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GEORG WALLS

HEALTH CARE AND SOCIAL WELFARE IN COOPERATION

JYVÄSKYLÄN YLIOPISTO, JYVÄSKYLÄ 1982

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The Finnish Report for the International Investigation of the Structure and Methods of Interprofessional Cooperation from the point of View of Assessing their Outcome.

Initiated by the European Centre for Social Welfare Training and Research, Vienna. (ECSW R 10 (1979)

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ABSTRACT

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The report presents: 1) the frames and the reasons for the interrelation and cooperation between social welfare and health care in Finland, 2) the actual research on linkages between municipal social welfare and primary health care service delivery systems, and 3) assessments upon the outcome of cooperation. The report is a part of the international project "Primary Health Care: Cooperation between health and welfare personnel" initiated by the European Centre for Social Welfare Training and Research (ECSW) The expansion of health and welfare services has made it difficult to overview these fields of official responsibility. This is one reason for the demands on cooperation and delegation of authority in the hands of the executive staffs. Another argument in favour of cooperation between social welfare and health care is the fact that many functions are overlapping. The report brings forth empirical evidence of the cooperation networks of the social service and health care personnel. Thereby the key roles in respect of collaboration are revealed. The evaluation of the need of cooperation is related to the degree of crystallization of the professional role. Hence, the social welfare personnel expresses a stronger desire for contacts with the health care delivery systems than do the professionals of health care.

INTRODUCTION

This report presents at first the frames and the reasons for the interrelations and cooperation between social welfare and health in Finland. Secondly, the actual research on linkages between municipal social welfare and primary health care service delivery systems is pointed at. A third emphasis is upon the outcome of cooperation. The outcome is measured indirectly by the assessments made by representatives of the sectors concerned.

The report is carried out as a part of an international project initiated by the European Centre for Social Welfare Training and Research

> "PRIMARY HEALTH CARE: COOPERATION BETWEEN HEALTH CARE AND WELFARE PERSONNEL
>
> An international investigation of the structure and methods of interprofessional cooperation from the point of view of assessing their outcome."
>
> (ECSW Project R 10 1979)

The Finnish report is mainly based upon the guidelines of the international project (ibid.), published in the Swedish report (Westrin 1981 Appendix III). However, the ambition of the writer has been to present some of the empirical data derived from numerous studies closely related to the topic and carried out under the supervision of Heikki Kaitalo and the author. This has eventually removed the Finnish report farther from the guidelines than may be the case of the other national reports.

Objective of the International Investigation

The objective of the study, as stated in the guidelines for the preparation, is:

"To compare and contrast the experience of interprofessional work in health and welfare care in the local community as it is practised in various countries with a view to analysing emerging trends and the presumptive advantages and disadvantages of different patterns. This analysis is to be concerned with both structure and process and will include both general trends and specific illustration of particular significance.

The primary aim of the study is therefore to search for similarities and differences of interprofessional work as it is practiced currently in various countries. This aim is to be achieved through the compilation of similary structured descriptions of the structure and process of interprofessional work (while a national standard system is not assumed) illustrated by typical cases of cooperation and discussion of trends." (ECSW 1979).

Scope of investigation

The study is concerned with:

- all forms of interprofessional cooperation (whether formal or informal, established or formative),
- The delivery of primary health care,
- all health and welfare personnel involved (i.e. not only doctors, nurses and social workers),

but limited to

- specified groups of clients.

(ibid, 3)

The data

The data requirement of the international study falls into two complementary groups:

(a) descriptive or structural data	(b) the process of care and directions of change
(i) administration/organisation	(i) policy, the priorities and concerns of the larger system; assumptions in the wider society regarding the nature of care
(ii) professional status, structure and practice	(ii) trends and developments in the evolution of professions; impli-

	cations of role change
(iii) patterns of client care and 'usual' professional interaction	(iii) changing features in local provision of care; informal changes in professional relationships vis-a-vis different client groups
	(ibid, 4)

The participants of the international investigation number altogether 10. This means that the coordinator of the project Dr. Claes-Göran Westrin has in his hands an international puzzle, which is to be gathered according to the guideline. In order to facilitate the puzzle work the Finnish report brings the main findings and characteristics together in the summary.

The writer of this report has presented parts of it to experts in the field of social welfare and primary health, namely:
Eino Heikkinen, Professor of Social Medicine, University of Jyväskylä
Leo Paukkunen, Professor in Social Policy, University of Jyväskylä
Jaakko Tuomi, Head of the combined Agency of Social Welfare and Health in the city of Lappeenranta.

Furthermore, the author has had the opportunity to benefit from several contacts to research colleagues, field workers, administrators and students of social policy, sociology and primary health. The cases reported in the appendix are confidentially selected by the field workers of some agencies of Social Welfare and Mental Health.

This report could not have been written without the initiatory work by my research colleague in the SOPUKKA-project M.A. Heikki Kaitalo. Much of the findings presented are directly or indirectly originating from our study made in 1977 under the auspices of the National Central Boards of Social Welfare and Health and the Ministry of Social Affairs and Health. The translations into English have been done by Mr. John Clarkson, Mr. Heimo Turkkinen and Miss Elina Randell. The Ministry of Social Affairs and Health, the Finnish Academy and the Institute of Social Policy at the University of Jyväskylä have each contributed to pay the costs of the translation and the typing of the report.

I hereby wish to Thank all of you who have cooperated in the realization of the Finnish report!

Finally, my thanks are also due to Jyväskylä Studies in Education, Psychology and Social Research as well as to its editor, Dr. Helena Hurme.

Jyväskylä the 15th of October 1981

Georg Walls

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NATIONAL CHARACTERISTICS

Finland formed an integral part of the Kingdom of Sweden from the 12th century until 1809, when it was united with the Russian Empire as an autonomous Grand Duchy. During this time the existence of a Finnish nation became gradually established and separate institutions were created. Independence was declared in 1917 accompanied, however, by a civil war between whites and reds in 1918. A republican constitution was adopted in 1919.

An important feature of Finland's constitution is the long tradition of local self-government, including the right of local authorities to levy income tax. The communes are governed by elected councils, under which operate a number of politically representative boards heading sectors of local administration such as education, health, social welfare, public works, land use and town planning.

The administration and financing of health care and social welfare services are based on the responsibility of the local authorities to organize the services. The health and social service system is thus a mixture of national and local funding. The supervision and control is the responsibility of the central state administration. The present number of communes is 464 (Social Welfare..., 1980, 3-4).

The population of Finland numbers almost 4.8 million. The occupational changes affecting the social structure of the population have been sharp. For ex. the agrarian population has diminished from 46 % of the labour force in 1950 to about 14 % in 1980. Even this percentage is, however, higher than in most West-European countries. The rate of married women in the labour force in the year 1977 was one of the highest in the world, 78 % (Tilastokeskus). Compulsory school lasts from 7 to 16 years of age. Demographically, it can be seen, the population has clearly aged from the 50's, the percentage of people 65 years and older being in the year 1975 10.8 % as compared to 6.6 % 15 years earlier. The birth rate in 1975 was 13.9 o/oo (Social Welfare..., 1980,1-2).

The Finnish economy is mainly based on wood working, processing and converting, and to an increasing degree also on metal and engineering. It is easily affected by international fluctuations. In periods of economic decrease or stagnation the unemployment rate is fairly high. During the last stagnation the rate of registered unemployment rose at most to 7.5 %. The present figure is about 5 %. Also the in-migration as well as the emigration, particularly to Sweden, has been considerable (ibid. and Tilastokeskus).

PART I. RECENT HISTORY AND EXISTING FRAMES OF HEALTH AND WELFARE SERVICES

In order to understand the present situation of the social welfare and health systems and their interrelations it is worthwhile to get an insight in the historical background of the systems.

1. THE DEVELOPMENT OF SOCIAL WELFARE IN FINLAND

The first public manifestations of social security in Sweden - Finland were the exhortation of 1571 of building a cottage hospital in every parish and the begging regulation of 1642, according to which congregations were obliged to build poorhouses (Kuusi II 1931, 961-967). In order to minimize the expenses there arose a system of district care according to which houses that belonged into the same district one at a time took care of the poor or wretched person that was commended to them (Piirainen 1958). Historically social security has two old roots, one which begins from the family and congregation and the other from the journeymanguilds and crafts of handicraftsmen (Waris 1980, 169; c.f. Kuusi I 1931, 117-124).

A little more than a hundred years ago the care of paupers, poorly off old people living alone and orphans was managed by a system where the maintenance was entrusted to the lowest bidder by public auction. Besides this there was the poorhouse for those not cared for by either the families or the bidder system mentioned. In the 1870's the old poorhouse system as well as the hospitals were transferred from the church to secular authorities, i.e. municipalities and the state. In this way social welfare and health became social questions and areas of public concern (c.f. Walls, 1980, 47).

The Paupers' Edict of 1879, inherited from the Russian Empire, remained for long almost the only statutory prescription in the field of social welfare. The responsibility of the communes to give assistance was restricted to concern only children, the feeble-minded, the chronically ill and the senile. There was no obligation to assist anyone outside these categories. The system of poor relief was divided into

open care and institutional treatment. Regardless of their age, those in need for the latter were taken care of in poor houses (Piirainen 1958).

Finally, in 1922, the old Paupers' Edict was replaced by the Poor Relief Act. This Act obliged the communes to run homes for the care of the indigent. Though this law was an improvement on earlier enactments, it still provided only minimum relief for the poor and the sick, with no attempt to develop self-sufficiency (Social Welfare..., 1980, 9).

The Social Assistance Act of 1956, the changes made in it in 1971 and the Act of Social Welfare Administration from 1956, which is currently (1981) being brought up to date, are the main laws regulating the implementation of aid, services and social welfare in these cases where other arrangements for personal and/or family livelyhood and welfare fail. In this sense the social assistance is the last resort.

The system of institutional treatment remained however for long unaffected by the democratization of society. For ex. these adult communal home inmates who were under the guardianship of the commune, were deprived of their right to vote, a humiliating situation that prevailed up to 1956 in Finland. It is obvious that this depersonalization has affected the attitudes toward communal homes among the population , especially among the old.

In 1936 three laws on social security were passed, namely, the Child Welfare, Alcoholics and Vagrants Acts. These laws signed the beginning of the specialization of social welfare legislation for different target groups. In the 1930's several reforms in the population and family policy were initiated. However, the realization of these had to wait until the end of World War II. Only the maternity care legislation was passed 1937. Though none of the benefits granted according to these laws were intended to replace poor relief, they in fact reduced the need for such assistance. The main principle was the use of administrative means to prevent phenomena regarded as dangerous to society and its future development (ibid.).

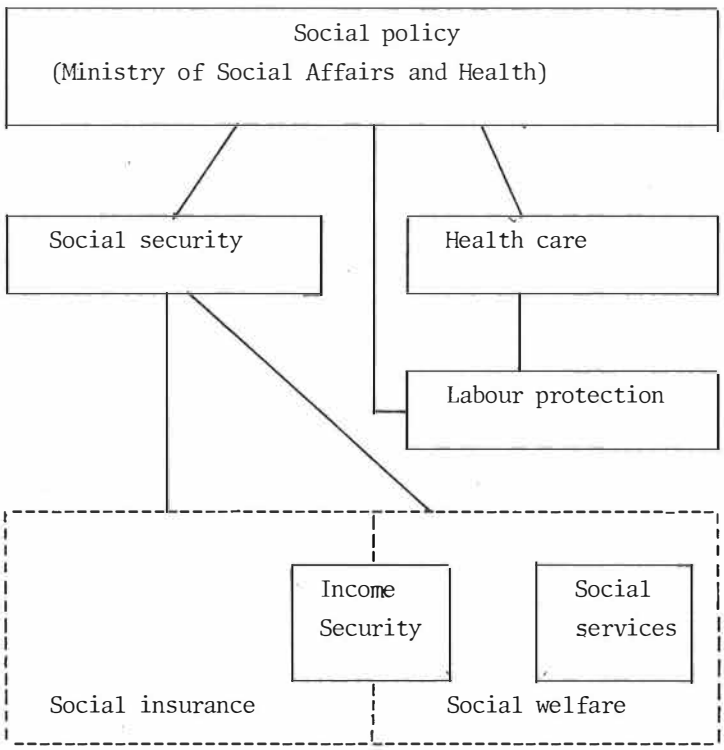
The earliest pension schemes in Finland were started by tradeguilds in the 17th and 18th centuries (Social Insurance..., 1981, 3). In general, however, the social security system was realized comparatively late in Finland. The National Pensions of 1936 became of importance after the legislative reforms of 1956. The pensions were no longer fixed according to the sums of money paid as insurance fees. A national pension is then the basic pension, supplemented by earnings related pensions for employees and the self-employed.The law on sick insurance was passed in 1962 and the laws on work pensions in the 1960's. The security in case of unemployment is realized through state unemployment compensations and unemployment reliefs granted by the trade unions' unemployment funds to their members (Social Welfare..., 1980, 9).
The Social Insurance Institution, which administers the flat-rate National Pensions, and Sickness, and Maternity Insurance, is an independent unit gowerned by public law and supervised by Parliament. In the private sector, earnings-related pensions for employees are handled by insurance companies, funds, and foundations. A central Pensions Security Institute keeps an Employment Pension Insurance Register (Social Insurance..., 1981, 4-5).

Income security classed as welfare was improved by the Draftees' Dependents Act of 1948, the Disability Allowance Act of 1951 and the Child Maintenance Advanced Act of 1963 (superseded by the Child Maintenance Security Act of 1977 (ibid.,10). A consequence of the war was the large number of the war wounded who needed special welfare. The Disabled Persons Welfare Act of 1946 did not cater for all the war wounded: institutional welfare for the most severely disabled remained dependent on the Poor Relief Act. The income security of war victims was augmented by the Military Injuries Act of 1948 (ibid., 9).

It can be concluded that in general Finland has followed the example of Sweden as regards the development of social welfare whereas the models for the social benefit systems originate from Sweden, France and Great Britain. The guides in the development of the social insurance system have correspondingly been Germany and the other Nordic countries.

The decisionmaking, the administration, and the implementation of so-

cial welfare used to be rather centralized in Finland. The state boards for social welfare and health care had to make fairly detailed decisions concerning the allocation, use, misuse, and planning of resources and institutions etc. In the year 1977 a reform was carried out with the result that over 50 000 instances of decisionmaking were handed over to county or local boards and agencies. It must, however, be emphasized that in Finland the counties are not parlamentarically representative organs with the authority to make decisions independently of the government (Sosiaali- ja terveysministeriö 1978).

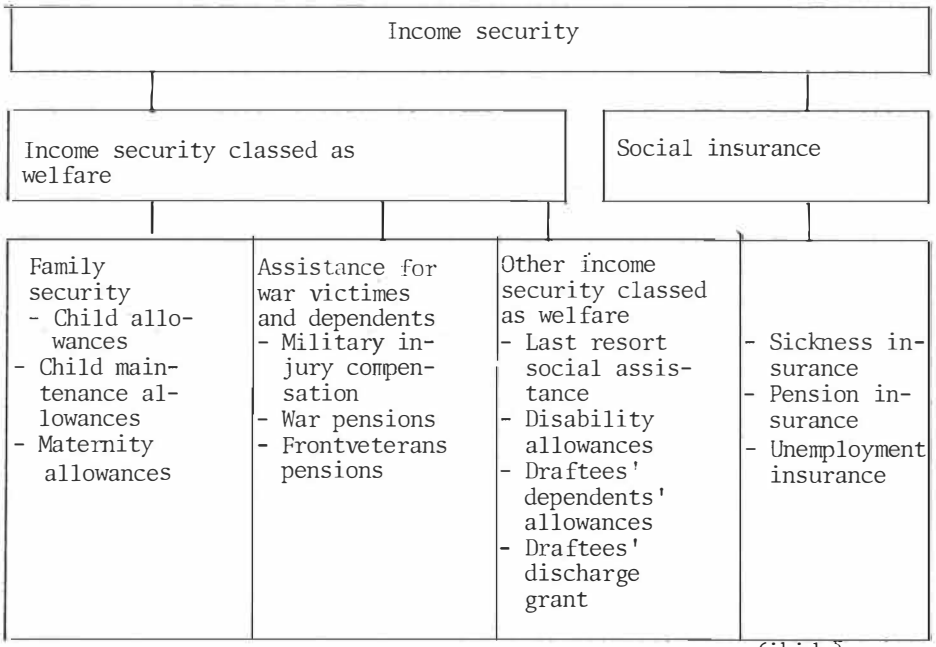


(Social Welfare..., 1980, 5).

Figure 1. Social Policy Divisions in Finland

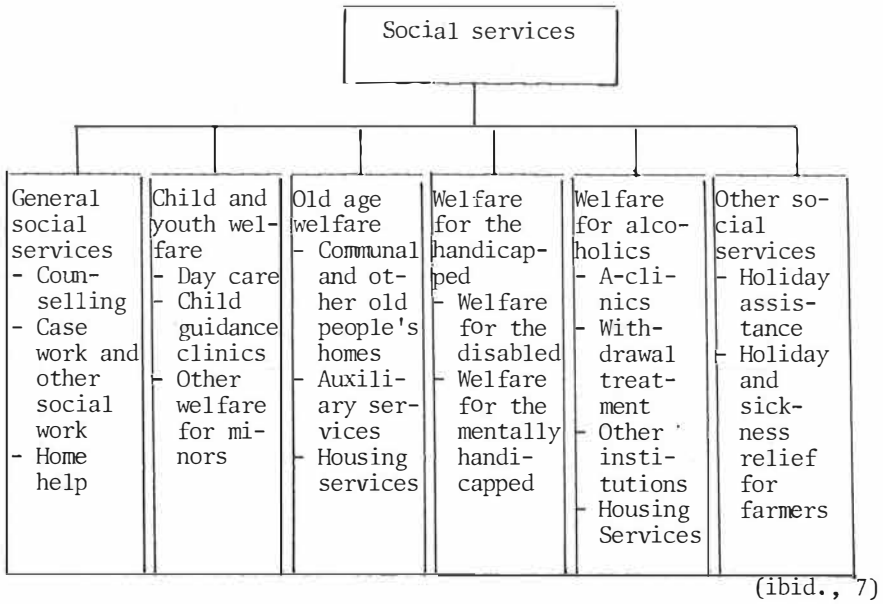
The decisionmaking is the responsibility of one ministry. The implementation of the social welfare and health care, however, is the task of specific central state boards, agencies and centres.

