin pelkän oman (suppean) näkemyksensä ulkopuolelle. Tämän toteutuessa olisi artikkeli jo ajanut tehtävänsä erittäin onnistuneesti.

Seedhousen (1996b, 231-232) innoittamana jätetään vielä yksi ajatus leijumaan ilmaan. Tällä hetkellähän terveydenhuollon reformien tavoitteina on pääosin kehittää nykyistä terveydenhuollon systeemiämme. Mitä jos muuttaisimme näiden reformien tavoitteiksi terveydenhuollon systeemin kehittämisen sijaan kansakuntamme terveyden kehittämisen? Mitä tällöin tapahtuisi?

VIITTEET

[1] Seedhouse (1996b) muistattaa terveys käsitteen monimerkityksellisyydestä. Siinä missä terveydenhuolto voidaan määritellä laajasti tai suppeasti, myös itse terveys voidaan käsittää monin eri tavoin. Terveydenkin määritteleminen on tällöin tärkeää reformoimisen yhteydessä. Tässä artikkelissa terveydellä tarkoitetaan Rowlandin ja Cooperin (1983, 1) tavoin fyysisen, sosiaalisen ja mentaalisen hyvinvoinnin positiivista olotilaa, jossa jokainen näistä tekijöistä on vaikutussuhteessa toisiinsa. Terveys tulisi tällöin nähdä kokonaisuutena, eikä vain pelkkänä fyysisenä terveydentilana.

[2] Myös Abel-Smith (1996, 14-15) huomauttaa, että enemmän kehittyneissä maissa ei ole löydettävissä selkeää yhteyttä terveydenhuollon kulutuksen sekä eliniänodotuksen välillä.

[3] Käytetään myös suomennosta ”ilkeä ongelma” (kts. esim. Sotarauta 1996, 118-119 & Pösö 2005). Ongelman ilkeys kuvastaa kuitenkin pirullisuuden käsitettä enemmän ongelman eettistä pahuutta. Pirulliset ongelmat eivät kuitenkaan ole luonteeltaan kieroutuneella tavalla ilkeä, vaan Rittelin ja Webberin (1973, 160) mukaisesti

”pahanlaatuisia vastakohtana hyvänlaatuisiin tai turmiollisia kuten noidankehä tai pulmallisia kuin haltijat tai aggressiivisia kuin leijonat verrattuna lampaiden rauhallisuuteen”.

[4] Kompleksisuustieteillä tarkoitetaan muun muassa kompleksisuus- ja kaaosteoriasta koostuvaa teorioiden joukkoa (Mathews, White & Long 1999). Voidaan käyttää myös nimitystä ”uudet tieteet” (Murray 2003). Kompleksisuusteorioiden teoria-asemien kyseenalaistamisten myötä voidaan puhua myös esimerkiksi kompleksisuusajattelusta ja kaaosajattelusta (kts. esim. Willamo 2005). Tässä artikkelissa tullaan keskittymään pääosin kompleksisuustieteiden sisällään pitämään wicked problematiikkaan. Kompleksisuusteoria sekä kaaosteoria tulevat saaman huomiota laajemmassa mittakaavassa tulevissa julkaisuissa.

[5] Esimerkiksi Vartiainen (2005) on kuitenkin käsitellyt lyhyesti terveydenhuollon reformeja wicked problematiikan näkökulmasta. Hänen mukaansa reformien suunnittelussa ja toteutuksessa ei ole otettu tarpeeksi huomioon ongelmien monimutkaisuutta. Jos tulevaisuudessa ongelmien pirullinen luonne huomioitaisiin paremmin, olisivat reformit Vartiaisen mukaan todennäköisesti onnistuneempia kuin mitä ne tähän päivään asti ovat olleet.

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Tieteellinen artikkeli

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Wicked-problematiikan käsitteellinen tarkastelu

Uusia näkökulmia terveydenhuollon johtamiseen

Tiivistelmä

Kompleksinen maailma pitää sisällään erittäin kompleksisia ongelmia. Nämä ongelmat ovat niin sanottuja pirullisia ongelmia. Niitä on vaikea määritellä ja periaatteessa mahdoton ratkaista lopullisesti. Pirullisten ongelmien vastakohtana ovat kesyt ongelmat. Kesyjen ongelmien suhteen ei ole epäselvyyttä siitä, mikä on ongelmana ja kuinka ratkaisun suhteen tulisi edetä. Nämä kaksi käsitettä muodostavat wicked-problematiikan käsitteistön.

Wicked-problematiikkaa käyttävät tutkijat väittävät, että hallintotieteissä tänä päivänä vallitseva paradigma ei ole yksinään täysin pätevä ratkaisemaan pirullisia ongelmia. Jos tämä väite pitää paikkansa, on *wicked*-problematiikan tarkastelu erittäin tarpeellista. *Wicked*-problematiikkaa ei ole vielä juurikaan käyty läpi suomalaisessa tieteellisessä kirjallisuudessa. Tässä artikkelissa on tarkoituksena täydentää tätä tyhjiötä luomalla käsitteellinen katsaus *wicked*-problematiikkaan.

Käsitteellinen tarkastelu viittaa siihen, että pirulliset ongelmat todellakin pitävät sisällään piirteitä, joita nykyiset ongelmanratkaisutavat eivät pysty yksinään ratkaisemaan. Esimerkiksi terveydenhuollossamme tulevaisuudessa odottavien merkittävien ongelmien vuoksi nykyisiä ongelmanratkaisutapoja tulisi *wicked*-problematiikka-ajattelun mukaisesti kehittää niin, että ne olisivat valmiita kohtaamaan näitä erittäin kompleksisia pirullisia ongelmia.

Asiasanat: kompleksisuus, ongelmat, hallinto, johtajuus, terveydenhuolto

Abstract

Conceptual examination of the concept of wicked problems
New perspectives in the health care leadership?

Complex world has very complex problems. These problems are so called wicked problems. They are hard to define and basically impossible to solve for good. The opposite of wicked problem is tame problem. In tame problems there isn't unclarity about the problem definition and the solving methods. These two concepts form the concept of wicked problems.

Researchers using the concept of wicked problems assert that the dominant paradigm in modern administrative science isn't suitable to solve wicked problems alone. If this assertion is correct, it is very necessary to examine this concept. Concept of wicked problems hasn't been yet discussed much in Finnish academic literature. By making a conceptual examination, this article tries to step in and increase this discussion.

Conceptual review points out that wicked problems indeed have features, which the present problem solving methods can't solve by themselves. For example because of the major problems waiting in health care, the modern problem solving methods should be developed accordingly the concept of wicked problems so, that they would be ready to confront these very complex wicked problems.

Keywords: complexity, problems, administration, leadership, health care

1. Katsaus wicked-problematiikan perusteisiin

Muuttuva maailma tulee kohtaamaan väistämättä yhä monimutkaisemmiksi muuttuvia ongelmia (kts. esim. Rittell & Webber 1973; Raisio 2007). Yksi tapa nähdä nämä ongelmat on tarkastella niitä *wicked*-problematiikan mukaisen ajattelumallin kautta. Tämä ajattelumalli suhtautuu hyvin kriittisesti vallitseviin lineaarisiin ja reduktionistisiin ongelmanratkaisutapoihin. Niiden ei nähdä pystyvän ratkaisemaan kompleksisia ongelmia (Rittel 1972; Conklin 2005).

Wicked-problematiikkaan perehtyneet tutkijat esittävät, että *wicked*-problematiikan avulla on mahdollista nähdä ongelmien todellinen luonne. Se kuinka nämä ongelmat nähdään, on erittäin tärkeää ongelmista selviytymisen kannalta. Vääränlainen tapa nähdä nämä ongelmat voi johtaa lyhytaikaiseen onnistumiseen, mutta pitkällä tähtäimellä väärä valinta voi kuitenkin kostautua (Ackoff 1974, 28).

Ongelman määrittely on tällöin vähintäänkin yhtä tärkeää kuin oikeiden ratkaisutapojen suunnittelu. Ne ovat keskinäisessä riippuvuussuhteessa toisiinsa. Toisin sanoen ne ovat jatkuvan rakentumisen kohteena. Ongelma määrittelee ratkaisun. Ratkaisun suunnittelun myötä tulee esille uusia asioita, jotka puolestaan muokkaavat uudelleen ongelman määritelmää. Tämä on loputon prosessi, joka päättyy kompleksisissa ongelmissa lopulta siihen, että ratkaisun todetaan olevan tarpeeksi hyvä. Täydellistä ratkaisua ei ole olemassa. (Rittel 1972; Conklin 2005.)

Jos tämä ajattelu pitää paikkansa, on vallitseva lineaarinen suunnittelu käytännössä kykenemätön ratkaisemaan erittäin kompleksisia ongelmia. Tässä artikkelissa tullaankin käsittelemään tätä vallitsevasta paradigmasta eroavaa näkökulmaa monimutkaistuvan maailman hallintaan. Päätarkoituksenaan tällä artikkelilla on tuoda julki *wicked*-problematiikkaa hallintotieteiden kentällä. Kyseistä teemaa ei ole käyty suomalaisessa tieteellisessä kirjallisuudessa laajasti läpi, joten sen käsittely on aiheellista[i].

Lisäksi voidaan nähdä, että terveydenhuoltoa odottaa tulevaisuudessa erityisen suuret haasteet. Erityinen huomio tässä artikkelissa annetaan siten terveydenhuollon hallinnolle. Eksplisiittisenä tavoitteenaan artikkelilla onkin tällöin saada lukijat näkemään maailma ja sen ongelmat uudella tavalla; tavalla, joka ehkä mahdollistaisi selviytymisen monista edessämme odottavista erittäin kompleksisista ongelmista.

Kesyt ja pirulliset ongelmat

Wicked-problematiikka jakautuu kahteen keskeiseen käsitteeseen; kesyihin ongelmiin eli englanniksi *tame problem* sekä pirullisiin ongelmiin eli englanniksi *wicked problem*. Käytännössä nämä ongelmat ovat toistensa vastakohtia. Eli siinä missä kesyt ongelmat ovat useimmiten helposti määriteltyjä ja helposti ratkaistuja, ovat pirulliset ongelmat puolestaan vaikeasti määriteltävissä eikä niihin ole olemassa mitään helposti löydettävissä olevaa ratkaisua (Clarke & Stewart 2000, 377–378).

Kesyä ongelmaa on tällöin mahdollista verrata esimerkiksi shakkipeliin. Shakissahan on selkeät ohjeet, jotka ohjaavat pelin kulkua ja peli päättyy silloin, kun jompikumpi pelaajista voittaa. Siinä on siis selkeä loppuratkaisu. Lisäksi shakissa on rajattu – vaikkakin erittäin suuri – määrä erilaisia ratkaisuja. Jokainen peli on käytännössä toistoa siinä mielessä, että jos opettelee kerran pelin säännöt, osaa tällöin pelata peliä aina yhä uudelleen. Kesyt ongelmat ovat tällöin käytännössä niitä samoja jokapäiväisiä ongelmia, joita me ratkomme onnistuneesti päivästä toiseen samalla rutiinilla kuin aina ennenkin.

Pirulliset ongelmat ovat kuitenkin täysin toisenlaisia ongelmia. Laajimmassa mahdollisessa merkityksestä näitä kyseisiä ongelmia ovat esimerkiksi terrorismin torjunta ja ilmastonmuutokseen puuttuminen. Ne ovat ongelmia, joiden ratkaisuun ei todellakaan ole olemassa mitään valmiita ohjeita. Rittel ja Webber (1973: 161–167) ovat nähneet, että pirullisille ongelmille olisi löydettävissä ainakin kymmenen keskeistä piirrettä. Alla keskeiset piirteet esiteltynä:

1. **"Pirulliselle ongelmalle ei ole olemassa mitään lopullista ja täysin täsmällistä määritelmää."** Ongelman ja ratkaisun määritteleminen on kytketty yhteen. Ratkaisun määrittäminen määrittää ongelman, joka määrittää taas uuden ratkaisun ja niin edelleen. Koska kaikkia ratkaisumahdollisuuksia ei ole mahdollista määritellä, ei pirullisen ongelman lopullinen määritelmä ole mahdollinen.
2. **"Pirullisella ongelmalla ei ole pysähtymissääntöä."** Pirullisen ongelman ratkaiseminen ei ole mikään peli, joka loppuu ratkaisuun. Ei ole olemassa mitään pelin sääntöjä, jotka kertoisivat, milloin ratkaisu on tapahtunut. Ratkaisuehdotuksia on mahdollista aina parantaa, joten suunnittelija pystyy käytännössä halutessaan ja resurssien riittäessä aina parempaan lopputulokseen.
3. **"Ratkaisut pirullisiin ongelmiin eivät ole oikeita tai vääriä, vaan hyviä tai huonoja."** Koska lopullinen ratkaisu ei ole mahdollinen, mikään pirullisen ongelman ratkaisu ei ole koskaan oikea tai väärä. Sen sijaan ongelmien onnistuneisuus ilmenee ihmisten omista subjektiivisista käsityksistä. Joidenkin mielestä ratkaisu voi olla hyvä, joidenkin mielestä huono kun jotkut taas voivat pitää sitä tyydyttävänä.
4. **"Pirullisten ongelmien ratkaisujen arvioimiseen ei ole olemassa välitöntä ja täydellistä tapaa."** Pirullisten ongelmien ratkaisujen vaikutusten jatkumo on ääretön sekä ajallisesti että tilallisesti. Kaikkia mahdollisia ratkaisun aiheuttamia vaikutuksia on mahdoton arvioida nopeasti, saati sitten täydellisesti.
5. **"Jokainen ratkaisu pirulliseen ongelmaan on ainutkertainen toiminto, koska ei ole mahdollista oppia kokeilun ja virheen kautta. Jokaisen ratkaisuyrityksen merkitys on huomattava."** Pirullisten ongelmien ratkaisuihin ei voi suhtautua kokeiluna. Sosiaaliset, pirulliset ongelmat vaikuttavat ongelman laajuudesta riippuen lukemattomien ihmisten elämään. Jokainen ratkaisu vaikuttaa tällöin näiden ihmisten elämään ja jos ratkaisu epäonnistuu, ei sen vaikutuksia saa pyyhittyä pois. Lisäksi epäonnistumisten ratkaisuyritykset voivat vielä johtaa uusiin pirullisiin ongelmiin.
6. **"Pirullisilla ongelmilla ei ole laskettavissa olevaa – tai tyhjentävästi esitettyä – määrää mahdollisia ratkaisuja, eikä myöskään mitään hyvin määriteltyä listaa suunnitteluun sisällytettävistä sallituista toimintamalleista."** Pirullisiin ongelmiin on käytännössä loputon määrä ratkaisuja. On mahdotonta, että ratkaisua suunniteltaessa voitaisiin tällöin huomioida jokainen mahdollinen ratkaisutapa.

i Vaikka wicked-problematiikka on 1970-luvulta lähtöisin oleva käsitteistö, on sitä alettu huomioida englanninkielisessäkin tieteellisessä kirjallisuudessa enemmissä määrin vasta viime vuosina. Tämän vuoksi osa artikkelissa käytettävistä lähteistä on esimerkiksi konferenssipapereita. Varsinaisissa tieteellisissä lehdissä jul-kaistut artikkelit ovat vielä vähälukuisia.

7. "Jokainen pirullinen ongelma on luonteenomaisesti uniikki." Vaikka pirullisilla ongelmilla onkin yhtenäisiä piirteitä, niiden erityisyydet voivat kuitenkin tehdä nämä yhtenäisyydet lähes merkityksettömiksi.
8. "Jokaista pirullista ongelmaa voidaan pitää toisen ongelman oireena." Pirullisille ongelmille ei ole olemassa mitään luontaista tasoa. Alemman asteen ongelmien voidaan tällöin nähdä aina olevan osa ylemmällä tasolla olevaa ongelmaa. Oireiden ratkaisun sijaan paras vaihtoehto olisi tarttua varsinaiseen ylimmällä tasolla olevaan ongelmaan.
9. "Pirullisen ongelman esittämät epäjohdonmukaisuudet voidaan selittää monin eri tavoin. Selityksen valinta määrittelee ongelman ratkaisun luonteen." Selittävien tekijöiden valinta määrittää ongelman ratkaisun luonteen. Selittävien tekijöiden valinta riippuu puolestaan monista tekijöistä. Esimerkiksi ihmisten omat aikomukset ja resurssit ratkaista ongelma vaikuttavat selittävien tekijöiden valintaan. Suunnittelijan maailmankuvalla on myös tärkeä merkitys epäjohdonmukaisuuksien selittämisessä.
10. "Suunnittelijalla ei ole oikeutta olla väärässä." Ne, jotka pyrkivät vaikuttamaan pirullisiin ongelmiin, vaikuttavat samalla lukuisten ihmisten elämään. Koska tarkoituksena ei ole löytää mitään äärimmäistä ratkaisua, vaan tarkoituksena on parantaa käsillä olevaa ongelmaa, ovat päättäjät ja suunnittelijat vastuussa tekemisistään.

Englanninkielinen käsite *wicked problem* on aikaisemmin suomennettu ilkeäksi ongelmaksi, pahaksi ongelmaksi ja jopa kinkkiseksi ongelmaksi (esim. Sotarauta 1996, 118–119; Pösö 2005; Spangar & Jokinen 2006). Tässä tutkimuksessa käytettävä pirullisen ongelman käsite eroaa täten aikaisemmista suomennoksista.

Uudelle suomennokselle on selkeä määritelmällinen syy. Ensinnäkin adjektiivi *wicked* voidaan suomentaa sanakirjakäännösten mukaan muun muassa pahaksi ja ilkeäksi. Englannin kielellä *wicked* pitää kuitenkin sisällään enemmän kuin pelkän pahuuden ja ilkeyden. Bennin (1985: 796) mukaan pelkkä ilkeä tai paha ihminen *evil*-adjektiivin mukaisesti ei ole sama kuin *wicked* eli pirullinen. Pirullisen ihmisestä tekee vasta tietoisuus omista teoistaan.

Sama pätee omalla tavallaan pirullisuuteen myös asioissa. Pirullinen ongelma on tällöin ylemmällä kompleksisuuden tasolla kuin pelkkä ilkeä tai paha ongelma. Kyse ei ole siis siitä, miten sanakirja suomentaisi käsitteen *wicked problem*. Sen sijaan tulee ottaa englanninkielisen termin tausta huomioon ja pyrkiä löytämään sille kaikista sopivin vastaava käsite suomen kielestä.

Rittel ja Webber (1973: 160) painottavatkin juuri sitä, että he eivät tarkoita *wicked problem* -käsitteellään suinkaan kyseisten ongelmien sisällään pitämää eettistä puolta. Sen sijaan pirulliset ongelmat ovat heidän mukaansa *"pahanlaatuisia vastakohtana hyvänlaatuisiin, turmiollisia kuten noidankehä, juonikkaita kuin haltijat tai aggressiivisia kuin leijonat verrattuna lampaiden rauhallisuuteen"*. Mason & Mitroff (1981: 10) vertaavat pirullista ongelmaa puolestaan tarujen hydraan, joka kasvattaa aina lisää päitä yhden poikki lyödyn pään tilalle. Robertskin (2000: 2) on pohtinut *wicked*-problematiikan mukaisia ongelmia ja kuvaileekin niiden ratkaisuprosessia seuraavasti: *"...it is experienced as ambiguous, fluid, complex, political and frustrating as hell. In short, it is wicked."* Ongelma on siis pirullinen, ei paha eikä ilkeä!

King (1993) näkee ongelmien luonteille kolme eri tasoa. Alimmalla tasolla ovat kesyt ongelmat. Keskivaikeaksi ongelmaksi hän näkee niin sanotun sotkun, joka on käännös englannin kielen sanasta *mess*. Ylimmän tason ongelmat ovat Kingin mukaan kuitenkin sen lisäksi, että ne ovat niin sanotusti sotkuisia, myös erittäin pirullisia.

Sotkujen eli monimutkaisten tai vaikeiden ongelmien ero pirullisiin eli kompleksisiin ongelmiin on selkeä. King (1993: 112) jakaa tällöin eri ongelmatyypit E. F. Schumacherin mukaisesti divergentteihin ja konvergentteihin. Kesyt ongelmat ovat tällöin konvergentteja niiden varsinaisessa merkityksessä eli ne tarjoavat samaan lopputulokseen johtavia ratkaisuja käsillä olevaan ongelmaan. Sotkutkin ovat vielä siinä mielessä konvergentteja, että niissäkin on mahdollista ennemmin tai myöhemmin päästä yksimielisyyteen ratkaisuista.

Pirulliset ongelmat ovat puolestaan divergenttejä, koska niiden ratkaisuyritykset johtavat loppujen lopuksi vain useisiin eri ratkaisumahdollisuuksiin eli pirulliset ongelmat johtavat toisin kuin kesyt ongelmat ja sotkut eriäviin mielipiteisiin. Kun sotkuihin lisätään sosiaalis-poliittisia tai esimerkiksi moraalis-hengellisiä piirteitä tulee niistä silloin Kingin (1993) mukaan luonteeltaan pirullisia.

Edellä on esitelty kymmenen pirullisten ongelmien piirrettä. Pirullisen ongelman ei kuitenkaan tarvitse pitää sisällään jokaista näistä piirteistä ollakseen määriteltävissä pirulliseksi, vaan pirullisuudesta on olemassa myös eri asteita. Myöskään kesy ongelma ei ole täysin sama kuin yksinkertainen ongelma. Ongelma voi esimerkiksi olla teknisesti erittäin kompleksinen ilman, että se kuitenkaan olisi pirullinen. (Conklin 2005.)

Pirullisia ongelmia ei kuitenkaan aina nähdä sellaisina. Toisaalta kyse voi olla vain siitä, ettei niitä osata tunnistaa. Ongelmana voi myös olla suoranainen halu olla näkemättä niitä sellaisina. Halu välttää näkemästä ongelmia pirullisina voidaan Jeff Conklinin (2005) tavoin nähdä luonnolliseksi viettymykseksi pitää ongelmia kesyinä. Hän kirjoittaakin, että *"kuka haluaisi ottaa käsiteltäväksi ongelman, jota määritelmän mukaan ei voi ratkaista!?"*.

Vastakkaisesta näkökulmasta katsottuna sekin toki on mahdollista, että kesyt ongelmat nähdään tarpeettomasti pirullisiksi. Ongelmasta tehdään tällöin hankalampi kuin se oikeasti onkaan ja näin vain aiheutetaan tarpeetonta harmia. (Pösö 2005: 5.) On kuitenkin myös mahdollista, etteivät kesyt ongelmat jää kesyiksi. Ajan muuttuessa ongelma voi alkaa vähitellen monimutkaistua päätyen lopulta erittäin pirulliseksi ongelmaksi (Kreuter ym. 2004: 444). Loppujen lopuksi se voi olla joku mitättömän pieneltäkin tuntuva asia, joka käynnistää tämän kompleksistumisen prosessin.

Jeff Conklin (2005) on luonut *wicked*-problematiikkaan oman näkemyksensä. Hän näkee *wicked*-problematiikan osana laajempaa pirstaloituneisuuden käsitettä. Kyseisellä käsitteellä hän tarkoittaa ilmiötä, *"joka vetää erilleen jotain, joka on potentiaalisesti kokonainen"* aiheuttaen näin *"pirstaloituneisuudesta johtuvaa kärsimystä"*. Conklinin määritelmän mukaan pirstaloituneisuus pitää sisällään ongelmien pirullisen luonteen sekä sosiaalisen ja joissakin määrin myös teknisen kompleksisuuden. Pirullisuudella määritelmässä tarkoitetaan ongelmien erityistä luonnetta. Ongelmat ovat tällöin pirullisia ongelmia, ja ne toimivat voimana, joka ajaa asioita kohti sirpaloituneisuutta.

Määritelmässä mukana oleva sosiaalinen kompleksisuus tarkoittaa puolestaan käsitteillä olevassa asiassa mukana olevia

eri toimijoita määrän sekä erilaisuuden suhteen. Luontaisesti sosiaalinen kompleksisuus ajaa suunnittelua ja päätöksentekoa kohti sirpaloituneisuutta.

Lisäksi Conklin puhuu vielä teknisestä kompleksisuudesta. Sirpaloituneisuuteen ajavana ongelma se ei ole yhtä merkittävä kuin asian pirullisuus tai sosiaalinen kompleksisuus, mutta sekin on kuitenkin potentiaalinen vaikuttaja sirpaloituneisuuteen. Esimerkiksi ongelman ratkaisussa tarvittavat eri teknologiat, niiden väliset vuorovaikutukset sekä tekniikan jatkuva kehittyminen voivat ajaa lisääntyvään sirpaloituneisuuteen.

Tieteellisessä kirjallisuudessa on myös esitetty monenlaisia samanlaisia käsitteitä kuin mitä *wicked*-problematiikka on tullut esittäneeksi (kts. esim. Ackoff 1974; King 1993). Osaltaan nämä muut käsitteet ovat tyyliltään samanlaisia kesyjen ja pirullisten ongelmien määritelmien kanssa. *Wicked*-problematiikan nähdään kuitenkin tarjoavan hieman radikaalimman ja kauemmaksi näkevän näkökulman muihin esitettyihin ajatusmalleihin verrattuna (esim. Conklin 2007: 4).

Wicked-problematiikalla on myös selkeät kytkökset kompleksisuustieteisiin. Kytköksistä huolimatta kyseisiä teemoja koskevat akateemiset julkaisut eivät kuitenkaan muutamia harvoja poikkeuksia lukuun ottamatta (esim. Watt & Willey 2005) tiedosta toisiaan[ii]. Käytännössä *wicked*-problematiikan mukaiset pirulliset ongelmat ovat kuitenkin osa kompleksisuustieteiden esittämää maailmankuvaa. Tämän vuoksi niiden käsittely yhdessä olisi erittäin tärkeää. Esimerkiksi **Jalonen** (2006) on jo käsitellyt kompleksisuusajattelua yhteiskuntatieteissä, jolloin tämä artikkeli keskittyy luomaan vastaavalla tavalla näkökulman *wicked*-problematiikkaan.

Jotkut voivat nähdä kompleksisuusajattelun tai *wicked*-problematiikan vain antavan jo aikaisemmin esitetyille asioille uusia nimiä. Vaikka asia olisikin näin, on se kuitenkin yksi käytettävissä oleva metodologinen työkalu. Ovathan kompleksisuusajattelun ja *wicked*-problematiikan sisällään pitämät käsitteet kuitenkin *rikkaita runollisia metaforia* kuten perhosefekti, outo attraktori tai pirullinen ongelma. Eli vaikka osittain olisikin totta, että vanhoja ideoita yritetään myydä uudella tapaa, niin fakta kuitenkin on se, että usein uusi kieli saa aikaa uusia luovia ideoita. (Begun, Zimmerman & Dooley 2003: 269.)

ii Tämä johtuu todennäköisesti siitä, että wicked-problematiikka liitetään usein systeemiteoriaan. Mutta jos nähdään Kingin (1993) tavoin, että pirullisen ongelmat ovat luonteeltaan emergenttejä (ongelmat ja niiden ratkaisut kehittyvät täysin uusilla arvaamattomilla tavoilla) sopivat ne paremmin kompleksisuustieteiden mu-kaiseen maailmankuvaan. Staceyn, Griffinin ja Shawnin (2000) mukaan kompleksisuustieteiden tulisi perustua ideaalisimmin muuntautuvaan teleologiaan. Muuntautuva teleologia (transformative teleology) näkee ke-hityksen kulkevan kohti tuntematonta tilaa. Tulevaisuus on tällöin jatkuvan rakentamisen kohteena ja täysin uuden syntyminen on mahdollista. Systeemiteorioissa täysin uuden syntymistä ei puolestaan nähtäisi tällä tapaa mahdolliseksi.

2. *Wicked*-problematiikan soveltaminen hallintotieteissä

Wicked-problematiikan mukaiset pirulliset ongelmat tuovat uuden ulottuvuuden hallintotieteellisen tutkimuksen avulla käsiteltäviin ongelmiin. Ne auttavat näkemään nämä erittäin kompleksiset ongelmat uudesta näkökulmasta. Kaikki hallintotieteen käsittelemät ongelmat eivät toki ole luonteeltaan pirullisia, mutta kaikista keskeisimmät ongelmat kuitenkin todennäköisesti olisivat erittäin lähellä sitä, mitä pirullisilla ongelmilla pyritään tarkoittamaan. Erityisesti laajat yleismaailmalliset ongelmat ovat lähes poikkeuksetta määriteltävissä pirullisiksi ongelmiksi. Masonin ja Mitroffin (1981: 5, 20) mukaan nämä kyseiset ongelmat ovat niin laajoja kokonaisuuksia, että "käytännössä jokainen yleismaailmallinen poliittinen ongelma on suhteessa kaikkiin muihin yleismaailmallisiin ongelmiin".

Esimerkkinä tällaisesta yleismaailmallisesta ongelmasta voisi olla esimerkiksi laajojen maailmanlaajuisten epidemioiden torjuminen. Myös useat suppeammat hallinnolliset ongelmat, kuten esimerkiksi eräiden terveydenhuollon toimipisteiden tai toimintojen lakkauttamiset, voivat erittäin todennäköisesti olla pirullisia ongelmia. Tämä todennäköisyys on erittäin suuri varsinkin silloin, kun käsitteillä olevasta asiasta ei ole mahdollista saada kaikkea mahdollista tietoa ja kun yksimielisyyttä valittavista toimenpiteistä ei ole olemassa (kts. taulukko 1).

Wicked-problematiikkaan perehtyneiden tutkijoiden mukaan tavanomaiset hallintotieteellisen tutkimuksen perinteet eivät ole yksinään päteviä ratkaisemaan pirullisia ongelmia. Esimerkiksi nykyaikaiset NPM- ja tulos- ja laatujohtamisen suuntaukset ovat osittain puutteellisia. Ne pyrkivät hallitsemaan jotakin, jota ei käytännössä voida hallita. Pirullisia ongelmia kun ei määritelmän mukaan voi täysin kontrolloida. Ne ovat yksinkertaisesti liian dynaamisia kokonaisuuksia ja vaativat tällöin osakseen täysin uudenlaista suhtautumista. Seuraavaksi käydään läpi *wicked*-problematiikan mahdollista antia hallintotieteellisen tutkimuksen sekä myös käytännön toiminnan kentille. Tarkastelu ei ole mikään kaikenkattava, mutta se antaa kuitenkin kuvan *wicked*-problematiikkaa käyttävien tutkijoiden maailmankuvasta.

Ackoff (1974: 22–31) jakaa suunnittelun eri näkökulmat neljään eri tyyppiin: epäaktivismiin, reaktivismiin, preaktivismiin sekä interaktivismiin. Kyseiset tyypit on esitelty lyhyesti taulu-

Taulukko 1.
Pirullisten ongelmien sijoittautuminen arvojen ja tiedontason perusteella. (Balint ym. 2006: 5; Committee of Scientists 1999: 131.)

	Yksimielisyys arvoista	
Tiedontaso	**Korkea**	**Matala**
Tarpeeksi tietoa	Rutiininomainen analyysi ja ajoittainen asianomaisten ja asiantuntijoiden tarkastus. *Päätökset helppoja, ongelmat kesyjä*	Asianomaisten pohdinta ja ajoittainen asiantuntijoiden tarkastus
Alustava/ aukkoja/ erimielisyyttä/ tutkimusta tarvitaan	Asiantuntijoiden pohdinta ja ajoittainen asianomaiset tarkastus.	Asiantuntijoiden ja asianomaisten pohdintaa. *Päätökset vaikeita, ongelmat pirullisia.*

kossa 2. *Wicked*-problematiikan mukaisen suunnittelun voidaan nähdä olevan lähinnä interaktivistista suunnittelutyyppiä. Ensinnäkin interaktivistit uskovat pelkän tulevaisuuden ennustamisen sijasta enemmän itse halutunkaltaisen tulevaisuuden rakentamiseen. Pelkkä selviytyminen tulevaisuudessa ei riitä, vaan interaktivistien mukaan tulisi pystyä aina parempaan. Vaikka interaktivistit ovatkin idealisteja, heidän tavoittelemansa ideaalit eivät kuitenkaan ole sinänsä pelkkää utopiaa, vaan välttämätön osa jatkuvaa kehitystä. Eli vaikka näitä ideaaleja ei ehkä voisikaan koskaan saavuttaa, ne kuitenkin luovat jotakin konkreettista mitä tavoitella. Ideaalipäämäärät kokevat myös muutoksia ajan edetessä, joten ne vaativat jatkuvaa uudelleen määrittelyä.

Interaktivistit näkevät muutoksen laajana kokonaisuutena. Siihen kuuluu tällöin paitsi itse systeemi kaikkine sen osineen, myös systeemin ympäristö, joka voi laajimmasta tapauksessa pitää sisällään koko maailman. Interaktivismin suhteen on aiheellista huomioida tilallisen ulottuvuuden lisäksi myös ajallinen ulottuvuus. Interaktivismissa myös ajallinen ulottuvuus on laajempi kuin muissa suunnittelutyypeissä eli interaktivistit pyrkivät luomaan katseensa mahdollisimman kauas tulevaisuuteen. Tämä siksi, että he uskovat lyhytaikaisten saavutusten aiheuttavan usein suurempia tappioita pidemmällä aikavälillä. Lyhyen aikavälin tappiot ovat sen sijaan interaktivistien mukaan hyväksyttäviä, koska ne ovat usein edellytys pitkäaikaiselle voitolle. Tällöin tasapainottelu eri aikavälien välillä on tarpeen. (Ackoff 1974: 28.)