The income security can broadly be divided into social welfare and social insurance. The social services are, however, also closely related to income security.



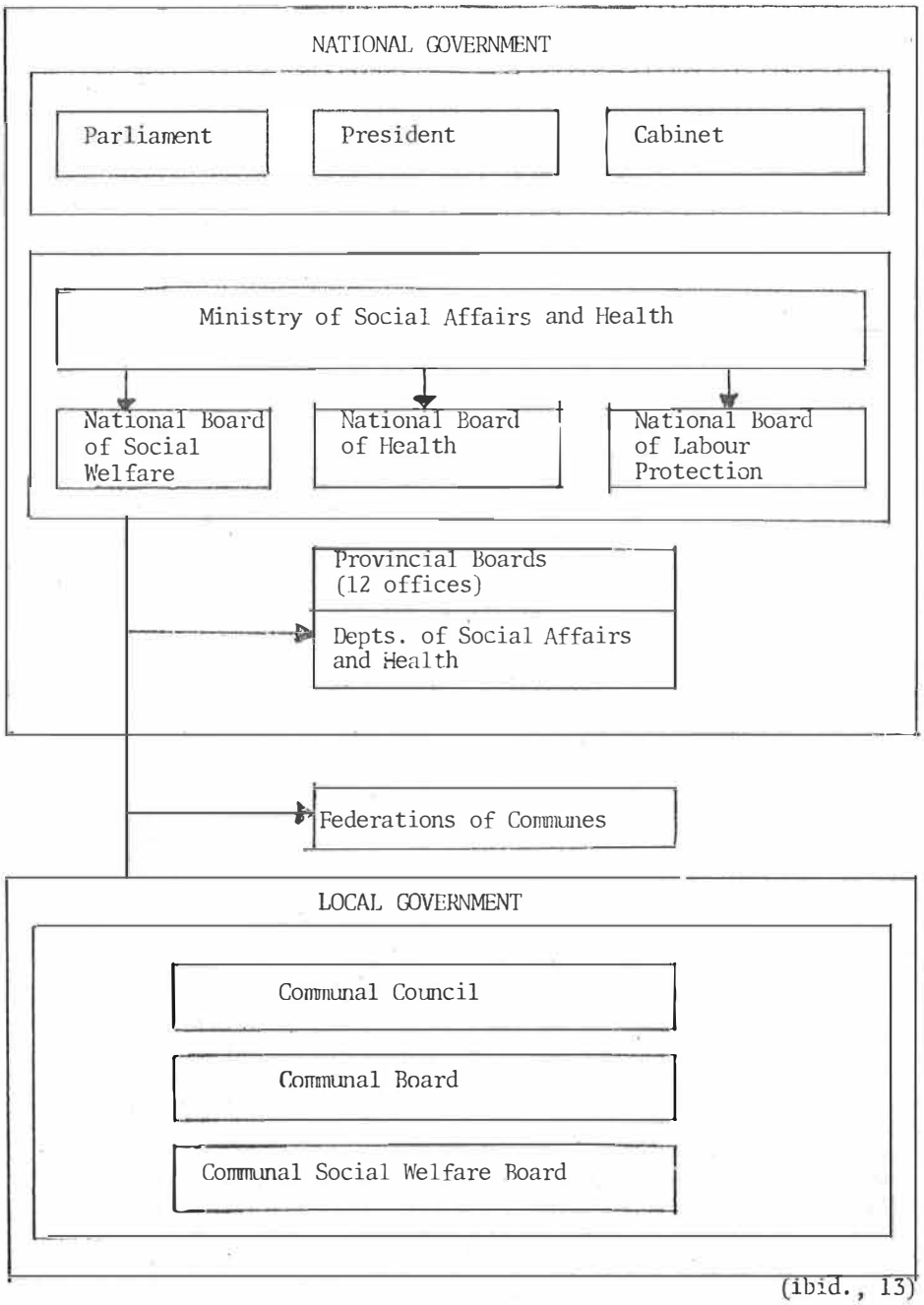
(ibid.)

Figure 2. Income security systems in Finland



(ibid., 7)

Figure 3. Social services in Finland



(ibid., 13)

Figure 4. Administration of Social Welfare in Finland

It ought to be pointed out that the municipals are responsible to take care of their members according to the central principle of local self-government.

2. THE MUNICIPAL SOCIAL WELFARE

The municipal social welfare in Finland is based upon the individual needs assessment. The realization of the social welfare varies a great deal due to differences between the communes in size and economic capacity. This is true especially for the individually assessed social allowances.

The last resort social assistance is provided for persons whose means are not sufficient to assure their livelihood or care. The assistance is given either in cash or as institutional care. The expenditures of the institutionally based treatment constitute the major part of the municipal social expenditures. In contrast the expenditures for the domestic support amounts to a mere 5 % of the total social welfare costs. However, the part of the supporting shares of the old-age pensions and the housing support constitute a large expense item for the municipalities (Social Welfare..., 1980).

This is true as long as the reform of the state support for the municipal social welfare is not accomplished (the s.c. VALTAVA-reform). This means that the state support to social welfare for institutional care of children, youth and the aged has been almost minimal as compared to health and education.

Earlier the principal aim of the municipal social welfare system was to help those already in need. Nowadays, however, a main purpose is to prevent the development of situations which would lead to the need of social welfare and aid. As a consequence the social welfare legislation has expanded so that it now includes all citizens and not longer those in immediate need only.

An example of the reorientation in social welfare is the expansion of social services from the 60's on. Childrens' day care has been the fastest-growing social service, other developing services are home-help given at times when the families or an individual, mostly an aged, have special difficulties in their activities or daily life, the child guidance and the family counselling. Income transfers also contribute to achieving the aims set up for family policy. However, all income trans-

fers have together succeeded in compensating families for only a fifth of the extra costs due to their children (Social Welfare ..., 1980, 24-29).

The state social welfare legislation has developed slowly according to the needs risen within the boundaries of the resources available. After the I and II World War the invalids, the widows and the orphans were the priority groups. This is one reason for the fact that there is no integrated social welfare legislation in effect in Finland.

The Social Welfare Agency in Tampere, which is the second largest city in Finland, can serve as an example for the organization of the Finnish social welfare at the level of an individual commune.

According to the rule for the officials subordinate to the Board of Socia. Welfare of the city of Tampere, the Social Welfare Agency is divided into four sections: the General Section, the Social Relief Section, the Economy and Accounting Section and the Institutional Section. In addition there is a Planning and an Information Office. The sections are divided further into offices according to specific tasks.

The General Section is divided into following offices:
1) The Childrens' Protection Office, which is responsible for the activities related to childrens' protection, youth care and the care of the population as far as these tasks ar related to the range of social welfare
2) the Maintenance Grant Office, which is responsible for functions due to the Childrens' Inspector and owing to considerations and maintenance
3) the Day Care Office, which is responsible for the functions due to the childrens' day care division.

The Social Welfare Section in turn is divided into following offices:
1) the Social Relief Office, which is responsible for the functions laid upon it by the social relief division
2) the Domestic Help Office, responsible for the functions connected to domestic help and domestic aid

3) the Social Support Office, responsible for social support and the tasks given by the division of the social institutions
4) the Office for the Care of the Intoxicated, which has to deliver the services given by the Division for the Care of Intoxicants

The duties of the Section for Economy and Accounting are related to the management of the property of the Social Welfare Board as well as the care of the economy and accounting.

The functions of the Institutional Section are related to the institutions subordinate to the Social Welfare Board.

The tasks of the Planning and Information Office are to produce statistical and informational material needed by the Social Welfare Board and Office.

In the year 1978 there were altogether 149 employees in the following posts:

1 Head of the Social Welfare Agency
4 Heads of the Sections
1 Assistant Lawyer
6 Sections Secretaries
1 Hostess
1 Day Care Inspector
2 Family Care Inspectors
1 Researcher
1 Inspector for the Disabled
4 Heads of Offices
1 Assisting Childrens' Inspector
1 Inspector for matters related to Childrens' Subsidies
1 Social Adviser
1 Inspector for the Military assistances
2 Supervisors for the Invalids
10 Advisers for the Family Day Care
10 Office Secretaries
29 Social Field Workers (Social Inspectors)
2 Cashiers
and additional assisting staff.

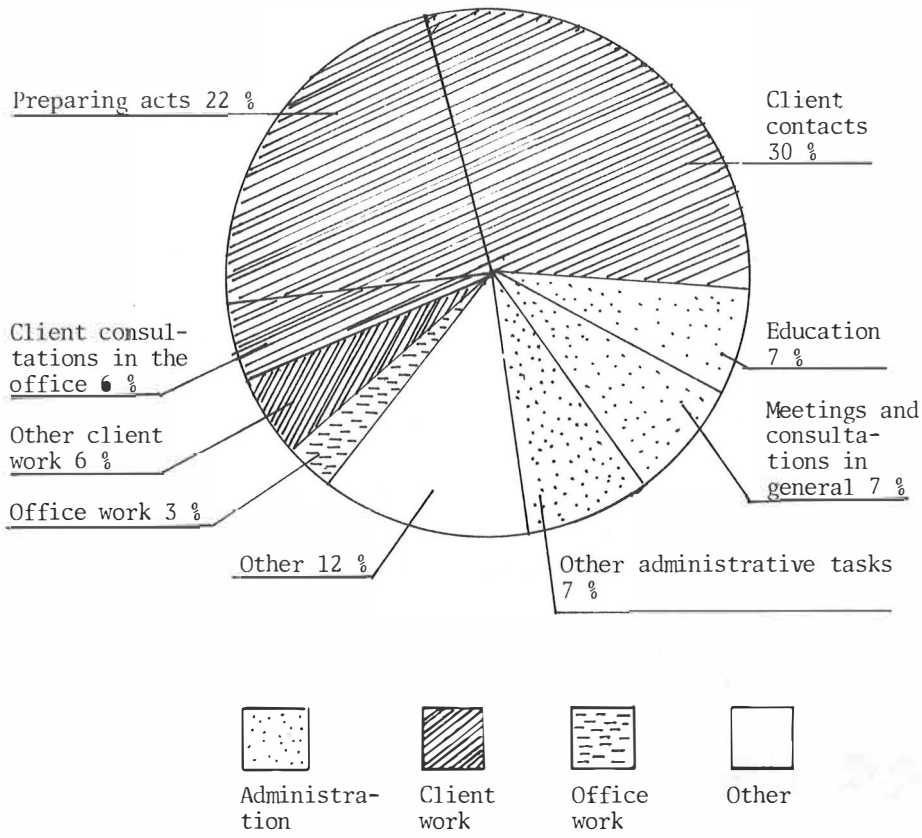
In addition to the personnel mentioned above, there are functions within the Social Welfare Agency which include 71 Domestic Help Supervisors and 76 Domestic Aiders.

More than 60 offices operate under the auspices of the Social Welfare Board. The number of the employees of these offices is approximately 1.100. (Tampereen... 1978)

On the other hand there are about 200 municipalities in Finland with a population less than 20.000 as compared to the 165.000 inhabitants in Tampere. For the small, mostly rural communes, the Social Welfare Board handles almost totally the matters related to social welfare without any far reaching separation into sections and/or divisions. The personnel of the Social Welfare Agency is almost minimal, mostly consisting of one social secretary and a few assisting secretaries. The secretary is at the same time responsible for the management, the fiscal duties as well as social field work. He or more likely she, is really a multiworker.

The work routines of the employees of the social welfare agencies for each category specifically illustrate the content of the Finnish municipal social welfare work. Here I present the results from a fresh study made by the National Board of Social Welfare representing 11 communes, most of which have a population ranging from 3.000 - 20.000; however the largest commune, the city of Joensuu has a population of about 44.000 (Sosiaalitoimiston..., 1981).

The results showing the work routines of the social workers are of special interest here. According to the study the work routines are as follows:



(ibid., 79)

Figure 5. The work routines of social workers (%)

The central tasks of the social workers are related to the assessment of the conditions and the needs of the clients, the drawing up of a sustenance plan together with the client, and its realization, contact-keeping with the client, the support of clients and finally, the delivery of services (ibid., 80).

The yearly growth rate of the social expenditures in Finland has been about 9 % since year 1950. This growth has been even faster than in the other Nordic countries. According to main purpose the social expenditures in 1980 were as follows:

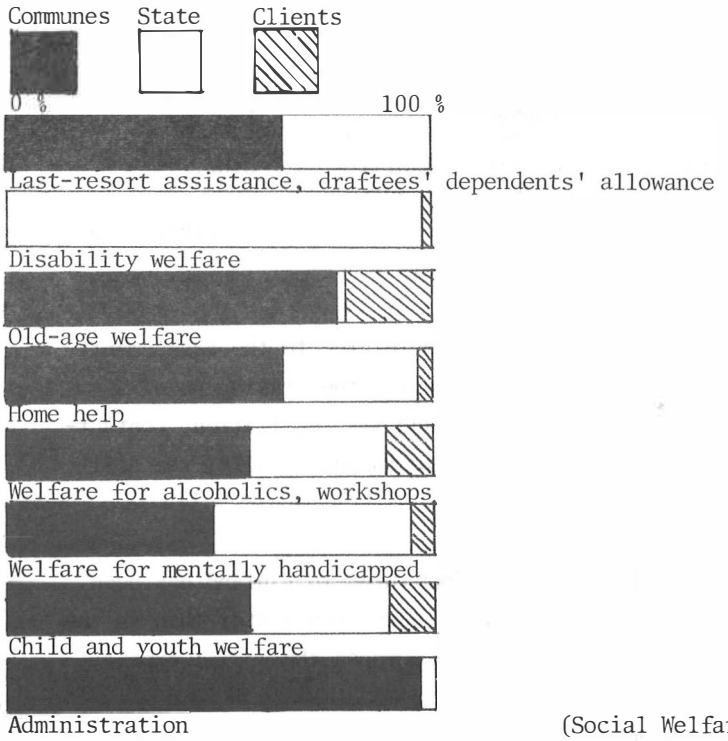
Table 1. Social expenditures in Finland in 1980

	Mill. Fmk	%
Health and sickness	9.200	24
Pensions	15.600	40
Family and children	7.100	18
Other social security	7.100	18
Together	39.000	100

(Pitsinki 1981, 2)

The share of the social expenditures of the gross national product was in year 1980 20.9 while the corresponding figures for Sweden was no less than 36 %, for Denmark 27 % and for Norway 23 % (ibid., 3).

The share of the state and the municipals of the financing of the social expenditures was in year 1979 46 %, the same as the employers' share. The share of the insured the said year was 8 % (ibid., 5).



(Social Welfare..., 1980, 19)

Figure 6. Percentage distribution of costs of social welfare between communes, the State and clients in 1977

The proposed administrative reform (VALTAVA) on the financing and planning of social welfare and health, would mean an increase in state subsidies especially for institutional social welfare. At the same time social welfare would be linked to health in continuous planning and dealt with economically on a fifty-fifty basis.

The exististing situation has amongst other meant that the state shares for the care of cronics, mostly aged, in municipal institutions, have been almost minimal. On the contrary, the health centres and the hospitals have recieved considerable state subsidies. This in turn has led to an expansion of the demand for expensive care facilities provided by the health institutions.

According to the proposal for a new law on social welfare (Hallituksen, .., 1981, 6) social work is defined as the supervision, guidance and solving of social problems as well as other supportive activities made by the professional personnel of social welfare, which maintain and promote the security and the achievements of the individual and the family as well as the functioning of communities.

3. EVOLUTION OF HEALTH CARE

In health care the evolution in Finland has followed the main streams in Europe. The dominating medical school has been and still is strongly influenced by natural sciences. This approach has meant that the weight is put on curative medicine, hospitals and technology instead of primary health and preventive measures. This in turn has lead to the situation where the limits as to the development of health care are no longer primarily medical or technical but economic or connected with personnel resources (Sairaalaliitto 1977, 17).

The Law on Hospitals, in effect since 1957, meant an integration of the areas of responsibility of the state and the municipalities. Up to then the municipalities provided the primary health care through a system of physicians hired by the communities. The mental and the tuberculosis hospitals were run by the communities, too. However, the state administered the central hospitals and the county and general hospitals (ibid.).

In the year 1957 the hospitals were transferred under the authority of the federations of communes. The process was completed in 1965 when special central hospital districts were erected (ibid.). This reform means that nowadays the hospital system in Finland is almost totally governed by municipal authorities through the federation of communes.

In Finland, matters concerning health care fall in the main within the province of the Ministry of Social Affairs and Health. The highest executive authority is the National Board of Health. However, the medical service of the armed forces comes under the Ministry of Defence and similarly the health care of the prisons under the Ministry of Justice. The Ministry of Education, again, is responsible for the obligatory medical inspections and health care of university and college students (Niemelä et. al. 1979).

Besides the duties of the National Board of Health, a number of tasks of environmental health care (including food) is assigned to the Department of Veterinary Medicine of the Ministry of Agriculture and Forestry. Statutory food control is for the most part supervised by the

National Board of Business and Industry serving under the Ministry of Commerce and Industry (Niemelä et. al. 1979).

In addition, certain tasks connected with health care are entrusted to the Social Insurance Institution. Of these must above all be mentioned the deciding on and granting of benefits in accordance with the sickness insurance legislation. Furthermore, tasks classed as health care are also delegated to the National Board of Labour Protection and the National Board of Social Welfare (ibid.).

As far as preventive health care is concerned, the Primary Health Care Act (i.e. public health) is of special importance. The goals of the law are at bottom administrative and financial and in this sense it is a frame law. The leading principles are the attainability of health services, the emphasis on planning, the equality approach, flexibility, cooperation, free care, and the effectuation of the law step by step. The Primary Health Care Act requires that for the laying down of the more concrete duties consecutive five-year plans shall be worked out (Kaipainen 1975, 83-89; Niemelä et. al. 1979, 32-33).

Primary health care divides into care of the health and nursing of the sick; i.e. into health centres and hospitals. Care of the health and nursing of the sick operate each under its own legislation. To organize health care is in principle a communal responsibility and the duties of statutory cooperation are performed by statutory federations of communes.

The arguments in favour of passing the Primary Health Care Act included a statement to the effect that public health care work should be arranged to provide services for a population of ca. 10.000 to 13.000 inhabitants. Communes rich in population could take care of primary health care work alone but smaller communes had to unite and form federations. By the end of 1978, 213 administrative units of primary health care work had been set up, of these 100 were formed by one commune and 113 by two or more communes (SVT 1979).

To secure the effective operation of the establishments for giving treatments, Finland is divided into special central hospitals, tubercu-

losis sanatorium, and mental hospitals districts.

Prevention of mental disorders is a central field of cooperation. Thus mental health offices must work together with local health centres and child guidance centres. Efforts are being made to develop the capability of mental health offices so that they in collaboration with health centres, mental hospitals and out-patient departments of general hospitals, would be able to offer the open care psychiatric services required to satisfy the needs of the population plans (Valtakunnallinen, .., 1980).

A problem concerning the whole health centre system is generated by lack of continuity in the distribution of treatment, which in turn is caused by the rather marked tendency of health centre doctors to move from one position to another as well as by movers of population combined with concentration of services and absence of home visits. That being so there is no opportunity to bring about such a close relationship between the doctor and the patient as is essential for propt and successful treatment; in each case of illness one must start from the very beginning. And if the worst come to the worst, the patient must during one period of illness seek medical aid from several doctors, which certainly prevents any form of safe relationship between the parties from being established. An excellent example of this is offered by out-patient contacts, which in a most pronounced manner reveal a type of treatment, where an active nurse repairs a flaw or a malfunction in a passive object, viz. a patient. There is no time for any deeper examination of background factors.

A further problem of health centre activities is found to be deficiencies in the availability of services and in cooperation between groups of officials. As the health centre services become more and more diversified there has not been in these areas the kind of development that was expected. It is for this reason that the national plans for public health care work have laid a special stress on qualitative improvement and functional intensification of health centre performance.

The outpatient care of the country differs from the corresponding arrangements in other European countries in that Finnish health nurses have for long had an extraordinarily large share of the care on their responsibility. The duties, at least some of them, which in Finland

are traditionally attended to by health nurses, are in general taken care of by doctors elsewhere in Europe.

Forms of cooperation between the National Board of Health and the National Board of Social Welfare include consultative contacts, requests for statement, mutual information and educational activities. Demands have been expressed for increased cooperation especially at the stage of planning and preparation of matters (Jussila, 1975, 349). In the report of the commission to plan a division of duties in the administrative branch of the Ministry of Social Affairs and Health it is recommended that duties should be transferred from the higher levels of administration to the lower (Komiteamietintö 1976:22).

4. HEALTH CENTRE AS THE BASIC UNIT OF FINNISH PRIMARY HEALTH SERVICES

For the application of the Primary Health Care Act each commune or each federation of communes must have a health centre. The concept of terveyskeskus in the Finnish language is a direct translation from the English health centre or the Swedish hälsocentral.It is to be noted that the latter terms both refer to health services placed inside one building with specific tendency towards outpatient care and preventive health care. Another characteristic of these centres is that they provide the primary services of public health care (Aer & Rokka 1975, 145).

The Finnish legislation on primary health care doesn't confine the health centre to mean a certain physical totality. Instead, the health centre usually operates in several buildings. The concept of health centre is developed to bring the primary health activities of the municipality under the guardianship of one decisive and coordinative authory, the head physician. The head physician of the health centre is the head of all other physicians and the other officials of the health centre. Before the passing of the Primary Health Care Act no one of the physicians was officially superior to another. Instead, all municipal physicians were under the guidance of the municipal Health board in the same way as the municipal dentists and the advisory agencies (ibid., 146-147).

The head nurse is the central official what comes to the personnel administration of the health centre. The head nurse is considered to function as the central expert in respect of the nursing as well as the head of the personnel of the health centre, with the exception of the physicians, the dentists and the financial manager (ibid., 147-148).

The central duties of the health centre are as follows:

a) Health information, which according to the law is stipulated as the first obligation of the municipality;
b) The provision of hospital care for the inhabitants of the municipality, which includes the examination made by the physician, the care given by the physician and controlled by him, and the medical rehabilitation and the first aid within the municipality;
c) The arrangement of the transportation of the sick, which earlier wasn't anyone's duty;
d) The work for the prevention of dental diseases, which includes as well the advisory, i.e. the preventive functions, as the care. On the other hand, the care of dental diseases has been arranged at the moment for parts of the population of the municipalities.
e) School health care, which includes as well the control of health conditions of the basic schools, the secondary schools and the vocational schools as the health care of the pupils and the specialized research necessary for the assessment of their health situation.

(ibid., 150-151)

Practically, the health care in Finland is realized by the municipal health centres, the private medical stations or by private practizing physicians. The diversified organizational activities characteristic for Finland, ought to be considered too.

For ex. there exists more than a hundred nationwide organizations occupied in the fields of aid, in client-/patient interests articulation, in care and in rehabilitation. It should also be remembered that preventive health education and rehabilitation activities are handled by the social insurance and work pension systems as well as by private insurance companies. Last but not least, the importance of the influential labour market organizations, especially in the field of labour protection and health, ought to be considered.

The professionals of the health centres besides of the chief physicians and the head nurses, are divided according to their main function as follows:

1. The health information staff
   - 1.1. the health nurses
   - 1.2. the health centre physicians
   - 1.3. the health centre psychologists
   - 1.4. the physical rehabilitation advisers
   - 1.5. the nutritional advisers
   - 1.6. the health centre assistants (the aiding nurses)
   - 1.7. the social workers, either in connection to the health centre or available through cooperation with the municipal social welfare agency

2. The sick care staff
   - 2.1. the health centre physicians (the guidance, selection, care and control of patients by the physicians on duty)
   - 2.2. the health nurses
   - 2.3. the trained nurses
   - 2.4. the health centre assistants (the aiding nurses)
   - 2.5. the other professionals groups occupied in health information

3. The ambulance service personnel
   - 3.1. the medical caretakers and the ambulance drivers
   - 3.2. the municipal authorities (the fire department) and the private ambulance drivers and - enterprises

4. The personnel of the laboratory and the X-ray sections
   - 4.1. the specialized physician (for ex. the roentgenologist)
   - 4.2. the laboratory nurses
   - 4.3. the X-ray nurses
   - 4.4. the trained nurses
   - 4.5. the health centre assistants (the aiding nurses)

5. The personnel of the school health care
   - 5.1. the school physicians
   - 5.2. the school health nurses

5.3. the school psychologists
5.4. the medical treatment gymnasts
5.5. the physical rehabilitation advisors
5.6. the school teachers (health education etc.)

(Rintanen 1975, 156-172)

The vocational classification of the health centre is profoundly versatile. It ought however to be kept in mind that these vocations are not to be found in all health centres. The personnel resources are defined by the special characteristics of the functional areas of the health centre, above all by the population basis. According to the central aims of the primary health care consideration should also be paid to the flexibility of the structure of the personnel and of the division of work.

The main outlines of the Finnish health and hospital care are here characterized according to the levels of health care presented by WHO (WHO 1976):

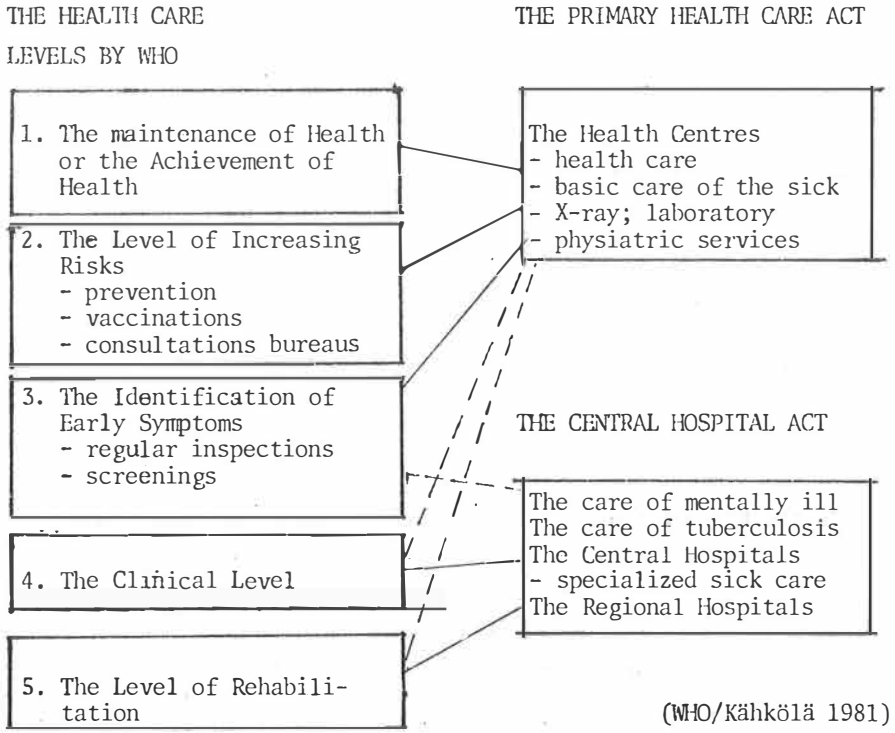


Figure 7. Health care levels by WHO compared with the Finnish primary health care

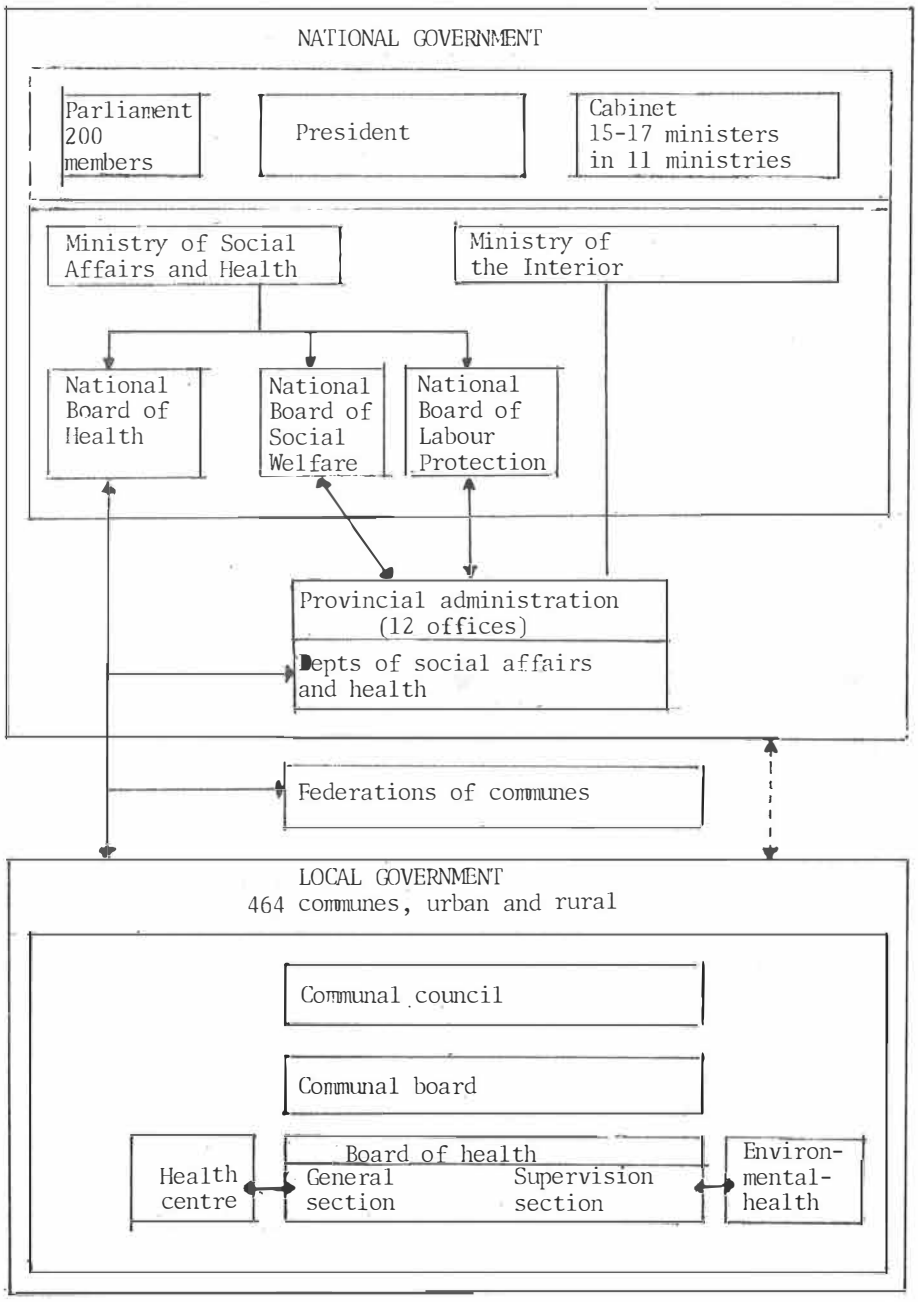
The central task of the Finnish health centres is the delivery of primary care directly or indirectly. Thereby the diagnostic and cooperative facilities become of great importance. The social welfare services required are usually afforded by the municipal social welfare agencies and by voluntary organizations operating in specific sectors in the field of welfare.

(Health Services...,1979, 15)

Figure 8. Functions of health centres and links with other forms of health care in Finland

The Finnish health centres are then the main providers of primary health care services. If and when the cooperation between the health centre and the service delivery systems is functionally operating the role of the health centre as the first hand identifier of the physical, psychic and social interrelations of the problems people face is accentuated.

The administration of health resembles that of social welfare. However, the strongly crystallized role of the physician as a professional ought to be kept in mind. This means that the doctor mostly has the "final word" in medical questions in arguing with the communal board members. The same does not hold for the social workers to such an extent.



(ibid., 13)

Figure 9. Health administration in Finland

PART II. COOPERATION BETWEEN SOCIAL WELFARE AND HEALTH CARE - BACKGROUND AND CURRENT PRACTICES

The social welfare and health care systems in Finland differ from each other as far as their decisionmaking, implementation, and financing are concerned.

1. ON THE BACKGROUND OF COOPERATION

The Paupers' Edict mentioned stipulated that every town had to elect a special government, later a board, to look after the care of the poor. This obligation was one of the central issues in the statute; the other organs of the town were no longer allowed to see to the care of the poor (V.P./Sos.turva 1980 7, 312). The state was responsible for medical care by means of its network of county hospitals and county doctors. It was the municipalities' duty to take care of the poor. The biggest towns, however, did provide some medical care of their own. Both of these public judicial organizations financed their operations mainly through their share of the tax income (Tainio, 1976, 49).

It should be noted that there has been cooperation between municipalities ever since the first municipal laws were made. Thus the 1865 statute on the municipal government in rural districts prescribed the municipalities which came under a joint municipal administration. It also prescribed the joint municipal meeting. Wider cooperation came into being in the 1920's when large municipal corporations were formed for the establishment and maintenance of tuberculosis sanatoria and district asylums. The actual system of municipal corporations was established in 1932. Within the statutory municipal corporations cooperation was obligatory (Komiteamietintö 1960:A4).
The interrelations between the social welfare and health care systems have already been demonstrated for a long time in Finland. This is apparent from the discussion about the social links between sickness and health. This discussion has been carried on in the Finnish medical journals for nearly a hundreds years now and it has been particularly

important as an incentive to sociomedical thinking and measures (Rauhala, 1978). In this connection it should also be remembered how important the early sociopolitical ideas and measures were from the point of view of work safety, in particular. In general, it can be said that labour policy is traditionally an area for cooperation as far as social and medical measures are concerned. In addition to the actual hazards at work, the question of work safety has from the very beginning been linked with the length of working hours (cf.among others, Kuusi I-II, 1931).

Providing greater organizational stability for the cooperation between the social welfare and health care systems has been widely discussed in Finland in various connections ever since the early 1960's. The establishment of the Ministry of Social Affairs and Health in 1968, to replace earlier Ministry for Social Affairs, must be seen as a concrete result of the above development. In this connection the National Board of Health from the Ministry of Interior was transferred under the Ministry of Social Affairs and Health, and also, as a new central office, the National Board of Social Welfare (A. 1968/405) was established.

It was only at the turn of the 1960's and 1970's that attention began to be given to organizing cooperation on the local level in Finland. On the initiative of the Ministry of Social Affairs and Health, a committee brought up ten areas for cooperation and also presented an administrative division of responsibility concerning them. It was particularly in connection with the preparation of the Primary Health Care Act that the organization of combined social welfare and Primary health boards was brought up. The report of the Primary Health Care Committee (Komiteamietintö 1969:A3) states that one alternative on the local level would be transferring the tasks of the Primary Health board and the Social Welfare board to a completely new board, i.e. a combined Social Welfare and Primary Health board. The Planning Committee of Primary Health Care (Komiteamietintö 1971:B4), in turn, proposed that the municipal Primary Welfare Board and the Primary Health Care Board should be combined as a Primary Health and Social Welfare Board.

2. CURRENT COOPERATION PRACTICES

The system of public administration works on three levels. On the national level, the supreme control and authority over the social welfare

and health care system belong to the Ministry of Social Affairs and Health, while the implementation belongs to the central offices of the Ministry i.e. the National Board of Social Welfare and the National Board of Health. The integration of social welfare and health care is implemented as cooperation between, on the one hand, the Social Welfare, Child Care and Populations departments of the National Board of Social Welfare, and, on the other hand, the Primary Health Care department of the National Board of Health, on the basis of the annual budgets and medium-term plans (Jussila, 1975, 432).

The forms of cooperation between the National Board of Social Welfare and the National Board of Health include mutual negotiations between the personnels, requests for statements, exchange of information, and, to a certain extent, training and education as well as interaction on training courses, and in particular, work groups (ibid.).

On the regional level, the supervision and control of social welfare and health care belong, correspondingly, to the county government's Social Welfare and Primary Health department (A. 1971/119). The task of the Social Welfare and Primary Health department is, on the one hand, to guide, plan and coordinate the county-level social welfare and health care, and, on the other hand, to guide and advise the municipalities. Further, its task is to arrange regional training courses for the personnel in this field. The Social Welfare and Health departments of the counties work in cooperation with the county governments' School departments, Regional Planning officials, Employment officials, and the municipal or other corporations producing social welfare or primary health services (ibid., 341).