Vaikka *wicked*-problematiikkaa käyttävistä tieteellisistä julkaisuista tulee helposti esiin kyynisyys siihen, ettei pirullisia ongelmia voi ratkaista eikä maailmaa hallita, ei tämä kuitenkaan ole mitään varsinaista epätoivoa. Pääosin ongelmien pirullisuuteen perehtyneet tutkijat näyttäytyvät nimittäin interaktivistien kaltaisina idealisteina, jotka uskovat parempaan tulevaisuuteen. Vaikka nämä tutkijat eivät käytännössä kannustakaan ennustamaan tulevaisuutta tai valmistautumaan tulevaisuutta varten, ei tämä viittaa kuitenkaan mitenkään kyynisyyteen. *Wicked*-problematiikan sekä kompleksisuusajattelun mukaisesti tarpeen on ennemminkin mahdollisuuksien luominen: luodaan mahdollisuuksia ja annetaan luovuuden ja innovaatioiden johtaa täysin uudenlaisiin emergentteihin ratkaisuihin ja lopputuloksiin. Tämä tulee muistaa, kun seuraavaksi käsitellään tarkemmin *wicked*-problematiikan piirteitä, joista asiaan perehtymätön voi saada osittain jopa kyynisenkin kuvan.

Pirullisista ongelmista ei voi selviytyä yksinkertaisin ratkaisuin. Ensinnäkään niitä ei voi niin sanotusti kesyttää eli niiden pirullista luonnetta ei voi poistaa esimerkiksi lyömällä lukkoon ongelman määritelmä keksimällä sellainen helppo ongelma, joka olisi myös helppo ratkaista. Pirullista ongelmaa ei voi myöskään ratkaista pelkästään opiskelun avulla. Mikään määrä opiskeluja kun ei voi varmistaa lopullista varmuutta pirullisen ongelman ratkaisusta. (Conklin 2005.)

Kokemuksen ja näyttöön perustuvaisuuden roolitkin ovat yksinään riittämättömiä. Muutos on tällöin niin nopeaa, että reagoiminen siihen pelkästään kokeilun ja erehdyksen kautta on liian hidas tapa vaikuttaa (Ackoff 1974: 5). Koska tulevaisuutta ei voi ennustaa, voi näyttökin parhaimmassa tapauksessa toimia vain ohjenuorana päätöksenteossa (Blackman ym. 2006: 71). Lisäksi pirullista ongelmaa ei voida ratkaista valitsemalla kokonaisongelmasta vain tietty osa-alue tai toisaalta pyrkimällä ratkaisemaan ongelmat ratkaisemalla ne inkrementaalisesti yksi kerrallaan (Churchman 1967: 141–142; Mechanic 2006).

Miksi pirullisia ongelmia ei sitten usein nähdä sellaisina? Voi olla, että loppujen lopuksi kysymys on yksinkertaisesti siitä, että pirulliset ongelmat ovat ihmisten tavanomaiselle ajattelulle vieraita. Toisin sanoen ne loukkaavat ihmisiä sillä ajatuksella, että niihin ei olisi olemassa mitään ratkaisua. Ihminen ei voisi siis voittaa ongelmaa. (King 1993: 112)

Vaikka pirullisia ongelmia ei voikaan sanan suoranaisessa merkityksessä ratkaista, ei niiden tarvitse kuitenkaan vaikuttaa mitenkään ylipääsemättömiltä. Eli vaikka emme pystyisikään

Taulukko 2.
Suunnittelun eri tyyppejä (Ackoff 1974: 22–31)

Suunnittelutyyppi	Ajatusmalli	Toimintatapa	Suunnittelun rooli
Epäaktivismi	"Asiat ovat nyt hyvin, eikä niitä tarvitse muuttaa"	Erinäisin tavoin pyritään estämään muutokset. Tuotetaan turhia dokumentteja varsinaisen toiminnan sijasta. Reagointi vain vakaviin uhkiin.	Eivät usko suunniteluun, eivätkä edes ongelmien ratkaisuun.
Reaktivismi	"Ennen kaikki oli paremmin"	Pyrkivät näkemään kompleksiset ongelmat helppoina ongelmina, joihin on olemassa helpot ratkaisut. Luottavat toiminnassaan kokemukseen, patenttiratkaisuihin.	Patenttiratkaisutyylistä ongelman ratkaisua, varsinaisen suunnittelun sijasta.
Preaktivismi	"Tulevaisuus tulee olemaan parempi kuin menneisyys tai nykyisyys. Tarpeen ennustaminen ja valmistautuminen"	Näkevät tulevaisuuden kontrolloimattomaksi, mutta uskovat pystyvänsä kontrolloimaan sen vaikutuksia. Suunnittelu pääosin loogisuuteen, tieteellisyyteen ja kokeiluun perustuvaa. Muutos pyritään saamaan aikaan systeemin sisällä. Ympäristössä oleviin muihin systeemeihin ei pyritä vaikuttamaan.	Suunnittelijoilla vastuu vain suunnitelman tekemisestä. Vastuu sen toteuttamisesta muilla. Suunnittelua tulevaisuutta varten.
Interaktivismi	"Tulevaisuus tulee olemaan parempi kuin menneisyys tai nykyisyys. Tarpeen uhkien estäminen ja mahdollisuuksien luominen"	Pyrkivät suunnitelmaan ja kontrolloimaan omaa kohtaloaan. Suunnittelu sekä positivismiin että hermeneutiikkaan perustuvaa. Muutos pyritään saamaan aikaan itse koko systeemissä ja sen ympäristössä.	Suunnittelun avulla rakennetaan uutta halutunkaltaista tulevaisuutta.

ratkaisemaan ongelmaa, on meidän kuitenkin aina mahdollista määritellä ongelma ja pyrkiä löytämään siihen enemmän tai vähemmän tehokas ratkaisu. (Pacanowsky 1995: 37.) Hookinsin (2005: 269) tavoin voidaan todeta, ettei pirullisia ongelmia voida käytännössä ratkaista lopullisesti, mutta niitä voidaan kuitenkin kehittää siedettävimmiksi. Fakta on tällöin se, että edessämme on uudenlaisia ongelmia. Kyseessä on kokonaan uusi peli, johon vanhat säännöt eivät toimi ja johon uusia sääntöjä ei ole vielä päätetty. (Wang 2002: 509.)

Miten pirullisiin ongelmiin ja yhä kompleksisemmaksi muuttuvaan maailmaan tulisi sitten suhtautua? Ensinnäkin jos haluamme saada pirullisiin ongelmiin tehokkaita ratkaisuja, tulee meidän muuttaa merkittävällä tavalla vakiintuneita toimintatapojamme. Tarvitaan uusia ongelmanratkaisutapoja, joiden voidaan nähdä olevan paitsi vaatimattomampia myös kunnianhimoisempia kuin aikaisemmat keinot. Ne eivät yritä löytää mitään yhtä täydellistä totuutta ja ovat siinä mielessä vaatimattomia. Kunnianhimoisuus ilmenee puolestaan uusien ongelmanratkaisutapojen vaativissa tavoitteissa. Ne eivät tällöin tarjoa mitään yhtä tiettyä ratkaisua, vaan pyrkivät enemmänkin toimimaan avustajina monimutkaisissa ratkaisuprosesseissa. (Rosenhead & Mingers 2002: 1–2.)

Van Bueren, Klijn ja Koppenjan (2003: 193) puolestaan käsittelevät pirullisiin ongelmiin liittyvää epävarmuutta. He jakavat tämän epävarmuuden kognitiiviseen, strategiseen sekä institutionaaliseen epävarmuuteen. Heidän mukaansa kognitiiviseen epävarmuuteen liittyy epätietoisuus itse ongelman luonteesta. Tällöin ei ole varmuutta siitä, että mikä esimerkiksi aiheuttaa ongelman ja kuinka sitä pitäisi lähteä ratkaisemaan.

Strateginen epävarmuus johtuu puolestaan pirullisten ongelmien ratkaisuprosessissa mukana olevien asianomaisten suuresta määrästä. Van Bueren, Klijn ja Koppenjan näkevät tämän epävarmuustekijäksi, koska suuri asianomaisten määrä voi johtaa helposti myös useisiin erilaisiin strategioihin, jotka puolestaan voivat saada aikaan pysähtyneisyyttä ja suoranaisia lukkiutuneita tilanteita sekä pahimmassa tapauksessa myös odottamattomia lopputuloksia. Kolmanneksi epävarmuustekijäksi Van Bueren, Klijn ja Koppenjan (emt. 193) määrittelevät vielä institutionaalisen epävarmuuden, jonka he näkevät olevan seurausta päätöksenteon monitasoisuudesta. Pirullisten ongelmien ratkaiseminen tapahtuu tällöin monella eri poliittisella sektorilla paikallisista ja kansallista sektoreista aina kansainvälisiin sektoreihin asti. Tämä tekee päätöksenteosta institutionaalisesti erittäin pirstoutunutta. Näiden kolmen epävarmuustekijöiden vuoksi van Bueren, Klijn ja Koppenjan näkevätkin asianomaisten välisen kanssakäymisen kehittämisen erittäin tärkeäksi tekijäksi pirullisia ongelmia koskevassa päätöksenteossa.

Muun muassa Roberts (2000), Clarke ja Stewart (2000), Grint (2005) sekä Balint ym. (2006) ovat käsitelleet erilaisia *selviytymisstrategioita* pirullisiin ongelmiin. Ensinnäkin Roberts (2000) pohtii kolmen eri selviytymisstrategian roolia pirullisten ongelmien ratkaisussa. Nämä strategiat ovat autoritaarinen, kilpailuhenkinen sekä yhteystyöhenkinen strategia. Sinänsä Robertsin valinta kutsua kyseisiä strategioita selviytymisstrategioiksi on aiheellista, koska pääasiassa pirullisiin ongelmiin ei kuitenkaan ole olemassa mitään lopullista ratkaisua. Sen sijaan pirullisista ongelmista on mahdollista selviytyä joko hyvin tai sitten vähemmän hyvin. Taulukossa 3 on esitetty keskeiset piirteet kustakin selviytymisstrategiasta.

Vaikka kussakin kolmessa strategiassa on hyvät ja huonot puolensa, käsittelee Roberts (2000) lähemmin erityisesti yhteistyöhenkistä selviytymisstrategiaa. Tällöin omien kokemustensa perusteella hän tuo esiin neljä erityistä havaintoa pirullisten ongelmien selviytymistavoista. Ensinnäkin yhteistyöhenkisen selviytymisstrategia edellyttää usein sitä, että *"siihen epäonnistutaan"*. Epäonnistumiset auktoritaarisissa sekä kilpailuhenkisissä strategioissa johtavat lopulta siis viimeiseen mahdolliseen ratkaisuun eli yhteistyöhön. Yhteistyön mahdollisesti suuret kustannuksetkin tuntuvat tällöin pieniltä muiden strategioiden epäonnistumisten aiheuttamien kustannusten myötä.

Taulukko 3.
Selviytymisstrategioita pirullisiin ongelmiin. Roberts (2000: 3–7)

Strategia	Käytettävissä silloin kun...	Käyttötarkoitus	Hyödyt	Haitat
Autoritaarinen	Valta keskittynyt muutamalle.	"Kesyttämisstrategia" eli vähennetään konfliktia antamalla päätösvalta muutamalle asianomaiselle.	Vähentää ongelman kompleksisuutta, nopeuttaa ratkaisuprosessia ja tekee siitä vähemmän kiistanalaisen sekä mahdollisesti tekee ratkaisuprosessista "asiantuntevamman" ja "objektiivisemman".	Valtaa hallussaan pitävät voivat olla väärässä. Heillä voi olla yksinään suppea näkemys asiasta. Vallan keskittyessä muutamalle, kansalaiset voivat loitontua yhä enemmän päätöksenteosta.
Kilpailuhenkinen	Valta laajasti jakautunutta. Kamppailua vallasta.	"Nollasummapeli". Voittaja määrittelee ongelman ja valitsee ratkaisun.	Kannustaa uusien ideoiden etsintään ja pitää vallan liikkeellä.	Voi äärimmillään johtaa väkivaltaan. Kuluttaa resursseja, jotka voisi käyttää varsinaiseen päätöksentekoon.
Yhteistyöhenkinen	Valta laajasti jakautunutta. Ei kilpailua.	"Win-Win-tilanne". Pyritään yhteistyön avulla ottamaan huomioon kaikkien etu.	Jakaa kustannukset, hyödyt ja riskit. "Yhteistyössä on voimaa".	Voi kasvattaa transaktiokustannuksia. Vaikeuttaa yksimielisyyteen pääsyä. Tarvitsee harjoittelua. Voi kasvavan erimielisyyden myötä vaikeuttaa päätöksen tekoa.

Toisekseen pirullisten ongelmien kesyttämiseen pitäisi suhtautua varoen, sillä jos päätöksentekoon osallistuu useita eri osallistujia, on ratkaisu käyttäen auktoritaarista selviytymisstrategiaa erittäin hankala saavuttaa. Naiivi usko siihen, että pirulliset ongelmat voi ratkaista yrittämällä kesyttää ne, johtaa käytännössä epäonnistumiseen.

Kolmanneksi Robertsin (2000: 13–15) kokemusten perusteella pirullisten ongelmien ratkaisun kannalta olisi oleellista saada kaikki asianomaiset mukaan yhteistyöhön. Kullakin asianomaisella on oma käsityksensä ongelmasta ja sen ratkaisusta, ja yhdistelemällä näitä näkemyksiä mahdollistuu yhteinen oppiminen. Selviytyminen pirullisista ongelmista mahdollistuu tämän oppimisen ja sen pohjalle rakennetun yhteisymmärryksen myötä.

Lisäksi yhteistyöhenkisen selviytymisstrategian olisi hyvä olla myös avoin itseorganisoitumiselle sekä yhteisevoluutiolle. Tämä Robertsin esittämä neljäs havainto korostaa sitä, että yhteistyömuodoille tulisi antaa vapaus kehittyä omillaan. Liialla valvonnalla ja rajoittamisella kun on tapana vähentää luovuutta ja täten vaikeuttaa ongelmanratkaisua. Lopuksi Roberts (emt. 16) painottaa vielä *uskon* tärkeyttä selviytymisessä pirullisista ongelmista yhteistyön kautta. Tällä uskolla hän tarkoittaa toivoa siihen, että on olemassa parempi tapa tehdä asioita, ja ymmärrystä siitä, että aina on kuitenkin mahdollista epäonnistua, ja halukkuutta kaikesta epävarmuudesta huolimatta luottaa valittuun ratkaisuun. Roberts (emt. 15) tiivistää tämän nöyryyttä vaativan prosessin *uskonaskeleeksi*".

Hieman vastaavalla tavalla kuin Roberts (2000), myös Grint (2005) tulee yhdistelleeksi eri ongelmatyyppejä eri strategioihin. Grintin näkökulma tarkastelulle on kuitenkin selviytymisstrategioiden sijaan varsinaisissa johtamisstrategioissa. Kyseiset ongelmat ja niihin liittyvät johtamistyypit esitetään taulukossa 4.

Johtajuus on ajan antaessa myöten loogisin tapa yrittää selviytyä pirullisista ongelmista. Grint (2005: 1475) tuo kuitenkin esiin yhden johtajuuteen liittyvän ironian. Tällä hän tarkoittaa sitä, että vaikka *leadership*-tyylinen johtajuus onkin nähtävissä pirullisten ongelmien *ratkaisemisen* suhteen tärkeäksi johtamistyyliksi, on se kuitenkin taulukossa 4 esitetyistä tyyleistä kaikkein vaikein. Lisäksi se on usein päätöksentekijöiden mielestä myös kaikista vältettävin vaihtoehto.

Kun johtajuuteen kuuluu esimerkiksi vastausten antamisesta sijasta kysymysten kysyminen, tämä voi päätöksentekijöiden mielestä johtaa heidän arvovaltansa alenemiseen äänestäjien silmissä. Lisäksi *leadership*-johtajuuden mukainen ratkaisutyyli voi johtaa pitkiin yhteistyöprosesseihin, jotka eivät kuitenkaan käytännössä anna mitään ihmeratkaisua. Poliitikoille kyseinen ratkaisutapa ei tällöin loogisesti ole mitenkään ihanteellinen.

Taulukko 4.
Eri johtamistapojen liittyminen ongelmatyyppeihin. (Grint 2005: 1472–1477).

Johtamistapa	Ongelma	Kuvaus
Command /komentaminen	"Kriittinen"	Toimintatapana vastausten antaminen. Ei ole aikaa johtajuudella. Tarve nopeasti antaa vastauksia olivat ne sitten hyviä tai huonoja.
Management /hallinnointi	"Kesy"	Toimintatapana prosessin organisointi. Ongelma on esimerkiksi toistunut ennenkin ja se ratkaistaan samalla rutiinilla kuin aikaisemmin.
Leadership /johtajuus	"Pirullinen"	Toimintatapana kysymysten kysyminen. Johtaja ei pysty yksinään antamaan vastauksia kysymyksiin, joten hän pyrkii etenemään yhteistyön avulla.

Taulukko 5.
Erilaisia tapoja yrittää selviytyä pirullisista ongelmista. (Balint ym. 2006).

Strategia	Kuvaus	Hyödyt	Haitat
"Varotoimi-periaate"	Ennen kuin pirullisten ongelmien ratkaisuun pyrkivä toimintastrategia toteutetaan, tulisi strategian puolestapuhujien todistaa, että strategia on turvallinen.	Keskittää huomion ratkaisun aiheuttamiin mahdollisiin pitkäaikaisvaikutuksiin, tahattomiin seurauksiin sekä mm. julkisen osallistumisen tärkeyteen.	Ei ota huomioon itse "varotoimiperiaatteen" aiheuttamia mahdollisia tahottomia seurauksia, on politisoitunut ja voi mm. laskea innovatiivisuutta.
Mukautuva hallinnointi	Hallinnointia toimintastrategioiden kokeilujen, evaluointien, sekä sopeuttamisien kautta eli "oppimista tekemällä".	Auttaa selvittämään tieteelliseen epävarmuuteen liittyviä kysymyksiä mm. pohtimalla eri strategioiden vaikutuksia.	Jättää huomioimatta sosiaaliset tekijät eli ei pysty esimerkiksi ratkaisemaan eri asianomaisten vastakkaisia arvoja.
Julkinen osallistuminen	Kansalaisten tai asianomaisten ottamista mukaan hallinnollisen toiminnan analysointiin, suunnitteluun, valintaan ja mahdollisesti myös toteuttamiseen.	Tuo luottamusta ja helpottaa yhteistä oppimista. Vähentää konflikteja ja mm. voimistaa demokratiaa.	Lisää resurssien kulutusta, pitkittää päätöksenteko, huonontaa päätöksen laatua ja mm. lisää väittelyä.
Oppiva verkosto	Yhdistää muiden strategioiden parhaat puolet. Pyrkii löytämään mahdollisimman paljon erilaisia ratkaisumalleja yhdistelemällä tieteellisiä metodeja ja asianomaisten preferenssejä.	Tuo esille asianomaisten näkemykset, jotka voidaan tieteellisin keinoin muokata eri ratkaisumalleiksi. Tällöin erilaisten mallien määrä todennäköisesti suurenee, ja todennäköisyys löytää malli, joka saisi laajaa hyväksyntää kasvaa.	(Loogisesti ajateltuna mm. kallista ja aikaavievää)

Grint (2005: 1478) muistuttaa myös siitä, että hänen näkökulmansa mukainen johtajuus johtaa helposti ongelmien monimutkaisuuden myötä kasvaneeseen epävarmuuteen ja sen myötä kansalaisten lisääntyneeseen osallistumiseen. Tämä puolestaan johtaa siihen, että päättäjät pyrkivät tietoisesti vähentämään epävarmuutta esimerkiksi nopeuttaakseen päätöksentekoprosesseja. Tällöin johtamistapa voi muuttua helposti *leadership*-tyylisestä johtajuudesta komentamiseen. Päättäjät näkevät siis väärin perustein ongelman kriittiseksi ja muuttavat johtamistyyliään sen mukaiseksi.

Erehtyminen luulemaan ongelmaa kesyksi pirullisen sijaan voi johtaa katastrofaalisiin lopputuloksiin. Voidaan esimerkiksi pohtia, miten olisi käynyt aikanaan Kuuban kriisissä, jos presidentti J.F. Kennedy olisi nähnyt silloisen ongelman kesynä pirullisen sijaan. Siinä missä Kennedyn sotilasavustajat näkivät ongelman kesynä ja vaativat tällöin pikaisia vastatoimia Kuubaa ja Neuvostoliittoa vastaan, näki presidentti Kennedy ongelman pirullisena ja pyrki siten ottamaan huomioon monet eri vaihtoehdot ja kysymään mahdollisemman paljon kysymyksiä. Koska Kennedy teki oikean ratkaisun pyrkimällä ratkaisemaan oikean ongelman, täytyy meidän tänä päivänä vain onneksi pohtia sitä, että olisiko tuon kriisin räjähtäminen johtanut kolmanteen maailmansotaan. (Grint 2005.)

Myös Balint ym. (2006) esittelevät erilaisia tapoja selviytyä pirullisista ongelmista. He esittävät kolme tällaista tapaa, mutta näkevät kuitenkin etteivät nämä kolme ratkaisutapaa edes yhdessäkään kuitenkaan riitä saamaan aikaan pirullisten ongelmien ratkaisuun vaadittavaa laajasti hyväksyttyä päätöksentekoprosessia. Tällöin *varotoimiperiaatteen* käyttö, mukautuva hallinnointi sekä julkinen osallistuminen eivät riittäisi, vaan lisäksi tarvittaisiin myös Balintin ym. kuvailemaa oppivaa verkostoa. Nämä neljä mahdollista pirullisten ongelmien käsittelytapaa esitetään taulukossa 5.

Clarken ja Stewartin (2000) ajatuksia käyttämällä voidaan tiivistää pirullisista ongelmista selviytymiseen tarvittavat näkökulmat. Ensinnäkin he painottavat sitä, että kyseinen selviytyminen vaatii lineaarisen tai vaillinaisen ajattelun sijasta holistista ajattelua. Toisekseen pirullisista ongelmista selviytymisen kannalta olisi tärkeää ajatella ja työskennellä yli organisaatioiden sisäisten että ulkoisten rajojen. Kolmanneksi kansalaisten sisällyttäminen selvitysprosessiin olisi myös tärkeää. Pohjimmiltaan kyse on kuitenkin pääasiassa siitä, että erittäin olennaista selviytymisessä pirullisista ongelmista on kannustaa ihmisiä ajattelemaan ja työskentelemään uusilla tavoilla.

3. *Wicked*-problematiikka erityisesti terveydenhuollon hallinnossa

Voidaan väittää, että terveydenhuollossa oikeastaan yksikään asia ei ole yksinkertainen (Glouberman 2006). Glouberman ja Zimmerman (2002) jakavatkin terveydenhuollon ongelmat yksinkertaisiin, monimutkaisiin ja kompleksisiin ongelmiin. Helpoimmillaankin terveydenhuollon ongelmat ovat usein vähintään monimutkaisia, toisin sanoen sotkuja. Kompleksiset ongelmat ovat tällöin lähellä sitä, mitä pirullisilla ongelmilla pyritään tarkoittamaan. Glouberman ja Zimmerman (2002: 2) väittävät tällöin, että *"monet terveydenhuollon asiantuntijat kuvailevat kompleksisia ongelmia implisiittisesti monimutkaisina ongelmina ja siten käyttävät ratkaisuja, jotka ovat uskollisia rationaalisille suunnittelutavoille. Nämä johtavat usein sopimattomiin ratkaisuihin, koska ne laiminlyövät monia kompleksisuuden näkökulmia"*.

Myös Van Wyk (2003:141–143) on vahvasti sitä mieltä, että asennemuutoksella sen suhteen, miten terveydenhuollon suunnittelijat näkevät terveydenhuollon, olisi mahdollisesti positiivinen vaikutus terveydenhuollon suunnittelulle tulevaisuudessa. Aikaisempia ja nykyisiä terveydenhuollon epäonnistumisia hän selittää suunnittelijoiden epäonnistumisella silloin, kun olisi pitänyt ottaa huomioon terveydenhuollon systeemien kompleksisuus. Erityisesti tarkastelu kokonaisuuden kannalta on ollut hänen mukaansa puutteellista. Van Wyk (2003: 141) kirjoittaakin, että *"jokainen suunniteltu väliintulo, joka ei ota huomioon ongelmatilannetta kokonaisuudessaan tulee todennäköisesti parhaimmassakin tapauksessa vain lykkäämään vääjäämätöntä ja huonoimmassa tapauksessa vaikeuttamaan tilannetta vain entisestään"*.

Vartiainen (2005) kirjoittaa *wicked*-problematiikasta puolestaan terveydenhuollon reformien näkökulmasta. Hän näkee tällöin suurimman osan terveydenhuollon ongelmista olevan luonteeltaan pirullisia. Hän kuitenkin toteaa (emt. 175), että vielä tällä hetkellä *wicked*-problematiikan olemassaolon tiedostaminen on suhteellisen matalaa. Reformien suunnittelua ja toteutusta hallitsee tällöin pääasiassa traditionaalinen ajattelu, joka näkee terveydenhuollon ongelmat kesyinä, vaikka ne todellisuudessa ovatkin pirullisia.

Vartiainen näkee kolme syytä vallitsevalle traditionaalisen ajattelun dominanssille. Ensinnäkin terveydenhuollon ongelmat nähdään yksittäisinä, jollöin niitä yritetään ratkaista myös yksittäisinä tapauksina. Terveydenhuollon ongelmat ovat kuitenkin usein osa isompaa kokonaisuutta, jolloin ratkaisun pitäisi tapahtua kokonaisuutena.

Toisekseen ongelmana on se, etteivät päätöksentekijät, tutkijat ja poliitikot ole halunneet nähdä ongelmien todellista kompleksisuutta. Suurin osa heistä kuvittelee edelleen, että tämän päivän laajat terveydenhuollon ongelmat voidaan ratkaista kuten mitkä tahansa muutkin ongelmat. Kolmanneksi syyksi Vartiainen mainitsee vielä toimijoiden halun käyttää lineaarisia ongelmanratkaisumetodeja monimutkaisempien sijaan. Lineaarisissa metodeissa on omat houkuttimensa eli ne on helppo toteuttaa ja niillä saadaan aikaa nopeita ratkaisuja. Hyöty jää useimmiten kuitenkin erittäin lyhytaikaiseksi.

Seuraavaksi käydään esimerkinomaisesti läpi eräitä terveydenhuollon pirullisia ongelmia. Ensimmäinen käsiteltävä aihe on akuutti sairaus suhteessa krooniseen sairauteen (kts. esim. Brown 2006; Martinez-Lavin, Infante & Lerma 2007). Akuutti sairaus voidaan tällöin nähdä kesyksi ongelmaksi. Esimerkiksi katkenneen raajan suhteen ongelman määrittely sekä ratkaisu ovat yksinkertaisia. Asiantuntijuutensa avulla lääkäri pystyy näkemään, mikä on ongelmana. Sen jälkeen hän voi toimia koulutuksensa mukaisin opein ja hoitaa ongelman.

Krooninen sairaus on kuitenkin paljon kompleksisempi ongelma. Se koostuu monesta keskenään vuorovaikutuksessa olevasta tekijästä kuten elämäntavasta ja sosiaalisesta ympäristöstä. Ongelmaa ei tällöin ratkaista vain keskittymällä yhteen näistä ongelmista. (Brown 2006.) Fibromyalgia eli krooninen kiputila on esimerkki tällaisesta erittäin kompleksisesta kroonisesta sairaudesta. Ei ole selvää, mikä sen aiheuttaa ja kuinka sitä tulisi hoitaa (Martinez-Lavin, Infante & Lerma 2007).

Toinen erinomainen esimerkki terveydenhuollon pirullisesta

ongelmasta on hoitojonojen lyhentäminen. Ongelman korkeasta pirullisuuden tai kompleksisuuden tasosta ei ole epäselvyyttä ja kyseinen ongelma nähdäänkin lähes ideaaliseksi esimerkiksi erittäin pirullisesta tai kompleksisesta ongelmasta:

> *"The demand as well as the supply side are constantly influenced by a great number of factors which at the same influence each other mutually and this not always in a linear manner: the need for care or cure, the population structure, epidemiological factors, the way the insurance companies assess future needs, the number of personnel, the efficiency of the cure and care process, changes in the emancipation of citizens, the situation on the labor market, technological developments in the medical sector, existing capacities for child care, etc. But not only is a single waiting list influenced by such factors, other waiting lists (which are on their turn also influenced by a large number of factors) also influence the length of the waiting list..."* (Kenis 2006, 294)

Käytännössä ei ole edes varmuutta siitä, onko hoitojonojen olemassaolo edes se varsinainen ongelma. Toisin sanoen jos ongelma laajassa viitekehyksessä on ihmisten huono terveydentila, niin voi pohtia, auttaako siihen hoitojonojen lyhentäminen vai onko jokin muu tapa merkittävämpi. Lantz, Lichtenstein ja Pollack (2007) esittävätkin, että rajoittunut hoitoon pääsy ei välttämättä ole varsinainen ongelma esimerkiksi sosiaaliseen epätasa-arvoisuuteen tai eri ryhmien väliseen terveydelliseen haavoittuvuuteen. Heidän mukaansa terveydenhuollon pitäisi pyrkiä enemmän vain ihmisten terveydentilojen *hienosäätöön*, jolloin terveydenhuolto olisi vain yksi monista terveyteen vaikuttavista eri tekijöistä. Eli ehkä hoitojonojen olemassaolo on vain osa laajempaa pirullista ongelmaa, jolloin pelkästään hoitojonoihin – tässä viittaan hoitotakuuseen – keskittyminen vain käytännössä pahentaisi ongelmaa.

Kasvavaan ihmisten ylipainoisuuteen vaikuttaminen on myös pirullinen ongelma. Tällöin voidaan puhua jopa *ylipaino-epidemiasta*. Kuinka terveydenhuollon ja muiden tahojen tulisi reagoida tähän kasvavaan ongelmaan? Mikä itse asiassa on edes se varsinainen ongelma? Onko ongelma se, että ihmiset ovat ylipainoisia vai se, että he ovat huonokuntoisia? Nämä kaksi asiaa kun eivät kuitenkaan ole suoraan verrannollisia. Ylipainoinen, mutta paljon liikkuva ihminen voi nimittäin olla terveydentilaltaan hyvässä kunnossa. Entä millainen olisi sitten ratkaisu kyseiseen ongelmaan? Esitettyjä vaihtoehtoja ovat esimerkiksi olleet terveydelle haitallisten tuotteiden verotuksen korottaminen ja mainostuksen kieltäminen. Nämä ovat kuitenkin vain yksinkertaisia ratkaisuja erittäin kompleksiseen ongelmaan. Eagle ym. (2004) ovat todenneet, että *"ne jotka etsivät täydellistä suunnitelmaa varmaan ja onnistuneeseen ylipaino-ongelman ratkaisuun, tulevat pettymään. Ei ole olemassa mitään yhtä yksinkertaista ratkaisua. Ongelma on kompleksinen, moniulotteinen ja heikosti ymmärretty."*

Yksi mielenkiintoinen *wicked*-problematiikkaakin avaava esimerkki löytyy vielä terveydenhuollon rakenteellisista muutoksista kompleksisuusajattelun näkökulmasta. Zimmerman ja Dooley (2001) puhuvat tällöin yhteenliittymisistä eli englanniksi *merger* ja ilmaantumisista eli englanniksi *emerger*. Näistä kahdesta yhteenliittymiset kahden tai useamman terveydenhuollon toimijan yhteenliittymisenä ovat yksinkertaisia ratkaisuja erittäin kompleksisiin terveydenhuollon ongelmiin. Niiden vika on se, että ne eivät käytännössä muuta mitään eli ne vain säilyttävät vallitsevan tilanteen. Ideana tässä on se, että todennäköisesti kaikista kompleksisimpia terveydenhuollon ongelmia ei pystytä enää ratkaisemaan terveydenhuollon sisällä (kts. esim. Lalonde 1974; Illich 1975).

Yhteenliittymien sijaan tarvitaan ilmaantumisia. Näillä Zimmerman ja Dooley (2001) tarkoittavat *"kahden tai useamman organisaation yhteen tulemista tarkoituksena antaa synergian kehittyä luonnollisesti ajan kuluessa"*. Sen sijaan, että yhteenliittymä olisi tarkkaan suunniteltua ylhäältä päin, annetaan ilmaantumisissa ennemminkin tilaa luonnolliselle itseorganisoitumiselle. Lisäksi siinä missä yhteenliittymisissä liittyy yhteen erittäin samankaltaisia toimijoita, ilmaantumisissa moninaisuus on huomattavasti rikkaampaa. Kun yhteen liittyy tällä tapaa muitakin organisaatioita kuin pelkkiä terveydenhuollon toimijoita, mahdollistuu näin terveydenhuollon nykyisten vallitsevien olettamusten kyseenalaistaminen. Ehkä asioiden ei tarvitse siis olla terveydenhuollossa niin kuin ne ovat aina olleet.

Edellä esitetyn kaltainen ajattelu on todennäköisesti terveydenhuollon johtajia kiinnostavaa. Zimmerman, Lindberg ja Plsek (2001, 3–4) näkevät kaksi eri tekijää vastaukseksi siihen, miksi terveydenhuollon johtajat ovat kiinnostuneet kompleksisuusajattelun (ja siten myös *wicked*-problematiikan) mahdollisuuksista siihen tutustuttuaan. Ensimmäinen näistä tekijöistä on turhautuminen. Terveydenhuollon johtajat ovat tällöin turhautuneita traditionaalisiin hallinnollisiin metodeihin, eivätkä he enää usko saavansa niillä aikaan tarpeeksi. Osittain he ovat siis menettäneet uskonsa muun muassa strategisiin suunnitelmiin, koska loppujen lopuksi ne vain harvoin toteutuvat sellaisina kuin ne on suunniteltu. Kompleksisuusajattelu tarjoaa johtajille tällöin uudenlaista näkökulmaa. Näkökulmaa jonka mukaan kaikkea ei ole edes mahdollistakaan hallita.

Toinen Zimmermanin, Lindbergin ja Plsek (emt.) mainitsemista tekijöistä on resonanssi. Resonanssin myötä kompleksisuusajattelu tarjoaa kielen ja mallit sille, mitä monet terveydenhuollon johtajat jo intuitiivisesti tulevat tehneeksi. Näin he saavat intuitionsa taustalle myös tieteellistä ajattelua, joka puolestaan vahvistaa ja tuo perusteita heidän omalle intuitiolleen. Joku muukin on siis ajatellut kuin he, eivätkä he ole tällöin enää yksin omien ideoidensa kanssa.

4. Yhteenveto

Terveydenhuoltoa odottavat tulevaisuudessa yhä kompleksisemmiksi muuttuvat ongelmat. Väestön keski-ikä nousee, teknologia kehittyy ja esimerkiksi krooniset sairaudet lisääntyvät. Teknologian kehittymisen myötä yhä useampia sairauksia voidaan parantaa. Ongelmaksi tulee tällöin kuitenkin se, että hoito tulee todennäköisesti olemaan kallista, eikä sitä siten voida antaa kaikille. Kuinka hoidonsaajat tulisi sitten priorisoida? Nämä ovat vain joitakin esimerkkejä terveydenhuoltoa tulevaisuudessa odottavista merkittävistä ongelmista, mutta jo nekin viittaavat siihen, että tulevaisuus ei tule olemaan terveydenhuollolle helppo.

Tässä artikkelissa on tarkasteltu *wicked*-problematiikkaa ja sen mahdollista antia terveydenhuollolle ja sen hallinnolle. Ottaen huomioon terveydenhuollon kentän jatkuva kompleksistuminen, on *wicked*-problematiikan huomioiminen hyödyllistä. Jo pelkkänä metaforana sen on mahdollista saada ihmiset näkemään ongelmien luonne uudesta näkökulmasta. Laajempana kokonaisuutena ja varsinkin yhdistettynä kompleksisuusajatteluun *wicked*-problematiikka voi saada aikaan

myös jopa paradigman muutoksen kohti uudenlaista ajattelua.

Wicked-problematiikka puhuu pirullisista ongelmista. Esimerkiksi suurin osa terveydenhuollossa kohtaamistamme ongelmista on luonteeltaan juurikin pirullisia. Niitä on tällöin erittäin vaikea määritellä saati sitten ratkaista. Pirulliset ongelmat ovat divergenttejä. Niistä on tällöin erittäin vaikea saada aikaan yksimielisyyttä. Pirulliset ongelmat ovat luonteeltaan myös emergenttejä. Tällä tarkoitetaan sitä, että pirulliset ongelmat ja niiden ratkaisut kehittyvät käytännössä yllätyksinä eli täysin uudenlaisina odottamattomina lopputuloksina. Tämän mukaisesti pirullisten ongelmien kehityksestä ei koskaan voi olla varmuutta. Kaikkia mahdollisia kehitykseen vaikuttavia tekijöitä on mahdotonta ottaa huomioon.

Jos edellä mainittu pitää paikkansa, voidaan päätyä seuraavanlaiseen johtopäätökseen: Kesyt ongelmat ovat konvergenttejä ongelmia ja ne voidaan käytännössä ratkaista ottamatta huomioon muita vastaavia ongelmia. Niin sanotut sotkut ovat myös konvergentteja ongelmia, mutta niitä ei voida ratkaista huomioimatta muita ongelmia. Pirulliset ongelmat ovat puolestaan divergenttejä ja emergenttejä. (kts. esim. King 1993.) Tällöin kesyt ongelmat voidaan ratkaista vallitsevan lineaarisen ja reduktionistisen newtonilaisen ajattelun mukaisesti. Sotkut tarvitsevat puolestaan osakseen systeemiteoreettista lähestymistapaa. Systeemiteoreettinen näkökulma ei kuitenkaan ota huomioon emergenssiä eli asioiden kehittymistä niin, että syntyy täysin uudenlaisia odottamattomina lopputuloksia. Tämän vuoksi pirullisten ongelmien parempi ymmärtäminen edellyttäisi kompleksisuusajattelun näkökulmaa.

Mitä käytännön hyötyä *wicked*-problematiikasta voisi olla terveydenhuollon johtajille ja suunnittelijoille? Ensinnäkin *wicked*-problematiikkaa voisi käyttää hyväksi terveydenhuollon ongelmien paremmassa ymmärtämisessä. Carl Jungin (1875–1961) ajatuksia käsillä olevaan teemaan soveltaen voidaan todeta, että vaikka tämä ymmärrys ei ehkä ratkaisisikaan pirullisia ongelmia, on siitä kuitenkin ehdotonta hyötyä sikäli, että pystytään tulemaan toimeen ymmärrettävissä olevan tietämättömyyden kanssa. Toisin sanoen *wicked*-problematiikka auttaisi ymmärtämään sen, että kaikkia ei ole edes mahdollista ymmärtää.

Jos tämä hyväksyttäisiin faktana, muuttaisi se merkittävästi terveydenhuollon hallinnon työtä. Johtamistapa muuttuisi tällöin Grintin (2005) määrittelemästä hallinnoinnista kohti varsinaista johtamista. Johtaja myötäisi tällöin, ettei hän tiedä kaikkea ja ettei hän myöskään pystyisi pitämään kaikkia asioita kontrollissaan. Sen sijaan, että johtaja näkisi nämä heikkoutena, hän pikemmin hyväksyisi tilanteen ja muuttaisi sen edukseen. Johtaja pyrkisi tällöin luomaan ympäristön, jossa olisi tilaa luovuudelle, innovaatioille, itseorganisoitumiselle sekä emergenssille. Tiivistetysti ilmaistuna sen sijaan että johtaja pyrkisi ennustamaan tulevaisuutta ja pyrkimään kontrolloimaan sitä, hän ottaisi tavoitteekseen ennemminkin mahdollisuuksien luomisen. Toisin sanoen asioilla on tapana järjestyä, kun niille vain annetaan tilaisuus järjestyä.

Tämä artikkeli jää käsitteelliseksi tarkasteluksi *wicked*-problematiikan teemaan. Laajempi tieteellinen tarkastelu tulee tapahtumaan myöhemmissä julkaisuissa. Jo tällaisena suppeana tarkastelunakin *wicked*-problematiikka avaa ovia uudenlaiseen ajatteluun ja varsinkin uudentyyppiseen maailmankuvaan. Maailmasta on väistämättä tulossa kompleksisempi, jolloin kaikki mahdollinen tätä kompleksisuutta ymmärtämään auttava ajattelu on tervetullutta. *Wicked*-problematiikka toimii toivottavasti yhtenä tällaisena ymmärrystä lisäävänä ajattelumallina.

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Pirulliset ongelmat terveydenhuollossa – esimerkkeinä Kansallinen terveyshanke ja hoitotakuu-uudistus

Harri Raisio

Kansallisen terveyshankkeen (2001–2007) synnyn taustalla oli huoli kasvavista ongelmista terveydenhuollon toimintaedellytyksissä ja palvelujen saatavuudessa (STM 2002a, 3). Erityisesti hoitojonot olivat venyneet huolestuttavan pitkiksi. Terveyshankkeeseen kuuluneen hoitotakuu-uudistuksen tarkoituksena oli jonojen lyhentäminen ja vakauttaminen. Maailma on kuitenkin avoin ja dynaaminen kompleksinen järjestelmä. Kaikki ei aina mene niin kuin on ajateltu.

Kansallinen terveyshanke ja hoitotakuu-uudistus olivat mekanistisia ratkaisuyrityksiä julkisen sektorin tehokkuuden ongelmaan. Tässä artikkelissa tarkastelen julkisen sektorin tehokkuutta monitulkintaisena ongelmana hankkeiden muodostaman kehyksen läpi. Ongelma ei ole yksitulkintainen edes rajattuna pelkkään hoitojonojen lyhentämiseen. Jonoja ei lyhennetä suljetussa tilassa, eikä lyhentämisen vaikutuksia voida rajata ainoastaan hoitoon pääsemiseen. Kansallista terveyshanketta ja hoitotakuu-uudistusta tarkastelemalla havainnollistan terveydenhuollon monitulkintaisuutta.

Käsittelen monitulkintaisuutta niin sanotun wicked-problematiikan eli pirullisten ongelmien näkökulmasta. Joskus pirullisista ongelmista käytetään myös suomennosta "ilkeä ongelma" (Sotarauta 1996, 118). Näissä ongelmissa monitulkintaisuus on tärkeä elementti. Wicked-problematiikka voi tarjota hieman radikaalimman ja kauemmaksi ulottuvan näkökulman kuin muut samankaltaiset ajatusmallit (esim. Conklin 2007, 4). Toisaalta on tarpeen myöntää, että monitulkintaisuuden käsitteellä on vahvemmat teoreettiset juuret kuin pirullisilla ongelmilla. Vaikka tämä problematiikka sai syntynsä jo 1960-luvun loppupuolella, sen käsittely on lisääntynyt vasta viime vuosina. Ajattelutapojen samankaltaisuuksista huolimatta on muistettava, että samojen asioiden esittäminen uusissa ulkoasuissa on yksi metodologinen työkalu; toisin sanoen uudenlainen kieli saa aikaa uusia luovia ideoita (Begun ym. 2003, 269).

Artikkelin näkökulma Kansalliseen terveyshankkeeseen ja hoitotakuu-uudistukseen perustuu terveydenhuollon reformin ideaalimalliin (ks. Raisio 2007), joka puolestaan pohjautuu kompleksista maailmankuvaa tukeviin tieteisiin. Joskus kompleksisuus- ja kaaosajattelun monista eri teorioista käytetään nimitystä "uudet" tieteet (Murray 2003). "Uusien" ja "vanhojen" tieteiden ero

hahmottuu esimerkiksi teleologian eli asioiden tarkoitusperäisyyttä käsittelevän filosofisen opin kautta. Kärjistettynä vanhat tieteet perustuvat sekulaarisen luonnonlain teleologiaan. Tulevaisuus on tällöin vain vanhan toistoa, eikä täysin uuden syntyminen ole mahdollista. Uudet tieteet perustuvat ihanteellisimmin muuntautuvaan teleologiaan: tulevaisuutta rakennetaan jatkuvasti ja täysin uuden syntyminen on mahdollista. (Stacey ym. 2000.) Toisin sanoen vanhoissa tieteissä ajattelumalli on lineaarinen, ja maailma nähdään newtonilaisen ajattelun mukaisesti koneistona. Uusissa tieteissä ajattelumalli on epälineaarinen ja maailma avoin ja dynaaminen. Esimerkkejä kompleksista maailmankuvaa tukevista tieteistä ovat kompleksisuusajattelu, wicked-problematiikka sekä tarkoituksellisen muutoksen teoria ICT (Intentional Change Theory).

Monitulkintaisuuden ja pirullisten ongelmien yhdistämisen lisäksi tämän artikkelin tarkoituksena on lisätä keskustelua hallintotieteellisen paradigman muutoksesta poispäin vallitsevasta, newtonilaisesta hallintaa painottavasta ajattelumallista. Uutta paradigmaa kuvaavaksi esimerkiksi olen valinnut viime aikoina eniten keskustelua herättäneen terveydenhuollon reformikokonaisuuden. Kansallisen terveyshankkeen ja erityisesti hoitotakuu-uudistuksen esimerkit havainnollistavat, kuinka vaikeaa terveydenhuollon uudistusten on todellisuudessa päästä niille asetettuihin tavoitteisiin.

Hoitojonojen lyhentämiseen tähtääviä uudistuksia pidetään yleensä tyyppiesimerkkeinä erittäin kompleksisista ongelmista, joten juuri hoitotakuu-uudistuksen käyttö esimerkkinä on perusteltua. Tässä artikkelissa oletuksena on, että julkishallinnon toimet hoitojonojen lyhentämiseksi epäonnistuvat usein (ks. esim. Kenis 2006). Tämän oletuksen pohjalta tarkastelen ongelmanasettelun ja -ratkaisun kompleksisuutta terveydenhuollossa sekä testaan terveydenhuollon reformin ihannemallin soveltuvuutta terveydenhuollon uudistamiseen.

Artikkeli perustuu saatavilla olevaan Kansallista terveyshanketta koskevaan aineistoon kuten suunnitteluasiakirjoihin, selvityksiin ja seurantaraportteihin, siis pääasiassa viranomaisdokumentteihin. Itsenäisiä tieteellisiä julkaisuja Kansallisen terveyshankkeen suunnittelusta ja toteutumisesta ei ole paljon. Koska viranomaisdokumenteissa on havaittu puutteita (ks. esim. VTV 2008), niiden objektiivisuuteen ei voida täysin luottaa. Kaikki aiheesta käyty keskustelu ei myöskään päädy dokumentteihin, joten aineiston perusteella on hankala tehdä johtopäätöksiä tietyistä tässä käsitellyistä asioista. Näitä epäkohtia korjaa tutkimus, jossa samaa aihetta tarkastellaan haastatteluaineiston perusteella (Raisio 2009).

Luon aluksi katsauksen ongelmien eri tasoihin. Sen jälkeen esittelen terveydenhuollon reformin ideaalimallin ja vertaan Kansallista terveyshanketta ja hoitotakuu-uudistusta tähän malliin. Lopuksi esitän kokoavia johtopäätöksiä.

Kesystä pirulliseen ongelmaan

Ongelmat voidaan jakaa kolmeen tasoon niiden kompleksisuuden mukaan (Rittel & Webber 1973). Kesyt ongelmat ovat kompleksisuudeltaan yksinkertaisimpia, konvergentteja eli yhtenäiseen näkemykseen johtavia ja yksitulkintaisia. Ongelman ratkaisusta saati määrittelystä ei ole suurta epäselvyyttä: oikea ja kaikkien hyväksymä ratkaisu on helppo löytää. Sotkuiset ongelmat ovat kompleksisuudeltaan keskitasoa. Ne ovat edelleen konvergentteja ongelmia, mutta kompleksisuutta lisää eri tekijöiden keskinäinen vuorovaikutus. Siinä missä kesy ongelma voidaan ratkaista irrallaan muista ongelmista, sotkun ratkaiseminen vaatii eri tekijöiden vuorovaikutussuhteiden tarkastelua. (King 1993.)

Useista terveydenhuollon ongelmista on tullut niin kompleksisia, ettei niitä voida ratkaista yksinkertaisin toimenpitein (ks. Raisio 2008). Ne ovat pirullisia eli kaikkein kompleksisimpia ongelmia. Niihin ei ole löydettävissä yhtä ainoaa oikeaa ratkaisua saati määritelmää. Mitä enemmän niitä tutkitaan, sitä enemmän mielipiteet niistä erkaantuvat toisistaan. Pirulliset ongelmat ovat siis monitulkintaisia ja divergenttejä. Niissä on samankaltaisia piirteitä kuin inhimillisessä kanssakäymisessä: sosiaalis-poliittisia ja erityisesti moraalis-eettisiä piirteitä. Nämä ovat tärkeitä tekijöitä, jotka erottavat pirulliset ongelmat muuntasoisista ongelmista. (King 1993.)

Pirullisten ongelmien taustalla on oletus, että muuttuvassa maailmassa tullaan väistämättä kohtaamaan yhä monimutkaisemmiksi muuttuvia ongelmia (Rittel & Webber 1973). Vallitsevat lineaariset ja reduktionistiset ongelmanratkaisutavat eivät yksinään riitä ratkaisemaan niitä. Kun lineaarisesta ja reduktionistisesta ajattelusta siirrytään kohti epälineaarista ja kokonaisvaltaista ajattelua, ongelmien luonne voidaan nähdä uudella tavalla. (Rittel 1972; Conklin 2005.) Tämä uudenlainen ymmärtäminen on tärkeää, jotta pirullisista ongelmista voitaisiin selviytyä.

Pirullisten ongelmien suhde monitulkintaisuuteen

Monitulkintaisuuden käsitteeseen sisältyy oletus ihmisten ajattelutapojen epätäydellisyydestä ja moninaisuudesta (ks. Vakkurin ensimmäinen artikkeli tässä teoksessa). Tämä on näkökulmana myös wicked-problematiikassa. Yksi pirullisten ongelmien piirre on, että ongelmaan sisältyvät epäjohdonmukaisuudet voidaan selittää monella tavalla, ja selityksen valinta määrää, miten ongelma ratkaistaan (Rittel & Webber 1973, 166).

Monitulkintaisuus on siis keskeinen osa pirullisia ongelmia. Ensinnäkään pirullisen ongelman lopullista ja oikeaa määritelmää ei voida esittää yksiselitteisesti. Toiseksi ongelman "lopullinen ratkaisu" ei ole yksiselitteinen. Ei ole mitään varmuutta, että ratkaisu olisi pysyvä ja ettei sitä voitaisi enää parantaa. Kolmanneksi ratkaisun arvostelu ei ole yksiselitteinen. Toiselle ratkaisu voi olla hyvä, toiselle huono, jollekin muulle välttävä. Ratkaisun arviointikaan ei

ole yksiselitteistä. Pirullisten ongelmien ratkaisujen vaikutusten jatkumo on ääretön sekä ajallisesti että tilallisesti. (Rittel & Webber 1973.)

Monitulkintaisuuden käsitteellä ja wicked-problematiikalla on kuitenkin myös eroja. Wicked-problematiikka jakaa ongelmien ratkaisutavat jyrkemmin eri kategorioihin. Lisäksi siinä annetaan enemmän painoa ongelman ymmärtämiselle kuin sen ratkaisutavalle ja painotetaan, että pirullisiin ongelmiin ei itse asiassa ole olemassa ratkaisua. (Conklin 2007, 4.)

Terveydenhuollon reformin ideaalimalli

Kompleksista maailmankuvaa tukevat tieteet luovat vallitsevasta paradigmasta eroavan kuvan siitä, miten terveydenhuoltoa tulisi ihanteellisimmin uudistaa. Oletuksena on, että vain harvat viime vuosina toteutetut reformit vastaavat tätä ideaalia. Useimmat uudistukset onkin toteutettu 1700-luvulta lähtöisin olevan newtonilaisen ajatusmallin mukaan. Tällöin maailma nähdään deterministisenä suljettuna systeeminä. Todellisuudessa maailma on avoin, dynaaminen ja kompleksinen systeemi, jota ei voida koskaan täysin hallita. (Morçöl 2005, 4.) Reformien suunnittelussa ja toteutuksessa ei ole otettu tarpeeksi huomioon ongelmien kompleksisuutta (Vartiainen 2005). Jos ongelmien pirullinen luonne huomioitaisiin paremmin, uudistukset myös onnistuisivat paremmin. Terveydenhuollon reformin ideaalimalli (ks. Raisio 2007) pyrkii vastaamaan näkemystä maailmasta avoimena ja dynaamisena systeeminä.

Ideaalimalli perustuu terveydenhuollon reformin määritelmään, joka on kehitetty Harvardin yliopiston DDM-projektissa (Data for Decision Making Project). Tämä määritelmä sekä ideaalimallissa käytetyt teoriat tukevat toisiaan, jolloin määritelmän valinta on perusteltu. Terveydenhuollon reformi on "vakaa, tarkoituksellinen ja fundamentaalinen muutos" (Berman 1995). Terveydenhuollon reformin ideaalimalli rakentuu näiden kolmen käsitteen ympärille. Kullakin on oma, tärkeä roolinsa, ja lisäksi ne ovat riippuvaisia toisistaan. Tarkoituksellisuuden voi nähdä olevan uudistuksen perusta alusta loppuun. Fundamentaalisuus eli perinpohjaisuus koskee reformin suunnittelua ja toteutusta. Vakaus on tärkeää uudistuksen toimeenpanon jälkeen.

Tarkoituksellisuus

Tarkoituksellisuudella viitataan siihen, että reformi tulee rakentaa rationaalisesti eli sen tulee perustua suunnitteluun ja näyttöön (Berman & Bossert 2000, 2–3). Muutos ei ole sattumanvarainen vaan tarkoitettu tapahtuvaksi (WHO 1997, 3).

Kompleksisuusajattelua soveltava ICT pureutuu juuri tarkoituksellisuuteen. Se tukee tarkoituksellisuuden valintaa yhdeksi terveydenhuollon ideaalimallin osaksi. ICT pohjautuu ajatukseen, että muutos on toimivin silloin, kun se ei tapahdu sattumalta vaan tarkoituksella. Ilman tarkoituksellisuutta muutokset ovat hitaita ja tuottavat lopputuloksia, jotka eivät vastaa sitä, mitä

halutaan. Tällaiset muutokset heikentävät ihmisten mielialaa ja nakertavat uskoa tulevaisuuteen. (Boyatzis 2006, 619.) Tarkoituksellinen muutos perustuu vapaaehtoisuuteen ja on haluttu ja tarkkaan harkittu (Howard 2006, 660; Dyck ym. 2006, 672). Tarkoituksellisuuteen kuuluu, että uudistuksia suunniteltaessa ja toteutettaessa pyritään ymmärtämään niiden taustalla oleva logiikka ja filosofia. Ilman tätä ymmärrystä uudistus ei voi toimia (Seedhouse 1996b, 233).

Kompleksisuusajattelun, wicked-problematiikan ja tavanomaisen ajattelun mukaisessa suunnittelussa on eroja siinä, miten näyttöön perustuminen määritellään. Tavanomainen strateginen suunnittelu on tarkkaa pitkän aikavälin suunnittelua, mutta kompleksisuusajattelussa suunnittelu on ennemminkin vain "tarpeeksi hyvää". Koska tulevaisuutta ei voi täysin ennustaa, liian tarkka suunnittelu on turhaa ja jopa haitallista. Joustavuus, mukautuvuus ja luovuus ovat tarkkaa suunnittelua tärkeämpiä. (Zimmerman ym. 2001, 26–28.) Myös Herbert A. Simonin (1997, 118–199) klassiset näkemykset tukevat osittain tätä näkökulmaa. Simonin mukaan on etsittävä tyydyttäviä ratkaisuja, koska rajoittunut rationaalisuus (ks. Vakkurin ensimmäinen artikkeli tässä teoksessa) estää täydellisten ratkaisujen löytymisen.

Kompleksisuusajattelussa suositaan pääosin kokeilemista. Epävarmuuden olemassaolon vuoksi on turha tuskailla (Zimmerman ym. 2001, 35–36). Oikean menettelytavan tulisi antaa nousta esiin tekemällä erilaisia kokeiluja epävarmuuden ja erimielisyyden vallitessa. Pirullisissa ongelmissa näkemys on hieman erilainen. Koska asiat muuttuvat nopeasti ja koska tulevaisuutta ei voi ennustaa, yrityksen ja erehdyksen kautta eteneminen on liian hidasta ja näyttö voi parhaimmillaankin olla vain ohjenuora päätöksenteolle (Ackoff 1974, 5; Blackman ym. 2006, 71). Jokainen pirullisen ongelman ratkaisu on ainutkertainen, joten jokainen ratkaisuyritys on tärkeä (Rittel & Webber 1973, 163). Tällöin on siis varottava liiallista kokeiluihin nojautumista.

Tällainen vapaampi suunnittelu ei kuitenkaan tarkoita, että suunnittelu puuttuisi kokonaan. Vapaammassa suunnittelussa valitaan tietoisesti suunnittelutapa, joka ottaa huomioon maailman kompleksisuuden ja joka näkee tämän myönteisenä mahdollisuutena, ei uhkana. Suunnitteluun siis suhtaudutaan pohjimmiltaan eri tavoin, mutta suunnittelun tarve ei katoa. Tulevaisuuden ennustamattomuus ei tarkoita, että kaikki suunnittelu olisi turhaa (Cilliers 2000). Tiedon keräämisestä on aina hyötyä, ja tulisikin varmistaa, että suunnittelun tukena on riittävästi tietoa.

Fundamentaalisuus

Terveydenhuollon reformin ideaalimallissa fundamentaalisuudella tarkoitetaan suunnittelun ja toteutuksen laajuutta. Mitä useampi osa-alue uudistuksessa huomioidaan, sitä fundamentaalisempi se on. Lisäksi fundamentaalisuudella tarkoitetaan reformin suunnitteluun ja toteutukseen osallistuvien tahojen lukumäärää.

Pirullisten ongelmien selvittäminen vaatii lineaarisen tai vaillinaisen ajattelun sijasta kokonaisvaltaista ajattelua (Clarke & Stewart 2000). Kokonaisuuden hahmottaminen on tärkeää; jos käsittelyaluetta rajataan, jotkin ongelman selvittämisessä olennaiset asiat voivat jäädä pimentoon. Monimutkaiset ongelmat ovat harvoin sellaisia, että ne voitaisiin ratkaista vain yhtä osatekijää muuttamalla (Ackoff 1978, 118). Pirullisia ongelmia ratkaistaessa on tärkeää työskennellä organisaatioiden sisäisten ja ulkoisten rajojen yli sekä ottaa myös kansalaiset mukaan (Clarke & Stewart 2000, 383–384). Eri ihmisillä on usein erilaisia käsityksiä näistä vaikeasti ymmärrettävistä ongelmista. Useampien ihmisten ottaminen mukaan ratkaisutyöhön merkitsee erilaisten näkökulmien lisääntymistä ja näin pirullisten ongelmien syvempää ymmärtämistä.

Terveydenhuollon reformin ideaalimallin mukaista fundamentaalisuutta voidaan arvioida yhdysvaltalaisen taloustieteilijän William Hsiaon (2003) määrittelemien terveydenhuollon ohjaussäätimien sekä PAHO:n (Pan American Health Organization) jäsenhallitusten kehittämien ohjausperiaatteiden avulla. Hsiaon ohjaussäätimet (taulukko 1) keskittyvät erityisesti reformin suunnittelun fundamentaalisuuteen. Näihin viiteen ohjaussäätimeen vaikuttamalla hallitukset voivat saada aikaan merkittäviä tuloksia toteuttamillaan reformeilla. Ohjaussäätimet ovat rahoitus, organisaatio, maksut, sääntely ja vakuuttelu. Mitä useampaa ohjaussäädintä uudistus käyttää, sitä fundamentaalisempi se on.

Taulukko 1. Hsiaon terveydenhuollon ohjaussäätimet. (Hsiao 2003, 9–19.)

Ohjaussäädin	Selitys
Rahoitus	Rahan hankkimis- ja käyttötavat: rahoituskeinot, rahoituksen jakaminen, säännöstely ja institutionaaliset sopimukset rahoituksesta.
Organisaatio	Terveydenhuollon järjestämisen mekanismi: kilpailu, hajauttaminen, yhdistyminen ja omistussuhteet.
Maksut	Tavat välittää rahoitus yksilöille ja organisaatioille: kannustinpalkkiot kuluttajille ja tuottajille.
Sääntely	Hallituksen tapa käyttää pakkovaltaa yksilöihin ja organisaatioihin: lait, tutkinnot ja ohjesäännöt.
Vakuuttelu	Tapa vaikuttaa ihmisten uskomuksiin, odotuksiin, elämäntapoihin ja mieltymyksiin: mainostaminen, koulutus ja tiedon levittäminen.

PAHO:n määrittelemät terveydenhuollon ohjausperiaatteet (taulukko 2) keskittyvät terveydenhuollon reformin toteutumisen fundamentaalisuuteen. Ne ovat oikeudenmukaisuus, vaikuttavuus ja laatu, tehokkuus, vakaus sekä yhteiskunnallinen osallistuminen. Ihanteellinen uudistus olisi tällöin sellainen,

joka edistäisi jokaista ohjausperiaatetta, ja vältettävä uudistus puolestaan sellainen, joka toimisi niitä vastaan. (López-Acuña 2000, 1, 5.)

Taulukko 2. PAHO:n terveydenhuollon ohjausperiaatteet. (López-Acuña 2000, 7–8.)

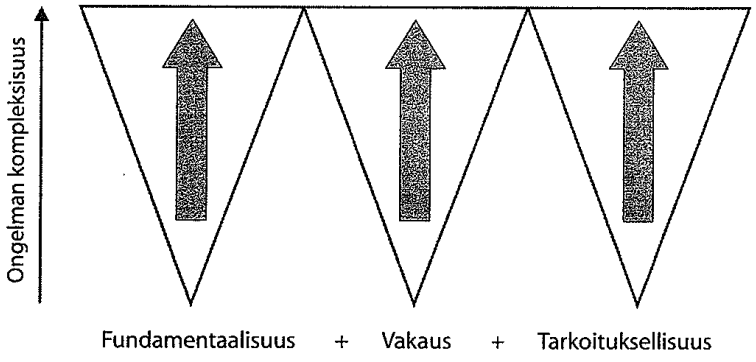
Ohjausperiaate	Selitys
Oikeudenmukaisuus	Ovatko terveydenhuollon uudistukset parantaneet oikeudenmukaisuutta palvelujen kattavuudessa, resurssien jakelussa ja käytössä sekä hoitoon pääsyssä?
Vaikuttavuus ja laatu	Ovatko uudistukset parantaneet terveydenhuollon teknistä ja koettua laatua sekä kansalaisten terveydentilaa ja vähentäneet kuolleisuutta?
Tehokkuus	Ovatko terveydenhuollon uudistukset lisänneet resurssien käytön ja hallinnoinnin tehokkuutta?
Vakaus	Ovatko terveydenhuollon uudistukset parantaneet hoidon tuottajien legitimiteettiä ja hyväksyttävyyttä sekä varautumista terveydenhuollon tulevaisuuden haasteisiin?
Yhteiskunnallinen osallistuminen	Ovatko terveydenhuollon uudistukset parantaneet yhteiskunnallista osallistumista ja hallintaa terveydenhuollossa?

Vakaus

Vakaudella tarkoitetaan sitä, ettei reformi ole pelkkä lyhytkestoinen toteuttamaton ajatus tai kertaluontoinen muutos ilman pysyviä vaikutuksia vaan toteutettu, pitkäkestoinen ja vakaa uudistus (Berman & Bossert 2000, 2–3). Vakauden vaalimisen tärkeys korostuu kompleksisuusajattelussa ja wicked-problematiikassa. Niiden mukaan maailma on avoin ja dynaaminen systeemi, jossa ongelmat ja niiden ratkaisut muuttuvat jatkuvasti. Ongelmat eivät pysy ratkaistuina, joten hetkittäistä vakautta tuova ratkaisu ei vielä ole lopullinen. Tilanteen seuraaminen sekä suunnitelmien muokkaaminen olosuhteiden muuttuessa on erityisen tärkeää (Ackoff 1974, 31–33).

Uudistusten vakaudelle voidaan määritellä kolme vaihetta. *Perustamisvaiheessa* reformi on otettu käyttöön, sen peruselementit ovat vakiintuneet ja toiminta on tehokasta ja odotettua. *Kypsymisvaiheessa* uudistus on laajasti hyväksytty ja sen toteutus on piintynyttä. Peruselementtien toteutuminen ja ylläpitäminen ei vielä tee uudistuksesta vakaata. Sen tulee kehittyä olosuhteiden muuttuessa. *Kehittämisvaiheessa* keskitytään uudistuksen kasvuun ja kehitykseen. Tällöin vastataan muutostarpeisiin ja pyritään ymmärtämään uudistusta paremmin. Vakaus tarkoittaa hankkeen "kykyä säilyttää perususkomuksensa ja arvonsa ja käyttää niitä hyväkseen sopeutuessaan muutoksiin ja ympäristön paineisiin". (Century & Levy 2004, 4–6.)

Kuvio 1 selventää edellä esiteltyä ideaalimallin rakennetta. Kuvion mukaisesti ideaalimallin osa-alueet ovat riippuvuussuhteissa toisiinsa. Jos jokin niistä epäonnistuu, on vaarana, että koko uudistus epäonnistuu. Malli rakentuu niin, että uudistuksen tulee olla sitä tarkoituksellisempi, fundamentaalisempi ja vakaampi, mitä kompleksisempi ratkaistava ongelma on.



Kuvio 1. Terveydenhuollon reformin ideaalimalli.

Kansallinen terveyshanke ja hoitotakuu-uudistus

Tarkastelen hoitotakuu-uudistusta kokonaisuutena ottaen huomioon koko Kansallisen terveyshankkeen ja sen eri osa-alueet. Oletuksena on, ettei hoitotakuu voi toimia, jos yksikin terveyshankkeen muista osa-alueista epäonnistuu. Kiinnitän kuitenkin huomiota erityisesti hoitotakuuseen, sillä se sai terveyshankkeessa suuren roolin verrattuna muihin osa-alueisiin. Hoitotakuuuudistuksen tarkastelu on mielenkiintoista myös siksi, että hoitojonojen lyhentäminen ja vakauttaminen on osoittautunut monimutkaiseksi ongelmaksi myös muualla kuin Suomessa (Kenis 2006).