On the local level, a reform which would correspond to that on the level of the ministry or the county, has not been generally achieved as yet. It must be noted, however, that there has been, and continues to be, cooperation between the various communal administrative units as well as between these units and various voluntary social welfare and health care associations and organizations. The regulations concerning the representatives of the boards include certain stipulations about their educational background. Having the same people in the two boards helps to promote the mutual exchange of information and cooperation

between the different administrative units.

Three towns in Finland, i.e. Kerava, Lappeenranta and Kotka, have combined Social Welfare and Primary Health Boards and, correspondingly, combined Social Welfare and Primary Health Offices working under the boards. A recently completed research project (SOPUKKA) (Kaitalo 1977-1979, & Walls 1978) initiated by the National Boards of Social Welfare and Health, gives an account of the experiences that have been gained from combining the boards. The project is based on the experiences of different groups of personnel (the total of 67 different occupational titles). It should be pointed out, however, that the first combined boards and offices started working only in 1972 in Kerava, which means that no long-term proof of the efficiency of the combined administrative organization exists (Kaitalo & Walls, 1978).

The task of the social welfare agency is to promote the conditions of as well the individual client as of the municipality at large. In this respect cooperation is considered a tool when trying to realize holistic aid projects as well as when identifying the diverse needs of the client (Sosiaalitoimiston..., 1981, 66).

Administratively the organizing of cooperation can be divided according to position as follows:

1. Cooperation at the decisionmaking level
   - a combined social welfare and health care board
   - unified consultative bodies
   - joint board members

2. Cooperation at the operative level

a) The indirect operative level (the strategic level)
   - a combined social welfare and health care office organization
   - a joint leading organ
   - joint working groups of officials in specific matters
   - provisional project groups
   - regular contacts of officials
   - information

b) the direct operative level (the field level)
   - a common operative unit
   - joint operative groups
   - integrated care responsibility
   - meetings, consultations
   - contacts of employees at the field level
   - information

(Kaitalo 1977, 9-10)

The list of cooperation models, that are at least to some extent in use in social welfare and health in Finland, witness the rich variety. The crucial question is therefore, how to realize such cooperation, that the intentions set up are going to be fulfilled. This necessitates experimentation and evaluation of the functionality of different models. Unfortunately, this work is only at its very beginning in Finland. The SOPUKKA-project is one of the first studies to evaluate some models, above all those of combined versus separate social welfare and health care decisionmaking boards, and vice versa, of combined and separate agencies at the operative level. Some evaluations are also made by the communes concerning the effects of cooperation in the handling of everyday routines, contact networks etc. However there is definite need of comparative research on the diverse cooperative practices adopted of the municipalities.

PART III. REASONS FOR HOLISTIC APPROACHES IN SOCIAL WELFARE AND HEALTH CARE[1)]

Here I shall discuss some interrelations of social and medical aspects as they manifest themselves in Finland today. I have chosen to approach the subject from the three angles of diagnosis, operation and evaluation and proceed in that order.

1. DIAGNOSIS OF SOCIAL AND MEDICAL CONNECTIONS

An objective definition of the social and the medical component is based on an analysis of their phenomenal level, that is, their external connections and consequences. In addition to objective diagnosis, subjective and normative ways of diagnosis may be mentioned as it has been done in studies of poverty and welfare (e.g. Townsend 1971, NOU 1976).

1.1. On Differences in Mortality Rate

Unequal distribution of economic wealth indicates differences in mortality rate in relation to both time and place. On the other hand, mortality is also socially differentiated. Medical science was able to demonstrate that there in fact were causal connections between social conditions and the occurrence of illness. However, medical science didn't extend the analysis to apply to systems of society or the social and economic inequality maintained by them. That there is regional variation in the mortality rate is quite obvious. One may only point out the differences in the mortality rate on the respective sides of the East-West axis of Finland. In addition, there is the sharp contrast of the relatively low infant mortality to the mortality rate of middle-aged men, which stands high even in international comparisons (Komiteamietintö 1973, 23).

In today's Finland the differences in the mortality rate present them-

1) Based on Walls 1981 b)

selves also in relation to professional categories. As a survey made by the Central Statistical Office reveals, the mortality rate of loggers, construction workers and miners as well as of deckhands and machinemen is twice as high as that of the categories with the lowest mortality rate, namely teachers and clergy (Sauli 1980). In general, the mortality rate is higher in occupations involving physical rather than intellectual activity. On the level of trades and industries, the differences appear in the direction basic trades - service occupations, with certain exceptions, e.g. hotel and restaurant business.

1.2. Frequency of Sickness and Health Services

Between sections of population marked differences are found also in the frequency of sickness, whether measured with criteria derived from ecology, source of livelihood, occupation or standard of living.

The latest information is offered by the Social Insurance Institution in an extensive study by interviews covering over 15 years of the people's health and social security (Byckling 1978; see also Sosiaalivakuutus 5-6/80). The individual samples taken in 1964, 1968 and 1976 show that country people have during the whole period reported a chronic illness more often than city people. When the respondents were divided into five groups according to the income earned by the head of the family the previous year, the number of those reporting a chronic illness was in every sample clearly highest in the lowest fifth and passed, an increase in the frequency of chronic illness was observed in the higher income classes (Savolainen-Klaukka 1980, 144-151).

The connections between the availability of medical services, the level of income and the use of health services, are revealed in the material of the study mentioned above. Nyman infers that, all in all, medical services were more often used by the lower income classes than by the higher. The phenomenon was linked with the variation in the frequency of illness in the different income classes. However, if the situation is analysed on the basis of the frequency of illness, the services were used more often by the higher income classes than by the lower. The

selective nature of the use of health services is also emphasized by the fact established in the study that the influence of the distant location of a person's home on his use of health services increased between the years 1969 and 1976 (Nyman 1980, 152-163).

In general, the research workers of the National Social Insurance Institution regard the development of the people's state of health as positive and like to think that the latent need for medical services has probably decreased (Savolainen-Klaukka ibid.). On the other hand, social development doesn't seem to have reduced the specific distribution of the maintenance of health and the occurrence of illness between sections of population.

2. SOCIOPOLITICAL REASONS FOR COOPERATION

2.1. Reasons for Social Assistance and Connections with Health Care

Home relief as the primary form of social assistance reflects, at least indirectly the before-mentioned transformation of health care into social welfare. Thus when Sihvo compared cases of home relief to see what were the reasons for the need for help, she found that in 1970 the need for social assistance was principally caused by illness (47 %).

The next largest groups of reasons were unsocial way of living (16 %), old age, disablement, etc. (14 %) and unemployment (12 %). On the other hand, by 1978 market fluctuations had raised unemployment to the position of the most significant reason for needing assistance (36 %). Illness was now second after having fallen since 1970 as much as 19 percentage units (to 28 %). The third reason in order of importance was in the later year of comparison unsocial way of living (18 %) whereas old age, etc. had fallen 6 percentage units (to 8 %) (Sihvo 1980, 834).

In a study of receivers of social assistance made in Vaasa by Salo it was established that illness had a weakening effect on social existence. 48 % of the heads of families who had received social assistance for over 3 years had suffered from illnesses, of the unmarried as many

as 73 %. Of the persons assisted for a short period of time, with or without families, ca. 50 % had suffered from illness while the amount in the material for comparison was 10 % (Salo 1962, 98-134).

The before-mentioned intertwinement of the social and the medical aspect reveals itself within the groups of reasons. Overlapping and interpenetration become realities whenever a person is a client of both social welfare and health care. It has been estimated that no less than 80-90 % of social welfare clients live in constant need for various kinds of medical services. The majority of the client groups common to the both forms of service consists of the old, the disabled, the mentally defective, alcoholics and, above all, the sick (Jussila 1975, 329).

The fact is that there can be no realization of some of the services prescribed in the Primary Health Care Act such as the care of the chronically ill, the nursing of the ill at home as well as medical rehabilitation and to some extent even health information, without the many forms of social services connected with them. No more can there be any realization of certain social welfare services, like the care of the disabled, the care of invalids, social rehabilitation, the care of intoxicant abusers and child guidance centre activities, without the services of health care connected with them (Kymen läänin... 1975).

It is evident that an increase in cooperation is required as the nature of social welfare and health care changes from curative towards preventive and open care becomes more emphasized. On the other hand, the clients find it harder and harder to utilize what is being offered to them by the more and more finely divided service delivery systems. This threatens to ruin the original objectives of preventive and holistic approach or at least makes them seem all the more difficult to reach. The situation may also be in part due to a process of development going on in the sphere of decisionmaking and administration where the objectives and the resources become separated from each other. If this is the case, it is quite obvious that any increase in cooperation between the differentiated and the differentiating services is only one way to brake the trend. Fundamental solutions must at this point be looked for in structures of the systems and the social factors affecting them.

Thus the reasons for social assistance and areas of emphasis in health care both indicate the importance and position of cooperation in the realization of the objectives and resources of social welfare and health care. Cooperation as such doesn't render the existence of the two systems questionable. On the contrary as a result it is possible to obtain information on alternative solutions and perhaps eventually adopt some of them.

2.2. Old Age and Illness

The arrangements for the care of the chronically ill and especially the assistance to and care of the old have created nearly unsurpassable obstacles in front of the officials of social welfare and health care, organized as they are according to their respective branches of administration. Old age and chronic illness, apart and together, both contain a possibility and most often a factual appearance of combinations of problems.

According to the findings of a survey comissioned by a working team studying the care of the chronically ill, the largest and most problematic group consists of the chronically sick old people (21 % of these are over 65 years old) who because of their helplessness need to be institutionalized or who in home care need measures of assistance and care several times a week. Of the chronically sick old people in institutional care in 1978 60 % were nursed in communal homes and in communal and private old-age homes, 17 % in health centre hospitals, 13 % in mental hospitals, 8 % in other general hospitals and 2 % in other institutions. The figures express, Niemi concludes, that a great deal of the responsibility for taking care of the chronically ill is shouldered by social authorities (Niemi 1980, 40-43).

2.3. Alcohol Injuries as Indicators of Connections

By way of further illustration one may point out alcohol as an expression of a combination of problems. The results arrived at in a research

project of alcohol economy show that in 1978 5.7 % of all patient days in all hospitals were caused by alcohol. More than one half of these days were spent in curing mental disorders. Correspondingly, of all duty clinic and open care visits of that year 2.4 % were brought about by alcohol (Alkoholipolitiikka 1980).

Alcohol injuries manifest themselves in the sector of social welfare also in the fact that the care of alcoholics and drug addicts represents 45 % of the social welfare expenses arising from alcohol. Furthermore, 21 % of child welfare cases originated in the use of alcohol either by the child or youth in question itself or by its provider (ibid.).

The results from the research project of alcohol economy bring tangibly out how intertwined the environmental, social and psychic components are on the diagnostic as well as on the operational level. Perhaps it is not possible to give an account of the nature of the intertwinement until the answer to the question "why do people drink?" is found. The answer may very well be multidimensional, i.e. consists of several factors as necessary partial reasons for drinking, and only a combination of these forms an adequate explanation.

Thus the diagnosis of the connections between the social and the medical component is quite as essential as the separate diagnoses of these components. From the existence of interrelations it is then possible, on the operational level, to draw conclusions concerning objectives, functions and interventions.

2.4. The Perception of Illness - a Mixture of Social and Medical Considerations

Raitasalo (1976) states, how of late there have been efforts to define illness in terms of several sciences as a holistic disorder, as an unsuccessful adaption to both social and natural order and as a disturbance of an individual's ability to function socially, to wich a personally experienced state of emotional instability is linked as an integral part.

Illness is a passing or a lasting state which is recognized by its symptoms. Illness is a psychological experience, a state perceived by the person himself representing his individual inner model of illness, Raitasalo continues (ibid.). His presentation of a person's inner model of illness, based on the original by Kalimo, distinguishes: 1) discovery and sensory perception of symptoms, 2) definition of illness, 3) consideration of outer reactions of adaption aimed at restoring the balance and 4) selection of reactions of adaption (ibid.132).

So it is clear that the psychosocial factors which either expose a person to illness or prevent him from getting ill are common ground for the social and the medical component. The operational key problem concerning decisionmaking, administration as well as execution is how social welfare and health care manage to take into account the various reasons for, the contexts and the combined effects of these loading factors. The solution obviously requires active contacts between the areas of responsibility and cooperation as a constituent part of their structure.

PART IV. JUSTIFICATIONS FOR AND AREAS OF COOPERATION

In various connections, securing satisfactory conditions for human fulfilment and well-being has been the primary aim of social welfare and health care. Widening the concept of health to mean the optimal human well-being WHO has emphasized the significance of the mutual interaction of man's biological, psychical and social components from the point of view of health and/or illness.

1. JUSTIFICATIONS FOR COOPERATION

With regard to the organization of the interrelations and cooperation between social welfare and health care, the various seminars arranged jointly for the personnel of these fields have been of importance (for example, Administrative Seminar for Social Welfare Personnel, 1970, Planning Seminar for Health Care, 1971, in Lappeenranta, and a seminar on the cooperation between Social Welfare and Health Care, 1973, in Tyrväntö; see Sos.turv. Kesk.l. 1974).

The preparation of the public health legislation in Finland helped to break down the traditional barriers between medicine and the social sciences.

In social welfare it has not yet been possible to establish intermunicipal, cooperative units, which would correspond to those in public health. This might be achieved, however, according to a proposed bill, which is being prepared and which relates to social administration (Sosiaali- ja terveysministeriö, 1978). In committee reports concerning the aims and education of social welfare (1971:A25 and 1973:A7), also the cooperative aspects of social welfare have been emphasized when prevention, constructivity and normality are aimed at.

In the above-mentioned seminar on the cooperation between social welfare and health care in 1973, the main justifications for cooperation which were brought up were as follows:

- the development of social welfare and health care organizations;
- the integration of overlapping functions and tasks and elimination of gaps in the border areas;
- feasible dimensions and use of joint resources;
- the changing of attitudes among the different occupational groups;
- accessibility of services;
- performing the alleviating, preventive and constructive functions and tasks set to social welfare and health care

(Sos.turv. Kesk.l. 1974, 14-15)

Especially the fact that social welfare and health care share the same clients has made it necessary to integrate and even combine the aims and resources. It has been estimated that about 80-90 % of the clients of social welfare need continuously different types of health care services and are, in this respect, clients with multiple problems or multiple symptoms (Jussila 1975, 329).

The largest groups of clients who need the services of both social welfare and health care are the aged, the handicapped, the mentally disabled, alcoholics, and above all, the sick. Even today illness or disease accounts for one third of the reasons why people turn to social welfare in order to get regular social benefits - and the situation is this quite irrespective of the national sickness insurance legislation. In addition to this, tens of thousands of people receive temporary social benefits annually in the form of hospital treatment (SVT XXI B:19).

There are decrees about the cooperation between social welfare and health care in, for example, the Social Welfare Administration Act (1950/34), the Public Health Act (1972/66; 6§) and the Public Health statute (1972/205; 5§), the Child Welfare Act (1946/52; 5§), the Welfare for Intoxicant Abusers Act (1961/96; 38§), and the National Plan for the Public Health Work (yrs. 1979-83). It should be pointed out, however, that the cooperation stipulations are almost invariably rather general and they can be interpreted in different ways. The stipulations do not contain any accurate instructions about the implementation

of cooperation, nor do they say who or which body is responsible for giving advice or orders about the practical realization of the cooperation (Tuomi 1978, Mäkinen 1980, 15).

When we take into account the very general nature of the cooperative obligations as well as the fact that the "built-in" social organs have not been stipulated by decrees, we can see that so far the actual cooperation measures in many cases depend on individual initiative, thus varying greatly from one administrative unit to the other both in contents and length of time.

2. AREAS OF COOPERATION

On the local level, there has always been administrative cooperation between the social welfare and public health personnel, even though it has not been officially organized. However, this cooperation often occurs only in certain cases. This type of unofficial cooperation can be quite flexible when a particular case and a particular acute problem are being dealt with. The danger here is that such cooperation is often sporadic and dependent on people who are "willing to cooperate". If and when there are properly functioning contacts between the different administrative units and the elected board members and officials, then cooperation will also work. If, on the other hand, there are gaps in the information, competence or attitudes, then there is also the danger that hardly any cooperation will take place.

Tuomi (1978) regards the combination of administrative units as the most effective form of organized cooperation. As was mentioned earlier, this has been done in three towns in Finland where the social welfare and health care units have been combined. Another possibility is to establish a joint executive organization for the two units. This system has been adopted in the municipality of Lempäälä in Finland.

A more general form of cooperation is to arrange joint meetings for the different administrative units. To function properly, this system presupposes regular meetings and careful preparatory work. Regular work meetings and cooperation groups for the personnel of the two administ-

rative units offer still another form of cooperation. Tuomi concludes that effective cooperation will only be achieved if these meetings and work groups carry on for a long period of time (ibid.).

The problems and areas, which social welfare and health care have in common and in which cooperation might be possible, have been studied in various connections.

The public health committee in the County of Kymi recorded the following 19 areas for cooperation in 1975:

- organizing cooperation
- information about cooperation
- subsistence benefit
- social insurance and benefit
- social and health guidance
- out-patients' care
- home service
- rehabilitation
- care of minors
- care of school pupils
- care of handicapped
- work safety
- care of intoxicant abusers
- care of aged
- child day care
- private home care for children
- institutions for child care
- care of chronically sick
- old age institutions

(Kymen läänin... 1975)

It should be remembered that cooperation is no panacea, but above all a tool which is well suited for certain situations and problems. Cooperation between different administrative units does not as such change society's rules of game or the structures maintaining society or regulating the societal policy. Cooperation can, however, on its part, expand the knowledge of not only the prevailing rules of game and the prevailing structures, but also of the mediating relations through which societal problems are transformed into social welfare and health care problems registered and interpreted by the administrative systems (see Walls 1980).