Uudistuksen tausta

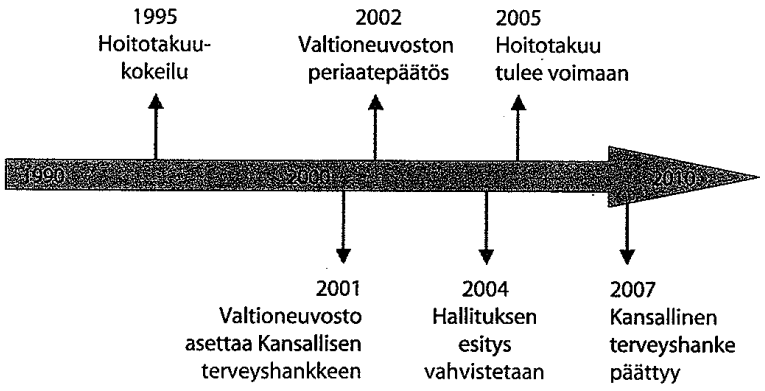
Ensimmäinen maininta suomalaisesta hoitotakuusta on löydettävissä valtioneuvoston ohjeesta sosiaali- ja terveydenhuollon järjestämisestä vuosina 1995–1998 (Rissanen 1997, 5). Samoihin aikoihin aloitettiin toimet hoitotakuuuudistuksen edistämiseksi. Ensimmäinen toimista oli hoitotakuukokeilun aloittaminen syksyllä 1995. Sosiaali- ja terveysministeriö, Suomen Kuntaliitto, sairaanhoitopiirit ja kunnat halusivat selvittää kokeilun avulla, kuinka hyvin hoitotakuu soveltuisi Suomen terveydenhuoltoon ja mitä vaikutuksia sillä olisi (Liukko 1997, 7).

Vuoden 2001 alussa otettiin ensimmäinen askel kohti säädöksin vahvistettua hoitotakuuta, kun nuoriso- ja lastenpsykiatrian hoitotakuu tuli voimaan

(Pylkkänen 2003, 37). Varsinainen koko terveydenhuoltoa koskeva hoitotakuu alkoi edetä vuoden 2001 syyskuussa, jolloin valtioneuvosto asetti Kansallisen terveyshankkeen (Kansallisen hankkeen terveydenhuollon tulevaisuuden turvaamiseksi). Hankkeen käynnistämisen taustalla olivat kasvavat ongelmat terveydenhuollon toimintaedellytyksissä ja palvelujen saatavuudessa. Tavoitteeksi asetettiin "väestön terveystarpeista lähtevän hoidon saatavuuden, laadun ja riittävän määrän turvaaminen maan eri osissa asukkaan maksukyvystä riippumatta" (STM 2002a, 3).

Hankkeen suunnitelmaa ja toimeenpano-ohjelmaa laadittaessa tehtiin tilannearviot ja toimenpideohjelmat viidestä ongelmakokonaisuudesta eli (1) terveyden edistämisestä ja ehkäisevästä työstä, (2) hoitoon pääsyn turvaamisesta, (3) henkilöstön saatavuudesta ja osaamisen parantamisesta, (4) terveydenhuollon toimintojen ja rakenteiden uudistamisesta sekä (5) terveydenhuollon rahoituksen vahvistamisesta. Nämä väliraportit jätettiin tammikuussa 2002. Lopulliset ehdotukset terveydenhuollon tulevaisuuden turvaamiseksi jätettiin saman vuoden huhtikuussa, jolloin valtioneuvosto myös antoi asiasta periaatepäätöksen. (STM 2002a, 9–10.)

Ennen kuin varsinainen hoitotakuu tuli voimaan, hoitojonoja oli jo yritetty eri tavoin purkaa. Heinäkuussa 2002 valtioneuvosto myönsi 25 miljoonaa euroa valtionavustusta tutkimus- ja hoitojonojen purkamiseen (STM 2002a, 15). Tuolloin toteutetussa hankkeessa oli paljon puutteita (esim. STM 2004, 109). Samaan aikaan Kansallisessa terveyshankkeessa asetettiin työryhmä valmistelemaan ohjeita hoitoon pääsyn parantamiseksi ja hoitojonojen lyhentämiseksi ja vakauttamiseksi. Työryhmä jätti muistionsa tammikuussa 2004 (STM 2004). Asia eteni hallituksen käsittelyyn ja esitys vahvistettiin syyskuussa (HE 77/2004). Lait hoitoon pääsystä ja hoitojonojen pituudesta tulivat voimaan maaliskuussa 2005 (ks. kuvio 2). Samaan aikaan otettiin käyttöön myös yhtenäiset kiireettömän hoidon arviointiperusteet.



Kuvio 2. Hoitotakuu-uudistuksen eteneminen.

Uudistuksen tarkoituksellisuus

Kansallisesta terveyshankkeesta ja hoitotakuu-uudistuksesta on kiistelty ja niitä on arvosteltu paljon (esim. Linnakko 1997, 29; Rintala 1999, 181–182; Rimpelä 2004; Ryynänen ym. 2004, 55). Uudistusta ajavat hallituspuolueet ja siitä hyötyvät kuluttajat ja yksityiset palveluntuottajat ovat tietenkin olleet vahvasti hoitotakuu-uudistuksen kannalla. Julkiset palveluntuottajat ja palvelujen maksajat ovat puolestaan pääosin vastustaneet sitä. (Vuorenkoski 2006.)

Ongelmana on pidetty erityisesti resurssien puutetta. Tämä nähdään ongelmakohdaksi myös sosiaali- ja terveysvaliokunnan mietintöön (13/2004 vp) sisältyvässä vastalauseessa, jossa todetaan, että "valtion vastuu ei (...) rajoitu pelkästään lakien säätämiseen, vaan sen on huolehdittava myös siitä, että kunnilla on tosiasialliset edellytykset vastata lainsäädännön toteuttamisesta". Hoitotakuu-uudistuksen toteuttaminen ei siis ole ollut täysin haluttua tai vapaaehtoista. Sen suunnittelu on ollut nollasummapeliä (Roberts 2000), jossa voittaja määrittelee ongelman ja valitsee ratkaisun. Tällainen menettelytapa tulee kalliiksi pirullisissa ongelmissa – usein tuloksena on epäonnistuminen. (Vrt. Ahosen artikkeli tässä teoksessa.)

Hoitotakuu-uudistuksessa on panostettu sekä suunnitteluun että näyttöön perustumiseen. Näyttöön perustumisesta kertoo vuonna 1995 aloitettu hoitotakuukokeilu. Myös vuonna 2001 voimaan tullut lasten- ja nuortenpsykiatrian hoitotakuu on tarjonnut näyttöä uudistuksen suunnittelulle ja toteutukselle. Hoitotakuukokeilun ja takuun voimaantulon välissä ehti kuitenkin vierähtää kokonainen vuosikymmen. Maailma muuttui noiden vuosien aikana, ja kokeilun antama näyttö voidaankin asettaa kyseenalaiseksi. Toisaalta näyttöä negatiivisista seikoista ei juuri ole otettu huomioon. Jo kun hoitotakuukokeilua arvioitiin, jotkut haastatellut totesivat, ettei hoitotakuu kenties ole oikea keino parantaa suomalaisen erikoissairaanhoidon toimivuutta. Lisäksi arvioinnissa tuli ilmi, että kokeilun tulokset olivat pääosin lyhytaikaisia. (Rintala 1999, 181–182.) Myös lasten- ja nuortenpsykiatrian hoitotakuun arvioinnissa todettiin, ettei hoitotakuu ollut päässyt tavoitteisiinsa (Pylkkänen 2003, 69–70). Näiden palvelujen saatavuus ei sittemmin ole juuri kohentunut (STM 2007a, 17).

Hoitotakuun suunnitteluvaiheessa perehdyttiin tutkimuksiin muiden maiden hoitotakuista (Hetemaa ym. 2003). Tutkimusten perusteella tiedettiin, että muualla toteutetut hoitotakuumallit eivät juuri olleet tuottaneet pitkäaikaisia tuloksia (esim. Rissanen 1997, 5; HE 77/2005, 15). Suomalaisen hoitotakuun ei haluttu lankeavan samaan, vaan tarkoituksena oli hallita hoitojonojen pituutta kokonaisvaltaisesti (Rissanen 1997, 5). Kansallisen terveyshankkeen suunnitteluasiakirjoissa tuodaan muutaman kerran esille järjestelmänäkökulma. Tällöin korostetaan, että hoitoon pääsyä tulee tarkastella kokonaisuutena, jolloin uudistuksen mahdolliset sivuvaikutukset pystytään ehkäisemään paremmin. Seuraavat esimerkit ovat työryhmämuistioista:

> Säädöksiä ja muita sääntöjä laadittaessa ja kehittämistoimenpiteitä suunniteltaessa on otettava huomioon paitsi kokonaisuus myös järjestelmän monimutkaisuus ja sen sisällä olevat ristiriitaiset voimakentät. Muutoin suunniteltujen toimenpiteiden "sivuvaikutukset" voivat helposti muodostua tavoiteltuja vaikutuksia merkittävämmiksi. (STM 2004, 19.)

> Yhdenkin ehdotuksen toteuttamatta jättäminen vaikeuttaa mahdollisuutta saada muiden tarjoamat hyödyt täysimääräisinä. Kokonaisuus toimii vain, kun sen kaikki osat ovat käytössä. (Mäkelä & Niinistö 2002, 1.)

Käytännössä nämä toteamukset ovat jääneet vain kauniiksi ajatuksiksi, sillä kaikki reformin osa-alueet eivät ole toteutuneet (esim. STM 2007a).

Hoitotakuu-uudistuksen ja Kansallisen terveyshankkeen suunnittelu on joka tapauksessa ollut laajaa. Terveyshanketta suunnittelemassa oli johtoryhmän lisäksi viisi työryhmää, joista kukin teki raportin omasta aihealueestaan. Johtoryhmä teki lopullisen ehdotuksensa näiden raporttien pohjalta. Myös varsinainen hoitojonoja käsitellyt työryhmä panosti suunnitteluun esimerkiksi tilaamalla Stakesilta kirjallisuuskatsauksen ja järjestämällä seminaareja (esim. STM 2002b). Kansallinen terveyshanke ja hoitotakuu-uudistus eivät siis olleet sattumanvaraisia vaan suunniteltuja ja tarkoituksellisia uudistuksia.

Kompleksisuusajattelun näkökulmasta hankkeiden suunnittelu ja tavoitteenasettelu on kuitenkin ollut osittain jopa liian tarkkaa ja rajaavaa. Samaan päädytään sosiaali- ja terveysministeriön (STM 2006) julkaisussa, jossa todetaan, että Kansallisen terveyshankkeen osahankkeet ovat noudattaneet terveyshankkeen tavoitteita jopa liiankin tarkasti. Tämän vuoksi hankkeet ovat monella tavalla toistensa kaltaisia, eikä uudenlaisia, innovatiivisia hankkeita – joille erityisesti olisi kysyntää – ole juuri päässyt syntymään. Tämä huomio tukee kompleksisuusajattelun mukaista "vain tarpeeksi hyvän" suunnittelun tarvetta. Suunnittelussa pitää jättää varaa innovaatioille ja "ilmaantumiselle" eli yksinkertaisesti asioiden tapahtumiselle (Sotarauta & Kosonen 2004, 25).

Uudistuksia suunniteltaessa tulee ymmärtää niiden taustalla oleva filosofia ja logiikka. Ilman tätä ei oikeastaan edes tiedetä, mitä ollaan tekemässä (vrt. Sinervon artikkeli tässä teoksessa). Terveydenhuollon ja terveyden käsitteiden määritelmillä on suuri merkitys sille, millainen terveydenhuollon uudistuksesta tulee. Nämä käsitteet ovat toisistaan riippuvaisia, eli esimerkiksi terveyden määritteleminen suppeasti tai laajasti vaikuttaa terveydenhuollon määritelmään. Jos terveys ymmärretään suppeasti sairauden poissaoloksi, lääketieteellisen hoidon rooli on hallitseva. Jos terveys määritellään laajasti kokonaisvaltaiseksi hyvinvoinniksi, terveydenhuollon rooli laajenee sairaaloiden ja muiden hoitolaitosten ulkopuolelle. Kun filosofiset määrittelyt puuttuvat,

oletusarvo on, että lääketieteellinen hoito asetetaan etusijalle (Seedhouse 1996a, 10–11).

Filosofinen pohdinta on työryhmämuistioiden perusteella jäänyt vähäiseksi hoitotakuu-uudistuksessa ja Kansallisessa terveyshankkeessa. Määritelmät on otettu vallitsevien näkemysten mukaisina selvioinä. Tämä voi tarkoittaa sitä, että käsiteltävät ongelmat on nähty kesyinä, jolloin suunnitteluvaiheessa esitetyt kysymykset ovat myös olleet kesyjä tai korkeintaan monimutkaisia. Olisi tarvittu pirullisia kysymyksiä, joihin ei ole olemassa selviä vastauksia (Zimmerman ym. 2001). Niiden tarkoituksena on saada ihmiset paljastamaan oletuksensa puheena olevasta asiasta. Kysymys on pirullinen silloin, kun siihen on juurtunut paradoksi tai jännite. Tällaiset kysymykset johdattavat kohtaamaan epäjärjestyksen ja kaaoksen, jossa luovat ideat ja innovaatiot syntyvät.

Kansalliseen terveyshankkeeseen ja hoitotakuu-uudistukseen liittyvässä dokumenttiaineistossa ei kyseenalaisteta vallitsevia näkemyksiä. Myös haastatteluaineisto (Raisio 2009) vahvistaa tätä. Suunnittelu on ollut rajattua. Siinä ei ole annettu tarpeeksi tilaa luovuudelle ja innovaatioille. Esimerkiksi tärkeä sosiaalipalvelujen näkökulma rajattiin suunnittelun ulkopuolelle. Tällainen reduktionistinen, rajoittunut ja filosofisesti köyhä suunnittelu ei ole kompleksisuusajattelun mukaista.

Filosofisen tarkastelun sijaan Kansallisessa terveyshankkeessa ja hoitotakuu-uudistuksessa on käytetty varsin pragmaattista lähestymistapaa. Uudistus on kuitenkin pääosin rationaalisen reformin kriteerien (Seedhouse 1996a) mukainen: hoitotakuu-uudistuksessa on määritelty uudistuksen kohde, käsitelty terveydenhuoltojärjestelmän alkuperäisiä tavoitteita, pohdittu, miksi ne eivät enää täysin toteudu, sekä suunniteltu keinoja, joilla nämä tavoitteet voidaan uudistuksen jälkeen toteuttaa. Tällainen reformin taustalla olevan logiikan ymmärtäminen ei kuitenkaan vielä tarkoita kokonaisuuden ymmärtämistä. Kesyssä ongelmassa pelkkä ongelman periaatteiden ymmärtäminen olisi riittävä edellytys sen ratkaisemiselle, mutta pirullisessa ongelmassa tarvitaan lisäksi rajoittamatonta ja kriittistä filosofista pohdintaa.

Uudistuksen fundamentaalisuus

Fundamentaalisuutta tarkastellaan Hsiaon ohjaussäätimien avulla (ks. taulukko 1). Ensimmäinen niistä on rahoitus. Rahoitus huomioitiin heti Kansallisen terveyshankkeen suunnittelun alussa ja siitä laadittiin selvitys (Huttunen 2002). Tällöin ja myös suunnittelun myöhemmissä vaiheissa puhuttiin rahoituksen lisäämisestä, kuntarahoituksen vakauden ja ennakoitavuuden parantamisesta sekä asiakasmaksuja ja maksukattoa koskevien säännösten uudistamisesta.

Toinen ohjaussäädin on terveydenhuollon organisaatio. Kansallisen terveyshankkeen suunnittelussa huomioitiin myös tämä osa-alue. Selvityksiä tehtiin muun muassa rakenteiden uudistamisesta sekä työnjaon ja yhteistyön kehittämisestä (Ihalainen & Brommels 2002; Silvola & Kalske 2002).

Tärkeimmiksi tavoitteiksi esitettiin perusterveydenhuollon järjestäminen seudullisina ja toiminnallisina kokonaisuuksina sekä erikoissairaanhoidon jakaminen erityisvastuualueisiin (esim. STM 2002a, 6).

Maksut kannustimina ovat kolmas ohjaussäädin. Kannustimia voidaan soveltaa asiakkaisiin, henkilökuntaan ja organisaatioihin. Kansallisessa terveyshankkeessa kohteena oli pääasiassa terveydenhuollon henkilökunta, erityisesti lääkärit. Suunnitelmissa puhuttiin erikoismaksuluokasta luopumisesta ja muun muassa tulospalkkauksen kehittämisestä sen korvikkeeksi (STM 2002c).

Neljäs ohjaussäädin on sääntely. Hoitotakuu-uudistuksen tavoitteena oli saada aikaan hoitoon pääsyn vähimmäisajat määrittelevä laki. Tarkoitus oli myös ottaa käyttöön yhtenäiset hoitoon pääsyn arviointiperusteet. Kansallisen terveyshankkeen suunnitelmissa puhuttiin myös terveydenhuoltoalan tutkintojen uudistamisesta. Tavoitteena oli kehittää moniammatillinen johtamiskoulutus, joka vaadittaisiin kaikilta lähi- ja keskijohdon tehtäviin hakevilta. Lisäksi henkilöstön täydennyskoulutusta haluttiin vahvistaa ja terveydenhuoltoalan koulutuksen aloituspaikkoja lisätä. (STM 2002c.)

Vakuuttelu on viides Hsiaon määrittelemistä ohjaussäätimistä. Kansallisen terveyshankkeen suunnitelmissa tätä ohjaussäädintä ei varsinaisesti mainittu. Hankkeessa oli kuitenkin mukana terveyden edistämisen osa-alue, jonka välineenä vakuuttelua eli tiedon levittämistä voidaan pitää. Suunnitelmissa ei kuitenkaan esitetty juuri mitään konkreettisia keinoja vakuuttelun toteuttamiseksi. Kuitenkin tavoitteeksi esitettiin edistää Terveys 2015 -kansanterveysohjelman linjausten mukaista toimintaa, jossa vakuuttelulla on suuri rooli. (STM 2002a, 1–2.)

Tässä on käsitelty vain muutamia Kansallisen terveyshankkeen suunnittelun osa-alueita. Jo niiden perusteella voidaan sanoa, että hankkeen suunnittelu on varsin fundamentaalista: se pitää sisällään lähes kaikki Hsiaon ohjaussäätimet. Suunnittelun fundamentaalisuus ei kuitenkaan vielä tarkoita, että reformi kokonaisuudessaan olisi fundamentaalinen. Se, mitä on suunniteltu, ei aina välttämättä toteudu.

Terveyshankkeen suunnitteluun osallistui laaja joukko asiantuntijoita ja toimijoita (lähes 400) (STM 2002c). Myös hoitotakuu-uudistuksen suunnittelusta vastaava työryhmä teki yhteistyötä lukuisien tahojen, esimerkiksi ammatti- ja potilasjärjestöjen kanssa (STM 2004, 12). Erityisesti hoitotakuun suunnittelun päävaikuttajia olivat kuitenkin hallituspuolueet ja eduskunta. Yksityisten palveluntuottajien ja kansalaisyhteiskunnan toimijoiden – myös potilaiden – vaikutus on joidenkin näkemysten mukaan jäänyt lähes olemattomaksi (esim. Vuorenkoski 2006; Raisio 2009).

Hankkeen tavoitteiden toteutumisen fundamentaalisuuden tarkastelu perustuu pääosin terveydenhuollon tulevaisuuden turvaamisen seurantaryhmän raportteihin. Seurantaryhmän tehtäviksi määriteltiin muun muassa periaatepäätöksen toteutumisen seuranta, arviointi ja edistäminen (STM 2002a, 11).

Ryhmässä oli jäseniä monilta hallinnonaloilta ja järjestöistä. Koska seuranta-ryhmän tulokset eivät kuitenkaan perustu tarkkoihin tieteellisiin tutkimuksiin, niihin on hyvä suhtautua varauksella.

Terveydenhuollon rahoituksen vahvistaminen on yksi tarkastelluista osa-alueista. Raporttien mukaan rahoitus vahvistui ja kuntarahoituksen vakaus ja ennakoitavuus parani, kun valtion osuutta sosiaali- ja terveydenhuollon rahoituksesta lisättiin. Kansallisen terveyshankkeen käynnistyessä osuus oli noin 24 prosenttia, mutta se nousi noin 34 prosenttiin vuoteen 2007 mennessä. Asiakasmaksuihin tai maksukattosäännöksiin ei hankkeella juuri saatu aikaan muutoksia. (STM 2007b, 19, 21–22.)

Terveydenhuollon organisaation uudistaminen ei edennyt odotuksien mukaisesti. Tavoitteena oli järjestää perusterveydenhuolto seudullisiksi ja toiminnallisiksi kokonaisuuksiksi ja erikoissairaanhoito erityisvastuualueiksi. Näissä tavoitteissa ei juuri edistytty. Rakenteellisten uudistusten tapauksessa tilanne oli hankkeen lopussa lähes sama kuin sen käynnistyessä. Osa-aluetta koskevat suunnitelmat näyttävät jääneen pöytälaatikkoon (Saranummi ym. 2005). Osaltaan tätä selittää se, että Paras-hanke kunta- ja palvelurakenteen uudistamiseksi aloitettiin vuonna 2005 päällekkäin Kansallisen terveyshankkeen kanssa (STM 2007a, 21). Kuitenkin esimerkiksi laboratorio- sekä kuvantamispalvelujen toimintojen yhdistämisessä edistyttiin ja päivystysyhteistyötä kehitettiin (STM 2005, 20; STM 2007a, 25).

Maksut kannustimina eivät saaneet tärkeää osaa Kansallisessa terveyshankkeessa. Suunnitelmissa oli erikoismaksuluokasta luopuminen ja tulospalkkauksen ja muiden kannustinjärjestelmien luominen sen tilalle. Hankkeen päättyessä ainakaan tulospalkkaus ei ollut saanut vahvaa jalansijaa terveydenhuollossa (STM 2007a, 19; STM 2008, 11). Erikoismaksuluokasta luovuttiin suunnitellusti asteittain vuoden 2005 maaliskuusta alkaen. Tilalle on tullut mahdollisuus järjestää erityispoliklinikkatoimintaa, josta voidaan pyytää erityisiä potilasmaksuja (esim. Mattila 2006, 135).

Hankkeessa saatiin aikaan joitakin uusia säännöksiä. Vuonna 2004 tulivat voimaan täydennyskoulutusta koskevat lainmuutokset sekä sosiaali- ja terveysministeriön asetus terveydenhuollon henkilökunnan täydennyskoulutuksesta (STM 2005, 17). Ministeriön arviointikyselyn mukaan näiden täydennyskoulutussuositusten toteuttamisessa on onnistuttu kohtalaisen hyvin (STM 2007a, 19). Myös moniammatillisen johtamiskoulutuksen valmistelu on edennyt, vaikka koulutus onkin vielä koordinoimatonta ja sirpaleista (STM 2007b, 10; STM 2008, 11). Lääketieteellisten tiedekuntien aloituspaikkoja on lisätty.

Hoitoon pääsyn määräajat kirjattiin lakiin ajallaan suunnitelmien mukaan. Myös yhtenäiset hoitoon pääsyn perusteet otettiin käyttöön ainakin osassa terveydenhuoltojärjestelmää. Myöhemmissä arvioinneissa hoitotakuun osion nähtiin toteutuneen varsin hyvin. (Myllymäki & Rintanen 2006; STM 2007a, 18.) On kuitenkin huomioitava, että julkishallinnon tuottamat raportit

hoitotakuun toteutumisesta ovat yksipuolisia eivätkä anna todellista kuvaa hoitotakuun onnistumisesta. Potilaille tehtyjen kyselyiden perusteella on esitetty, että potilaiden kokemukset hoitotakuusta eivät olisi niin myönteisiä kuin viranomaisten palaute antaa ymmärtää (ks. YTY 2006).

Hoitoon pääsy koheni ja jonot lyhenivät, vaikkakin ehkä vain väliaikaisesti. Pitkät hoitojonot ovat ongelma erityisesti hammashoidossa (Rintanen & Nordblad 2007). Myös terveyskeskuslääkärin vastaanotolle pääsy on vaikeutunut, ja joissakin tapauksissa potilaille ei ole edes voitu antaa vastaanottoaikaa (Myllymäki & Rintanen 2007). Näiden ongelmien on nähty johtuvan muun muassa lääkäripulasta. Myös palvelujen kysyntä on kasvanut: erikoissairaanhoidossa lähetteiden määrä on lisääntynyt selvästi (Isolauri 2006). Lisäksi lääkärit kokevat, että heidän työnsä on aikaisempaa kuormittavampaa ja että potilaat kohdistavat heihin entistä enemmän paineita (Lääkäriliitto 2005). Jo Kansallisen terveyshankkeen suunnitelmissa todettiin, että "osa henkilökunnasta työskentelee tällä hetkellä suorituskyvyn rajoilla" (STM 2002c). Tilanteessa on tehokkuusparadoksin piirteitä: tehokkuutta kasvatetaan henkisen ilmapiirin ja toiminnan eettisyyden kustannuksella (Wright 1997, 11–12).

Jos vakuuttelu ohjaussäätimenä mielletään terveyden edistämiseksi, sen toteutuminen Kansallisessa terveyshankkeessa oli vähäistä. Hanke ei juuri tehostanut terveyden edistämistä tai ehkäisevää terveydenhuoltoa (STM 2007a, 16; STM 2008, 20). Jotain kuitenkin saatiin aikaan: syksyllä 2006 julkaistiin terveyden edistämisen laatusuositukset, ja saman vuoden alussa tulivat voimaan terveyden edistämistä koskevat uudistukset kansanterveyslakiin. Myös kansalliset ravitsemussuositukset uudistettiin ja ravintolatupakointi kiellettiin. (STM 2007b, 1–2.)

Terveyden ja hyvinvoinnin laitoksen tutkimusprofessori Matti Rimpelä (2004, 53) on kritisoinut terveyden edistämisen jäämistä muiden päämäärien jalkoihin Kansallisessa terveyshankkeessa: "Puhe terveysprojektista antoi ymmärtää, että tavoitteena oli edistää suomalaisten terveyttä. Käytännön kehittämistyö ja myös investoinnit näyttävät kuitenkin keskittyvän sairaanhoitoon." Hän pitää mahdollisena, että terveyshankkeen vuoksi terveyden edistäminen eriytyy entistä enemmän muusta terveydenhuollosta ja terveydenhuollon kehittäminen muuttuu sairaanhoitopolitiikaksi (Rimpelä 2004, 83).

Rimpelä myös kumoaa väitteen, jonka mukaan terveyden edistämiseen keskittyvä Terveys 2015 -ohjelma ja Kansallinen terveyshanke vastaisivat tasapainoisesti suomalaisen terveyspolitiikan kehittämisestä. Hänen mukaansa nämä kaksi ohjelmaa ovat täysin eri asemissa. Verrattuna Kansalliseen terveyshankkeeseen Terveys 2015 -ohjelman voimavarat ovat olemattomat. Lisäksi sen toimet kohdistuvat terveydenhuollon ulkopuolisiin tahoihin, ja ohjelman tavoitteiden oletetaan toteutuvan informaatio-ohjauksen eli tiedon levittämisen varassa. (Rimpelä 2004, 85.) Väite näiden ohjelmien samanarvoisuudesta ei siis pidä paikkaansa.

Toteutuksen fundamentaalisuudesta voidaan tehdä huomioita myös PAHO:n määrittelemien ohjausperiaatteiden avulla (ks. taulukko 2). Käytettävissä olevien tutkimusten ja dokumenttiaineiston perusteella näiden periaatteiden toteutumista on vaikea arvioida, joten tarkastelu on suuntaa antava.

Periaatteista ensimmäinen eli oikeudenmukaisuus on osittain parantunut erityisesti hoitotakuu-uudistuksen vuoksi. Hoitojonot ovat lyhentyneet ja potilaat pääsevät hoitoon aikaisempaa nopeammin. Myös yhtenäiset hoitoon pääsyn perusteet vaikuttavat myönteisesti oikeudenmukaisuuteen. Toisaalta oikeudenmukaisuuden voidaan tulkita huonontuneen. Esimerkiksi alueelliset erot hoitoon pääsyssä ovat edelleen suuria. Lisäksi painopiste on suuntautunut operatiivisille aloille (esimerkiksi kirurgiaan tai ortopediaan) kroonisten sairauksien jäädessä sivuun (esim. STM 2007a, 17–18). Myös lasten- ja nuortenpsykiatriassa hoitotakuun toteutumisessa on ollut suuria ongelmia; eduskunnan oikeusasiamies on jopa joutunut puuttumaan asiaan (EOAH 1205/2004). Oikeudenmukaisuuden ongelmana voidaan pitää myös sitä, että terveyden edistäminen on jäänyt hoitotakuun varjoon. Vuosia 2003–2005 koskevassa hankearvioinnissa todettiin, että terveyden edistämisen hankkeita oli ollut kovin vähän (STM 2006, 20). Sosiaali- ja terveysministeriö onkin korostanut, että olisi tarvetta siirtää terveyspolitiikan painopiste sairauksista ja hoitojonoista ehkäisevään terveydenhuoltoon (STM 2005, 14).

Toisesta periaatteesta eli vaikuttavuudesta ja laadusta ei vielä tässä vaiheessa voida todeta mitään kovin luotettavaa. Joidenkin näkemysten mukaan Kansallisen terveyshankkeen ja hoitotakuu-uudistuksen vaikutukset palvelujen laatuun ovat marginaalisia (ks. esim. Vuorenkoski 2006). Tehokkuuden lisääntymisestä eli kolmannen periaatteen parantumisesta on jonkin verran näyttöä. Esimerkiksi henkilöstön työnjako on parantunut, ja todennäköisesti resursseja käytetään tämän vuoksi tehokkaammin (Hukkanen & Vallimies-Patomäki 2005). Myös sähköisten sairauskertomusten käyttöönotto tehostanee toimintoja.

Kansallisen terveyshankkeen ja hoitotakuu-uudistuksen alkuvaiheissa palvelun tarjoajien legitimiteetti ja hyväksyttävyys kasvoivat, mikä vaikutti myönteisesti vakauteen, neljänteen ohjaavaan periaatteeseen. Sittemmin usko hankkeisiin kuitenkin alkoi hiipua (esim. *Helsingin Sanomat* 25.1.2007; 29.1.2007). Hankkeet myös jonkin verran paransivat tulevaisuuteen varautumista lisäämällä lääkäreiden koulutuspaikkoja ja rahoitusta. Viides periaate eli yhteiskunnallinen osallistuminen on hankkeissa jäänyt sivuun, mikä on suuri puute, sillä kansalaisten olisi tärkeää olla mukana kehittämässä terveydenhuoltoa.

Kansallisen terveyshankkeen toteutus ei ole ollut yhtä fundamentaalista kuin sen suunnittelu. Kaikkiin tavoitteisiin ei ole päästy. Kaikesta huolimatta hankkeessa saatiin aikaan paljon hyvää. Hoitotakuu-uudistuksen tavoitteet toteutuivat jonkin verran paremmin.

Uudistuksen vakaus

Vakaudeltaan hoitotakuu oli ensimmäisessä (perustaminen) ja toisessa (kypsyminen) vaiheessa vuosina 2005–2006. Perustamisvaiheen jälkeen toiminta vakiintui, mikä oli pääosin odotettua. Hoitojonot lyhenivät. Kypsymisvaihe nivoutui sulavasti perustamisvaiheeseen, eli uudistuksesta tuli varsin nopeasti laajasti hyväksytty. Kuitenkin jo vuoden 2007 selvityksissä puhutaan hoitotakuun ongelmista (ks. esim. Rintanen & Nordblad 2007; Myllymäki & Rintanen 2007; Stakes 2007).

Yhteiskunnalliset olosuhteet ovat alkaneet muuttua. Esimerkiksi työvoimapula sekä hoidon kysyntä ovat kasvaneet. Hoitotakuu-uudistuksen tulee sopeutua näihin muutoksiin ja lisätä vakauttaan siirtymällä kehittämisvaiheeseen. Voidaan sanoa, että hoitotakuu-uudistus on kehittymisen sijaan taantunut. Uudistusta ei ole päivitetty juuri millään tavalla. Matti Vanhasen vuoden 2007 hallitusohjelmassa on kuitenkin seuraava maininta: "Arvioidaan terveydenhuollon hoitotakuun toimivuus ja tehdään tarpeelliset muutokset aikarajoihin ja toimintamalleihin" (Valtioneuvosto 2007, 52). Lisäksi erityisesti hammashuollossa hoitotakuu oli alusta lähtien liian kunnianhimoinen, eli sillä ei käytännössä ollut mahdollisuutta onnistua vallitsevissa olosuhteissa. Hoitotakuu on ajautunut kriisiin ja kaikki osapuolet ovat tilanteeseen tyytymättömiä. Hammashuollossa uudistus ei siis ole sopeutunut kompleksiseen ympäristöön.

Kansallisen terveyshankkeen muut osa alueet ovat vakaudeltaan monilla tasoilla, mutta vain harva niistä on ehtinyt edetä kehittämisvaiheeseen. Osa hankkeista ei ole yltänyt edes perustamisvaiheeseen. Asiakasmaksujen uudistaminen ja laajat rakenteelliset erikoissairaanhoidon muutokset ovat esimerkkejä tällaisista hankkeista.

Vastaavatko uudistukset ideaalimallia?

Kansallisessa terveyshankkeessa ja siihen kuuluneessa hoitotakuu-uudistuksessa tarkoituksellisuus, fundamentaalisuus ja vakaus ovat paljon alhaisemmalla tasolla kuin ongelman luonne vaatisi. Hankkeen keskinkertaista tarkoituksellisuutta selittää ensinnäkin se, että varsinkaan hoitotakuu-uudistus ei ollut täysin haluttu tai vapaaehtoinen. Toiseksi uudistuksen suunnittelusta puuttui laaja filosofinen pohdinta, ja kolmanneksi suunnittelu oli osittain liian tarkkaa ja rajoittavaa – ei siis "vain tarpeeksi hyvää" suunnittelua.