PART V. COLLABORATION BETWEEN HEALTH AND SOCIAL WELFARE PERSONNEL

1. INTERPROFESSIONAL COLLABORATION PATTERNS

The SOPUKKA project mentioned earlier, was initiated by the Finnish National Boards of Social Welfare and Health in 1977 (see Kaitalo & Walls 1978). The research approach was to study empirically the effects of the integration of the decisionmaking boards and the administrative offices of social welfare and health care realized in three towns in Finland, namely Kerava, Kotka and Lappeenranta. Some other communes had also considered the possibility to combine their board organizations. Instead of this, they have searched for more informal ways of integrating some service delivery systems. To enable comparisons we included eigth other communes in our survey (ibid.).

The survey sample includes a total of 795 professionals within social welfare and health care and is representative of professional groups that have potential for cooperation such as doctors, nurses, social workers in health centres, medical treatment personnel, home sick care nurses, psychologists and voice training therapists, communal health supervisors, government job supervisors from the health care system, home help personnel, old age and child care workers, and finally, administrative personnel representing both delivery sectors. The data was collected in directed group inquiries in the presence of one of the researchers. 71 % of the sample was approved for final analysis. We also inquired the board members. The drop out was however bigger for the board members than for the executives (ibid.).

According to the study, satisfactory cooperation exists in none of the parallel areas of social welfare and health care, such as home help/ home nursing, children's day care centres/children's health centre care activities, care of alcoholics, invalids and the aged, especially the chronically ill (ibid.). The social welfare system showed itself to cooperate more actively than the health care sector as a rule, although the degree of cooperation is generally low. Similary, the need for sectorial cooperation was evaluated as higher in the sphere of social

welfare which actually cooperates more actively. Furthermore, the attitudinal "readiness" to collaboration is also higher in the social welfare sector measured by the opinions of professions sectorial. This tendency may be explained by the difference at the basic level in sectorial collaboration (ibid.).

The combined social welfare and health care organization model showed a higher degree of actual cooperation between the personnel groups representing different occupations. Consequently, the need for cooperation proved to be lower on the field level in the combined system than in the separate, the traditional system (ibid.).

Comparing different organizational frames gave some evidence in favor of the hypothesis on the importance of organizational frames for behavioral modifications, in this case actual cooperation and interprofessional collaboration or the lack of it in spite of declared willingness to collaborate.

The collaboration patterns for the professions involved were as follows (because of the complex networks only some typical professions are presented here):

Table 2. Means of the most and the next important contacts of social welfare professionals to health care professionals (%)

From To	Heads of Soc.Welf.	Social workers	Home help workers	Alcoh. care	Childr. Day care	Instit. care
Heads of Health	40	6	12	15	5	12
Doctors	15	21	16	31	27	32
Home sick care	18	16	29	14	12	17
Health nurse	20	33	33	26	54	29
Special. personn.	7	24	10	14	2	10
% (n)	100(32)	100(42)	100(50)	100(15)	100(29)	100(34)

—,-- = percentage concentrations

(counted from Kaitalo 1979 table 6)

Most contacts of social welfare professionals to health care are horizontal, i.e. the heads are in touch with each other, the field workers collaborate with their colleagues in health care etc. Only about 10 % of the contacts of social welfare field workers are taken to heads of health care (Kaitalo ibid.).

The contact network of social welfare is more complex than that of health care. About a third of all contacts by the health service professionals with social welfare are directed towards the heads of that sector. This indicates a deficiency in collaboration especially for the health care, which primarily seems to contact social welfare for coordinative reasons. The distributions also indicate a greater aptitude to collaborate in administration than at the field level (cf. ibid.).

The collaboration patterns indicated here need to be retested. Especially problems of reliability arise when empirical measurement of collaboration is attempted.

Table 3. Means of the most and the next important contacts of health care professionals to social welfare professionals (%)

From / To	Heads of Health	Doctors	Home sick care	Health nurse	Special. personn.
Heads of Soc.Welf.	36	30	40	18	36
Social workers	21	21	20	39	29
Home Help workers	26	26	35	37	24
Alcohol. care	1	2	-	3	5
Childrens Day care	2	2	-	-	-
Institut. care	14	20	5	3	3
% (n)	100(48)	100(22)	100(13)	100(31)	100(22)

—,-- = percentage concentrations

(counted from Kaitalo 1979, table 7)

2. ACTUAL AND EXPECTED COOPERATION

2.1. Cooperation Expectations and Networks in Alcoholic Care

Petra Vainio has studied the cooperation patterns of the Alcoholic Care centre of the city of Lappeenranta (53.000 inhabitants) (Vainio 1981). Her aim was to get information as well about the internal collaboration between the staffs of the service delivery systems as about the external cooperation between the Alcoholic Care centre and the other organizations in the city involved in one way or another in activities related to alcoholic care.

The data on internal collaboration was collected by interviewing the executives of the Alcoholic Care centre and its operative units. The Alcoholic Care centre's operative units are the Alcoholic Care clinic, the Youth station and the Alcoholic Service agency. The curative institutions subjected to the Care centre's operative units are the Aversion Station, the Care Home, the First Aid Shelter and the Shelter Home (ibid., 68-70).

Accordingly, the external cooperation between the Alcoholic Care Centre and the other service delivery systems of the city in the field of alcoholic care, was analyzed. The executives occupied with problems related to alcoholic care were asked to keep contact diaries for a week in September 1978. The organizations included were altogether 15 and the number of executives keeping diaries was 52 of whom 42 returned the diary properly filled (ibid., 81).

The levels of cooperation were divided into a normative, a strategic, and an operative level. One problem in studying internal collaboration on different levels is usually the low number of respondents for some levels. Therefore there is need of repetitive research. However, it is possible to envisage some directions even according to this single study.

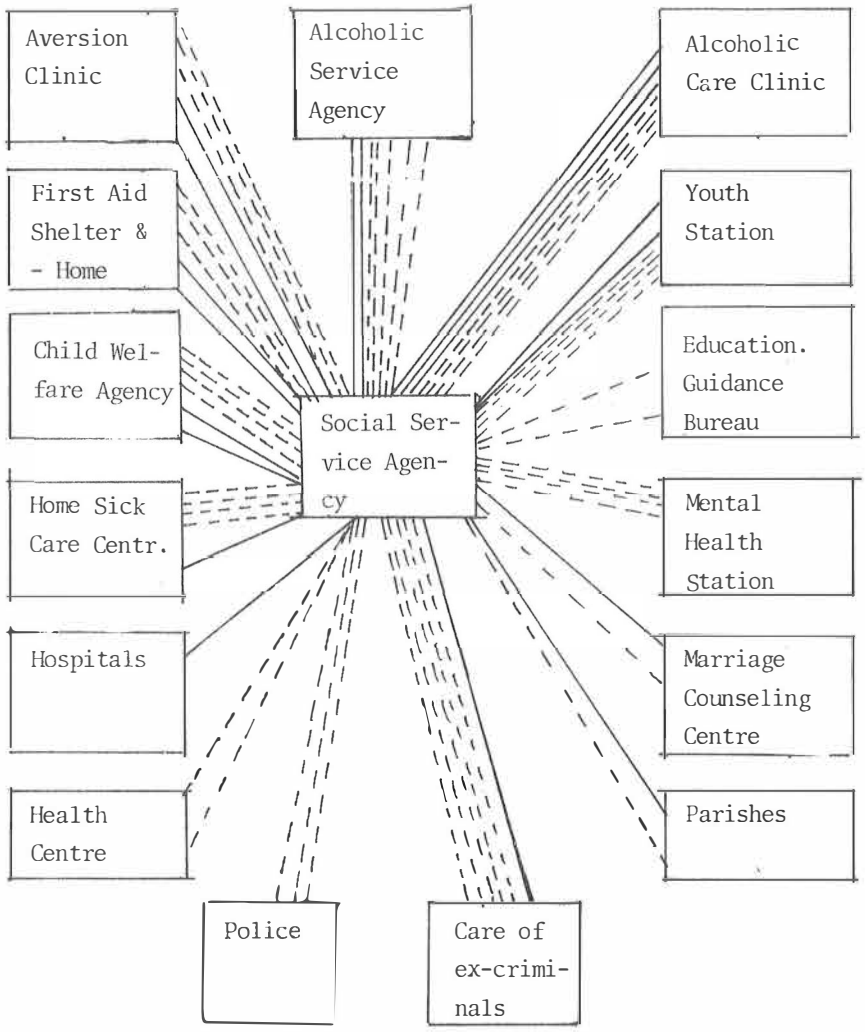
Table 4. Evaluations of the amount of actual and expected cooperation between units involved in alcoholic care at the moment in Lappeenranta %

	Actual	Expected
Very high	-	43
Fairly high	28	38
On the average	48	12
Modestly	17	2
Very low	2	-
Can't tell	5	5
% (n)	100(42)	100(42)

(based on Vainio 1981, tables 1. and 2., 82)

There is clear evidence that the expected or the "ideal state" of cooperation is on a considerable higher level than that of the actual state. This finding is consistent with the findings in the SOPUKKA-project and also with the results from studies on actual and ideal influence in organizations (see for ex. Tannenbaum 1968; Walls 1973 and 1980 b)). On the other hand the majority of the respondents find the actual situation of interorganizational cooperation to be on an average level. It ought to be kept in mind that cooperation is not an aim in itself but must always be evaluated from the point of view of the managing of the problems in question.

The contact diaries provided information for constructing network maps of the cooperation between the different organizations involved in alcoholic care activities. Here only one contact mapping is presented, the one picturing the reciprocal need of cooperation expressed by the Social Service Agency and its cooperative partners. The map illustrates the demand of cooperation in Finnish alcoholic care in cities.



(in Vainio 1981, 116)

Figure 10. Service delivery systems in need of cooperation with the Social Service Agency (————) and those systems with which the Social Service Agency is in need of cooperation (------) in alcoholic care matters. (Need of cooperation declared as strong)

The contact maps show the complexity of cooperation even within a single problem area. Especially concerning the Social Service Agency it was shown that a need of cooperation was expressed more clearly to the

agency than from the agency outward. Most contacts are with the Alcoholic Service Agency and the Child Welfare Agency. More than one fourth of all contacts consists of client consultation and statements of the actual situation of the client. (ibid., 93).

In addition to the information obtained from the contact diaries, the executives of the Alcoholic Care Centre were asked about their partners in cooperation. On the normative and the strategic levels the most important cooperation partners were the Board for Social Welfare and Health (the combined board), and the Board for Alcoholic Care. On the operative level there proved out to be many important external cooperation partners, among them the Social Service Delivery Agency, the Child Welfare Agency, the Marriage Consultation Bureau, the Parishes, the Association for the care of ex-criminals, the police, the Central for Home Sick Care and finally, the hospitals (ibid., 86).

The results indicate that the majority of the employees at the Social Welfare Agency experiences a need of considerably more collaboration than the present situation provides at the moment. However, the respondents are of the opinion that cooperation with employees of other organizations involved in social welfare is almost satisfactory.

2.2. Actual and Expected Cooperation of Social Welfare

The cooperation and collaboration patterns of the Social Welfare Agency of the city of Jyväskylä were studied in year 1980 by Siivola and Ylätalo. The approach of the researchers was to include all employees of the Welfare Agency, that is the leaders, the planners, and the staff personnel actively involved in field work activities with clients or patients. The assistant personnel was left outside the study. The members of the Social Welfare Board were included in the research but analyzed separately. Because of the considerable drop out of the board members the study is reliable only for the staff, of whom 196 were included in the study. The data was collected by questionnaires, which were delivered to the units where the respondents worked. The

respondents were also informed about the study ahead. The representativity was 81.6 %, which means that only 16 employees did not return the questionnaire. The corresponding figure for the 24 representatives of the board was only 50 %. (Siivola & Ylätalo 1981).

The need of collaboration at the Social Welfare Agency was evaluated as follows:

Table 5. Evaluations of the need of collaboration within the Social Welfare Agency and between the agency and other organizations involved in social welfare activities %

	With social welfare	Between social welfare and other organizations
A great deal more than at the moment	9	4
Considerably more than at the moment	59	55
The actual situation is convenient	31	40
Less than at the moment	-	-
A great deal less than at the moment	1	1
%	100	100
(n)	(151)	(143)

(in Siivola & Ylätalo ibid.).

The distribution express a more distinct need of an enlarged collaboration among the employees within the Social Welfare Agency than between the employees of the agency and the employees of organizations outside the Welfare Agency but involved in questions related in one way or another to social welfare. In respect of the cooperation with the Primary Health Care system, (i.e. the Health centre of the city of Jyväskylä) the opinions were:

Table 6. Evaluations of the amount of actual and expected cooperation between the social welfare Agency and the primary health care %

	Actual	Expected
Very high	19	58
Fairly high	52	34
Can't say	13	7
Fairly low	15	1
Very low	1	-
%	100	100
(n)	(126)	(123)

(ibid.).

The results are almost consistent with the findings of Vainio (see Vainio, table 4). According to Vainio 81 % expected more collaboration between units involved in alcoholic care in Lappeenranta. The corresponding figure in the study by Siivola and Ylätalo is 92 % and concerns the collaboration between the Social Welfare Agency and the Primary Health Care of Jyväskylä. Correspondingly the figures for the actual amount of collaboration are almost the same when taking into account that the alternative "On the average" was included in the questionnaire of Siivola and Ylätalo. As 76 % of the respondents included in the study by Vainio considered the actual amount of cooperation to be at least on the average the proportion of that opinion among the respondents in the study by Siivola and Ylätalo was 71 %.

This consistency in findings derived from separate studies is a proof of reliability of the measures. There remains of course a possibility of systematic bias due to for instance the profilation of the questions etc. Anyhow, the results witness a desire for an enlarged cooperation on the side of social welfare. This result is in line with the findings of the SOPUKKA-project and all the studies related to that project.

3. ON THE BALANCE OF COOPERATION

The incongruence between the actual and the ideal state of cooperation is shown by the figures below. The collaboration partners involved are the municipal Social Welfare Agency, the Alcoholic Care Clinic, the Educational Guidance Bureau, the Health Centre, and the Mental Health Centre, all active in the city of Tampere (165.000 inhabitants).

The findings on the collaboration balance of the parties mentioned derive from a research study made in 1978 by Paula Mäkinen under the auspices of the SOPUKKA-project. The study comprised the field workers of the units mentioned, i.e. those professionals directly occupied in the delivery of services other than institutional care, to ordinary citizens.

The data was collected through a method of informed questionnaire during one week in 1979. The sample comprised of 111 professionals. The drop out was 14 %.

Table 7. The frequency of contacts in client matters taken by the Social Welfare Agency to other service delivery parties and the contacts to the Welfare Agency (%)

Frequency of contacts	The Alcoh. clinic		The Educ. bureau		The Health centre		The Ment. centre	
	By	To	By	To	By	To	By	To
Often	80	3	25	-	9	13	22	-
Medium	10	7	42	7	12	37	22	15
Rarely	10	87	33	90	79	47	56	82
Lacking	-	3	-	3	-	3	-	3
%	100	100	100	100	100	100	100	100
(n)	(10)	(30)	(12)	(30)	(34)	(30)	(9)	(30)

(based on Mäkinen 1980, tables 1. and 2.)

Consistent with the findings of the SOPUKKA-research study the Social Welfare Agency is more eager to establish contacts to the Health Centre

than vice versa. However, the Social Welfare Agency collaborates only sparsely with the small specialized service delivery clinics, bureaus and centres. This is at least partly owing to differences in size of the partners involved. Anyhow, the small organizations, especially the Alcoholic Care Clinic and Educational Guidance Bureau are comparatively often in contact with the Social Welfare Agency (c.f. Mäkinen, ibid.). An additional explanation to the differences in cooperation between the partners studied is their official status. The Social Welfare Agency and the Health Centre are both municipally governed organizations and regulated by acts and rules while some of the specialized service units are at least formally voluntary organizations.

4. THE SERVICE DELIVERY SYSTEMS AND THE CLIENTS

The contact patterns of the clients to the service delivery systems discussed were specifically studied by Marjut Saarenpää. The clients included were chosen by means of a focused sample method. According to this method the sample covers all clients. The criteria for a client to be included in the sample were at least 17 years of age, ability to answer the questionnaire and guarantees that considerations due to care did not rise obstacles (Saarenpää 1981).

The questionaires were handed over to the client during one week in March 1979 by field workers selected at random. The clients filled out the questionnaire at home except for the clients of the Alcoholic Care Clinic, who answered the questionnaire at the clinic. The number of clients included in the study was 246. Of these an average of 70 % returned the questionnaires (ibid.).

The circulating of the clients from one agency to another was studied by asking the respondents about their contacts to separate service delivery systems specifically for each client group.

Table 8. Contacts taken by clients to different service delivery systems specifically for each system %

From / To	Soc.Welf. agency	Alcoh. clinic	Educat. Guid.b.	Health centre	Mental Health c.
Soc. Welf.ag.	.	9	4	-	-
Alcoh.clinic	-	.	4	1	-
Educ.Guid.b.	-	-	.	-	-
Health cent.	2	12	7	.	11
Ment.H.cent.	-	2	-	-	.
Other syst.[x)]	2	-	4	4	11
Several syst. (unspecified)	9	16	15	1	6
No contacts outside	87	61	66	94	72
%	100	100	100	100	100
(n)	(61)	(43)	(27)	(61)	(37)

x) Other systems include the Court, the Marriage Counseling, private medical services and the Kindergarten.

(based on Saarenpää, tables 5.-9.)

The circling of clients appears to be almost minimal according to their personal evaluations. However, it must be pointed out, that the respondents presumably reported the contacts made to solve their acute problems. Therefore the contacts to tackle problems at long sight may have been left unconsidered. The question on contacts did not include any time limits. The results indicate a need for evaluations to be made on other bases than subjective assessments. The "lifecycle" of the problem ought to be considered. The fact that some of the delivery systems have parallel services is of course very functional from the point of view of the client although questionable from the point of view of the delivery system and the society.

5. REASONS FOR, KEY PERSONS IN AND EXISTING STATE OF COOPERATION

5.1. Reasons for Cooperation

The main justifications for cooperation conveyed by expert seminars and committee reports are presented in chapter IV. However, the SOPUKKA-project and the studies linked to that project, included questions about the reasons why the personnel thought they need cooperation with social welfare/health care in the performance of their jobs. Because the question in the SOPUKKA - study schedule was put in an open form, there were some difficulties concerning both the advancing of arguments and the analysis of them.

Nevertheless, the answers for reasons for cooperation offer a basis for the outlining of certain tendencies. (Table 5 published in Kaitalo 1979). Here we shall concentrate on those employees (altogether 225 in the sample) in the administration and in the actual field organization of social welfare and health care who, according to their own report, took part in cooperation at least as much as their fellow employees or more than that.

Regardless of the level they are working on the employees of social welfare and health care gave most often the general or problem-based need for development as a reson for cooperation between the field of activity (24 %) of the answers coming from social welfare and 43 % of those from health care. The second largest group of arguments consists of the general parallellism of functions and the mutual clientele (17 % and 18 %). In the third place are found the knowledge of the grounds for measures and information (19 % and 8 %). The parallel organization of functions, the division of labour and the use of resources are mentioned by 9 % of the employees of social welfare and 12 % of the employees of health care.

The existence of the obligation to cooperate doesn't seem to be considered a reason for cooperation, since it is stated by only 1 % of the employees of social welfare and by none of health care (ibid.).

It is to be noted, that the obligations based on law are of general nature and being already written down they are taken for self-evident facts. Furthermore, the division of arguments may also have been affected by the dissimilar distribution of opinions within the different sectors caused in turn by differences in cognition (ibid.).

5.2. Key Persons in Cooperation

The practical interaction between social welfare and health care is also an indication of the fact that the need for cooperation has become recognized. Starting from individual employees' experiences the SOPUKKA - project studied how the contacts were directed between the sectors. From the point of view of the subject under discussion, especially the practical interaction on the operational level seems interesting. In the sphere of social welfare it is above all those social workers who deal with the problems arising in the territory between social welfare and health care that are in a kind of a key role as far as cooperation is concerned. As problems of this territory stand out intoxicants, invalidity, mental disablement, problems of child care and psychic disorders (Kaitalo 1979).

As for health care, the key roles of cooperation are played by the health nurse and the social worker at health centres. Also doctors and physiotherapists as well as psychologists and voice training therapists hold a key position as regards cooperation in certain partial and specified functions of social welfare (ibid.).

It is evident that there are certain professions which are of special importance in everyday cooperative and collaborative activities. Therefore it is necessary to draw up contact maps whereby the linkages become revealed.

The key roles in social welfare with respect to cooperation and personal collaboration with health care on the field level were according to the client groups in question:

a) the social workers dealing with problems in-between, in the field of care of alcoholics, care of the disabled, the mentally disturbed or retarded and the child care;

b) Those officicals and field workers primarily occupied with problems related in one way or another to psychic disorders;

c) Social welfare personnel involved in home help activities;

In health care, respectively, the most important cooperation and collaboration key roles seem to be held by:

a) the health nurse. The key position of the health nurse was emphasized in the opinions given by the social welfare respondents of the SOPUKKA-project;

b) the social workers of the hospitals and health centres. The social workers have close contacts with the social agencies

c) the specialized personnel including for ex. the health psychologists and the voice therapists. These roles are however not crystallized to the same extent as the role of the health nurse, and even more, the doctor.

(cf. Kaitalo & Walls 1978, 24-35; Kaitalo 1979, 50-54)

5.3. Existing State of Cooperation

In the analysis of the state of affairs prevailing in cooperation the balance of cooperation both within and between the sectors must be kept in mind. Within the sectors the cooperation of the administrative level with the other sector and here with the nearest equivalent level is the most extensive. The deficiency in cooperation shows itself bigger on the executive than on other levels. On the other hand it must be remembered that the specialization of administrative bodies has created strong boundary lines between the sectors. It is not possible to cross

the sectors with the help of coordination resting upon the present administrative structure alone (Kaitalo 1979, 63-64).

A comparison between the sectors shows that the deficiency in cooperation experienced in the field of social welfare is distinctly more marked than that of health care (Kaitalo & Walls 1978, 49-51).

As it was stated above, in the SOPUKKA-project the measuring of cooperation was based on subjective opinions and not on external, so called objective definition. Furthermore, the employees of health care express the need for cooperation with less precision than the employees of social security (ibid.).

According to the study made by Mäkinen altogether 65 % of the answers of the professionals occupied in the service delivery systems in the city of Tampere expressed need for more cooperation with the organizations as far as the serving of the clients is concerned. Only one third was satisfied with the present state of cooperation. The need for increased cooperation is most conspicuous at the Social office and the Child Guidance centre (Mäkinen 1980).

The study in question shows that the need for cooperation grows not only absolutively but also relatively with the size of the organization. On the other hand, large organizations are already more engaged in cooperation than the smaller ones. So the size of the organization seems both to increase the need for cooperation, especially in-between cooperation, and to make it feasible.

Another study by Manninen, directed at the same organizations and based on contact diaries shows that, compared to the quantity of their clients and tasks, cooperation was rather immaterial. As for subject matter, the contacts between the studied organizations had most often reference to the client being guided to appropriate care or to the present problem and/or the situation of the client. Next frequent were the contacts within one's own organization in order to make arrangements for the client, beginning of treatment etc.). The contents of the contacts were not noted to differ very much between the organizations with the exception of the Social Welfare Office, where the majority of the contacts concerned the economic circumstances of the clients (Manninen 1980).

The SOPUKKA-project and the theses for the MA - degree connected to the project indicate, that there exists great variation as to the grounds for cooperation. Only a part of the effected cooperation is direct consequence of the conception of the human being as a totality. Need for cooperation is created in like manner by various malfunctions, which within the systems weaken their governability.

6. OBSTACLES FOR COOPERATION

Difficulties in linking social welfare and health care services together to meet the needs of multiple problem clients may arise owing to:

a) the location of services;
b) the norms and regulations affecting the delivery of services;
c) the decisionmaking process;
d) the organization of service administration;
e) the resources available, economic, personnel etc;
f) the knowledge about services;
g) the attitudes towards cooperation;
h) the readiness to collaborate

The obstacles to linkages between the social welfare and health sectors seem to vary according to the organizational level in question. The administrators included in the SOPUKKA-project, especially those managing social welfare, characterized the obstacles as well as the needs for cooperation very extensively. The obstacles mentioned by the field workers were more specified, although the social welfare professionals defined the obstacles in a more comprehensive way than the health care professionals (Kaitalo & Walls 1978, 32-35).

The question on obstacles to cooperation and collaborative relations between social welfare and health systems and professionals were rather unspecified in the interview schedule of the SOPUKKA-project. This is the reason why it is not possible to draw any final conclusions concerning the importance of each hindrance or holder of a key role for cooperation.

It ought to be kept in mind that cooperation and collaboration are basicly dynamic activities, which include besides quantitative aspects, also qualitative dimensions, cognitive, attitudinal etc. A study that concentrates on crosscut research data is able to catch the "dynamics" only superficially.

The obstacles for cooperation and collaboration were asked for too in the study by Siivola and Ylätalo. The obstacles reported concern as well the collaboration within the Social Welfare Agency as the cooperation between the Social Welfare Agency and other organizations involved in social welfare activities.

Table 9. Main obstacles of collaboration within the Social Welfare Agency and in respect of cooperation between the Social Welfare Agency and other delivery systems %

	Within the Social Welfare Agency	Between the Social Welfare Agency and other systems
Great amount of routine work	35	33
Shortage of time in general	38	42
Duty of secrecy and its interpretation	2	3
Unclear definitions of the responsibility	12	10
Difficulties in work relations	4	2
Limited scope of decisionmaking	6	4
Some other obstacle	-	-
No obstacle	3	6
%	100	100
(n)	(144)	(127)

(Siivola & Ylätalo 1981)

As was demonstrated in the SOPUKKA-project earlier, the duty of secrecy is of no bigger importance what concerns the evaluations made by the employees of the Social Welfare Agencies. Partially the same holds for the division of work and responsibility. The main obstacles are identified as related to problems of shortages of resources. The routi-

nes make it difficult or almost impossible to carry on cooperation and the time shortages resulting from the great amount of work routines accentuate the cooperation difficulties.

The results derived from the studies indicate in my opinion a need for rethinking in the field of social welfare. If and when there is need of cooperation to solve or at least to regulate the problems under work, there must be at the same time channels for cooperative and collaborative efforts. It is quite possible that the shortage of time caused by an ever expanding demand for aid and services is a consequence of too little cooperation. In other words the social welfare system is in some kind of a vicious circle. This is making it very difficult not only for the employees but also for the clients to find the proper way out in order to clear the problems and not only to deal with them inside the circle. Social welfare remains without contacts to other delivery systems which provide resources for solving problems now only registered and regulated.

PART VI. PARTICIPATION AND INFLUENCE

1. ON THE INFLUENCE OF THE PARTIES IN SOCIAL WORK[1)]

The social welfare agency, although a part of the general official social security system in Finland, is the responsibility of the communes. The social work legislation in Finland only gives the general framework. The government of the municipality appoints the representatives for a given period of the social work board. These appointments are predominantly made on a political basis. To accomplish the work the communes have established agencies, which include social directors, social secretaries, social workers, clerks, etc. However, as the majority of the almost 500 municipalities in Finland are fairly small, with populations ranging between 2.000 - 20.000, most of the social agencies have only a secretary as an all-round (wo)man, and perhaps only one or two additional social workers.

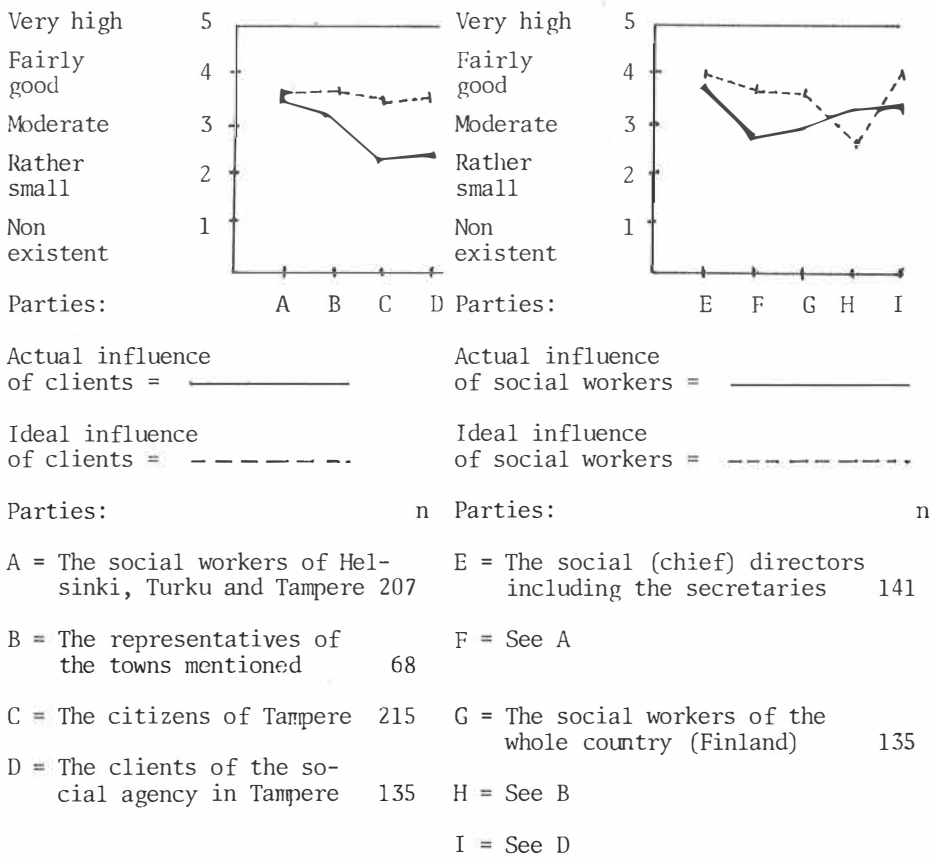
In contrast to the small social agencies, which are situated mostly in countryside, the Social Department in Helsinki, is divided into separate divisions and had (1979) ca 300 full time employed trained social fieldworkers. Correspondingly, Turku and Tampere, the next biggest towns in Finland, had each about 40 social fieldworkers.

The social workers in these agencies were included in a research, which also comprises the representatives, i.e. the elected members of the boards and sections, and representative samples of clients and citizens of Tampere[2)]. The groups included are called parties because they are in one way or another, actually or potentially participants in the social security. They were asked for their opinions on the position of specific personnel categories as well as that of different client groups. These parties were also asked about the influence of social workers and clients in matters concerning themselves.

1) Based on Walls 1980, 71-77.

2) The research team consisted of Juha Karvala, Pirjo Kiiskinen, Sulo Nykänen, and Georg Walls (See Karvala 1974, Kiiskinen 1972, Walls 1970, 1., 2., 3., and 1973, Nykänen 1975).

The study included some questions concerning the opinions of specific social work parties towards the actual and ideal (the expected) influence of social workers and clients in matters pertaining to their field and function in social work:



Parties:	n
A = The social workers of Helsinki, Turku and Tampere	207
B = The representatives of the towns mentioned	68
C = The citizens of Tampere	215
D = The clients of the social agency in Tampere	135

Parties:	n
E = The social (chief) directors including the secretaries	141
F = See A	
G = The social workers of the whole country (Finland)	135
H = See B	
I = See D	

Figure 11. The opinions of the parties of social work toward the actual and ideal influence of a) clients and b) social workers

The curve which indicates the actual and expected influence of clients on decisions made in their particular case, shows at first that the difference between the actual situation and the ideal is considered to be the smallest among the social fieldworkers. On the contrary, the citizens and the clients perceive a clear difference between the ac-

tual state concerning the clients' possibilities to exert influence as compared to what the situation ought to be. While the actual influence curve shows a falling slope, the ideal curve remains almost at the same level irrespective of the evaluator group in question. In other words, there seems to be some kind of similarity in opinions concerning the ideal state of things which however doesn't have its counterpart in the real world as it operates for the moment.

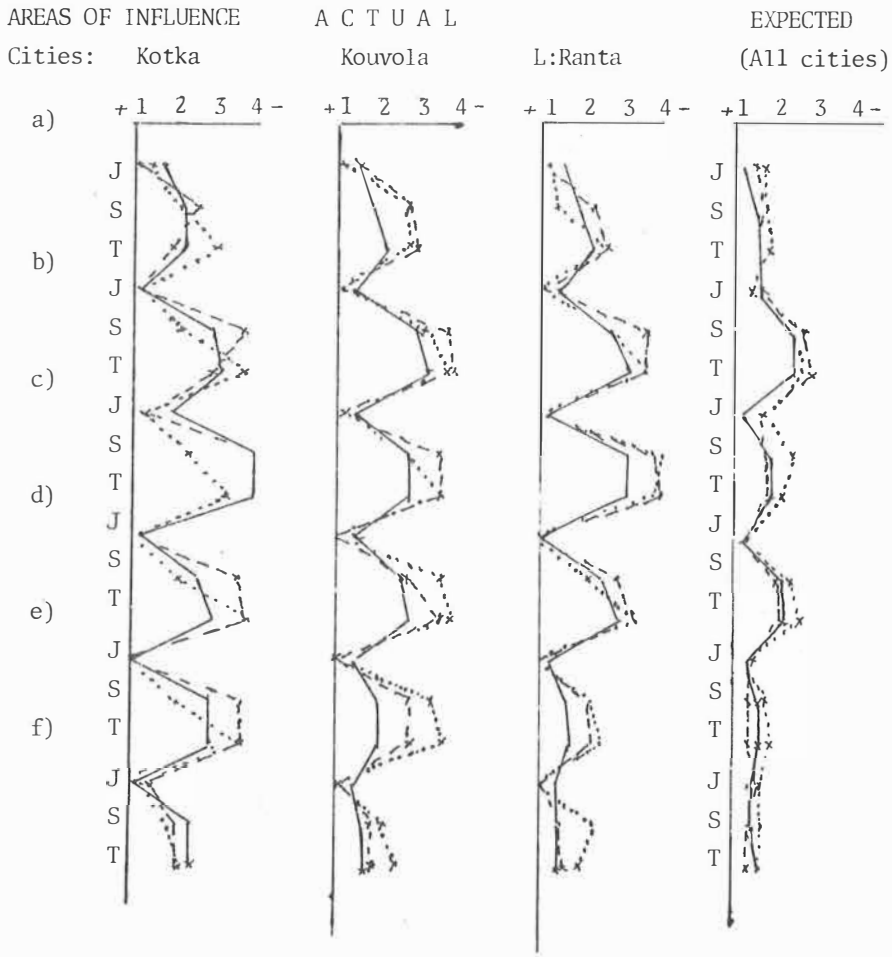
The same findings, which were in evidence in the control curve concerning the chances of a client to exert influence on the decisions made in his particular case, also seem to be true as to the possibilities of social workers to influence the decisionmakers, i.e. the representatives in the boards and sections. The leading officials i.e. the social directors and the section secretaries, are apt to think that the actual possibilities of social workers to influence the decisions concerning themselves are better than the social workers themselves think they are. Especially interesting is the fact that the representatives think that the social workers already have too much actual influence and thus the representatives are inclined to narrow the accumulated influence of the social workers. It should be remembered that in this particular case the final decisionmaking lies in the hands of the representatives and a change in favor for the social workers may be considered a loss by the representatives.

Concerning the equality approach in regard to equal possibilities to influence the result which is well known also elsewhere, indicates that resistance to enlarge democracy in organizations is viewed differently depending on which group is concidered. Because the representatives on the social board are elected by the communes according to the ideals of representative parlamentarism, they are supposed to represent the totality, i.e. in this case the citizens of Tampere. However, on the organizational level, the democratic arrangements do not necessarily constitute guaranties either what comes to the officials or the "consumers", in this case the clients.

2. ON INFLUENCE WITHIN SOCIAL WELFARE AGENCIES

In a study on the prerequisites for workplace democracy and influence in communal social welfare agencies Tuija Nieminen - Kurki (1974) has analyzed the influence of the officials in different areas in line with Lund & Martini (1971) and Lund (1972). (The study is related to the study on "Status and Influence in Social Work in Finland" made in 1970 by the author (c.f. Walls 1970, a), b), c) and 1973)). The agencies of three cities in the county of Kymi, namely Kotka, Kouvola and Lappeenranta, were included in the study. The data was obtained through questionnaires delivered to all employees, altogether 87, in early 1974.