Kokonaisvaltainen suunnittelu Kansallisessa terveyshankkeessa ja hoitotakuu-uudistuksessa näyttäisi onnistuneen ainakin jossain määrin. Terveyshankkeen suunnittelussa otettiin huomioon monta eri osa-aluetta. Jos kaikki suunnitellut toimet olisivat onnistuneet, uudistus olisi ollut varsin fundamentaalinen. Näin ei kuitenkaan käynyt. Monet tärkeät tavoitteet kuten toimintarakenteiden mittava uudistaminen sekä laaja terveyden edistäminen jäivät käytännössä suunnitelmiksi. Lisäksi vähäistä fundamentaalisuutta selittää erilaisten näkemysten ja osallistujien puute suunnittelussa.

Vaikka Kansallinen terveyshanke olisi onnistunut saavuttamaan kaikki tavoitteensa, se ei silti olisi täysin vastannut ideaalimallin mukaista terveydenhuollon reformia. Kun tarkoituksellisuus on vähäistä, edes fundamentaalinen uudistus ei etene. Suomen terveydenhuollossa ilmenee tulevaisuudessa yhä kompleksisempia ongelmia, joihin nykyinen terveydenhuollon rakenne ei yksinään pysty vastaamaan. Tarvitaan uudenlaisia ratkaisuja, joiden kehittämiseen osallistuu koko yhteiskunta. Kun tarkoituksellisuus lisääntyy eli kun suunnitteluun tulee mukaan filosofista pohdintaa ja kriittisiä puheenvuoroja mahdollisimman monilta osapuolilta, syntyy kollektiivista älykkyyttä, jonka avulla voidaan laatia uudenlainen, ehkäpä nykyiset rakenteet ja toimintatavat kyseenalaistava fundamentaalinen uudistus.

Terveydenhuollon uudistuksissa vakauden säilyttäminen on hankalaa. Kansallisen terveyshankkeen osa-alueet ovat vakaudeltaan monilla eri tasoilla: osa on jäänyt perustamisvaiheeseen ja osa on vastikään pantu toimeen. Jotkut hankkeet ovat jo piintyneitä ja laajasti hyväksyttyjä. Hoitotakuu-uudistus on toteutettu ja se on saavuttanut kypsymisvaiheen. Kehittämisvaihetta se ei kuitenkaan vielä ole saavuttanut. Uudistus ei siis ole tarpeeksi vakaa vastatakseen ongelman kompleksisuutta.

Kansallinen terveyshanke ei päässyt kokonaisuutena kohteenaan olevan pirullisen ongelman tasolle. Tämä voidaan havaita esimerkiksi siinä, että hoitotakuun odotettiin vähentävän erityisesti sairauspäivärahapäiviä ja -korvauksia. Ne ovat kuitenkin vain lisääntyneet (Pekurinen ym. 2008, 28). Jokin odottamaton tekijä on mahdollisesti jäänyt huomaamatta suunnittelussa, minkä vuoksi myös tulokset ovat olleet odottamattomia.

Kansallisen terveyshankkeen kykenemättömyys käsillä olevan ongelman ratkaisemiseen todennäköisesti vain lisää reformeja tulevaisuudessa. Uudistuksia on liikaa jo nyt. Länsimaissa on toteutettu niin paljon terveydenhuollon reformeja, että niistä on kärjistetysti puhuttu epidemiana (Chinitz 1997, 236). Iskulauseena pitäisikin olla: "Vähemmän hankkeita – enemmän vaikuttavia hankkeita!" (STM 2006, 45).

Löytyikö Graalin malja?

Kansallisella terveyshankkeella ja hoitotakuu-uudistuksella on yritetty ratkaista erittäin kompleksinen ongelma: kuinka toteuttaa terveydenhuolto kustannustehokkaasti ja säilyttää samalla palvelujen saatavuus ja laatu? Tämän ongelman ratkaisuyrityksiä on verrattu Graalin maljan etsimiseen (Alban & Christianson 1995). Se on selvästi pirullinen ongelma, jota on vaikea määritellä ja käytännössä mahdoton ratkaista lopullisesti.

Kansallisen terveyshankkeen ja hoitotakuu-uudistuksen tarkastelu tuo ilmi, että terveydenhuollon ongelmiin sisältyy monia vaikeasti määriteltäviä ja toisistaan riippuvaisia tekijöitä. Esimerkkinä tästä on se, että terveyden

edistäminen on jäänyt hoitotakuun jalkoihin, minkä vuoksi sairauksien hoito on saanut terveydenhuollossa liian korostuneen aseman. Sairaanhoitopolitiikan tarjoamat keinot eivät kuitenkaan riitä. Terveydenhuollon kasvavien ongelmien ratkaiseminen vaatisi laajempaa lähestymistapaa.

Terveydenhuollon reformin ideaalimalli voisi mahdollisesti toimia ohjenuorana terveydenhuollon uudistamisessa. Ensinnäkin sen soveltaminen pakottaa pohtimaan ratkaistavien ongelmien todellista kompleksisuuden astetta. Toiseksi se huomioi uudistusten fundamentaalisuuden, tarkoituksellisuuden ja vakauden tärkeyden sekä niiden väliset riippuvuussuhteet. Ennen kaikkea ideaalimalli tukee siirtymistä lineaarisesta, reduktionistisesta ajattelusta kohti epälineaarista, kokonaisvaltaista ajattelua. Tällöin avautuu tilaisuus nähdä ongelmat uudella tavalla. Ymmärretään, ettei ole olemassa mitään terveydenhuollon Graalin maljaa.

References in Appendix 8.

Health care reform planners and wicked problems

Is the wickedness of the problems taken seriously or is it even noticed at all?

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Abstract:

Purpose: The purpose of this paper is to examine the planning of the National Health reform – especially the "guarantee for care" reform within it – from the perspective of the concept of wicked problems. This concept asserts that it is of utmost importance to see the true level of complexity of the problems to survive them. This paper tries to answer the question of how the planners of the health care reforms see the problems they are trying to solve.
Design/methodology/approach: This is an interview study. A total of 12 people who participated in the planning of the examined reforms at some level were interviewed. The interview method was a semi-structured thematic interview. The research analysis is theory originated content analysis.
Findings: The hypothesis of the article was that the planners of the examined reforms did not focus enough on the complexity of the problems they tried to solve. The research, however, shows that the wickedness of the problems was often noticed. Unfortunately it was not taken as seriously as it should have been. In other words, the planners mostly saw that the problems were very complex, but even then the solutions were only like solutions for tame problems or messes.
Originality/value: The paradigm shift from Newtonian science – which sees the world as a deterministic system – to a more complexity endorsing view is on its way. The world is a dynamic and open system which cannot be controlled. This paper gives its own contribution, from the perspective of health care problems and reforms, to advance this paradigm shift.
Keywords: Complexity theory, Health services
Paper type: Research paper

Introduction

Grint (2005) writes about "the macabre reinvention of Hercules' struggle against the Hydra". With this he points to the War on Terror and especially to the war in Iraq. They seem to be battles without an end. First of all, we are not even sure what the real problem is. Neither do we know when the situation is really solved, for there is no stopping rule. In addition we do not have and never will have a 100 per cent perfect plan to solve these problems. These problems are just too complex. What we are talking about now are some of the features of wicked problems, defined by Rittel and Webber in 1973.

Modern health care problems can also be seen as very complex, i.e. wicked problems (Glouberman and Zimmerman, 2002). For example, the case study of this article, the Finnish National health reform (i.e. the National project to secure the future of health care) and

especially the "guarantee for care" reform within it with its goal of decreasing waiting lists, has been characterized by a high level of complexity:

> "The demand as well as the supply side are constantly influenced by a great number of factors which at the same influence each other mutually and this not always in a linear manner: the need for care or cure, the population structure, epidemiological factors, the way the insurance companies assess future needs, the number of personnel, the efficiency of the cure and care process, changes in the emancipation of citizens, the situation on the labor market, technological developments in the medical sector, existing capacities for child care, etc. But not only is a single waiting list influenced by such factors, other waiting lists (which are on their turn also influenced by a large number of factors) also influence the length of the waiting list..:" (Kenis, 2006)

Health care, along with its surroundings, is changing with such haste, that it is impossible to control it. However, the dominant management science tries do to just that (Pitts, 1993; Conklin, 2005). The implications can be seen in the reforms which have failed to accomplish their objectives. Therefore, it can be asserted that the planners of health care reforms do not always see the true form of the problems they are trying to solve. They do not take complexity sufficiently into consideration. For example, according to Vartiainen (2005), if the planners would see the true complexity of the problems, then the reforms would be more successful than they are currently.

This article tries to answer the question of how the planners of the health care reforms see the problems they are trying to solve. With this it is hoped that we can get a better understanding of the important question: why the health care reforms tend to fail. This article will be followed by an article which approaches the major Finnish National health reform, and especially the "guarantee for care" reform within it, from the perspective of document analysis (not yet published). According to that article, the results of this health reform are not nearly as good as was hoped. It has done many good things, but it has not managed to rise high enough to be able to face the complexity of the health care system and its surroundings. The assertion is that the planners of this wide health reform did not focus enough on the complexity of the problems they tried to solve.

Structure and method

This is an interview study. The interviewees consist of 12 people in high status jobs, who in some way participated in the planning of the reform of the case study. Some of these interviewees had multiple roles and a wider perspective on the subject (see Table 1). The interviewees also represent extensively different planning work groups and, in addition, they come from different backgrounds. The researcher chose the interviewees according to the preceding qualities. Third sector representatives were included as interviewees even though their role in planning was only marginal. The potential of the third sector, however, is highly significant, so their voice is important and interesting to be heard. Politicians were excluded. The focus of the article is on the preparation process in which the politicians only played a minor part.

Table 1. Roles of interviewees.

Member/ representative of:	***Executive group of National health reform***	***Task forces of National health reform***	***"Guarantee for care" work group***	***Monitoring group***	***Third sector***
Amount	2	5	4	3	3

The interviews were conducted mainly at the workplaces of the interviewees. The average time for each interview was one hour, the longest being one and a half hours. The interviews were recorded and transcribed. The interview method was semi-structured thematic interview. The themes were clear and the questions were made according to these themes. The questions asked in the actual interviews depended on the answers and backgrounds of the interviewees. Not all the questions could be asked from all interviewees. Therefore, the interviews were conducted more like discussions than perfectly structured interviews. This way the individual voice of the interviewees came more clearly into view (see for example Hirsjärvi and Hurme, 2001).

The focus of the article is in the planning processes, for the role of those involved is of major importance. Jalonen (2007) has also used this view from the perspective of decision making in municipalities: "…decision making is the acceptance of prepared propositions and the real power is used in the preparation of matters". The research analysis is theory originated content analysis. The interview material was divided into different themes/questions according to the theory. Furthermore, the views of individual interviewees were divided into different groups under each theme. The results will be illustrated mainly using these particular groups.

The article begins by examining the reasons for why health care and its problems are complex. After this, the concept of wicked problems will be made clear. Before an examination of the results, the case study will be introduced.

Health care and complexity

According to researchers who have acknowledged the world of complexity thinking, health care is most definitely a complex adaptive system (CAS) (see e.g. Anderson and McDaniel, 2000; Peirce, 2000; Glouberman and Zimmerman, 2002). What then is CAS? According to Begun et. al. (2003), in the concept of CAS "complex implies diversity – a wide variety of elements. Adaptive suggest the capacity to alter or change – the ability to learn from perspective. A system is a set of connected or interdependent things". CAS is not a machine that could be repaired with just a few adjustments if needed. While a machine works mostly just the way it is supposed to, CAS cannot be expected to operate with the same certainty. So we are not talking about a machine here. Instead, CAS can be seen as a dynamic and open system which exhibits emergent behavior, like a living system.

Basically CAS is a living system. For example, our mind is CAS. So is our body. In the widest perspective the Earth is CAS and so is the whole cosmos. We can see complex adaptive systems all around us. What are the implications of all this? By comparing airplanes

and patients from the perspective of complexity, Munnecke (2000a) helps to clarify the potential implications of seeing health and health care as CAS. As we all know an airplane is a machine and as a machine it can be understood by understanding its parts because in a machine the whole equals the sum of its parts. An airplane also works independently of other airplanes and operates in quite a predictable environment. Patients as living systems cannot be understood simply by understanding the parts, because in living systems the whole is greater than sum of its parts. Neither do patients operate independently for they are constantly influenced by, for example, family, community and culture. So we are talking now about two totally different entities, the one being static, and the other in constant change with its environment.

Munnecke (2000a, b) also writes about fractals. With this he implies that "health care operates in much larger range of scales of behavior than the airline industry". Health is then considered to consist of many connected and interacting layers like, for example, gene, organ, individual, and species. If attention is given to one scale at time then the understanding of the whole cannot be achieved. So we should avoid sinking into the Devil's Staircase, a construction just like a staircase but with an infinite number of steps. The closer we look at the staircase the more steps will appear. This only leads to losing the "big picture". Trying to control health care is like trying to count the amount of the steps in the Devil's Staircase; it is impossible. Munnecke (2000b) concludes that "in the same way that congestive heart failure can create perfectly orderly sinus-rhythm heart waves, our attempts to control our health care system with perfectly orderly regulations and standards may indicate a pathology".

Complexity thinking also helps us to understand the fact that surprise is an intrinsic part of our world. It cannot be avoided. Of course surprises can be caused by a lack of knowledge, but mainly the nature of CAS is what makes the world unpredictable. The reasons for the unpredictability can be found from, for example, bifurcations, self-organization and co-evolution. When we accept the fact that these surprises are not usually our fault and that we cannot get rid of them by more planning and controlling, we can finally use them to our advantage. As McDaniel et. al. (2003) conclude "when we take CAS seriously, surprise will be a natural gift to us, and with a welcoming attitude, creativity and learning will be forefront".

The concept of wicked problems

The concept of wicked problems (see Rittel & Webber, 1973) consists of two main constructs, i.e. tame problems and wicked problems. A so-called tame problem depicts a problem that is by its nature simple. Basically, these are the problems we handle every day with the same routines and with almost guaranteed success. These problems are simple to define and also to solve. There is not much ambiguity with these particular problems and we do not need to change the dominant scientific paradigm to solve them.

A wicked problem, however, is a totally different story. This is a problem which is by its nature the most complex of problems. It is not enough that there is no solution to it, but in addition even the problem itself is very difficult to define. So the problem is not only about the solution, the definition of the problem also has major importance. Therefore, the definition and solution are in constant interaction with each other. In a global perspective, we can see wicked problems all around us. For example, global warming is a wicked problem. So is the war on terrorism. We can assert that there is no solid definition of these two problems for we are not even really sure what causes them. Neither does there exist any clear solution to these problems. In health care, a perfect example of a wicked problem is the goal to increase the equality in service delivering while at the same time trying to decrease the costs of health care. The ways of prioritizing services and adjusting the way of life of patients are also good examples of these very complex problems. Indeed, they are very ambiguous problems and the dominant scientific paradigm alone is not suitable to solve them (Rittel, 1972; Conklin, 2005).

King (1993) divides possible problem states into tame problems, messes and wicked problems. In the same way, Glouberman (2006) writes about simple, complicated and complex problems. Understanding the difference between these levels is important, for a solution to a problem on one level, does not work on a problem on another level. As King (1993) states: "continuing to try to 'tame' a world increasingly filled with messes, let alone wicked problems, makes it a dangerously unstable place".

At the bottom level of complexity is a tame problem. We can solve these with analytical methods and through specialization. Consensus is also easy to achieve about the problem and also about the solution. Mess is at the middle level of complexity. These are problems that cannot be solved without taking other problems into consideration. However, it is still possible to get a consensus. The problem of how to get a manned rocket to Mars can be seen as a good example of a mess. Wicked problems, however, are so complex that the more they are studied, the more people find divergent opinions about the problem and the solution. So, basically when messes start to include socio-political and moral-spiritual issues, wicked problems are born. It can also be seen that while tame problems are deterministic, messes are uncertain and wicked problems are emergent in nature. So surprises, as novel unanticipated outcomes, are a natural part of wicked problems. (King, 1993.) Wicked problems are then divergent and emergent problems. By this conclusion it can be asserted that tame problems can be solved with the ways of the dominant science paradigm. To solve messes a systemic approach must be included. But to try to survive wicked problems complexity thinking is needed.

The concept of wicked problems implies change in the design and planning processes. Rittel (1972) writes about "first generation planning" versus "second generation planning". Conklin (2005) for one uses "the waterfall" model versus "the jagged line" model as representing these two different kinds of design and planning processes. The former part of these planning styles is based on traditional thinking. This kind of planning is a linear process, starting with data gathering and continuing with data analyzing and the formulation of a solution, and ending with the implementation. This is a method, which seems to be

most often used, for example, in project management. In the latter type of these planning styles the planning process is under perpetual construction. So the problem definition defines the solution which for one defines the problem. This learning process continues indefinitely or at least until the outcome is decided upon to be good enough, for there is no perfect solution. It is necessary to realize that the understanding of every prospect of a wicked problem can never be achieved.

Wicked problem by definition cannot be solved. However, we can try to cope with the problem the best way we can (Pacanowsky, 1995; Hookins, 2005). There are some ways which can help us to survive wicked problems. First of all, we cannot implement tame solutions to wicked problems. That leads only to a worsening of the problem (Churchman, 1967). Nor can we use evidence based planning, experience, or trial and error to solve these problems for the future will not be the same as it was in the past. (Ackoff, 1974; Blackman et al., 2006). Solving only a part of the problem or solving the problem incrementally, step by step is not suitable either (Churchman, 1967; Mechanic, 2006).

Some survival methods have been introduced in the scientific literature (Roberts, 2000; Clarke and Stewart, 2000; Grint, 2005; Balint et al., 2006). According to these views, to survive wicked problems we need to think holistically, work with as many different people as possible, include citizens in the planning and decision making, and start thinking and working in fundamentally novel and creative ways. Instead of being managers of everything we need to be leaders who are not afraid to admit that we do not know everything. Instead of using authoritative or competitive strategies we need to use collaborative strategies which help us to achieve overarching win-win situations. Instead of trying to control everything, we need to live with this uncertainty as well as possible, seeing it as a possibility instead of a threat.

The Finnish National Health reform, especially the "guarantee for care" reform within it, as a case study

The Finnish "guarantee for care" reform (from now on GFC-reform) is one part of a wider National health reform. It was noticed that the operational precondition of health care and equal accessibility to care were having growing problems. So in 2001 the National health reform was set up to ensure care to every citizen regardless of their ability to pay for care. The reform had five parts: 1. viable primary health care and preventive work, 2. ensuring access to treatment, 3. ensuring the availability and expertise of personnel, 4. the reform of functions and structures, and 5. augmenting the finances of health care. (STM, 2002.)

The GFC-reform–as a part of National health reform–was implemented with success. Laws ensuring the access to care came into operation in 2005. With the laws it was ensured that patients get direct contact to health care, that they get an examination of their health situation in three days, that they get access to a specialist within three weeks of the writing of the referral, and access to actual care in three months and not later than six months. The GFC-reform started well and the amount of patients waiting for care decreased. But it

seems that the amount of patients waiting for care is already increasing, even in specialist medical care (see e.g. Stakes, 2007).

This article has highly a critical view towards the National health reform. Therefore it must be kept in mind that it did manage to make many improvements in health care. It, for example, managed to shorten waiting lists in specialist medical care (even though only pro tempore), to make some mid-sized structural changes, to increase the amount of doctors trained and to advance some working processes like the collaboration of nurses and doctors. There were, however, also significant failures like, for example, the failure to achieve any major structural changes. Also, there are still major problems in dental and mental care. Health promotion did not achieve much either. In the end, Finnish health care is still very much the same it was before.

Results

The interesting question is how especially the planners of the GFC-reform, and also the National health reform, saw the problems now being examined. Did they see them as tame problems easy to be solved, as messes which need a holistic approach, but which still are possible to solve, or as wicked problems which are a totally new kind of challenge? The hypothesis is that the problems were seen at the maximum as messes. Glouberman and Zimmerman (2002) also share this view that the problems of health care are mostly seen as complicated when they in reality are very complex or wicked. Not seeing the true form of the problem means that the solution will very likely be very short-lived, possibly with some disastrous side-effects.

The results will be examined under four different topics. The first will discuss the different views of the complexity of particular health care problems. The second sums up the pros and cons of the studied reform according to the opinions of the interviewees. The third will cover the topic of how cooperative the planning processes were. If the complexity of the health care and its surroundings were taken into consideration enough in the planning of the studied reform will be the focus of the last topic.

Tame problem, mess or wicked problem?

If the different levels of problems are thought as a continuum, from tame problem to mess and to wicked problem, then the views of the interviewees about the complexity of the discussed health care problems are divided widely across it. However, roughly examined, it can be seen that these views divide to three different groups. All of these groups acknowledge the complexity of health care in some way, but the views differ slightly (see Figure 1). The first group had the view that basically saw the problems at the most as a mess. In this case, the major health care problems, like the question of how to achieve well functional health care or how to make structural changes to health care, were seen as messes which can be solved, for example, with adequate and functionally used resources. This view,

however, sees that these problems can include some features of wicked problems and also that there are factors that make the bounded problem more complex. These factors were named different political views, the allocation of society's funds, and the divergent interests of many actors. So, in this view, the problem, when bounded, was seen in theory as a mess but in reality perhaps more like a wicked problem.

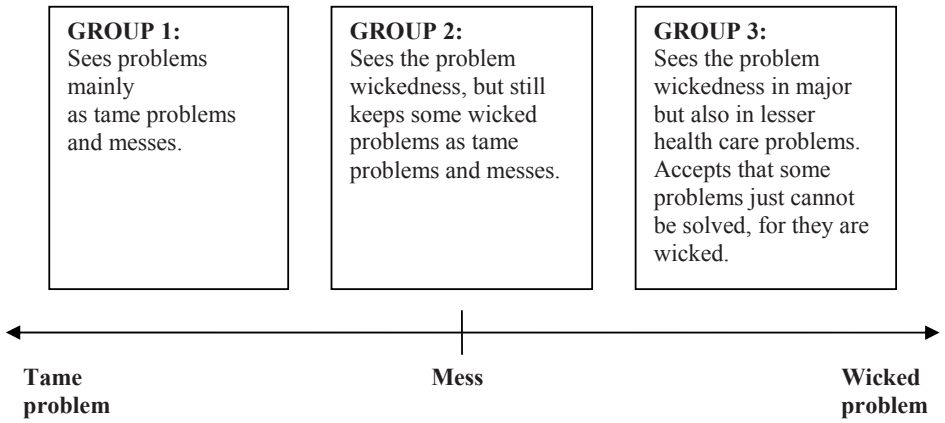

Figure 1. Different views on the complexity of the health care problems.

The differences between the views of the second and the third group are only slight. It can be seen that the second group saw the complexity of health care as whole to be situated at level three (i.e. the level of wicked problems). However, when the major health care problems were seen as wicked some others, like the problems that the GFC-reform tried to solve, were seen only as tame problems or messes. According to these views, the guarantee for care is so bounded that it cannot be understood as a wicked problem. It was seen to concentrate on simple problems when the most complex problems like chronic diseases were left out. Guarantee for care was then basically seen to consist of surgical procedures and thus it was perceived to be a very different world, concrete and simple. There was also the view that saw the guarantee for care from the perspective of surgical procedures as a tame problem, from the perspective of primary health care as a mess, and from the perspective of psychiatric care close to a wicked problem. According to this view, the guarantee for care from the part of surgical procedures was just a technical problem, especially when compared to psychiatric care.

Unexpectedly and contrary to the hypothesis of this article, most of the interviewees can be associated with the third group. This group saw health care as a whole as a complex system and in addition the problem of shortening the waiting lists was seen as a wicked problem or at least very close to it. The reasons for these views were, for example, that so many factors affect the guarantee for care that it under no circumstances is a tame problem. It was also understood that while it is easy to increase the state subsidy, this by itself does not guarantee anything. It is easy to increase money, but if it comes with an objective to get a given result, the problem becomes much harder. The following quotes sum up the most complexity endorsing views stated by the interviewees:

> "Problems of the third level (i.e. wicked problems) which are attempted to be solved through the first level (i.e. tame problems). Mechanical solutions to very complex problems."
>
> "Guarantee for care is not a simple problem, and it most definitely wasn't seen as such. Rather so that it was seen as a problem that is impossible to be solved. In the middle of this jungle of the need for resources, how do we find a consensus which everybody commits to and is content about?"
>
> "Problems that are attempted to be solved with the National health reform and with the GFC-reform, most of those are specifically on this level three… I think that most of the problems were seen to be on the second level (i.e. messes), especially the guarantee for care was seen to be on this level…"

Pros and cons of the studied reform

Interviewees were mostly satisfied with the National health reform as a whole. According to some of these views, the government has redeemed the promises that were given in the National health reform. The most positivistic opinions saw that its objectives have succeeded better than avarage and that the general grade of the National health reform would be around seven or eight, on a scale of four to ten. Successes were seen to be, for example, the increase of state subsidies of health care, minor structural changes and the increase of the education of medical personnel. The most critiques were received by the failing of the major structural changes.

When the discussion was bounded to the GFC-reform inside the National health reform, the opinions started to differ more. All in all, basically every interviewee saw that guarantee for care managed to do something good. For example, the statements from one of the interviewees "the end justifies the means" and "change is the most important" make otherwise negative or neutral opinions more optimistic. At least something was done. The success of the GFC-reform was seen to be that it managed to cut the waiting lists in the sector of surgical procedures. Some interviewees also agreed that guarantee for care had significant positive effects because it forced health care systems to improve their processes and therefore to change.

There were, however, some problems with the GFC-reform. Interviewees saw that it did not work equally well in all the different health care sectors. Most of the focus was given to specialist medical care. Primary health care, psychiatric care and dental care got much less attention. The most critiques focused on dental care, which was even seen to take steps backward, and to psychiatric care which was considered to be a downright outrage, especially on the part of mental health care for children and adolescents. One reason for the failing of guarantee for dental care was a flaw in resources. It was noted that resources cannot be made to be enough just by enacting a law that says the resources must be enough or as one interviewee stated: "It is like the Russian army ordering that a soldier doesn't feel cold, so he doesn't need a greatcoat at all". This same idea can also be seen to cover the other parts of the guarantee for care. The law was written, but it was not enough. In addition, it was perceived that the bad aspect of the GFC-reform was that it cannot cover the whole of health care and therefore the matter of who gets the care and who does not can be distorted.

It was also seen that the GFC-reform took the bottom away from health promotion. There were two differing views on this matter. According to first view, health promotion got high visibility in National health reform. For example, it was the first topic in the memorandum which covered the development plan of the National health reform. Another argument of this view was that just before the National health reform, the Health 2015-plan, which concentrates on health promotion, was written up. So it was not necessary to create the same paper again. These views do not remove the fact that health promotion was harmed by the GFC-reform. First, it was wondered if it was said in the Government decision-in-Principle on securing the future of health care that primary health care is the foundation of health care systems, and that health promotion was in an equally important role, then why so much money was put towards activity that in the end mainly focused on specialist medical care. Guarantee for care was seen one of these activities that mostly benefited specialist medical care. This was not a surprise to the interviewees as can be seen from one statement:

> "It is always that the sexy fields in health care like surgery and so on always beat, you know, these un-sexy fields like mental health and health promotion… It always happens, it is said, you know, that the sexy surgeons won…"

The common view was that the money was used so much for the guarantee for care system that health promotion was left in the backseat. So surgeries were increased and health promotion thereupon decreased. Basically, guarantee for care dominated the discussion of health care for two years very clearly according to interviewees, which of course influenced the field of health promotion. There is just not money for everything, so those activities are done that can be measured and as it was stated, the GFC-reform measures the amount of provided services. It was caricatured that: "Now it is beneficial to leave health promotion out and wait for a man to get diabetes and then give him a new pancreas. And then we get a new produced service and everything works well within the law."

Interviewees were of the mind that now is the time to give strong attention to health promotion. It seems that this is happening now, for the new government platform has strongly highlighted health promotion. It is seen as a countermove to the GFC-reform and as a one interviewee stated, "now is the time for health promotion". It was, however, also seen that the National health reform with the GFC-reform managed to raise the discussion of Finland's health care problems and therefore it significantly affected this day's conversation regarding health promotion.

Then there is the question of how long lasting the results of GFC-reform are. It managed to shorten the waiting lists, especially in specialist medical care, but do the interviewees see that it is a lasting result? Mostly it was seen that the queues for care will stay stable. However, there were also opinions that pointed out that the decreased waiting lists in specialist medical care will rise again to be as high as before and especially so if the processes of health care will not be improved. It was noted that at some time the demand will surpass the possible supply. In the beginning of planning, what could happen if specialist medical care applies too loose criteria for the access to care was feared. That would increase the queues, because it would be easier to get care. The more the queue lowers, the more people are interested in possible care. One of the interviewees saw that it is untenable to shorten waiting

lists by continuous clearing operations. Instead, according to this view, decreasing the queue to care must be a one-shot operation. After that one operation the demand for care must be kept low with the criteria for care and with the improved processes. With the criteria for care each patient is given points and if he gets enough, he will get the care. So the demand must be controlled.

A criterion for care has however got much critique. First, it was noted in the planning of the GFC-reform that this kind of criterion has been problematic, as it was acknowledged in other countries that have tried it. These criteria are easy to be manipulated and if the doctor feels that care is needed then the numbers can be defined so that the care is given. It was also wondered that if it was known that this kind of criteria does not work, then why they were implemented. Second, it was seen that criteria makes the care too mechanical. Some diseases are so complex that this kind of simple criteria just do not work.

In addition, it was also noted that the follow-ups of the GFC-reform are giving too positive feedback. Third sector organizations started to get a different kind of feedback from the patients about the results of guarantee for care and therefore they made their own evaluation. According to this, the results were not nearly as good as the authorities illustrated. Official follow-ups had forgotten the views of the patients. Numbers do not tell everything. Some patients, for example, valued other aspects more than fast access to care. And, of course, the official follow-ups did not mention clearly enough that there were dead people in the waiting lists and people who did not need care anymore. Just by removing them, the queue to care shortened. Table 2 will sum up the preceding views.

Table 2. Arguments for and against the National health reform, especially the GFC-reform within it.

ARGUMENTS FOR…	**ARGUMENTS AGAINST…**
-National health reform as a whole was partly successful -GFC-reform managed to do something, i.e. change is most important -GFC-reform forced health care systems to improve their processes and therefore to change. -GFC-reform managed to cut the waiting lists in the sector of surgical procedures -Health promotion got high visibility in National health reform. -National health reform with GFC-reform managed to raise the discussion of Finland's health care problems and therefore it significantly affected this day's conversation of health promotion.	-Not all the parts of National health reform succeeded -GFC-reform did not work equally well with all the different sections of care - Resources cannot be made to be enough just by enacting a law that says the resources must be enough - GFC-reform cannot cover the whole of health care and therefore the matter of who gets the care and who does not can be distorted. - GFC-reform took the bottom away from the health promotion -A criterion for care has gotten much critique -The queue to care will rise again -Follow-ups of GFC-reform are giving too positive feedback

How cooperative were the planning processes?

As Roberts (2000) states, the best way to survive wicked problems is to use collaborative strategies instead of authoritative or competitive strategies, for usually the two latter fail and lead to the last resort, i.e. collaboration. Interviewees were asked how they saw the planning of the National health reform and the GFC-reform. Was the planning authoritarian, competitive or collaborative? Roughly examined, the views of the interviewees' can be divided into two different groups.

The first group sees the planning of the National health reform consisting mainly of collaborative strategies, but also including some elements of authoritative and competitive strategies. A slight majority of the interviewees belong to this group. The reasons for this view were variable. Firstly it was noted that there was a large number of people, more than 400, included in the planning processes by the way of hearing processes. Second, it was perceived that the different actors in health care and society were participating positively in the reform. So there was only a little competition present. Third, it was seen that there was regional representativeness and an equal amount of men and women in the planning groups.

Some views in the first group, however, paid attention to the authoritative elements of the planning processes. So even though the collaboration was a dominant element, at some point of the planning, some authoritarianism emerged. It was seen that the closer the implementation got, the more authoritative the planning grew. Someone needed to take responsibility and make the choices of what objectives to highlight and what to bind off, etc. So basically if the collaborative approach does not work, then authorities must step forward and make the decisions. There was also a view that this kind of authoritarianism is not really that authoritarian because the decisions made by the authorities were not dreamed up. These decisions were based upon the discussions in the society, for example. Therefore, according to this view, these authoritative decisions were not that authorative.

The second group, on the contrary, perceived the planning processes mostly as authoritarian, but also included some competitive and collaborative elements. Many reasons for this view were provided. To begin with, some interviewees thought that third sector organizations were not included enough in the planning. They were heard, but that was not felt to be always enough. In addition it was perceived that it was regrettable that the patients were left out of the planning:

> "This inventiveness of patients and the use of the resources of sick people are still exactly in zero. If we would include these sick people in planning the results would be totally different and less money would be spent"

It was also stated that even though many people were heard in the planning, the final decision making power was concentrated to only a few. It must be noted that not everyone thought that as a bad thing.

> "These persons in charge had, in a way, major power to decide what will be written down…and as we can see with what kind of speed these matters were set forth, it was

> kind of authoritative, then, this reforming of legislation and increasing the amount of doctor trainees, yeah, it was done just like that. "
>
> "I myself thought that it would have been collaborative when we started to ponder it (the guarantee for care) through with team… But then I guess that at some point of the way it jumped to authoritative, of course, because the authority was the Ministry, which in the end made it (the final paper for the guarantee for care) without asking anything anymore from the team as a whole."