75 questionnaires were returned properly filled up. The drop out was then 14 %. The respondents were asked for their opinions on as well on the actual state as on the ideal, expected state of the possibilities to exert influence in a) external arrangements of their work (i.e. the work frames), b) in evaluations of the employees, especially when selecting applicants for jobs and when drawing up certificates of work, c) in transfers of employees within the agency from one job to another temporarily or permanently, or dismissing employees, d) in outwards directed activities, like cooperation with other service delivery systems or informatory activities, and when giving statements on the activities of the agency to other municipal agencies and to decisive boards etc, e) in the training of employees, which at that time predominantly was decided upon by the heads of the agencies, and finally f) in matters concerning the employees' vacations (ibid., 29-30, 62). The profiles for each personnel category are presented next. The curves are based on the means of the frequencies in the area of influence in question specifically for each employee category and agency.



a) External arrangements of work ($\bar{x}$)
b) Evaluations of employees ($\bar{x}$)
c) Transfers of employees ($\bar{x}$)
d) Outwards directed activity ($\bar{x}$)
e) Training of employees ($\bar{x}$)
f) Employees' vacations ($\bar{x}$)

J ———————
S - - - - - - - - - - - -
T . . . . . .

1. A great deal
2. Fairly much
3. To some extent
4. Not at all

+ - Mean $\bar{x}$

(based on ibid., figures 3 and 4)

Figure 12. Mean value profiles of the opinions of different levels of employees within the Social Welfare Agencies concerning actual and expected influence in certain areas submitted to decisionmaking (Nieminen-Kurki 1974, 63, 74)

The measures on the possibilities to influence for each personnel category of the social welfare agencies in the cities of Kotka, Kouvola and Lappeenranta concern only the decisionmaking within the agencies. Further, the areas of influence represent situations where there is room left in the acts and the statutes for alternatives, for ex. preliminary discussions, hearings etc. prior to the final decisionmaking by the agency heads or the decisive social boards.

As to the possibilities to influence upon decisionmaking concerning external work arrangements, i.e. environment factors, especially the assistant staff members, the agency clerks, considered their possibilities to influence rather minimal. Only 16 % of the clerks had ever been asked for opinions on external arrangements of work while the corresponding figure for the social workers is about 50 % and for the heads 85 %.

Especially the clerks were more pessimistic concerning their own possibilities to influence than were the two other categories of the clerks' possibilities. It is also worthwhile to observe that there were no corresponding differences what comes to the expected possibilities to influence. There exists in other words a high consensus of the ideal state of influence according to which the roof should be high up.

When asking for opinions of the personnel categories on the possibilities to influence, the evaluations concerning employees, i.e. certificates of work, selection of applicants etc., almost all the heads had been contacted while the percentage of the social workers and the clerks with whom the decisionmakers, the decisive boards had been in contact with, rose to only about 15 %. As well the social workers as the clerks rate their possibilities to influence as minimal although the clerks are of the opinion that the actual influence of the social workers is considerably higher than the social workers think it is.

The crucial question for the employees in respect to the possibilities to influence is obviously the possibility to influence upon the transfers of staff members within the agency. This holds true as well concerning shifting of employees from one job to another as in cases of

dismissals. 60 % of the agency heads had been asked for their opinions on transfers of employees when the certificate of work was made, while the percentage in the two other categories was only 13 %.

The social workers and the clerks consider the possibilities to influence in transfers of employees being totally in the hands of the heads. However, it is interesting to observe that the heads themselves rate the possibilities to influence for the two other categories astonishingly high. The agency clerks in turn rate their own possibilities somewhat higher than the two other categories evaluate the clerks' possibilities to influence in their own matters. The same phenomena is true for the evaluations of the clerks concerning the social workers' possibilities to influence. The heads and the social workers are both of the opinion that the social workers' possibilities to influence are minimal while the clerks think the possibilities of the social workers are at least fairly good.

Concerning the outwards directed activities, especially the cooperative and informatory activities to other agencies and communal decisionmaking boards etc., 85 % of the heads, 30 % of the social workers but only 6 % of the agency clerks had had the possibility to influence upon decisionmaking. Anyhow, the heads constitute the category which handles the decisionmaking ordinarily as can be witnessed from the curve on page 61. Here especially the social workers consider their possibilities as considerably weaker than the other groups think they are.

One main obstacle at the time of the study, and partly still at the moment, for taking part in the training activities, was/and is the fact that it means a loss of wage. Only three of the heads had not been asked for their opinions on the training of the personnel while about one third of the social workers and two thirds of the agency clerks had not been questioned. Especially the clerks seem to overestimate the social workers' possibilities to influence upon decisionmaking concerning training of the personnel if compared to the social workers' own opinions.

The possibilities to influence upon decisionmaking on the employees' vacations seem to be more evenly distributed than for the other areas of influence investigated. Each personnel category is able to take part in the decisionmaking on vacations according to the opinions of the respondents. The opinions are more consistent for the three personnel categories than is the case in respect of the five other areas of influence. This holds especially for the respondents at the Social Welfare Agency in the city of Kotka while the social workers of the agency of Kouvola are more pessimistic concerning their own possibilities to influence than are the other personnel categories in respect of the social workers' possibilities (ibid., 65-75).

It can be concluded from the findings of Nieminen-Kurki that there exists considerable inconsistency what comes to the possibilities to influence in some central areas of everyday work and labour relations activities between the main employee categories. The Social Welfare Agency proves to be a rather centralized organization what concerns the use of power. Also it is found out that there exists consistency in expectations concerning the ideal state of things, i.e. the expected influence. It seems of special importance to break down the vertical hierarchy in decisionmaking patterns in social work as it on the other hand is contrary to the essential requirements and principles of the practical client- social worker relationships. In other words, the frames of social work do not correspond to the fulfillment of the central principles and the philosophy imbedded in the methods of social work as based on equality, normality and an effort to collaborate for a deeper understanding of the problems in question. These findings underline at the same time the importance of sectorial research in social work and presumably in health services too. This research should not only tackle in-within problems but as well investigate the frames. This may then result in problem-mastering systems, which fulfill the intentions of the work and not primarily obligations of control and/or judicial arguments.

SUMMARY

1. ON THE BACKGROUND OF COOPERATION

The Finnish social welfare and health care systems developed relatively late if compared to the other Nordic countries. However, the tradition of local self government is long. This tradition has influenced the organization of social welfare, which is the responsibility of the municipalities, altogether 464. Besides the official social welfare the voluntary organizations have been of importance.

In health care the municipalities provided the primary health care services up to 1957 through a system of physicians hired by the communities. The law on hospitals, in effect since that year, meant an integration of the areas of responsibility of the state and municipalities. As far as preventive health care is concerned, the Primary Health Care Act (from the year 1972) is of special importance.

The general control of social welfare and health care in Finland is in the hands of the Ministry of Social Affairs and Health. In health care the Leagues of communes are important especially as providers of hospital and specialized medical care. According to the legislation on primary health care possibilities for cooperation between social welfare and health care are increased.

The organization and implementation of social welfare and health care in Nordic countries is a part of their official societal policy. This means then that these activities are directed under the guidance of parlamentarically elected boards.

Nowadays, the expansion of health and social welfare services has made it difficult to overview the broad fields of responsibility. Thereby the demands on cooperation and delegation of authority in the hands of the executive staff have risen. This is true especially in the field of social welfare.

Another argument in favour of cooperation between social welfare and health care is the fact that many functions are overlapping. This is true as well in respect of the needs of the clients and the patients as of the services provided by the separate social welfare and health care systems. It is estimated that an overwhelming majority of the clients of social welfare are in need of approaches of various kinds to tackle their difficulties.

The development in the field of primary health care in Finland has meant a shift of the centre of weight from institutional care, i.e. hospital, and medical care, on primary health care, and preventive public health measures. However, this shift is difficult to make without a simultaneously increasing awareness among all parties involved of the advances of new medical strategies and of the right ways and methods in developing services and measures in the field of primary health care. The approach on cooperation is therefore also a question of consciousness and not only a "technical" matter.

2. INTERPROFESSIONAL COOPERATION TODAY

The current cooperation between social welfare and health care in Finland is studied only sparsely. However, the combining of the social welfare and health boards and agencies at the municipal level in three cities in Finland has been evaluated in a research (the s.c. SOPUKKA-project) under the auspices of the national state boards of social welfare and health. According to the results, its seems evident that the establishing of frames for cooperation, influences the amount of cooperation on the level of decisionmaking and the administration. Furthermore, the research reports witness an increase in the detection of actual and/or potential areas of cooperation. On the contrary, the integration of matters relating to both social welfare and health care, seems to make it even more difficult for the members of the combined social welfare and health care boards to get acquainted with the acts and records, on which the decisionmaking should be based.

According to several M.A. theses connected to the SOPUKKA-project on

the experiences and attitudes of the board representatives and the professionals of the municipal social welfare and primary health agencies, there exists a considerable gap between the actual and the expected amount of cooperation in matters related to the delivery of services in order to tackle the needs of the clients and patients. A result, which is of special importance when measures are taken for an enhancement of cooperation, is the witnessed low correspondence of interorganizational cooperation expectations.

This result indicates a systematic need of mapping the cooperation networks of the social service and health care delivery system. Thereby the starting point ought to be a holistic view of the human being and/or the problem under consideration. This in turns points out the importance of education and mutual contacts with professionals working in separate delivery systems.

The cooperation from the client's or patient's point of view is not systematically studied in Finland. According to one thesis, the circling of clients measured by contacts taken by them to specified service delivery systems, appears to be almost minimal. On the contrary, it is expected that about 80-90 % of the clients are s.c. multiproblem clients, which very often necessitate cooperation between different service delivery systems. Therefore the empirical result on the low rate of use of different services in the hands of separate service delivery systems, when compared to the officials' evaluations of the clients' and patients' multiple problems, may primarily be a question of helplessness and unawareness of the clients and patients in the existing situation to use the complex and diversified service delivery systems.

According to a separate study on participation and influence within social work agencies made by the author, it was revealed that the opinions of the parties of social work varied a lot on what concerns the actual state of the clients' and social workers' possibilities to influence in matters pertaining to their field and functions in social work. On the contrary, the attitudes toward the desired, the ideal influence proved to be much more homogenous. However the board members

rated the social workers' possibilities to influence upon social work considerably higher than the social workers themselves. The same result holds for the ideal influence for the social workers as rated by the representatives of the boards. The finding indicates on one hand a low degree of crystallization of the professional role of social workers. On the other hand, however, the finding also indicates a state of tension in what concerns the question on the exercising of influence in the field of social welfare.

The prerequisites for workplace democracy and influence in municipal social welfare agencies were studied in one thesis. Especially the assistant staff members considered their possibilities to influence rather minimal. Of the social workers, however, about 50 % had been asked for opinions on arrangements of work conditions. On the contrary, when the social workers were asked on the possibilities to influence in matters concerning certificates of work, selection of applicants etc., only 15 % had been contacted by the decisive boards. Therefore, as well as the social workers as the clerks consider the possibilities to influence in transfers of employees being totally in the hands of the superintendents, the heads of the agencies. This question is crucial in respect of workplace democracy as well what concerns transfers within the workplace as separation from the job.

The differences in respect of the possibilities to influence between the different personnel categories also hold for outwards directed activities. While 85 % of the superintendents of the agencies studied thought they could influence in matters concerning outwards directed activities the corresponding figure for the social workers was 30 % and for the clerks only 6 %.

The results on the influence of the parties involved in social work indicate a contradictory situation as what comes to the goals set up for the activities and the systems and organizations built up to achieve the goals. This may be due partly to the fact that the role and the status of social work are unclear. Even in this respect a mutual interchange of information and experiences between social welfare and the other parties occupied in the field of sociopolitical and medical services seems to be of importance.

Obstacles for cooperation have been underlined in several official documents and expert seminars in Finland in the seventies. In a study cited earlier the main obstacle, concerning the collaboration within the social welfare agency as well as between the agency and other service delivery systems, is the shortage of time in general for cooperative purposes. The great amount of routine work impedes the erecting of contact networks and the establishing of multiproblem oriented service delivery systems operating functionally at the field level.

In respect of the cooperation between social welfare and health care there are some professions, which are especially important. In social welfare the heads of the agencies as well as the chief administrators are key persons. The social worker has a key role as what concerns cooperation on the field level. This is especially true for those workers dealing with problems "in-between", in the field of care of alcoholics, care of disabled, the mentally ill, and the child care. Likewise those officials and field workers who are primarily occupied with problems related to psychic disorders and the social welfare personnel involved in domestic help are key persons in cooperation.

In health care, the most important cooperation key roles are held by the public health nurses at the health centres, the social workers of the hospitals and health centres likewise, and finally, the specialized personnel, for ex. the health psychologists and the voice and medical therapists. Of course, the importance of the physician is evident in cooperation. However, when asking for the most important contacts of social welfare professionals to health care professionals it proved out that the majority of the contact patterns were horizontal, i.e. the heads of social welfare were in contact with the heads of health agencies, the social workers most often with the public health nurses in the field of domestic care etc. The same findings are true in case of the health sector. Anyhow, it could be seen that the contact network of social welfare is more complex than that of health care. However, one has to keep in mind that the studies take into consideration only some areas.

Health care may have other cooperation partners which were not included

in the frames of the studies consulted. Nevertheless, one ought to keep in mind that even the studies referred to here, are primarily operating within existing patterns of cooperation or the lack of them. This means then that the findings may not as such indicate the need of cooperation or some other arrangements, i.e. operative measures for handling with the acute and latent problems constantly varying as substances of a more rapidly changing world.

3. FUTURE PROSPECTS

Strictly speaking, the foundations for the official social welfare and health care organizations were laid long ago. This means at the same time that there is an imbedded resistance on the part of the organizations against changes. Therefore it is most important that critical research is going on, which tries to evaluate the social delivery systems without being directly part of the systems. As the social welfare and health care in the Nordic countries are officially governed and managed this means that it is possible to get data for research purposes. However, the research up to day has, to a fairly limited extent, been interested in questions concerning alternative ways of providing necessary services in the areas of welfare including health care. There is a saying that there is only one health but many diseases. Therefore a shift in the orientation within the field of social welfare as well as within health care towards preventive measures seems to be of extreme importance.

In Finland the suggested reform of the allocation of state subsidies, shares, for social welfare and health, the s.c. VALTAVA-reform, may be a milestone especially in what comes to the providing of resources for social welfare purposes. The social welfare services are primarily the concern of the local community. However, as the social welfare legislation has expanded, the state has taken more and more the financial burden of new reforms. This means then that some welfare activities, primarily traditional welfare activities like social (domestic help) reliefs, institutional care for aged, child protection including childrens' homes etc, are financed almost totally by the local municipal areas.

According to the VALTAVA-reform the state shares will cover also such services, which hitherto have remained mostly without support from outside the municipal budgets. The reform will especially have an effect on the care of the old. When the state subsidies are allocated in a consistent way covering all the main social welfare services, this evidently results in a uniform development of the services in question.

The VALTAVA-reform would also affect the situation of social welfare as compared to that of health care. The main principle for the allocation of state subsidies is the fifty-fifty principle. According to this the state subsidies are to be ordered to the two areas of responsibility on an equal basis as a total.

Thirdly, the reform means that the social welfare will have to make continuous five-years plans in the same manner as primary health care. This obligation in turn makes it possible to develop the two areas in a consistent way. As the municipal areas differ from each other in respect of their economic strength the state subsidies will be provided according to the economic situation of the local municipal area.

Altogether the VALTAVA-reform will most likely affect the realization of social welfare at the level of the municipalities. Besides this the reform relates social welfare to health care as well financially as cognitively and operatively. This obviously also affects the delivery of social welfare and health care services and may be a step toward preventive measures at least in social welfare.

Finally, the reform has an obvious effect on the relations between social welfare and health care. As both areas have a similar planning obligation, this puts them in contact with each other.

The division of work and specialization increases steadily in society. These tendencies are a consequence of the rationalization efforts characteristic not only within economic life but to an increasing extent also in the field of public services. However, the lines of development are in some respect contradictory. The specialization increases the knowledge about specific problems and makes it possible to

tackle them in a better way. However, the "ratio" behind this specialization loses the contact to the end results, which then become ends in themselves and for themselves. The latter implies the formulation of specified goals no longer consistent with the original, the general goals and principles set up for the activities.

In a situation of diversified goals and means which may become ends in themselves the need of cooperation becomes urgent. The same is true in situations of changing demand for services due to changing conditions in society and its subsystems and/or as a result of changes in the awareness of social problems earlier not considered as such. One example of this might be s.c. environmental problems.

In social welfare and health care the cooperation between the personnel groups will probably increase in Finland. This is due to the legislative reforms made but also to an increasing awareness of the relations between social and medical aspects. At the same time the education in medicine and social welfare/social work is becoming more and more interdisciplinary oriented. However, this shift of the point of responsibility of the disciplines toward interdisciplinary questions is a challenge for scientific education and research. The readiness to collaborate and cooperate and the factors affecting it obviously then become common concerns as well in medical as in social welfare training.

The studies made on influence in social welfare of the different personnel groups in matters directly relating to their position and work indicate a need of rebuilding the welfare organizations so that they are in line with the central goals for social welfare and the principles for social work. Now there is a contradiction between the organization of activities and the delivery of services. The organization fulfills the principles of public administration. This is of course an important aspect. The legal and control functions are a guarantee that the official social welfare fulfills the financial and juridical obligations. However, the social welfare activities ought to be flexible and take into consideration the human relations aspects especially in client work.

One solution to the problem of formal organizations versus informal

activities may be the delegation of power and authority as well within the organizations as regionally. In social welfare this means then a decentralization of the activities and the decisionmaking. A first step is an increase in the rights for the social worker to decide in matters directly relating to his or her functions and client work. The representatives of the boards are then able to concentrate on the general lines of the activities. This is the intention of the new legislation on social welfare in Finland, which will be in effect from the beginning of year 1982. At the same time this increase in rights and obligations of the social workers makes them more equal partners in cooperation with other professions, among those, the medical. An awareness of mutual gains of collaboration and cooperation is most likely to be achieved in dealing with equals. Finally, this would affect the social sector as a whole. The social and health problems most often affect the human being inseparably from each other. It is up to the representatives and professionals to adjust the operative measures according to this fact. Sometimes a single measure is enough, but especially in the field of social welfare, the measures must be collected from a working case containing instruments afforded by separate service delivery systems. Social welfare has to always relate its operations and services to the social contexts.