In the planning of the National health reform there were perceived to be some other defects. For example, it was thought by a few interviewees that the planning was slightly fragmented. There were many different task forces and it was felt that it would have been better if there would have been more collective gatherings of all the teams. Because of the fragmentation, the information did not always reach the other task forces. There were also some problems inside the working teams. Collaboration did not work in some cases and it was seen that some persons in charge acted like autocrats. As a result, some opinions were not taken into account and some relations even fell apart. Figure 2 sums up the views of these two groups.

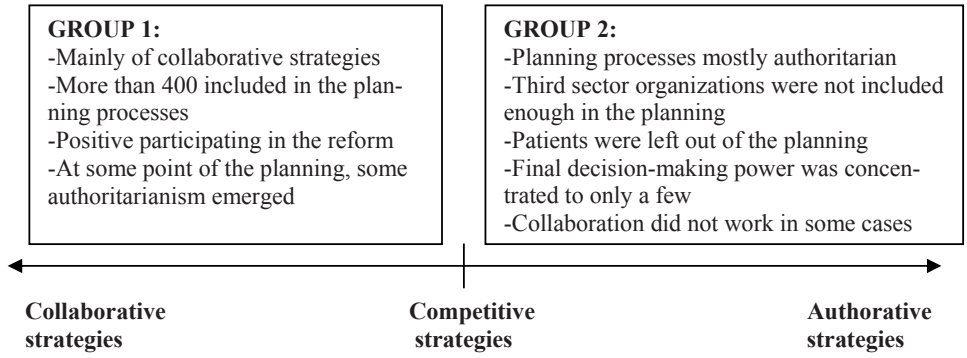

Figure 2. Views about the cooperation in planning of examined reforms

Was the complexity of the health care and its surroundings taken into consideration enough?

This final topic will concentrate on two slightly polarizing views about complexity. As has been stated earlier, the complexity of health care was mostly understood by the interviewees and also the National health reform was mainly accepted as a positive outcome. Again, however, it can be seen that the views about the holism of the case study reform divide into two different groups.

The first group defends the limited scope of the National health reform. According to this view there was only a limited amount of time to make the plans and then carry on. It was seen that if the National health reform would have been expanded by including social care, it would have become too big to swallow. Mainly linear progression, the quick identification of problems and very pragmatic actions were therefore justified in this view. As one of

the interviewees stated, “it is always the question of what baggage one chooses to carry, because if one loses strength before finishing, then it is a worse outcome compared to if one takes it home barren”.

When it comes to health promotion, the view was that it was an important part of the National health reform. It was taken into account and it was even written down as number one, but it was admitted that health promotion took place more in thoughts and words than in actions. Basically it was seen that it just was not possible to do everything: ”Maybe it must be thought so that every reform has its limits of what can be done, and in order to clear the queue it was necessary to focus so much force on it, so that not everything was able to be done”. This comment refers to the fact that not every part of the National health reform worked as well as guarantee for care.

It was also emphasized that the case study reform was a calculated shake-up of health services. Just before the National health reform, a decision in principle focused on public health was made. So the reform of health services was seen as a follow-up to that decision in principle. The same which was done to public health was intended to be done to health services. It was seen that health promotion was in the background and that next it was needed to shake up the long waiting times. As it was said: “it was not possible just to wait that preventive health care advances so much that people do not need so much care anymore…”.

The second group does not have as optimistic a view on the subject as the first group. From this group emerged a particularly interesting view which was somewhat more fundamental than the view of the first group. According to this view, much more holistic and even big-bang styled reforms are needed. It was also delineated that Finland is polarizing to two different kinds of nations and that Finnish health care is already in crisis. Those who have occupational health care are in an entirely different standing than those who do not. As one interviewee stated, the first time those who have the occupational health care face the truth is when they retire. What is happening now is basically that those who already have good care are given even more.

> “…this has already happened. It is now self-deception to say that we have, in primary health care this has at the very least happened, this polarizing and soon it will also happen in specialist medical care. It is only a matter of time.”
>
> ”…it is only going to get worse, it hasn’t had an effect at least in a time period of a few years to that problem which is related to equal access to care and also to care, that what level of care one gets. Finland is polarizing to two different kinds of nations and that’s just the way it is.”
> ”…no one can say that the Finnish health care isn’t already in crisis anymore. I think it is like sticking your head in the sand to say that everything is fine. I think that the system must be fundamentally changed.”

It was seen that public health care is protecting its own turf and that it does not acknowledge the potentials of the whole nation. Instead of putting the private and third sectors to better use, the public sector very likely just increases its own capacity. One reason for this was seen to be that a new kind of thinking is feared for it calls for such major changes that

people just do not dare to think that way. It is clear that the role of the private and third sectors was perceived to be significant by these interviewees. They emphasized that better use of these two sectors would have given much better results than what the National health reform has now given.

The view of the second group was basically that the planning of the National health reform and especially the GFC-reform was too pragmatic, too bounded and too linear. Partly it was seen that the complexity was taken into consideration enough. In this view it was stated that because the assignment, especially in the GFC-reform, was really strict it really did not give any free will to question the choices made and so endorse the complexity. It was felt that the problem was simplified and important elements were bounded off. As one interviewee expressed, when it became clear that there will be difficulties to finance the guarantee for care, a ministry official just stated to the task force, which was planning the guarantee for care, that "we are making a law here, so the mission of the task force is not to think about the financial situation of the municipalities". So the hands of the task force were quite limited:

> "…and I guess it was also thought if there is any reason to do the guarantee for care this simplified way, why not to the preventive care, but it wasn't our assignment. It was outside and that's just the way it was. It wasn't any health promotion guarantee"

> "…in fact I see that it is quite dangerous that we use this kind of defining of problems and that we begin supposedly to solve these problems. That is, you use this word linear, it is like that. It is linear thinking that cannot lead to anything else but to failure"

Partly it was seen that the complexity was not taken into consideration enough. The planning in the GFC-reform was perceived to be too pragmatic. The heard experts were too exceedingly lawyers and it was thought that maybe there should have been more experts of health policies. It was also seen that the views of experienced consultants should have been included in the planning processes. This would have brought new views to the planning. Therefore it was seen to be "worrisome that they (the government and municipalities) in a way do not dare to admit that they do not have the know-how and then to seek it from the places where changes have been done broadmindedly". Figure 3 sums up the preceding two views.

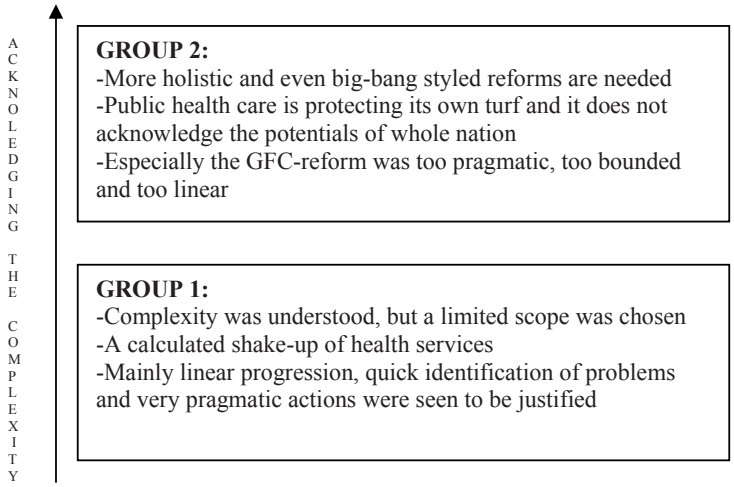

Figure 3. Views about the acknowledgement of the complexity

Conclusion

The subtitle of this article is "Is the wickedness of the problems taken seriously or is it even noticed at all?". According to the study the result is that the wickedness of the problems was mainly noticed, but that it was not taken as seriously as it should have been. In other words, the planners mostly saw that the problems were very complex, but even then the solutions were only like solutions for tame problems or messes. In the words of the concept of wicked problems, we are talking now about "taming the problem", which very likely never ends well.

Planning was partly perceived as bounded. It did not give enough breeding ground for innovations, self-organization or emergence. Problems were defined by few people and they were then to be solved. For example, guarantee for care was implemented as one of the solutions. Maybe in the beginning it was seen only as a minor part of the National health reform, but in the end it grew by its effects to a major role. It might be seen only as a simple thing that a guarantee like this comes into action, but the world is a complex place and even simple things can have enormous effects. Therefore, this simple GFC-reform has had major effects all over health care and also the society, and not all of these effects have been positive. For example, if one has the view that the medicalization and polarization of the society have gone too far, then the guarantee for care has not made these things much better. It might, for example, be pondered if these reforms of health care will only lead to profuse emphasis of health and health care at the expense of other important factors, making the problems even worse.

The view that not everything could have been taken into consideration is, however, alluring. Something was done and is not that which matters. If the reform would have been more fundamental, maybe then nothing would have happened. However the question of whether the complexity of health care and its surroundings should have been taken more seriously

into consideration in the planning of the National health reform is impossible to answer in retrospect. The world is a complex place with unknown futures so maybe thinking that "what if", is futile in the end. Whatever the answer, the following statements from one interviewee conclude this article:

> "but now I could of course in a completely different way, as I have been myself part of this and in responsibility myself, so I could, like, you know, with a deep chest note of experience, to highlight that maybe not then the fifth project or sixth or tenth, but now we shall do something little differently, because these problems haven't vanished anywhere. These are these, you know these wicked problems, they don't disappear anywhere. We just need to learn to live with them…"

> "I see that the biggest challenge is that we don't want to admit that wicked problems exist. If we would admit it, which isn't at all defeatism, but it is that that we understand the basic elements of this complex system, then the pain and also the fruitless work would lessen"

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The Public as Policy Expert: Deliberative Democracy in the Context of Finnish Health Care Reforms and Policies

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Abstract

The provision of health care in contemporary developed societies has become a so-called "wicked problem." Tackling the many important challenges is a daunting task—so much so, in fact, that it may prove to be a "mission impossible." This reality has significant implications for the crafting of health care reforms and policies. Moreover, and more fundamentally, there exists no widely accepted standard by which to generate, evaluate, and prioritize reform and policy proposals. In view of these difficulties, turning to the public for guidance may be the wisest course of action. Specifically, a democratic mechanism is needed by which the public can consider a range of policy directions and can deliberate the consequences and trade-offs in view of people's values and priorities. In short, some form of deliberative democratic exercise is called for. The chief aim of the present article is to highlight the possibilities for bringing the principles and methods of deliberative democracy to bear on health care in Finland, and in particular on developing proposals for reform and policy. The essay consists of four parts. First, I offer a theoretical perspective on deliberative democracy and its potential for dealing with "wicked problems." Second, I situate the theory in the context of the crisis of the Finnish welfare state. In part three, I consider the relative dearth of existing forms of deliberative democracy in Finland, and present an upcoming Finnish experiment on public deliberation. Finally, in part four, I examine the views of two groups: representatives of Finnish patient and disability NGOs, and a group of Finnish citizens. I ask whether they see the need for or value in increased citizen involvement in the planning of health care reforms and policies.

KEYWORDS: health care, Finland, complexity, deliberative democracy

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Introduction

The provision of health care in contemporary developed societies has become a so-called "wicked problem." Responding adequately to the health care needs of a large population, and doing so at a sustainable cost burden to society, is a task so complex, or "wicked," that it cannot be solved completely (e.g. Rittel & Webber 1973; Glouberman and Zimmerman 2002).[1] We can only try to manage it the best way we can (see Pacanowsky, 1995; Hookins 2005).

Tackling the many important challenges of health care is a daunting task—so much so, in fact, that it may prove to be a "mission impossible." This reality has significant implications for the crafting of health care reforms and policies. Moreover, and more fundamentally, there exists no widely accepted standard by which to generate, evaluate, and prioritize reform and policy proposals.

Simply put, even in developed societies it is not possible to organize equal and optimal care for everyone at a feasible cost. For example, populations are growing older; chronic diseases are increasing; medical technology is becoming ever more expensive; citizens continue to expect and demand more and better care; and resources available for health care are diminishing relative to other social priorities. In these circumstances, it is not humanly possible to build a health care system that affords all the best care medically possible (see e.g. Gaylin 1993). Yet this is precisely what most health care reforms and policies try to achieve. They are searching for the elusive (perhaps even mythical) "Holy Grail" of health care (see e.g. Alban & Christianson 1995).

The preceding conclusion suggests the need for a new approach to setting health care policy and crafting health care reforms (Raisio 2009a; 2009b). If it is not possible to find the one perfectly right solution, what is the best feasible or

[1] Wicked problems are highly complex, ambiguous and divergent problems. Specifically, Rittel and Webber (1973) attribute ten characteristics to such problems. Conklin (2005),without losing the essence of the concept, condenses the ten to the following six attributes:

- *"You don't understand the problem until you have developed a solution."* Every proposed 'solution' increases understanding of the problem, with the result that understanding of the wicked problem and its 'solution' evolve interdependently, basically forever.
- *"Wicked problems have no stopping rule."* A criterion which tells when the problem has been solved is missing.
- *"Solutions to wicked problems are not right or wrong."* Individuals can judge the solutions from their own viewpoint and all of them are basically equally right. For some the solutions are good, for others bad, and maybe to someone else good enough.
- *"Every wicked problem is essentially unique and novel."* There are similarities, but even the smallest of differences can override these.
- *"Every solution to a wicked problem is a 'one-shot operation'."* Every attempt to solve the problem has consequences which cannot be undone.
- *"Wicked problems have no given alternative solutions."* Continuous creativity is needed to generate possible solutions to wicked problems.

practicable solution? And how do we arrive at it? Can politicians, government officials, and health care professionals make this determination? In my view, they cannot—at least not by themselves. A technocratic, institutional approach will fail, as it frequently has (see, e.g. Yankelovich 1995; Mihályi 2008; Raisio 2009b). Instead of proceeding straightaway to the concrete, detailed provisions of a policy, we must—as a society—confront the inescapable hard choices with which health care presents us. We must seek a rough consensus about what we value and what our priorities should be (see Conklin 2005). This is something a technocratic elite alone cannot achieve. Experts possess no authority in the matter of allocating and prioritizing social values. In a democracy, only the citizenry may do so. And in order for the citizenry to carry out this difficult responsibility, institutional decision-making concerning the details of policy must be guided, supported, and preceded by the deliberative construction of a societal consensus.

Many modern societies have already started to realize the importance of public deliberation in the planning of health care reforms and policies. For example, the UK has been experimenting with Citizens' Juries since 1996 (Lenaghan 1999). However, in Finland deliberative democracy is still in its infancy, not only in the field of health care, but in every policy field. Concern about the lack of deliberation in Finland lies at the heart of this essay. As major problems and challenges in Finnish health care continue to resist solution, it is worth asking whether it is time for the public to grapple with the need to offer policy-makers clear guidance at the level of principles and priorities. Instead of creating a raft of new reforms and policies even before previous ones have been finished and evaluated (see Vartiainen 2005), perhaps we ought to find out what the public thinks when it has a chance to consider its options and the inevitable trade-offs (see Raisio 2009a).

Below, I begin with a perspective on deliberative democracy and its potential for dealing with "wicked problems." Second, I situate the theory in the context of the crisis of the Finnish welfare state. In part three, I consider the relative dearth of existing forms of deliberative democracy in Finland, and present an upcoming Finnish experiment on public deliberation. Finally, in part four, I examine the views of two groups: representatives of Finnish patient and disability NGOs, and a group of Finnish citizens. I ask whether they see the need for or value in increased citizen involvement in the planning of health care reforms and policies.

Part 1: Deliberative Democracy and Wicked Problems

In this section I will give reasons for considering deliberative democracy as the first, indispensable step toward the crafting of coherent, effective, and widely supported health care policy in Finland. I will do this in three stages. Each stage highlights a problem with a certain level of complexity and the implications for

citizen involvement. The stages are problem tameness, problem messiness, and problem wickedness (Rittel & Webber 1973; King 1993).

Tame problems[2] and habitual performance

If problem complexity were placed on a continuum from simplest to most complex, "tame" problems would be situated at one pole. A tame problem is easy to define and also easy to solve (Rittel & Webber 1973). It is a "convergent" problem (King 1993). There is almost no ambiguity in it. Solving the problem is straightforward—in time, a "linear" approach yields a solution. An example is repairing a machine (e.g. Roberts 2000). From their training and experience, technicians easily identify the problem and routinely apply standard procedures to solve it.[3]

Tame problems in matters of public policy and public administration could be solved without involving the public in the process. A small number of experts with the requisite training, experience, and specialized knowledge could readily identify the nature of the problem and the solution, neither of which is likely to occasion disagreement. (Weick & Roberts 1993).

For example, if the development of a national health care system were viewed as a tame problem – as often might be the case (see Vartiainen 2005; Raisio 2009a) – it would be assumed that a solution exists that could be devised by scientific or managerial experts. The solution would enable the system to respond effectively to growing and changing patient demands. Unfortunately, resources are always scarce relative to wants—everybody cannot be provided with everything. As Grint (2010) puts it, in the end there is a need for a political decision and, more specifically, for politically-charged health care priority-setting.

Even though health care as a whole will not yield to solutions suitable for tame problems, it includes tame parts. For example, in the case of surgery it is realistic to think (and certainly to be hoped, if one is the patient) that the problem to be solved by the surgical procedure is a tame one (Grint 2010).

[2] Solving tame problems can be compared to puzzle solving or solving a mathematical equation. Firstly, in tame problem there is then a well-defined and solid statement of the problem and a definite list of objectively evaluated right solutions and permissible operations, e.g. chess. Secondly, there are rules according to which certain groups of problems can be solved, e.g. equation groups. When solving tame problems it is possible to start all over if failed, no harm has been done by failing. Also, there exists stopping point for a tame problem, a point of closure. (Rittel & Webber 1973; Conklin 2005.)

[3] Solving tame problems has also been characterized as using the "waterfall model" (see Conklin 2005); as "normal science" (see Funtowicz & Ravetz 1994); and as "routine management" (see Grint 2005).

Messy problems and the collective mind

In "messy problems," complexity increases, but the problem remains a convergent one: even starting from different perspectives, problem-solvers can reach agreement concerning the nature of the problem and may eventually "converge" on a small range of solutions or even on a single one. Although tame problems can be solved by focusing on individual parts of the problem, a more systemic approach is needed to deal successfully with messy problems. In the latter case, the parts are interrelated in a manner and to an extent that requires close attention to interactions between the parts both in the present and in the future (King 1993). Hence the importance of an approach that sees "the big picture".

It is easy to understand why the involvement of citizens might be necessary for the solution of messy public problems. The messier a public problem is, the greater is the need for application of the "collective mind," the process by which many actors construct a collective view of the problem and respond to it through complementary actions (see Weick & Roberts 1993). According to Weick and Roberts (1993), the more heedfully[4] the interrelating between actors is carried out, the more developed and more capable of intelligent action the collective mind will be. And the more diverse the participation, the more comprehensive the "big picture" will be.

Weick and Roberts (1993) envision the importance of collective mind especially in situations where almost continuous operational reliability is needed. The presumption is that as collective mind (i.e., heedful interrelating) strengthens, the actors in the system begin to understand better the complexity they are faced with. The comprehension of unforeseen events grows, and as a result the incidence of errors within the system decreases. Conversely, when the collective mind weakens—i.e. when the interrelating deteriorates—actors grow more isolated, comprehension declines, and interrelating becomes more and more difficult. Individual mind begins to replace collective mind and problem wickedness begins to emerge: "As people move toward individualism and fewer interconnections, organizational mind is simplified and soon becomes indistinguishable from individual mind" (Weick & Roberts 1993: 378).

Messy problems are difficult largely because of their epistemic uncertainty. But with time and effort by people acting as a collective mind, they can yield to shared analysis and understanding. Citizens may make an important contribution to solving the problem by being part of the collective mind. Conventional institutional structures and processes, such as public hearings, may lead to

[4] "Heedfully" means "critically," "attentively," "purposefully," "consciously." (Weick & Roberts 1993).

efficient "solutions," but fail to produce effective, sustainable policies that require public acceptance and continued support.

Wicked problems and co-intelligence

When a problem gives rise to sensitive socio-political and moral-spiritual issues with respect to which people hold many divergent opinions, it becomes much more resistant to solution. Familiar examples are global warming, terrorism, and health care priority setting (see Raisio et. al. 2009). These are so-called "wicked problems," i.e. problems that are both very hard to define in a clear and widely acceptable way, and extremely difficult—even impossible—to solve to the enduring satisfaction of the contending stakeholders (Rittel & Webber 1973). The major difference between messy problems and wicked problems is that the eventual consensus that can be expected in messy problems gives way to stubborn dissensus. Instead of coherence, fragmentation prevails (Roberts 2000; Conklin 2005). This thwarts attempts to "engineer" solutions. Making progress toward solving wicked problems approaches in which every stage of planning must be viewed as an opportunity to enhance understanding of the problem and possible solutions (Jentoft & Chuenpagdee 2009; Conklin 2005; Funtowicz & Ravetz 1994). If tame and messy problems can be compared to unassembled pictures the outlines of which are known or readily discovered, wicked problems are akin to pictures that cannot be readily drawn, because they differ substantially in the minds of different stakeholders. Thus solving wicked problems is more about learning than knowing, and more about responding to something that has never happened than dealing with something that has occurred and been experienced previously (Conklin 2005; Grint 2005).

For example, the problem of long waiting lists in health care systems – an issue that has received considerable attention in discussions of Finnish health care –is a wicked problem (see Raisio 2009a). It is highly complex: myriad factors influence both demand and supply. Kenis (2006) mentions a few of these factors:

> "…the need for care or cure, the population structure, epidemiological factors, the way the insurance companies assess future needs, the number of personnel, the efficiency of the cure and care process, changes in the emancipation of citizens, the situation on the labor market, technological developments in the medical sector, existing capacities for child care etc."

Procedural attempts to decrease waiting lists – such as enacting time limits for accessing care, as has been done in Finland – generate "waves of consequences" (see Weber & Khademian 2008) that can and do prove unexpected. Shorter waiting times for surgical procedures, for example, might result in longer waiting times of psychiatric care (see Raisio 2009a). This is a form of "cannibalism"—

one part of the health care system is prioritized at the expense of the others (Bruni et. al. 2007). As one interviewee in a previous study (Raisio 2009a) observed, "Guarantee for care (i.e. patient is guaranteed to get the care in a certain time limit) is not a simple problem, and it most definitely wasn't seen as such. Rather so that it was seen as a problem that is impossible to be solved. In the middle of this jungle of the need for resources, how do we find a consensus which everybody commits to and is content about?"

Citizen involvement in the effort to solve wicked problems is important because such problems can be understood as "problems of interactions" (van Bueren, Klijn & Koppenjan 2003). In such problems, everyone possesses some portion of "the truth" (Roberts 2000). Lack of coherence creates a need for communication—for dialogue and deliberation—to "piece together" both the picture of the problem and its solution. The "collective mind" cannot be brought to bear if there is no foundation on which to build. "Co-intelligence"—"the ability to generate or evoke creative responses and initiatives that integrate the diverse gifts of all for the benefit of all" (Atlee 2003: 3)—is required simply to make sense of the problem.[5]

In a world that is highly fragmented, many problems become wicked ones. Understanding what is at stake and what the impact on others will be of adopting different possible solutions is crucial. That is precisely why the principles and practices of deliberative democracy are needed.

Deliberative democracy: Definitions, prospects and challenges

"Deliberation" is "debate and discussion aimed at producing reasonable, well-informed opinions in which participants are willing to revise preferences in light of discussion, new information, and claims made by fellow participants" (Chambers 2003). "Deliberative democracy" can then be defined as "an association whose affairs are governed by the public deliberation of its members" (Cohen 1991).

Although it may culminate in voting, public deliberation is not the same thing as voting.[6] Traditional voting is a purely private act, not public (Parkinson 2004). So are polls and surveys (Tenbensel 2002; Ralston 2008), which are a form of

[5] In the context of wicked problems, where blaming, dissensus and fragmentation prevail (Conklin 2005), co-intelligence has an important role to play. According to Hartz-Karp (2007), co-intelligence can help us to be the best we can be. In her view, there is a clear need for co-intelligence. In a world which has become so divided, the understanding of the life situations and the opinions of others is more important than ever. People can no longer afford (if they ever could) to concern themselves solely with their strictly personal interests, but must instead take into account the experiences, needs, concerns, and priorities of others.

[6] According to Cohen (2009), the results of voting based on aggregation of uninformed and unconsidered views are likely to differ from the results based on "voting among those who are committed to finding reasons that are persuasive to all…."

informal, unofficial "voting." All voting lacks the opportunity for interpersonal dialogue and deliberation among individual decision-makers (Lenaghan 1999). In contrast to public deliberation, which may result in a collective view shared to varying degrees by the deliberators and not identical to the individual views of any, voting merely aggregates, or adds up, the preferences (or opinions, desires, etc.) of the individual voters. (Warren 2008; Fishkin 2009).

Compared to a post-deliberation "public voice" (see Mathews 1999), aggregate opinion has at least three weaknesses. The first is its static character. Aggregation produces a static "snapshot" of a dynamic phenomenon: not the evolution of a stable "public judgment."[7] Aggregate opinion has "shallow roots" and is prone to change. The second weakness is that aggregate opinion is superficial. It consists of respondents' "off the top of the head," unreflective, immediate responses to a particular question or statement posed by a pollster or survey-taker. Aggregate opinion differs substantially from a considered *judgment*: what citizens *would* think—what they *will* think—after having adequate opportunities to consider other perspectives, explanations, evidence, and options for action. Finally, in contrast to a post-deliberation public voice, aggregate opinion lacks nuance. It does not reveal where the public agrees and where it disagrees, or the reasons why. It gives no indication of what underlies people's views or what might change them. (see e.g. Yankelovich 1991; Atlee 2004; Fishkin 2009; Kim et.al. 2009).

Conventional public meetings provide little opportunity for deliberation. Typically, time is short (Rawlins 2005); the issue is narrowly framed as one of approving or rejecting a specific policy proposal; the purpose is either to inform the audience or to gather comments (or worse, simply to defend the proposed policy against criticism); and members of the public are neither encouraged nor aided to deliberate among themselves in order to work through their differences in order to set a public priority. Public meetings frequently are dominated by persons or groups who have the largest stake in how the issue is resolved and who therefore bring intense passion to the issue, with the result that they are usually more intent on in making their own views known than listening to others' views. Public meetings can even be staged or "hijacked" for partisan political advantage. (Gregory, Hartz-Karp & Watson 2008; Fishkin 2009).

In contrast to traditional forums of public participation, deliberative forums offer "safe public spaces" for all citizens (or a representative sample thereof)—not just those having special interests—to meet and to "truly discuss and listen to each other." Fishkin (2009: 51, 33-43) has defined five conditions for a high-quality deliberative process. These are presented in Table 1.

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[7] Yankelovich (1991: 6) defines public judgment as "the state of highly developed public opinion that exists once people have engaged an issue, considered it from all sides, understood the choices it leads to, and accepted the full consequences of the choices they make."

CONDITION	DEFINITION
Information	"The extent to which participants are given access to reasonably accurate information that they believe to be relevant to the issue."
Substantive balance	"The extent to which arguments offered by one side or from one perspective are answered by considerations offered by those who hold other perspectives."
Diversity	"The extent to which the major positions in the public are represented by participants in the discussion"
Conscientiousness	"The extent to which participants sincerely weigh the merits of the arguments."
Equal consideration	"The extent to which arguments offered by all participants are considered on the merits regardless of which participants offer them."

Table 1. Five conditions for a high-quality deliberative process (Fishkin 2009: 33-43)

In practice, deliberative public processes and events remain relatively rare (Herne & Setälä 2005). But the number and variety of methods and tools for achieving public deliberation continue to grow, each having particular strengths and weaknesses. Some of the most common approaches are the National Issues Forums, Study Circles, Participatory Budgeting, 21st Century Town Meetings, Citizens' Juries, Planning Cells, Consensus Conferences, and Deliberative Polling (Rowe & Frewer 2000; Fung 2003).

Theoretical justifications for public deliberation are numerous. Deliberation, it is argued, is an aspiration implicit in all conceptions of democracy. Whether members of a parliament or merely of a local council, elected public officials are expected to engage in reasoned debate that improves the prospects for sound and equitable public policy. Insofar as politics falls short of that ideal—as it seems increasingly to do—deliberation is seen as an antidote to excessive influence by organized pressure groups, to partisanship, and to the self-interested desire to remain in office and to accumulate political power (Fishkin 2009). Similarly, public deliberation is considered desirable to counter the susceptibility of contemporary large-scale popular initiatives to manipulation by special interest campaigning (Ferejohn 2008; Warren 2008). It is unlikely, of course, that public deliberation will ever drive self-interested, power-based competition from democratic politics. But the more harmful practices of such competition might be curbed and the more damaging consequences might be limited if deliberation, with its implicit focus on the common good, could be more deeply and broadly institutionalized. (Cohen & Fung 2004.)

Table 2 sets out some of the other aims and benefits of deliberative practice. Viewed, though, from the perspective of problem "wickedness" described above,

the promise of public deliberation lies chiefly in its potential to mitigate the problem of "separateness" (see Fishkin & Farrar 2005). Wickedness stems in part from the diversity of viewpoints people bring to the problem and from the fact that those viewpoints typically are rooted deeply in different "worldviews," i.e., systems of connected factual and evaluative beliefs that are not readily bridged (e.g. Roberts 2004). The problem with "separateness" is that inhabiting different worldviews makes it difficult for people to comprehend fully and, more important, sympathetically, each other's experiences, perceptions, concerns, priorities, and so forth. It is not easy for people to accept, as Mary Parker Follett suggests with her analogy of piano keys, that "value comes not in separateness, but in relating" (Morse 2006: 10). When people are separated by worldviews, and when problems have roots in multiple worldviews, mutual comprehension becomes essential to analyzing the problem accurately and to creatively generating potential solutions (Briand 1999; Atlee 2008).

1. Informing policy	Identifying the public's values and concerns helps policy-makers make better decisions. When problems are close to citizens, they can give their own insights and then "offer critical pieces of the puzzle."
2. Legitimizing policy	When citizens engage authentically in decision-making processes, it is easier to legitimize outcomes.
3. Freeing a paralyzed policy process	Citizen participation can help loosen political deadlocks.
4. Helping citizens move toward "public judgment" on specific issues	With deliberation citizens can mature their opinions about discussed issues. They then understand issues better. Recognition of political manipulation is more frequent.
5. Promoting a healthier democratic culture and more capable citizenry	Deliberative public engagement helps strengthen democratic culture and practice. It provides new methods for democratic action.
6. Building community	With public deliberation it is possible to build stronger communities.
7. Catalyzing civic action	Deliberation facilitates civic action. Deliberation creates more active citizens.

Table 2. Purposes of deliberative public engagement (Friedman 2006: 17-20)

In deliberation something happens that typically fails to occur during ordinary political discourse. Much political discussion takes place within groups of persons having similar beliefs and values. Deliberation, in contrast, with its intentional commitment to inclusion, diversity, and equality of participation, makes possible a "moral discussion"—"a kind of ideal role-taking"—in which participants are asked to view issues from the perspectives of others (Fishkin 2009: 125). Deliberation enhances moral perception and facilitates empathy,

which make possible decisions that are not only sounder but also morally better (Fouke 2009). Precisely because self-interest is acknowledged and given its due, it can be transcended and the common good can emerge as an idea with concrete attributes (see Murphy 2005). Fishkin (2009) points to tentative empirical proofs which support the notion that public deliberation leads citizens to focus more on the public good.

To be sure, public deliberation has its critics. For example, Sanders (1997) argues that the principle of "mutual respect"—i.e. deliberators treating each other as equals and demonstrating respect by offering reasons that offer the other an opportunity voluntarily to assent to the proposition being argued for—is difficult to achieve, and achieve consistently. There will always be those who speak more, are more persuasive, and whose ideas count more than others. Similarly, there will always be people who speak less, are less likely to be listened to, no matter how well-reasoned and well-presented their ideas may be. Paradoxically, instead of promoting mutual respect, public deliberation can lead to unequal participation and influence.

Young (2003) highlights the challenges of deliberative democracy by juxtaposing the ideal types of a deliberative democrat and an activist. The practices of deliberative democracy, she argues, cannot make activism an unnecessary form of influencing political decision-making. In reply, Fung (2005: 399) writes of "deliberative activism," i.e. activism to achieve deliberative democracy: "I call this perspective deliberative activism because it holds that widespread inequality and failures of reciprocity can justify nonpersuasive, even coercive, methods for the sake of deliberative goals."

Not every issue requires or permits a deliberative approach. Deliberation demands time, resources, and commitment to seeing the process through. Yet even as we recognize the practical constraints on deliberation, we must bear in mind the often-unrecognized costs of failing to deliberate (see Cookson & Dolan 1999; OECD 2001; Roberts 2004; Bruni et. al. 2007). The main question then is whether the problem is "hot" or wicked enough to justify the use of resources for public deliberation (Atlee 2004; Roberts 2004). According to Yankelovich (1995) public deliberation is needed when an issue meets one or more of three criteria: the issue is significant to people's lives; there is a need for sacrifice; or special interests adopt positions that, even if amenable to compromise, would fail to address the needs and concerns of the great majority of ordinary citizens. Many wicked problems meet these criteria. Health care is one (see e.g. Raisio 2009a; 2009b). It may prove illuminating, therefore, to consider public deliberation in the context of the crisis of the Finnish welfare state.

Part 2. The Crisis of the Finnish Welfare State

Esping-Anderssen (1999) sees the construction of modern welfare states as a spectacular reformist achievement. He divides these welfare states into three types of regime: liberal, conservative, and social democratic. Finland belongs to the family of social democratic regimes. More specifically, Finland is a "Nordic welfare state" (see Kosonen 1998). It has a wide-ranging social policy, a high degree of equality between sexes, and low income inequality. Most social programs are supported by general taxation revenues, and out-of-pocket expenses for welfare services are moderate.

But things are changing. Kajanoja (2007) points out, for example, that disparity in incomes is growing, child poverty is increasing, and needs-based monitoring of expenditures for the disadvantaged is toughening. The impact of income transfers and taxation on income inequality is declining; low-income citizens are seeing their socioeconomic position relative to the well-off worsen. Moreover, public sector collaboration with the private sector is decreasing and privatization is increasing (e.g. Koskiaho 2008). Significantly, as the population ages, the dependency ratio is growing, causing a major challenge to the Finnish welfare state.

When the Finnish welfare state began to develop soon after the Second World War, conditions were favorable. Finland was an agricultural society with liberal values. The national division created by the Finnish civil war of 1918 had been healed by the Winter War with the Soviet Union during WWII, which unified the population. People were optimistic about the ability of government to improve the conditions of life (e.g., George 1996). Political support was strong, unemployment low, and economic growth robust.

The Finnish welfare state was at its peak in the 1980s. During the recession of the 1990s, challenges started to emerge. As economic growth began to diminish and unemployment rose, taxes were lowered in response. As a result, cuts in social expenditures were initiated (see Niemelä et. al. 2007).

Today, as we face a recession of unprecedented depth and breadth in the post-War period, and with one of the fastest "graying" populations in the world, the challenges to the Finnish welfare state are more severe than ever. This is especially clear in health care (e.g., Teperi et. al. 2009). With growth in GDP what it is now, the saturation point has been reached, and the public sector cannot expand further to meet the still-growing needs of citizens. Raising taxes remains a policy option, but it would be as politically unpopular as cutbacks in services (Jallinoja 1993). Policymakers are thus caught between a rock and a hard place. But something must be done. The question is, which values and priorities should determine how we go forward? This issue can be viewed from two perspectives.

First, at the core of the Finnish welfare state there is a major tension. This is between the elite striving to develop the welfare state and the citizenry wanting to

sustain it as it now is. According to surveys, citizens still strongly support the existence of the welfare state. A majority remain agreeable even to raising taxes if needed, especially if these are used specifically for health care services (see Forma et.al. 2007). The elite, on the other hand, urge cutting both taxes and public expenditures (Kajanoja 2007; Koskiaho 2008).

In its urge to make changes, the elite appeals to three facts.[8] The first is to globalization. The argument is that a closed and regulated welfare state doesn't work in the contemporary conditions of a globalized world: "The world around us has changed. Thus we also need to change...." A specific fear is that Finland cannot compete with the rising new economies. The second appeal is to the changing age structure, i.e., the "dependency ratio." Third, the perennially high unemployment rate is emphasized. It is argued that high taxation cannot be the salvation of the welfare state. Without more fundamental changes, it is said, the welfare state begins to regress. (Ruokanen 2004.)

Supporters of the continued development of the welfare state accuse its critics as stubbornly trying to sustain the status quo (see also Esping-Andersen 1996), and not seeing the reality as it now is.[9] They even treat the welfare state as sacrosanct—something not to talk about in a negative tone (e.g., "the modern day Soviet Union"). Discussion is defensive and open-mindedness, constructive engagement, and innovativeness are lacking. The way forward is to be shown us by elite leaders, who warn us that hard choices must be made, and the solutions may conflict with the public's views. Yet at the same time political leaders are accused of "Gallup-leadership"—instead of making bold choices for society, they slavishly follow the results of opinion polls. (Ruokanen 2004.)

The popular desire for continued development of the Finnish welfare state is recognized. It is thought that "defending and implementing the basic values of Finnish people is a common challenge to which every Finn has the responsibility to respond. In Finland, a shared outlook on the common values to which all the actors can commit must be found. After that the discussion of the implementation of these values and their practical realization will be easier than it now is" (Ruokanen 2004: 82). It seems, however, that such a shared outlook is not on the horizon (e.g., Julkunen 2005).

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[8] This outlook is based on a report of Finnish Business and Policy Forum EVA (Ruokonen 2004). For Report 57 notable Finnish decision-makers in the fields of science, business, and public policy and administration were interviewed.

[9] According to Ackoff (1974), the public behaves as an *in*activist, but the elite willing to reform the welfare state would like the public actually to take the role of *inter*activist. Inactivists believe everything is fine and thus don't see a need for a major change. They may even strive to block any changes. In contrast, interactivists believe we should seek a better future and should fulfill our potential as a nation to forge our shared and desired future, not settle for "good enough."

The second perspective on the question of which values and priorities should determine how we go forward begins with the contention that a fairly homogenous society, which Finland was at the founding of the welfare state, has become increasingly heterogeneous. The social values that were in the ascendancy—solidarity, equality, and fairness—have been challenged by rival values, such as liberty, competition, self-reliance, and risk-taking (Andersson 1993). The old values grew out of conditions that have now changed. Solidarity, for example, has been undermined by social fragmentation, globalization, and immigration (Andersson 1993; George 1996). The welfare state itself has been blamed for changing conditions. The argument is often heard, for example, that personal responsibility for one's family, neighbors, and community has been weakened by the knowledge that the state will step in to meet people's needs (see Einhorn & Logue 2003).

The tension then is between, on the one hand, equality and social solidarity, and on the other hand, individual freedom and greater income disparities. Wallgren (2007) believes it is unrealistic to think that the rich can still get richer, while at the same time, the position of the disadvantaged would also improve. The welfare state is thus facing an ethical choice: between social support for the disadvantaged and the promise of greater wealth for the educated, skilled, and capable. Wallgren (2007) calls for a public discussion marked by argumentation and the encouraging of social learning, resulting in a purposefully created social consensus. For him the desire for individual prosperity is neither constant nor independent of social conditions. The things citizens value can and do change.

The two preceding outlooks are partly parallel. The first criticizes the welfare state status quo and argues for radical development plans. The second stresses diminishing solidarity, equality, and fairness, and the ethical choice we are now facing. Both outlooks welcome change, but in addition it might be argued that both require a deliberative democratic process. This argument is based on the contention that the crisis of Finnish welfare state is a wicked problem.

Problem wickedness can be understood as characterized by two incoherencies, epistemic and axiological (see Conklin 2005). Epistemic incoherence is reflected in the uncertainty surrounding the causes of the crisis of the welfare state and, more fundamentally, disagreement over whether there even *is* a crisis. This uncertainty extends to the solutions offered in response. There is no objective knowledge which could tell us how to solve the problem. It is not only that we don't have the knowledge needed to define the problem or to devise the solution, but also that we also lack consensus on the values that should guide us.[10]

[10] The crisis of the Finnish welfare state might be characterized as a "super wicked problem" (Levin et.al. 2009; see also Lazarus 2009). A "super" wicked problem adds three additional features: 1. Time is running out. 2. No central authority. 3. Those seeking to end the problem are also causing it. As for the first of these, it might be, as some have argued (e.g., Ruokanen 2004)

There are two specific reasons why the wickedness of a problem would be mitigated by citizen involvement. First, by including citizens diversity increases. As "experts" in their own lived lives, they know the reality of the problem in a concrete, personal way. Their contribution deepens the understanding of the problem and provides insights that may lead to solutions previously not contemplated (see Clarke & Stewart 2000). More important, changes in the way people behave are more likely when people are involved directly in identifying solutions (APS 2007). The welfare state is highly valued by a large majority of Finns, but it cannot be sustained without changes in the way they live. As Clarke and Stewart (2000) write: "The wicked issues by their nature will be enmeshed in established ways of life and patterns of thinking; they will only be resolved by changes in those ways of life and thought patterns." Clark and Stewart argue further that traditional means for solving wicked problems, such as legislation and regulation, are by themselves inadequate to the task of achieving sustained behavior changes (e.g. APS 2007). Such changes will occur only when problems are widely understood, discussed and, most importantly, "owned." "Top-down" coercion will be resisted unless citizens willingly accept the changes they need to make (Clarke and Stewart 2000). Effective responses to wicked problems must be co-produced by policy-makers and citizens (e.g. Harmon & Mayer 1986).

In sum, then, there are three basic responses societies might adopt when confronted with "wicked welfare state" problems such as universal healthcare. First, public leaders could attempt to follow aggregate public opinion (Blum & Manning 2009). But by their nature wicked problems are such that people's opinions are apt to rest on insufficient and imperfect information. In order to provide meaningful guidance to policy-makers, people must work through the many complex issues involved (see Fishkin 2009).

A second approach would be for public leaders try to impose their views on a divided and potentially recalcitrant public. Such an attempt is unlikely to be sustainable, however. Emphasizing technocratic values such as fiscal restraint and efficiency is unlikely to prove popular when officials run for re-election (e.g. Randma-Liiv 2008). Moreover, technocratic knowledge has no democratic authority independent of that which the public accords it. Even if elected, policy elites lack the democratic political authority to prescribe values and value-priorities for the public. At some point, substitution of elite judgments for the

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that Finland is running out of time and soon will fall behind other countries. A regression could start that would be highly difficult to stop or reverse (analogous to climate change). As for the second feature, the issue of welfare state development is not an issue that could be handled solely within national boundaries. For example, the regulations of the EU and EMU have to be accommodated. Also, globalization is making is less and less likely that a single central authority will emerge to reduce the wickedness of the problem. Lastly, all of us who are trying to solve the perceived crisis of the welfare state are also causing it through our behavior towards others, our life habits, our use of welfare services and benefits, or our material affluence.

democratic judgment of the public threatens the legitimacy of a regime (Rawlins 2005). Because the issues of welfare, and especially of health care, are about the priority that should be assigned essential human values, only the public has the democratic political authority to resolve them. Finally, the public is the current and future consumer of health care. They are stakeholders as well in virtue of being taxpayers (Rawlins & Culyer 2004; NICE 2004; Rawlins 2005).

A third approach, then, would consist of public leaders enabling and encouraging citizens to engage in unhurried, well-informed public deliberation for the purpose of reaching a collective judgment about basic values and priorities. Wicked problems in societies suffering from symptoms of a declining consensus about the traditional aims and policies of the welfare state must intentionally reconstruct a workable consensus by recommitting themselves to democratic values, and to the values of deliberative democracy in particular. Only by doing so will they come to recognize that it is up to them, and them alone, to make the difficult choices and accept whatever uncomfortable changes must be made. They must see that it is irresponsible of them to "hide behind the mantra of 'cutting waste, fraud, and abuse'" (Yankelovich 1995: 16). The practice of deliberative democracy offers societies a chance to rebuild a broad consensus upon which coherent policy can be developed. In Finland, regrettably, such a practice remains much more theoretical than actual.

Part 3. Deliberative Practices in Finland

Unlike, say, Denmark, Finland lacks a tradition of deliberative democracy (see Table 1). Less-deliberative forms of public participation have been implemented. For example, so-called "near democracy" is found in Finland at the local level of government. "Near democracy" encompasses city forums, youth councils, and elder councils, among others. So-called human impact assessments and environmental impact assessments also strive to increase the involvement of citizens, permitting them to evaluate in advance the effects of proposed health and welfare or environmental policies (see e.g. Hokkanen 2008; Nelimarkka & Kauppinen 2004). But while they bring municipal decision-making closer to citizens, these forums fall well short of the deliberative ideal; for example, limited information provided to participants, uneven substantive balance, and less-than-full diversity of the participants have often characterized forums (see table 1). The relative brevity of the events also impedes adequate deliberation.

Finland has implemented various forms of online citizen participation, such as the knowledge society program "eTampere"[11]. Most of these are organized and conducted locally, giving inhabitants of municipalities an opportunity to comment on policies being considered or constructed in municipal councils. At the national

[11] See http://www.etampere.fi/english/.

level, Finland's Ministry of Justice maintains a website called Otakantaa[12]. This website, started at the beginning of 2000, can be viewed as the Finnish government's platform for citizen deliberation. Basically it is a place where citizens can offer their opinions about policies under preparation. Discussions usually last from two to four weeks, after which a summary is written and published. This summary is supposed to be used as a guide to decision making. Otakantaa has also organized internet-chats for citizens in which, for example, the ministers of the government have participated. However, Otakantaa has received criticism as a participatory mechanism. This criticism includes complaints that there are no guarantees that expressed opinions have little impact on decision-making; that participants are not representative of the population; that forums are not publicized adequately; and that the discussion can be intemperate or even uncivil (see Raisio 2009c).

Instances of genuine deliberative democracy with the goals of inclusivity and deliberativeness, such as Citizens' Juries and Deliberative Polls, are rare in Finland. To my knowledge only five of such have been implemented. These practices and an upcoming youth jury experiment will be described briefly below.

The first Finnish deliberative citizen forum was organized in Turku by Åbo Academi University in November 2006 (Setälä, Grönlund & Herne 2007). This deliberative forum was undertaken as a research experiment and, as such, has been described more fully than the other events. The event didn't adhere strictly to any particular deliberative format. It consisted of 135 participants who deliberated about the construction of the sixth nuclear plant in Finland. Even though this is a national-level issue, because of time and costs a random sample was taken from the populations of the municipalities of an electoral district of southwest Finland. The original sample was 2500 voters. Each received a survey and an invitation. Of these, 592 responded, and 244 were willing to participate to the event. After a final random sample to ensure representativeness with regard to age and gender, 194 people were invited, of which 135 arrived. Travel expenses, food, and a 100€ gift voucher were offered to the participants.

The deliberative event lasted one day and included time for two surveys (pre- and post-deliberation), reading the information material, hearings and questioning of four experts, small group discussions, and decision-making in small groups. Also, one survey was conducted afterwards. Small-group discussions were moderated. These included altogether twelve groups, of which ten were conducted in Finnish and two in Swedish. Two different kinds of decision-making procedures were used for purposes of comparison. Half of the small groups concluded with a secret ballot, the other six generated a final statement formulated jointly by members of the group. Because the purpose of the experiment was to

[12] "Voice your opinion". See www.otakantaa.fi.

gather research data, no direct influence on the decision-making was examined (Setälä, Grönlund & Herne 2007).[13] [14]

The other four Finnish examples are segments of wider international and European projects. They are summarized in table 3. Taken together, the foregoing five instances of deliberative democracy in Finland constitute a positive development. Even though none attained the deliberative ideal—whether because time was too short or participants were not representative or for other reasons—they contributed significantly to the discussion of the possibilities of deliberative democracy in Finland. Moreover, they support the contention of this article that in Finland citizen deliberation could take place more widely. For example, in the 2006 event addressing construction of a nuclear plant, the opinions of participants on the deliberative method used were surveyed (Setälä, Grönlund & Herne 2007). The scale ranged from 1 (disagree completely) to 4 (agree completely). The average responses were as follows: to the question whether participants thought that the experiment was pleasant, 3.8; to the question whether participants would participate again in a similar kind of forum, around 3.65; and to the question whether in policy decision-making methods like the deliberative citizen forum should be used, 3.37. Similarly, in the 2007 event on citizens' perspectives on the future of Europe, 93 percent of participants indicated that they liked the event very much; 89 percent said they would participate again in a similar event; and 11 percent said they might (ECC 2007b). Also, in the 2009 event on climate issues, 93 percent of the participants thought that the time spent in the event was worthwhile, and all of the participants concluded that similar events should be organized in the future (Lammi & Rask 2009).

However, deliberative forums are expensive. In the report of the Ministry of Finance (2001) it was noted that because deliberative forums are time-consuming and expensive, at that time it did not seem advisable to recommend that deliberative forums be implemented in Finland. As a recent positive sign, the new report of the Ministry of Justice (2010) mentions and even calls for deliberative discussion.

[13] Even though media was invited to the event, it was noted by the organizers that the experiment's purely scientific nature might have influenced the dynamics of the deliberations (Setälä, Grönlund & Herne 2007). Results might have been different if the participants had known their "judgment" would have been introduced into the policymaking.

[14] Event was replicated online in 2008.

Location and duration	Tampere, 24.–25.3.2007	Helsinki 14.–15.3.2009	Helsinki 15.–16.5.2009	Helsinki 26.9.2009
Topic/charge	"Finnish citizens' perspective on the future of Europe."	"What can the EU do to shape our economic and social future in a globalised world?"	To vision desired future by deliberating on the wishes, dreams, worries and threats related to the future scenarios.	To produce recommendations to the negotiators of Copenhagen climate conference 2009.
Organizer/s (national)	The Swedish Study Centre; The Educational Association and Citizens' Forum; Helsinki office of EAEA.	Main organizer the Swedish Study Centre.	National Consumer Research Centre.	Main organizer National Consumer Research Centre.
Participants	Random sampling based on criteria and implemented by market research company; 29 participants.	Random sampling based on criteria and implemented by outside research company; 70 participants.	Invitation sent to the members of the Consumer panel (>100 willing to participate); 29 were chosen according to criteria; 23 participated.	Advertised in magazines; from those willing to participate, a diverse sample was chosen; 107 participants.
Given information	Background information before the event; use of "resource persons"; online connections to European companions.	Use of "resource persons"; online connections to European companions.	Two interviews; information magazine.	Before-hand sent information material; four documentary videos.
Influence	Final report handed over to MP in a closing event; European level synthesis of national outcomes; Presented in the European Summit.	A panel of four candidates for European Parliament examined the results in the ending event; Final report handed over to Minister of Migration and European Affairs.	International expert workshop on the results (April 2010) followed with another round of citizens" juries (2.10.2010).	Results (global and national) handed over to the Minister of the Environment.
Other details	National consultations took place in 27 EU countries.	Open online-discussion preceded the event (generated 10 suggestions for the face-to-face event).	Included seven EU countries.	Around 4000 participants from 38 countries.

Table 3. Finnish experiments on public deliberation as part of wider international and European projects. (ECC 2007a; ECC 2009; Rask et. al. 2009; Niva & Rask 2009).

Encouraged by previous Finnish experiments in deliberative democracy and by the prospect of public deliberation, we at the University of Vaasa[15] are striving

[15] The author of this paper and two colleagues are the chief organizers of the experiment. Master's degree candidates in social and health management will participate in the experiment through different roles. Pedagogically, the experiment then reflects the growing need for teaching

to experiment with deliberative democracy in the fall 2010, and specifically to analyze for the first time in Finland the usability of a youth jury[16] on the topic of youth involvement.[17] The objective is to gather a representative sample of young people in Finnish language upper secondary education in the city of Vaasa. This sample will be a microcosm of the student population. Over three days, 24 young jurors will listen to and question witnesses; deliberate together in small groups and in plenary session; and arrive at a collective judgment on the topic. Local decision-makers will commit to offering a reply to the product of the deliberators. The theme of "involvement in school community" has been chosen by the steering committee. A focus group discussion prior to the jury will allow for a more-specific phrasing of the question.

The main research objective is to ascertain the usability of a specific format of deliberative democracy, i.e. a youth jury, in the context of Finnish schooling and youth involvement. The chief societal objective is to provide information to local decision-makers to support them in increasing youth involvement, and especially to afford young people an opportunity to influence policy with respect to issues important to them.

Part 4. Increasing Citizen Involvement in the Planning of Finnish Health Care Reforms and Policies

It has been argued here as elsewhere (e.g. Vartiainen 2005; Raisio 2009a) that many health care issues are wicked by their nature and therefore need to be approached in a more collaborative manner than is customary. Collaboration means, among other things, including citizens as key stakeholders (Clarke & Stewart 2000). But what do citizens themselves think? Do they want to increase their involvement on wicked issues such as health care policies and reforms? Do they believe they are capable of understanding issues that are highly complex? Do they see an important role for the public in the policy-making process?

Previous surveys on citizen participation and deliberation (e.g. Setälä, Grönlund & Herne 2007; Association of... 2008; Lammi & Rask 2009) have revealed positive responses to participation and deliberation on important social issues. Because it would be useful to find out whether this receptivity extends

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democracy in public administration education (see e.g. Bingham, Nabatchi & O'Leary 2005; Leighninger 2010).

[16] Carson, Sargant and Blackadder (2004: 7) define youth jury as follows: "A youth jury runs along the same lines as a citizens' jury, but the jury is made up only of young people, typically aged between 12-25. We believe that youth juries provide young people with a unique and stimulating way of talking about and being involved with issues that concern them and have an impact on their lives, their community and their country. A youth jury is a way for the wider community to listen to the voices of young people, and for the jury members to be exposed to a variety of different views."

[17] There was a clear call for action from "the field" to improve the involvement of youth.

specifically to issues of health care reform and policy, which are frequently controversial (see Raisio 2009b), a citizen survey on this topic was conducted.

One assertion in this article is that citizens are experts in their own right on matters about which no other expertise is available: their own (individual) values and value-priorities. They are experts in the matter of their own lives, their own lived experience. Representatives of Finnish patient and disability NGOs[18] were asked their point of view on this claim. These NGOs represent citizens who confront wicked health care issues at the point of greatest impact, as patients and clients. Do NGOs acknowledge this expertise? Representatives were then asked how strongly the NGOs believe patients/clients influence the planning of health care policies and reforms, and whether the role of patients/clients in the planning of health care policies and reforms in Finland should be strengthened.

Research methods

Two surveys were carried out. The first was sent to 30 representatives of Finnish patient and disability NGOs. These form a notable part of Finnish patient and disability NGOs working at the national level. The respondents were divided evenly between major national NGOs – the largest having more than 100,000 members– and small national illness-specific NGOs with a few hundred members. The response rate was average (63.3 %), with 19 responding. The respondents are indicated in Table 4.

Position	***n***
Executive director/secretary-general	12
Chairperson	1
Member of executive committee	1
Vice-member of executive committee	1
Development director	1
Specialist of Social Welfare and Health	1
MD, executive	1
Secretary	1

Table 4. The organizational positions of the respondents.

Respondents were asked open-ended questions using a qualitative electronic survey. The responses were analyzed using theory-originated content analysis, where the theoretical concepts are already known (Tuomi & Sarajärvi, 2002).

[18] Finnish patient and disability NGOs can be defined as nation-wide organizations with patients and/or close relatives as members, organized around recognized illnesses, diseases or handicaps (National Research and Development Centre for Welfare and Health [STAKES]). The structure of these organizations varies substantially depending on their size. Similarly, the tasks of these NGOs differ with regard to peer support, information-dissemination, influencing public opinion and lobbying, service-provision, and research (Toiviainen 2005).

Instead of letting the empirical data dictate the content of the theoretical concepts, the empirical data is used to preliminarily test the propositions postulated in this article.

The second survey probed the views of the citizens themselves. Finland's Ministry of Justice supported the survey by agreeing to post it on their website Otakantaa. It was an ideal location to ask citizens their views about the theme of this article. However, because the Otakantaa website is not well-known in Finland, 11 major national patient organizations were asked to promote the questionnaire to their members. Ten of the organizations agreed to do this. Information about the questionnaire was then published on their websites, discussion platforms, internet magazines, and journals.

Clearly, the voluntary nature of participation in the second survey introduced a bias in favor of citizens who are more active than average citizens. They visit government or NGO websites, or read member journals. Also, they find the time to respond to a survey. The responses thus give us no indication of the views of people who are less active, less interested, etc.

Overall the survey generated 153 responses. Women were over-represented and men under-represented (74 % and 26 %). The working age population was over-represented and the young and the elderly were under-represented (89 % and 11%). Respondents with more education, i.e. college, polytechnics or university education, were better represented than their counterparts with less education (71 % to 29 %). Additional variables were occupational group and place of residence. Among occupational groups the unemployed were under-represented (3 %). As for place of residence, one province is highly over-represented (47 %) compared to the 19 provinces. This is the capital area (Uusimaa). In short, the results of the survey cannot be generalized to the Finnish population as a whole. However, the results provide some preliminarily information about what one small group of citizens think about the questions put to them.

The quantitative questions, which formed the main part of the electronic survey, were analyzed using descriptive analysis, in which the results are presented in simple percentage values. At this stage of the study, the results, due to space limitations and the small size of the sample, will not be presented through cross tabulation. Cross tabulation was used, but since the answers clearly emphasized one view, they did not reveal any findings with major significance for this study.

The qualitative questions from the second survey were analyzed in the same way as the first survey, with theory-originated content analysis. These questions were about different kinds of participation methods. Respondents were afforded space to write comments about the survey at the end. These questions about participation methods will be discussed in another publication, but because

respondents wrote in the free space about their willingness to participate, etc., these comments will be reviewed briefly.

Views of representatives of Finnish patient and disability NGOs

Firstly, most of the NGO representatives surveyed thought that patients and clients had weak and non-existent influence on policy-making decisions. At the level of individual interaction with health care providers, patients and clients have minor input into decisions. But planners and decision-makers of health care reforms and policies take scant account of the view of ordinary citizens.

One common denominator among the responses was the emphasis representatives placed on the role of the NGOs in representing the views of the patients. There was however a slight parting of views between those who believed patients could influence only through NGOs and between those who believed also into a more direct possibility of influencing. For example from the negative point of view one representative remarked that "the ordinary patient doesn't have any other way to influence [health care policy] than through his or her own organization. The voice of an individual patient isn't heard anywhere… I don't believe in the prospects of an individual patient [influencing policy]….". However, negative views such as these can be considered not as a critique to direct influence of patients as such but more as a response to the weak and non-existent possibility for this influence, i.e. as one respondent stated "if real and genuine possibilities to influence would exists, there would hardly be a need for patient organizations to 'defend' the rights of the patients and to oversee their interests".

Respondents noted that, even though many efforts are made to hear the voice of the patients, the results are not usually very good:

> *"Many efforts are made, but if we examine how much the voice of the patients is really heard, the results aren't very impressive. They are listened to but not necessarily heard. Already in the hearing process a decision can be made not to make any more changes."*

Three representatives emphasized economic factors as one reason for the low level of patient participation:

> *"In planning the emphasis is usually given to economical and political actors."*

> *"The nation's and municipalities economic deficiencies and pressures clearly override (the role of the patients)."*

> *"For some reason, in health policy reforms, professional experts are also trusted as evaluators of patients' needs. Especially now as the economy is on top in every reform, the view of the patients is non-existent."*

One other interesting view emerged. According to one representative the role of the patient can be weak not only because of the actions of government, but also because of "the nature, seriousness, shame, and diverse care possibilities of the illness… The resources of the patients are already diminished [as a result of their focus on obtaining proper care]." So even though patients would like to influence the planning of health care reforms and policies, in some cases the patients just do not have the energy for it.

When it comes to strengthening the role of patients, twelve representatives clearly implied the need to strengthen this role of influencing health care reforms and policies. The rest seven representatives did not have as clear a view about this. For example, they continued to emphasize the role of the NGOs. According to them, by increasing the role of the NGOs, the patients' views would be better heard[19]. One of these representatives mentioned also the internet hearings where individual patients can express their opinions.

> *"The views of the individual patients are represented in patients' organizations, which bring out these views."*

> *"I don't believe in the prospects of an individual patient, but I hope more for contacts from the individual patients to the organization and in that way increase the circulation of information. This way the organization could more easily advocate the cases of the patients."*

One representative asserted that the basic things, like care for all, should take priority and only then would it be justifiable to start thinking about something like patient participation. Basically this means that some organizations already have their hands full with basic tasks and responsibilities, so it is necessary to ensure that they are carried out first.

Another representative observed that we need to remember that "every patient is an individual and one patient's view doesn't necessarily represent all the views

[19] According to Kim et. al. (2009) patient advocacy groups – such as the NGOs examined in this article – should not be confused with deliberative democracy. These groups work as interest groups and thus represent special interests. Deliberative democracy is not about negotiating or bargaining between representatives of special interests, but about reasoned deliberation between equal citizens (e.g. Cohen & Fung 2004). Also, as advocacy groups usually have the disadvantage of focusing intensely on a single issue, they can lose sight of the common good of a deliberative political process (Warren 2008). In contrast, the ideal of public deliberation is that it "focuses debate on the common good" (Cohen 2009). Particular interests must be weighed against the public interest and supported only insofar as they do not conflict with the latter.

in the treatment of some disease." This fact makes the participation of patients in the planning of health care reforms and policies more complex, for example in priority setting. How do we involve patients in the planning processes so that the views expressed are as diverse as they are in the population as a whole?

The views of the representatives who more strongly supported the idea of strengthening the role of patients were more optimistic. But even some of these views continue to acknowledge a role for the NGOs:

> *"… Disabled and long-term ill patients with low-incomes should be heard through organizations about the problems in everyday life in relation to planned decision-making."*

NGO representatives with more optimistic views saw many reasons why the views of the patients should be taken more fully into consideration. Their expertise was acknowledged:

> *"Clients or patients are experts of their own lives. Politicians should get to know their realities before making decisions."*

> *"Patients have a lot of information and experiences that are often missed in reforms and decision-making."*

Some representatives saw other benefits to patient participation: commitment, an understanding of many interrelating factors, and the strengthening of a humane policy:

> *"With a participative attitude we could achieve commitment to the planning of reforms, policies and services. We could achieve dialogue with service-providers, financiers and service-users and we would strengthen social capital. A participating service-user can create solutions together with professionals."*

> *"Citizens should have a clear knowledge about the direction in which we are taking our health care. This way it would be possible to evaluate the consequences already in the planning phase. It would make it easier to understand the synergy of many interrelating reforms and complexes."*

> *"Purely medical and economic dominance would then lessen and a life-advocating, humane attitude would strengthen and would be written down."*

Additionally, NGO representatives stated that it is not enough just to hear patients. The views of the patients must be genuinely heard:

"Internet-sites like Otakantaa are also good, but only if the suggestions by patients or clients are truly taken into consideration when planning reforms."

"According to the constitution, health care is equal and a good for all. It just doesn't come true like that. Clients should be asked more about how they have experienced the services and these enquiries should also be listened to."

From the foregoing we can infer with some justification that the views expressed by NGO representatives are consistent with a basic theme of this article: that ordinary citizens are "experts in their own lives," and that this is an expertise that is fundamentally important to the formation of sound, effective, and equitable public policy. The humane values and personal interests expressed by consumers of health care do not constitute information that policy-makers may simply assume or take for granted. Nor is it information that can be fully appreciated by the device of opinion polls. Citizens have stories to tell, and in those stories lie details and nuances that policy-makers cannot divine except by listening to people tell their own stories. Deliberative democracy represents a call for a democracy that is more responsive because it is more inclusive, more participatory, and more communicative than any existing mechanism by which the public may inform and guide the decision-making of government officials.

Views of Finnish citizens

The results of the quantitative part of the citizen survey appear below. Table 5 shows how the respondents view their potential, as individual citizens, for influencing the development of health care reforms and policies. Those who thought that their prospects were "quite poor" or "poor" (87 %) clearly outnumbered those who considered their chances to be "quite strong" or "strong" 8 %).

Strong possibilities (%)	**Quite strong…**	**Don't know**	**Quite poor…**	**Poor…**
3.92	3.92	5.24	42.48	44.44

Table 5. How respondents view their prospects, as individual citizens, for influencing the development of health care reforms and policies

To the question of whether the respondents want to influence policy-making more strongly, respondents answered clearly in favor ("yes," 71 %; "Maybe," 27 %). Only 2 % expressed no desire for greater influence.

Table 6 shows how important the respondents consider the participation of citizens to the development of health care reforms and policies. A strong majority (95 %) stated that citizen participation is "quite important" or "important." Not even one respondent considered the participation of citizens in the development of health care reforms and policies to be not important at all.

Important (%)	**Quite important**	**Don't know**	**Not that important**	**Not important**
65.36	30.07	3.27	1.31	0.00

Table 6. How important respondents consider the participation of the citizens in the development of health care reforms and policies.

One question in the survey asked whether respondents believe that an individual citizen has the capacity to understand the complex matters that are the focus of health care reforms and policies. The structure of the system of health care provision was given as an example of a complex matter. Table 7 shows a strong belief in citizens' capacities, with 79 % of respondents saying that they believe "completely" or "somewhat" that an individual citizen can comprehend the complex matters of health care.

Believes completely (%)	**Believes somewhat**	**Don't know**	**Doesn't believe exactly**	**Doesn't believe**
28.76	50.33	8.50	11.76	0.65

Table 7. Do respondents believe that an individual citizen has the capacity to understand the complex matters that are the focus of health care policies?

Respondents were also asked whether they would be willing to participate in a Citizens' Jury. A Citizens' Jury was described in its most demanding form, i.e. with a duration of four to five days. It was expected that respondents would be disinclined to such a time-intensive exercise. Surprisingly, only 12 % said they would not participate. Instead, almost 60 % said "yes" and 28 % "maybe."

From the qualitative portion of the survey, views about the themes of this article emerged. One view was a critique of the planning of health care reforms and policies. Respondents expressed the opinion that decisions are made by a small number of insiders; that there is not enough communication about the planned reforms and policies; that decision making is too lacking in transparency and closed to citizens; and that money is the determining factor in making decisions:

> *"Preparation of reforms should be transparent so that there would be communication as early as in the planning stage, so that it would be possible to have time for genuine influence. Decision-making in public administration (and in municipalities) is too cryptic and closed to citizens. Open debate doesn't take place and the opinions of citizens aren't listened to….."*
>
> *"If only there were notifications about these reforms somewhere. Seems to be they are only matters for insiders."*
>
> *"...As an individual citizen, I believe opportunities for influence very small; budget, money and surplus are decisive. That is sad."*

It also became clear that respondents did not have much trust in the knowledge of decision-makers:

> *"The only thing that I have is the experience about living as a disabled person through my life. As a survivor of polio, I have experienced one thing and another in health care through these years. Decision-makers and implementers don't know much about the reality."* [20]
>
> *"It would be a really good thing if individual people could take part in plans about health care services."*
>
> *"… Decision-makers are people who don't have even the slightest idea about the conditions and the world view of the people whose issues they make decisions about. That's why it would be important that the voice of the people whom the decisions influence would be heard. As far as I can see, the strength of the many would be the solution."*

There was, however, some skepticism in the answers about the possibility of making changes to increase citizen influence in planning of health care policies. This critique was expressed most frequently in the Otakantaa internet discussion forum:

> *"I really hope that citizens' forums like Otakantaa would yield results and that the opinions of citizens would be noticed, but unfortunately it seems that there is no hope of this happening…."*

[20]This reflects with what Thacher (2009) calls "the experiential gap," meaning that public officials constantly "take actions that have implications for people whose experiences they do not share, and they must continually make laws that affect lives they have not lived." As the "direct experience to draw from" stays marginal, the risks of misconstrual in the decisions may increase as a result.

Two additional perspectives of interest emerged. First, some of the respondents stated that they would prefer to exercise influence through third sector organizations. This parallels the views of some NGO representatives. Second, it was interesting to notice that respondents wrote highly personal information as well as voicing common critiques of Finnish health care in the open comments section of the survey. This suggests that many people do not have many chances to express their views, so they do so when they can, even though no one is likely to reply to them.

At the outset of this section it was noted that an important question that needs to be asked is, "what do citizens themselves think about the themes of this article?" viz., do they consider their involvement in the planning of health care reforms and policies important? The citizens who answered the survey clearly believe that at this moment their individual opportunities to influence the development of health care policy are quite limited. In the qualitative answers this sense of powerlessness came out strongly. This is not a state of affairs that respondents are content with. They very clearly want more influence on these issues.

Also, even though health care issues can be highly complex, respondents believed that an individual citizen has the capacity to understand these matters, although they are less certain of their capacity to do so than they are of the importance of having opportunities to express their views. It is possible that more experience with public deliberation would increase their confidence (see e.g. Bennett & Smith 2007). Additionally, respondents regarded the idea of deliberative practices – in this case, a Citizens' Jury – more positively than expected.

In general, then, the views of these citizens who responded to the survey are consistent with the theoretical perspective of this article.

As noted previously, generalizability of the results was not expected, given the limited, unrepresentative sample available for research. However, the results reported here are similar to those obtained from a survey with a more-adequate sample. A recent survey by the Association of Finnish Local and Regional Authorities (2008) of views held by residents of 14 Finnish municipalities on the question of municipal performance and decision-making randomly sampled 11,600 persons between the ages of 18-75, with a final sample of 5,183. Two results are of special interest. First, respondents were asked if the municipal residents' opportunities for participating in decision-making should be improved. On the issue of elder care, 78% of respondents agreed that improvement is needed. On the issues of health care development and planning, 74% favored more chances for participation. In contrast, on the issue of developing and planning for cultural services and libraries, only 39% were in favor of the proposition (Association of... 2008).

Second, on the questions of (1) whether municipalities should develop the feedback processes by which the views of service-users are gathered; (2) whether service-users should be involved more in planning than is customary; and (3) whether municipalities should organize more public hearings and discussion events which would include elected officials and municipal officials, the answers in favor were, respectively, 86%, 77% and 67% (with 26% neither for nor against) (Association of... 2008). Even though these answers are from a survey of views about local level municipal issues, the evident desire for increased citizen involvement is striking, and in line with the results of the health care surveys reported in this article.

5. Conclusions

Five claims have been made. First, there exists no "Holy Grail" of health care policy which those in positions of decision-making authority might discover and then, with perfect reforms and policies, solve the wicked problems of health care. Second, in order to tackle wicked problems effectively, public participation—especially participation of a deliberative nature—is called for. Acceptance of these propositions is a precondition for achieving coherence (i.e. shared understanding and commitment) on wicked health care issues such as the question of how to resolve the dilemma created by increasing health care demands and limited resources. Third, the abstract notion of deliberative democracy can be seen to have practical application in the case of challenges confronting the Finnish welfare state. Public deliberation could transform the discussion on the future of welfare state, and rebuild a broad consensus upon which coherent policy could be developed. Fourth, although only a few examples of Finnish public deliberation are available for analysis, and these few fell somewhat short of the deliberative ideal, they are something that hasn't been done before in Finland, and as such represent important progress in this crucial area of democratic theory and practice. Lastly, the results from two electronic surveys were presented. One included the views of NGO representatives and the other the views of a group of citizens. Both the NGO representatives and citizens were clearly in favor of increased citizen involvement in the planning of health care reforms and policies.

Overall, we can say that the way certain health care problems are perceived affects respondents' views of whether citizens should be involved in decision-making. If problems are considered "tame" or "messy," or if wicked problems are believed to be "tamable," the favored approaches remain technocratic ones (see Raisio 2009a). Involvement of citizens in planning is a marginal concern. However, if health care problems are perceived through the lens of wickedness – which is the right perspective on many health care issues (see e.g. Glouberman & Zimmerman 2002; Vartiainen 2005; Raisio 2009b) – then acknowledging the expertise of citizens and admitting them to the process is appropriate. This change

of visual angle could then have significant implications for the future planning of Finnish health care reforms and policies.

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DELIBERATING TOGETHER: PUBLIC DELIBERATION IN THE CONTEXT OF THE HUNGARIAN HEALTH INSURANCE REFORM[1]

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It is most often the case that planners of health care reforms and policies try to solve highly complex, or wicked problems. Issues that have no single experts. Collectively, by gathering many different people and bringing them to genuine deliberation, we can, however, create an emergent understanding and commitment, which helps us to tackle these problems. In this study, the prospects of public deliberation in the late Hungarian health insurance reform are examined. The Hungarian health insurance reform, as a highly debated and ultimately failed reform, is considered to be a useful model to exemplify the prospects of public deliberation. The objective is to point out how public deliberation could have improved the process of reforming the Hungarian health care.

Keywords: deliberative democracy, complexity, wicked problems, Hungarian health insurance reform

Jel codes: H83, I18, I38

1. INTRODUCTION

> *"A holistic health policy cannot be implemented by health professionals, health officials, and health ministers alone. No one in his right mind could attribute to these people the sole responsibility for dealing with such issues as smoking, poor physical fitness, drinking and driving, malnutrition, poor housing conditions, contaminated water supply, bad roads, environmental decay, inadequate income, etc."* (Lalonde 2002: 152).

Marc Lalonde (2002) quotes the significant French statesman Georges Clémenceau (1841–1929) saying "war is too important to be left to the generals". In the area of health, this can be changed to "health is too important to be left to

health care professionals, health officials and health ministers". In this article, from the view of health care reforms, this perspective is taken a bit further.

It is asserted in this article that even if the planning of a fundamental health care reform would include all the health professionals, government officials and politicians from all the different sectors of government, not just health care, it would not be enough. As long as citizens and, especially, patients are not sufficiently included in the planning, the results will not be sustainable. To concretise, no matter how good the plan to reform is, sometimes it cannot be implemented without the support of the public itself:

> "But the effectiveness of policies isn't just a matter of what works well – policies have to work in a way that society finds acceptable. Therefore, the appropriate level for policy intervention and the apportioning of responsibility is more than a question for policy makers – it is a care for national debate" (Foresight 2007: 12).

The subject of this article, the inclusiveness of citizens in the planning of health care policies and reforms, is approached theoretically from two different perspectives. The first is the perspective of complexity. Complexity thinking, the concept of wicked problems and the idea of collective intelligence, are used to explain why these complex health care issues need the participation of citizens. The second perspective is the view of deliberation, or deliberative democracy theory, which is used to review the advantages of citizen participation.

The theoretical part of the article will focus on asserting that the role of citizens in the planning of health care policies and reforms is vital.[2] A brief case study, in which the late Hungarian health insurance reform is examined, will follow the theory. The Hungarian health insurance reform, as a highly debated and ultimately failed reform, is considered to be a useful model to exemplify the prospects of public deliberation. The objective is to point out how public deliberation could have improved the process of reforming the Hungarian health care.

The material for the case study consists, on the one hand, of the available English literature on the discussed health care reform and, on the other hand, of the author's own perceptions during his six-month-research exchange in Hungary.[3] Because of lingual dilemmas, the observations in this article will be presented mostly in a general level. To make it clear, this study will not commit to say if the content of the Hungarian health insurance reform was "right" or not. Instead, it brings forth ideas for gaining more intelligence and wisdom to the planning of health care policies and reforms, not only in Hungary but worldwide.

2. WHY SHOULD THE PLANNING OF HEALTH CARE POLICIES AND REFORMS INCLUDE CITIZENS?

2.1. The view of complexity

> "… the most complex systems are social systems, and health care organizations are the most complex within that subdomain" (Begun – Zimmerman – Dooley 2003: 288).

Complexity thinking, or the theory of complexity, asserts that health care is a complex adaptive system (CAS) (e.g. Anderson – McDaniel 2000; Peirce 2000). By this it is meant that health care is not a machine. Instead, it can be seen almost as a living system which consists of a diverse set of interconnected elements and which is able to adapt and learn. This makes the basic Newtonian ideas of command and control partially useless, as it is impossible to keep this kind of complex system in control. There is no way one can acknowledge all the different actors and the various interactions between them. Neither can one predict the future and see all the possible outcomes (e.g. Zimmerman – Lindberg – Plsek 2001).

The idea of CAS's has implications on the way we see the role of citizens in the planning of health care reforms and policies. The most important factor in this is that a CAS has emergent properties. This means that a CAS as a whole is more than just its parts. For example, life is something that can exist only as a whole. The parts alone do not have the property of living. A CAS cannot, therefore, be divided into parts and then be understood in its entirety by gaining an understanding of the parts (Kauffman 1995). In the same way, health care cannot be comprehended, for example, just from the point of view of clinical care. The whole of health care is much more than that.

According to Wagenaar (2007: 24), this has momentous implications on public policy. From the perspective of tackling neighbourhood decline, he writes that:

> "It basically means that the usual strategy of bringing expert knowledge to bear on policy situations is flawed, or at the very least of limited value. Because expert knowledge is primarily aimed at the understanding (and alleged control) of the separate parts of the system (…), it threatens to miss the emergent properties of the system entirely. Policy outcomes are an emergent property of complex social networks."

From the perspective of the planning of health care reforms and policies, this implies that expert planners cannot understand the whole by themselves. They have their own areas of expertise, for which they tend to concentrate on that particular perspective. The risk is that the whole with its emergent properties will then be ignored. But by including citizens as well in policy-making, novel knowledge and information may emerge. This kind of "increased interaction among a larger number of actors increases variety within the system. Increased variety in

turn increases the number of potential solutions to whatever problem the system faces. Heterogeneity breeds creativity" (Wagenaar 2007: 42). By this way, the whole can be better understood.

The problems that health care policies and reforms try to solve are most often very complex matters (e.g. Glouberman 2006; Raisio, forthcoming). These can be called wicked problems (see Rittel – Webber 1973). Instead of tame problems, which are simple to define and also to solve, wicked problems present a completely new kind of challenge. They are the most complex of problems, to which there is no final and perfect solution. Even the definition of the problem is a challenge of its own. It is hard to know what the problem really is. The more the problem is studied, the more divergent opinions about the problem definition and solution are born (King 1993; Conklin 2005).

The concept of wicked problems implies many changes to the ways the modern paradigm tries to handle complex problems. Firstly, it supports the preceding view of complexity thinking. Ludwig (2001), for example, sees that there are no experts in wicked problems. He uses complex environmental problems as an example, but the same can also be said about complex health care problems. These issues are so wide and interconnected that gaining a complete understanding of them is humanly impossible. Consequently, according to Ludwig (2001), we need to interact with as many different actors as possible, for only together can we gain the expertise of these very complex problems. Also Vartiainen (2005), from the perspective of the planning of health care reforms, asserts that the inclusiveness of many different actors in the planning processes is of major importance.

Secondly, the concept of wicked problems supports especially the idea of citizen participation. There are two reasons to include citizens in tackling wicked problems. First, as Clarke and Stewart (2000: 384) write,

> "because the wicked issues represent intractable problems imperfectly understood, it is important that they are widely discussed, both to deepen understanding and to draw upon the experience of those who face these problems at their point of greatest impact".

In other words, it is essential to acknowledge the views of the people who face the true reality of the problems. As a result, a better understanding of the matter is possible. This can be seen to be true especially in case of patients with chronic diseases, as those illnesses are very complex problems. As they cannot be solved completely, patients must just live with them (Brown 2006), making the patients themselves the true experts.

The second reason is based on the view that because wicked problems usually require changes in the way people behave, changes in legislation or regulation alone will not solve wicked problems. According to Clarke and Stewart (2000: 379) therefore,

> "the wicked issues are likely only to be resolved by a style of governing which learns from people and works with people. The wicked issues require a participatory style of governing, because the changes have to be owned by the people".

As the unwanted behaviour of citizens is often a part of wicked problems, there is a need to change this behaviour. These changes are more easily achieved when citizens themselves participate in the planning processes. The Australian government has been a pioneer in acknowledging these matters on a governmental level (see APS 2007).

Also the idea of collective intelligence, or co-intelligence, supports the preceding views. Atlee (2004: 100) defines collective intelligence as "the capacity of a group, organization or community to manifest demonstrable intelligence that significantly exceeds the intelligence of any of its constituent individuals or partisan groups". This implies the existence of emergence, for the intelligence that is born from the collective is more than the sum of the intelligence of its members. The diversity in the collective is of major importance as well. As Atlee (2004: 99) writes, "people's differences are handled as resources for deepening collective understanding and creativity (…)", which means that the role of one individual in the planning of health care reforms and policies is only a minor one. The whole collective of diverse perspectives counts for much more. In a world which is getting more complex, co-intelligence has a major role to play (see e.g. Hakkarainen 2003).

Co-intelligence also implies that with true collaboration we can understand the interconnected wholeness better. With this comprehension, it is possible to make choices that benefit everyone, so basically co-intelligence "evokes the best in us". We then see more than our own selfish interests and understand that the views of others are also significant (e.g. Hartz-Karp 2007). As Hartz-Karp (2007) says, our communities, countries and the whole world have become so divided into rich and poor, for example, that there is a clear call for co-intelligence. And obviously, the citizens have an important part in creating this situation.

As a summary we can conclude that with complexity theory and the concept of wicked problems we can answer the question of why; that is, *why* these complex problems present us a completely new kind of challenge. In addition, the idea of co-intelligence partially answers the question of what; that is, *what* are the means to confront this challenge. Finally, the view of deliberative democracy answers the question of how; that is, *how* we can achieve these means. The issue of *why* and *what* have already been answered above. In the following, we turn to the matter of *how*.

2.2. The view of deliberation

> "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Declaration of Alma-Ata 1978).

Why is there a need for a new kind of democracy? Firstly, it can be noted that citizens have lost touch with the decision-making processes that are important to their lives to a significant degree (Mattinson 1999). Secondly, it is clear that problems in our societies have grown in scale, because of globalisation, for example, so that they can no longer be solved with traditional politics alone (Keskinen – Kuosa 2004). Thirdly, it can be seen that irrational and arbitrary outcomes often resulting from traditional problem solving methods, like basic voting and strategies based on competitive interest, increase this particular need (Hendriks 2006).

Deliberative democracy can be seen as a possible panacea for these contemporary problems of traditional representative democracy. Cohen (1991) defines deliberative democracy as "an association whose affairs are governed by the public deliberation of its members". Grimes (2008) for one sees deliberative participation as "a form of decision making in which citizens engage in discussion with decision makers to weigh the merits and problems of different alternative solutions in a specific matter of public concern". From the perspective of complexity thinking, the most suitable definition for deliberation is that of Grimes, as it emphasises the true decision making power of citizens.

There are many practices to achieve public deliberation (see e.g. Rowe – Frewer 2000; Fung 2003). One of the most discussed is the citizens' jury, which, basically is somewhat similar to an ordinary legal trial. In a citizens' jury, selected jurors come together usually for three to four days and they discuss the selected topic. Even though the jurors are laypersons, they are capable of achieving an understanding of complex subjects (e.g. Mattinson 1999; Bennett – Smith 2007; see also Reykowski 2006). They can increase their understanding by examining the evidence and interrogating witnesses. There are, however, differences between a citizens' jury and an ordinary legal trial. The interaction between the jurors themselves and also between jurors and witnesses is more interactive in a citizens' jury, for example (Iredale – Longley 1999), So far, citizens' juries have seemed to offer many positive experiences (e.g. Kenyon – Nevin – Hanlay 2003; Iredale et al. 2006).

Generally, there are many positive factors arising from public deliberation. Friedman (2006), for example, sees seven important purposes that citizen participation can serve. These are presented in *Table 1*. One especially interesting advantage of citizen deliberation from the perspective of health care is its ability to set health care priorities. It is then possible that "citizens who articulate and share

values as respect, generosity or equity may justify health-care priorities that create opportunities for all community members to gain mastery of their own lives". In other words, with deliberation citizens start to understand each other better and so they "may go beyond the self to serve others, and thus set innovative and responsive health care priorities" (Murphy 2005: 172, 174).

Table 1

Purposes of civic engagement

1. Informing policy	Public's values, preferences and concerns help policy makers to make better decisions. When problems are close to citizens, they can give their own insights and then "offer critical pieces of the puzzle".
2. Legitimising policy	When citizens engage authentically in decision-making processes, it is easier to legitimise the emerged outcomes.
3. Freeing a paralysed policy process	Citizen participation can help to remove political deadlocks.
4. Helping citizens move toward "public judgment" on specific issues	With deliberation, citizens can mature their opinions about the discussed issues. In addition to a clearer understanding of the matter, a better recognition of political manipulation emerges.
5. Promoting a healthier democratic culture and more capable citizenry	Deliberative public engagement helps to strengthen democratic culture and practice. It gives new methods for democracy to evolve.
6. Building community	With public deliberation, it is possible to build stronger communities.
7. Catalyzing civic action	Deliberation in the best case precedes civic action, creating more active citizens.

Source: Friedman (2006)

Two additional positive factors need to be emphasised here. Firstly, as Randma-Liiv (2008) states, "[p]ublic management is not a value-free exercise". Technocratic and democratic values, for example, can easily conflict, and scarce resources can press decision-makers to emphasise the former at the expense of the latter (Randma-Liiv 2008). More importantly, there exist social value judgments which, for example, scientific experts or politicians on their own, cannot make. These are, among others, about preferences and ethical principles, like whether we should give special priority to children and young people on behalf of elders. As these judgments are about essential human values, they should reflect the values of the whole collective: the current and future patients of health care systems and more generally the entire public, who are, stakeholders via taxpaying (e.g. Rawlins 2005).

Secondly and more importantly, reforming health care is characteristically about sacrifices (Yankelovich 1995). When there is a need for sacrifices, the need

for public deliberation becomes strong. As citizens in health care systems demand more than it is possible to provide or more than they are willing to pay, sacrifices are inevitable. Without public deliberation on the issue, there is no real chance for citizens to contemplate on the tough choices in reforming health care, such as priority setting.

Not all views about citizen deliberation are positive (see Sanders 1997). The most discussed issues are the problem of power (i.e. power relations in deliberative forums) and the problem of scope (i.e. the problem of achieving large-scale deliberative democracy). There are, however, many suggestions to adjust citizen deliberation according to these particular problems (e.g. Friedman 2006; Kadlec – Friedman 2007). Additionally, one especially important aspect of citizen deliberation is that talking with the citizens is not enough; the true power to influence is also needed (e.g. Svensson 2008). *Figure 1* summarises the theoretical background of this article.

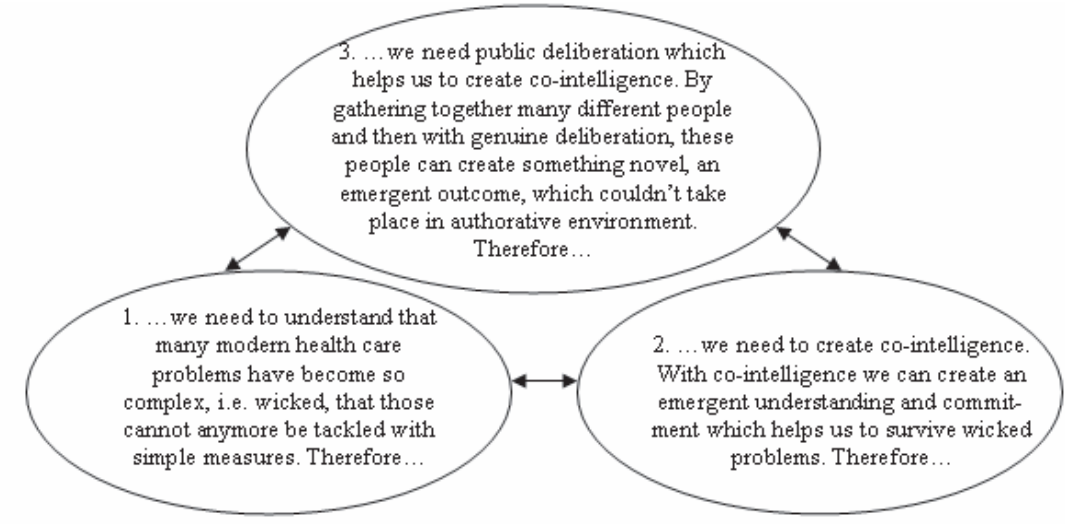

Figure 1. Simplified process of surviving wicked health care problems

3. THE PROSPECTS OF PUBLIC DELIBERATION IN THE HUNGARIAN HEALTH INSURANCE REFORM

This article is not about the actual content of the Hungarian health insurance reform or about the general state of the Hungarian health care. Those are discussed in detail elsewhere (e.g. Mihályi 2007; 2008a; Gulácsi et al. 2009). As pointed out before, this article will not commit to say if the content of the reform was a "right" or not. Resolutions to wicked problems, such as fundamental dilemmas in health

care, are not right or wrong ones. Instead, the standpoint to the "goodness" of the reform depends on who one asks. Furthermore, no matter how much research and evidence exists about the possible impacts of the likely reform outcomes, these are never certain. The world is far more complex than scientific evidence sometimes suggests. Taking these two aspects into consideration, that no one can exclusively state the reform to be the right one and that no evidence can guarantee the outcomes of planned reform, the focus in this article is to point out how to lessen the needless pain in reforming health care. In the Hungarian health insurance reform, this frustration and pain were crystal clear.

3.1. The process of the Hungarian health insurance reform

> *"... fiscal conditions require a reduction in public spending. At the same time, the relatively poor overall health status, the relatively low current level of public spending on health, and the need for improving the overall performance of the healthcare system probably justify more resources. This conjuncture exerts pressure on the government (and other actors in the healthcare system) to improve efficiency. However, decreasing public expenditure is a constraint for addressing several key obstacles to efficiency and quality of care."* (OECD 2008)

As seen in the preceding quotation, the Hungarian health care reformers have been, and still are, facing a rather wicked issue. Various attempts have been made to confront this. These include, among others, a reform of the pharmaceutical market, restructuring of hospital care and introduction of a so-called "visit-fee". It can be noted that the introduction of this "visit fee", that is, 300 HUF co-payments in primary, outpatient and inpatient care, came to play an important role in the breakdown of the Hungarian health care reform in its entirety.

More importantly, after a decade long deadlock in reforming Hungarian health care, an opportunity for a more fundamental health care reform was opened; a fundamental reform of Hungarian health insurance system was attempted (OECD 2008). In this partial liberalisation of the state-run single-payer health system, 22 new health funds would have been established with 49 percent ownership by private investors and 51 percent by the state. The hypothesis was that this mixed system would increase competition and achieve a better management control, which, for one, would rationalise the inefficient and costly health care system, and would lead to improved services (Mihályi 2008b).

On the 6th of June 2006, after the general election, a Socialist-Liberal coalition government was formed in Hungary. Soon the reform of the Hungarian health insurance system started to come into existence by the proposition of the junior coalition partner, the Alliance of Free Democrats, with the consent of the larger coalition partner, the Hungarian Socialist Party. The opposition to the initiative was

strong from the beginning. The largest opposition party, FIDESZ, with the Christian Democratic Peoples' Party proposed a referendum on cancelling the "visit fee", with FIDESZ even promising to bring back the former health insurance system when returning to the power. The planning of the reform proved to be a greater challenge than thought. According to Mihályi (2008b), at the end stage of the reform process, faith in the reform was lost and the aim became just to limit the damage and minimise the loss of prestige.

The opposition to reform plans came from many fronts. Firstly, it came from the opposition parties, but even from within the socialist-camp from influential socialist MPs. Secondly, it rose outside of parliamentary politics. Thirdly, the reform got critique outside the Hungarian borders as well (see e.g. Kutzin 2007). Trade union confederations provided strong resistance and the Hungarian Medical Chamber opposed the reform strongly, stating even to "block the law wherever they can" (Mihályi 2008b). Protests were organised, not only against the initiatives on health care but also on other planned government initiatives. On the 21st of November 2007, for example, the Democratic League of Independent Trade Unions arranged a large nationwide protest, which included not only demonstrations but also strikes. In small scale, the official demonstrations were followed by street turmoil by right wing radicals. On the 10th of December, a separate demonstration was organised by other trade union confederations, which was followed by more protests. On the 15th of December, for example, a peaceful demonstration was organised, along with more strikes on the 17th.

On the 17th of December, the new health insurance legislation was passed in the National Assembly, but the President refused to sign the bill, which was returned for reconsideration and passed again on the 11th of February 2008. On the 18th of February, the President had no choice but to sign the Health Insurance Act. This, however, did not guarantee the sustainability of the new health insurance system. What happened, with the words of Mihályi (2008b), was a "Sudden Infant Death Syndrome", bringing about the nationwide referendum on the 9th of March. Over 80 percent, with the participation rate of 50.51 percent, voted for the abolition of the "visit fee". The ferocity of the referendum surprised the Government, leading to a complete paralysis. An additional referendum was planned for the abolition of the new health insurance legislation, with a strong support for the initiative of more than 350,000 signatures. In the end, the Parliament abolished the "visit fee" and on the 26th of May 2008, the Health Insurance Act was repealed.

As stated above, in the Hungarian health insurance reform the frustration and pain are evident. In two years time, two health ministers were lost: one resigned, the other was dismissed. The Social-Liberal coalition broke down. Demonstrations and strikes were organised. Expensive referenda took place and more were initiated. Frustrations about politics grew. The opening for a fundamental reform

was lost. What remained was stagnation or the former status quo. Could this all have been avoided if public deliberation would have been taken place during the reform process?

3.2. Deliberating together on complex issues – in the Hungarian context

For Yankelovich (1995), public deliberation, as an informed debate, is needed when an issue meets one or more of three criteria: the issue is significant to people's lives; there is a need for sacrifice; and special interests oppose the planned end result. The Hungarian health insurance reform meets every one of these criteria. In the following, the need for public deliberation in the Hungarian context will be highlighted through three specific points.

The first point is about making the citizens face the reality of issues. It might be that the problem is not actually that citizens consider the reform a "wrong one". Instead, even though a professionally or politically suggested reform initiative could be a wise one, people can complain because they do not understand the problem or the proposed solution. As a result, people can start to fear the proposed changes and "settle for the status quo, however unsatisfactory, preferring it to change they do not understand and have not seriously considered". Yankelovich (1995) continues by saying that "the essence of the deliberative process is that it forces people to come to grips with reality". Citizens then see that improving health care services has only a limited applicability. As Rawlins (2005) states, "when presented with the facts and an opportunity to deliberate on them, people understand and accept that a publicly funded health care system cannot provide unrestricted resources without incurring unacceptable penalties for others". It is not possible, therefore, to "hide behind the mantra of 'cutting waste, fraud, and abuse'" (Yankelovich 1995).

The preceding point can be seen in the context of the Hungarian health insurance reform. There was a lot of debate about the reform, but it was a highly political debate taking place with too much haste and partly behind closed doors. There was not really a time to contemplate about the complex issues neither for the Members of Parliament who did not participate in the process of writing the text of the health insurance bill, nor for professional organisations. This was one reason why President Sólyom first refused to sign the law:

> "In the case of law, professional organizations were not briefed or received only delayed briefings on the text of the bill and – this is particularly true for professional colleges of physicians – did not have sufficient time to form opinions (…) We also must note that behind-the-scenes political compromises gave rise to continuous and significant changes in the bill, up until the very last moment before it went before parliament. A Member of Parliament

> cannot be expected to take a responsible position on a large number of amendments learned of only hours in advance of vote… I cannot agree with this type of procedure when passing a law that will fundamentally alter life in our society on long term." (Sólyom 2008)

If it is hard to form a contemplated opinion even for politicians and professionals, how then can it be assumed that individual citizens could do it? What resulted was that citizens did not understand either the necessity to change or the nature of the reform. The failure to communicate, or, better, to deliberate with the citizens, created strong resistance from their part (Edelényi – Neumann – Tóth 2008). As "the case book reform" of failure to deliberate, Clinton's health care reform in the 1990s suggests, there is debate and then there is deliberation. Debate is about win-lose situations, whereas the deliberation is more about win-win situations. All of this was stated by President Sólyom (2008):

> "I do not agree with this law, and therefore I will not sign it and promulgate it… First and foremost, no reform can hope to be successful unless it has the confidence of the citizens, who will have to pay the costs (…) I agree that the healthcare system must undergo reform. However, unless people trust and support a reform of this nature, it cannot succeed."

The second point is about the dilemma of sustainability in improving the Hungarian health care. Bonch (2009) has pointed out that the average time in office for ministers of health and director generals of the NHIFA is 1.5 year. There have been 11 of both between 1993 and 2008. The number of major reform programmes is also striking (Szócska – Réthelyi – Normand 2005). The problem of sustainability is now obvious. Szócska, Réthelyi and Normand (2005) name this as the "perverted policy cycle". Ministers change too often and so do the reform objectives. Officials who are left behind assume that the successor will halt the previous reform programmes, and, as a result, they suspend the implementation processes. As the minister changes, the administrative positions can also change (see Jenei 2008). Discontinuity increases, and confusion in politics and in the administration starts to extend further, to health care professionals and the public itself. More the cycle repeats itself, the more the frustration and pain increases. As a result, political deadlock may emerge. Citizen deliberation, however, can be used to free this paralysed policy process. With the co-intelligence of the public, it is possible to implement the policy with the support and goodwill of the citizens (see Hartz-Karp 2007). It can be pondered if the reform process of the Hungarian health care system, after the failed attempt with the health insurance reform, is in a paralysed situation needing the co-intelligence of citizens to free it.

The third point is about the situation of representative democracy in Hungary. Edelényi (2008) highlights this issue when pointing out the substantial increase in the number of referendum initiatives in Hungary. Their costs are one issue to consider, but more importantly "such initiatives also raise question about the effec-

tiveness of Hungary's representative democracy. They may also undermine the ability of any elected government to govern its people and also its credibility" (Edelényi 2008). So the issue might not only be about the difficulties with reforming Hungarian health care, but more fundamentally with dilemmas of representative democracy (see also Jenei 2008). Public deliberation can help with this too, not by replacing representative democracy, but by promoting a healthier democratic culture and more capable citizenry (Friedman 2006). Even though using public deliberation is costly in monetary terms, direct democracy, in the form of national referenda, is even more expensive (see Edelényi 2008; Jenei 2008), and not only from a monetary point of view.

Additionally, the fundamental wickedness of the issue of reforming health care supports the use of public deliberation in reforming Hungarian health care. Firstly, this wickedness implies that diversity deepens the understanding of the problems, and it increases the innovativeness of proposed solutions. Citizens are part of this diversity and their views have high value, as they are the true experts of the lives they live (see e.g. Akkazieva et al. 2006). The representative of WHO, for example, criticised the Hungarian health insurance reform to be too inflexible: "Don't let labels like these limit your choices" (Kutzin 2007). With this statement he referred to the health care models of Beveridge and Bismarck. With public deliberation more innovative responses could have been contemplated on. Secondly, problem wickedness suggests that laws alone are not enough to tackle highly complex problems. To think more fundamentally, the real problem facing Hungarian health care is that "why people in Hungary use the health services and take medicines so often?" (see Horvath 2007). As the health status of Hungarians is one of the lowest among the OECD countries (OECD 2008), can the simple solutions such as introducing the "visit fee" have a real influence, or do they just nourish the actual problem? As citizens are part of the problems, the possible "solution" to these issues needs the participation of the public itself. When citizens are taking part in problem definition and solution, they feel more strongly that they own the problem (see Scutchfield – Hall – Ireson 2006). Public deliberation can help to achieve this shared commitment to survive wicked health care problems.

4. CONCLUSION

This article discussed the prospects of public deliberation in the context of the Hungarian health insurance reform. As a reform effort, which involved not only disagreement about important values but also uncertainly about the reform outcomes, it forms a good occasion to highlight the prospects of public deliberation.

Even though the examination of the process of the reform is rather superficial, the possible prospects of deliberation are clear.

It can, however, be only pondered what would have happened if public deliberation would have been used in the reform of the Hungarian health insurance system. Maybe the understanding and commitment to the suggested reform would have grown nationally and it would have been sustained as such, with the goodwill of the people. Or maybe, through public deliberation, something truly novel would have emerged. Whatever the result, it can be stated with good confidence that needless pain and frustration would have lessened. This is one important lesson to be learned from the process of the Hungarian health insurance reform.

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NOTES

[1] The article is based on the author's commentary address at the Finnish-Hungarian Health-economics Conference at the Corvinus University of Budapest on 5th of February 2009 (Searching for the holy grail of health policies: The Finnish-Hungarian alliance).

[2] This is however only a brief introduction to the topic. For more fuller account see Raisio et al. (2009).

[3] The author spent six months (08.09.2008–28.02.2009) in the Health Economics and Technology Assessment Research Centre at the Corvinus University of Budapest.