TIIVISTELMÄ. Sosiaali- ja terveydenhuolto yhteistyössä

1. Lähtökohdat ja tehtävänasettelut

Tutkimusraportti on Suomen osuus Euroopan sosiaaliturvan tutkimus- ja koulutuskeskuksen (ECSW) koordinoimasta 10 maata käsittävästä projektista:

"Perusterveydenhuolto: Terveyden- ja sosiaalialan henkilökuntien välinen yhteistoiminta

Kansainvälinen tutkimus ammattienvälisen yhteistoiminnan rakenteesta ja muodoista tuloksellisuuden näkökulmasta arvioituna"

(ECSW projekti no R 10:1979)

Osanottajamaiden raportit perustuvat yhteisesti valmisteltuun tutkimussuunnitelmaan. Tutkimushanketta varten ei ole koottu uusia havaintoaineistoja. Hankkeeseen osallistuu sekä sosiaali- lääketieteilijöitä että yhteiskuntatieteilijöitä. Tutkimus-kokonaisuuden tieteellisen johtajan professori Claes-Göran Westrinin on siten mahdollista suhteellisen lyhyessä ajassa (vuoden 1982 loppuun mennessä) työstää projektin yhteisjulkaisu kansallisten raporttien pohjalta.

Suomen raportti rakentuu pääasiassa sosiaali- ja lääkintöhallitusten toimeksiannosta toteutetun ja allekirjoittaneen johtaman projektin (SOPUKKA) sekä siihen liittyvien erillisten opinnäytteiden löydöksille. Toimeksiantoprojektin tutkijana on toiminut YK Heikki Kaitalo ja opinnäytteiden laatijoina on joukko lähdeluettelossa lueteltuja opiskelijoita Jyväskylän ja Tampereen yliopistoista.

Tämän raportin tehtäviksi täsmentyivät 1) sosiaali- ja terveydenhuollon keskinäissuhteiden ja näiden sekä Suomessa vallitsevan ko. vastuualueiden yhteistoiminnan puitteiden ja perusteiden selvittäminen 2) sosiaali- ja terveydenhuollon kuntatasoisten toimipisteiden yhteyksien osoittaminen ja 3) yhteistoiminnan tuloksellisuuden analysoiminen pitäytyen mainittuihin tutkimusraportteihin sisältyvien yhteistoimintaosapuolten arviointeihin vallitsevasta sekä

edellytetystä yhteistoiminnasta, sen kohdistumisesta, määrästä, muodoista sekä edellytyksistä.

2. Sosiaali- ja terveydenhuollon keskinäissuhteet

Sosiaali- ja terveydenhuollon väliset suhteet ovat olleet esillä jo pitkään Suomessa. Lääketieteen aikakauslehdistössä lähes sadan vuoden ajan käyty keskustelu on ollut erityisen merkittävä sosiaalilääketieteellisen ajattelun ja toimenpiteiden virittäjänä (Rauhala 1978). Samoin on kiinnitettävä huomiota sosiaalipolitiikan ja erityisesti työpolitiikan piirissä jo varhain esitettyihin ajatuksiin ja suoritettuihin toimenpiteisiin ennen muuta työsuojelun alueella. Työpolitiikka muodostaa selvästi sosiaalisten ja medisiinisten näkökohtien ja toimenpiteiden päällekkäis- ja yhteistoiminta-alueen.

Sosiaali- ja terveydenhuollon perimmäisenä tarkoituksena on pidetty ihmisen suoriutumisen ja hänen hyvinvointinsa turvaamista. Terveyden käsite on vähitellen laajentunut kattamaan kaikkinaisen inhimillisen hyvinvoinnin. Erityisesti Maailman terveysjärjestö korostaa ihmisen fyysisten, psyykkisten ja sosiaalisten osien keskinäisen häiriöttömän vuorovaikutuksen merkitystä terveyden kannalta.

Sosiaali- ja terveydenhuollon yhteistoiminnan kiinteyttämistä on Suomessa kehitelty aina 1960-luvulta lähtien. Kehittelyn näkyvimpänä ilmauksena voidaan pitää sosiaali- ja terveysministeriön muodostamista vuonna 1968. Yhteistoiminnan järjestämiseen paikallistasolla kiinnitettiin Suomessa huomiota lähinnä vasta 1960-1970-lukujen taitteessa. Sosiaali- ja terveysministeriön toimeksiannosta aloitti vuonna 1968 työskentelynsä lääkintöhallituksen ja sosiaalihallituksen tehtävänjakoa selvittelevä toimikunta. Valmisteltaessa lakia kansanterveydestä tuotiin painokkaasti esille paikallistason organisointi sosiaali- ja terveyslautakuntien yhdistämiseksi.

Paikallishallinnossa ei ole Suomessa vielä yleisemmin toteutettu vastaavaa uudistusta kuin ministeriötasolla sekä läänintasolla sosiaali- ja terveysosastojen perustamisen muodossa. Kuitenkin yhteistoimintaa on jatkuvasti esiintynyt kunnallisten hallintokuntien samoin kuin näiden ja paikkakunnilla toimivien erilaisten

sosiaali- ja terveydenhuollon alan vapaaehtoisten järjestöjen välillä. Luottamushenkilöiden asettamissäädöksiin sisältyy myös sääntöjä valittaviksi tulevien koulutus- ja kokemustaustasta. Yhteisten luottamushenkilöiden käyttö on samoin edesauttanut eri hallinnonalojen keskinäistä tiedonvaihtoa ja yhteistoimintaa.

Kolmessa kaupungissa, Keravalla, Lappeenrannassa ja Kotkassa, on yhdistetyt sosiaali- ja terveyslautakunnat ja näiden alaiset yhteiset sosiaali- ja terveysvirastot. Vuonna 1979 valmistuneessa toimeksiantotutkimuksessa tehdään selkoa yhdistämisestä saaduista kokemuksista eri henkilökuntaryhmien (yhteensä 67 ammattinimikettä) kokemuksiin ja yhteistoimintakäytäntöihin pohjautuen (Kaitalo 1979; myös Kaitalo-Walls 1978).

Hallinnollista yhteistoimintaa ei ole syytä kehitellä itsetarkoituksena. Sen vuoksi Suomen raportissa on selvitetty sosiaalisten ja medisiinisten tekijöiden keskinäissuhteita ihmisten hyvinvoinnin sekä heidän terveytensä ja sairastavuutensa kannalta diagnostisesti, operatiivisesti sekä evaluatiivisesti. Tällöin on esitelty kuolleisuuden ja sairastavuuden demograafisia, alueellisia sekä ammattialoittaisia eroavuuksia Suomessa. Lisäksi on kiinnitetty huomiota ikääntymiseen ja tämän mukaan tuomiin samanaikaisiin sosiaali- ja terveydenhuollon sekä sairaanhoidon palvelutarpeisiin. Viimein on viitattu psyykkisen terveyden ja sairastumisen monisäikeisiin riippuvuuksiin samoin kuin väkijuomien käytön ja siitä aiheutuvien vaurioiden sosiaalilääketieteellisiin ja sosiaalipoliittisiin yhteyksiin. Mainitut esittelyt pohjautuvat sekundäärilähteisiin (ks. lähinnä lähdeviitteistä Alkoholipolitiikka, Byckling T., Niemi A., Nyman K., Raitasalo R., Sauli H., Savolainen E. & Klaukka T., SVT Terveydenhuolto 1979 sekä Tilastokeskus 1980).

3. Sosiaali- ja terveydenhuollossa toimivien yhteistyö

Raportissa pitäydytään kuntatasolla toteutuvaan yhteistyöhön sosiaali- ja terveydenhuollon toimipisteissä työskentelevien välillä. SOPUKKA-tutkimuksen kunnallisen sosiaali- ja terveystoimen työntekijäryhmien vastausten perusteella osoittautui sosiaalihuollon sektorilla työskentelevien ilmaisema yhteistoiminnan ja -työn tarve terveydenhuollossa työskentelevien ilmoittamaa tarvetta suuremmaksi.

Selviteltäessä yhteistoimintavajetta toimintasektoreittain ilmeni, että suorittava porras koki yhteistoimintavajeensa suurimmaksi. Sosiaalihuollosta ne sosiaalitarkkaajat, jotka työskentelevät sosiaali- ja terveydenhuollon välimaaston ongelmien parissa, ovat yhteistoiminnan kannalta avainroolissa. Välimaaston ongelmia ovat päihteet, invaliditeetti ja kehitysvammaisuus, vanhusten sekä lastenhuollon ongelmat ja psyykkiset häiriöt. Sosiaali- ja terveydenhuollon eri portaissa toimivat työntekijät ilmoittavat useimmiten sosiaali- ja terveydenhuollon yleisen tai ongelmakohdittaisen kehittämistarpeen syyksi toimialojen väliselle yhteistoiminnalle. Toiseksi yleisin perusteluryhmittymä on toimintojen yleinen samansuuntaisuus ja yhteisasiakkaisto. Vastuualueiden hallintoportaiden välinen yhteistoiminta on suurinta. Hallinnossa toteutettu erikoistuminen on toisaalta synnyttänyt voimakkaita sektorirajoja, joiden ylittäminen ei ole mahdollista pelkästään nykyisen hallinnon rakenteen vaarassa toimivalla koordinoinnilla (Kaitalo 1979). Yleisesti ottaen yhteistyötä ei pidetty riittävänä millään rinnakkaiseksi katsotulla vastuualueella, kuten kodinhoitajat versus kotisairaanhoito, lasten päivähoito versus lasten terveyskeskuspalvelut, alkoholistihuolto versus -hoito samoin kuin invalidi- ja vanhusten huolto ja -hoito. Vallitsevien yhteistyökäytäntöjen ja yhteistyötä koskevien odotusten välillä on siten, tosin ilmeisesti vaikeasti ylitettävissä oleva kuilu.

Yhdistyneen sosiaali- ja terveydenhuollon organisaatiomallin yhteistoiminta osoittautui erillistä mallia laajemmaksi sekä säännöllisemmäksi. Verrattaessa em. kolmen yhdistyneen mallin omaksuneen kaupungin sosiaali- ja terveydenhuollossa toimivien yhteistyöodotuksia erillisen mallin mukaan toimivien esittämiin odotuksiin ilmeni, että yhdistyneen mallin mukaan toimivilla oli alhaisempi koettu yhteistyön lisäämistarve. Tästä voi varovaisesti päätellä organisatoristen puitteiden merkityksestä käyttäytymismuutoksille työtilanteissa.

SOPUKKA-projektin tuloksista on myös todettavissa, miten useimmat henkilökuntaryhmien väliset yhteistyökontaktit ovat horisontaalisia, s.o. asemansa sekä vastuualueensa puolesta läheisesti toisiaan vastaavat työntekijäryhmät ovat yhteistyössä keskenään. Esimerkiksi sosiaalitarkkaajista ainoastaan 10% on yhteydessä terveydenhuollon johtoon. Sen sijaan 39% tarkkaajista pitää terveydenhoitajaa

tärkeimpänä yhteistyöosapuolenaan; terveydenhoitajista vastaavasti 33% katsoo sosiaalitarkkaajan olevan tärkeimmän yhteistyökumppanin.

Sosiaali- ja terveydenhuollossa ilmeneviä yhteistyökäytäntöjä, yhteistyöalueita, yhteistyöosapuolia, -tiheyksiä sekä yhteistyöhön kohdistuvia odotuksia on selvitelty eräissä opinnäytteissä (mm. Manninen 1980, Mäkinen 1980, Saarenpää 1982, Siivola-Ylätalo 1982, Vainio 1981). Yleistäen tutkielmien tuloksista on pääteltävissä, että vallitsevan ja edellytetyn yhteistoimintatilanteen välillä on melkoinen ero. Sosiaalihuollon työntekijöiden esilletuoma yhteistoimintatarve "hajoaa" myös useammalle taholle kuin on asian laita terveydenhuollon kohdalla. Lisäksi on todettavissa, miten yhteistyötase on negatiivinen nimenomaan sosiaalihuollon kohdalla, joka odottaa huomattavasti enemmän ei ainoastaan yhteistyötä muilta tahoilta vaan myös itse yhteistyöstä. Tulos lienee yhteydessä sosiaalihuollon vastuun laaja-alaisuuteen samoin kuin heikkoon ammatillistumiseen. Ei kyetä osoittamaan, mikä on nimenomaan sosiaalihuollon aluetta eikä tämä välttämättä ole paikallaankaan kun sosiaalihuollolla on viimesijainen kokonaisvastuu ihmisen hyvinvoinnista ja hänen suoriutumisestaan. Sinänsä kiintoisa on tulos, minkä mukaan esim. päihdehuollossa kohdistuu huomattavasti enemmän yhteistyöodotuksia kunnan (Lappeenrannan tässä tapauksessa) päihdehuoltoon kuin mitä tämä itse odottaa muilta (Vainio 1981). Toisaalta yhteistyöodotusten mittaaminen yhteistyöverkostoilla on sidoksissa ulkoisiin puitteisiin, resursseihin jne. Yhteistyö osoittautui siten tutkielman tulosten valossa varsin epätasapainoiseksi ei ainoastaan mitä tulee eri yhteistyöosapuolten odotusten heikkoon vastaavuuteen vaan myös vastuualueittain.

Usein on esitetty perusteena yhteistoiminnan kehittämisen tärkeydelle, miten peräti 80-90% asiakkaistosta on n.s. moniongelma-asiakkaita. Kuitenkaan ei Saarenpään tutkimista asiakkaista kuin murto-osa kiertänyt useammassa kuin yhdessä huolto- tai hoitopisteessä. Tällöin on tosin huomattava, että on ero diagnoosilla ja asiakkaan tai potilaan tosiasiallisella käyttäytymisellä. Näin ollen tulos saattaa lähinnä osoittaa sen, miten nykyinen hajautettu järjestelmä, missä usein kutakin palvelua varten on erillinen toimipiste, muodostaa tietyn esteen kansalaisen "täysitehoiselle" hakeutumiselle. Vastuu siirtyy tällöin sille toimipisteelle, jossa asiakas asioi ja toimipisteen tehtäväksi muodostuu laatia mahdollisimman kattava huolto- tai hoitosuunnitelma (ja myös huolehtia siitä, että se toteutuu).

4. Yhteistyö ja vaikuttaminen

Yhteistyön voidaan osaltaan katsoa perustuvan vaihtoon. Vaihdon edellytyksenä on ensinnäkin, että on jotain mitä vaihtaa, tietoja, taitoja tms. Toiseksi yhteistyöllä täytyy olla motiivi, käsitys siitä, että keskinäinen vaihto mahdollistaa sellaisen tavoitteen saavuttamisen, mikä ei erillisin ponnistuksin ole aikaansaatavissa. Kolmanneksi yhteistyö edellyttää osapuolilta tietynlaista tasavertaisuutta vaihtosuhteessa mitä tule kohteluun, pelisääntöjen noudattamiseen sekä keskinäiseen hyväksymiseen.

Yhteistyöosapuolien keskinäiset suhteet muodostuvat näin ollen merkityksellisiksi. Yhteistyöesteiksi muodostuvat tämän mukaan eriarvoisuus, hierarkkiset käskyvaltasuhteet, auktoriteettiodotukset jne. Tämän vuoksi pyrittiin kansainväliseen tutkimusprojektiin myös sisällyttämään "organisaatioilmastoja" sekä sosiaalialan ja terveydenhuoltoalan keskinäisiä suhteita valaisevia tietoja eri osanottajamaista.

Tässä raportissa käsitellään lyhyesti paria tutkimusta, joissa on selvitelty kunnallisen sosiaalitoimen piirissä vallitsevia organisaatiorakenteita, käskyvaltasuhteita sekä vaikuttamisen muotoja ja edellytyksiä. Asemaa ja vaikutusvaltaa sosiaalihuollossa käsittelevän tutkimuksen (Walls 1970 - 1973 ja 1980) perusteella todetaan mm., miten käsitykset sosiaalitarkkaajien ja eri asiakasryhmien tosiasiallisesta ja heille "tarjottavista" vaikutusmahdollisuuksista vaihtelivat merkitsevästi riippuen siitä, mikä sosiaalihuollon sidosryhmä oli arvioijana. Samoin havaittiin, että erityisesti sosiaalityöntekijät olivat taipuvaisia pitämään nykyisiä vaikutusmahdollisuuksiaan vähäisempinä kuin millaisiksi muut osapuolet ne arvioivat. Lisäksi työntekijöiden omat arvioinnit heille kuuluvista vaikutusmahdollisuuksista "alittivat" sen, minkä muut osapuolet olisivat olleet valmiit työntekijöille tarjoamaan. Toisaalta poikkeuksen tässä suhteessa muodostivat luottamushenkilöt, jotka katsoivat työntekijöiden vaikutusmahdollisuuksia voitavan jopa hieman kaventaa. Kaiken kaikkian em. tulokset viittaavat sosiaalityöntekijäammatin heikkoon identiteettiin ja alhaiseen vakiintuneisuuden asteeseen.

Tilanne osoitaa jännitteen vallitsevan eri sidosryhmien käsityksissä vaikuttamisen edellytyksistä, muodoista sekä asteesta suomalaisessa sosiaalihuollossa kuntatasolla. Toisessa vaikuttamista koskevassa tutkielmassa Tuija Nieminen-Kurki päätyi siihen, miten sosiaalitarkkaajat ainoastaan vähäisessä määrin tulivat kuulluiksi käsiteltäessä työhönottoa, sisäisiä järjestelyjä työpaikoilla sekä työntekijäin erottamista. Myöskään silloin kun kyse oli sosiaalitoimistojen suhteista ulospäin, muihin organisaatioihin, eivät työntekijät voineet saada sanaansa kuuluville. Tulokset viittaavat tietynlaiseen umpikujaan sikäli, että sosiaalityölle asetetut päämäärät ja pyrkimykset joissa korostuvat kokonaisvaltaisuus, demokratia ja yhteistyö, eivät toteudukaan itse työtilanteissa, työpaikan organisaatiossa.

Raportissa ei ole juuri voitu analysoida kahden eri vastuualueen, tässä sosiaali- ja terveydenhuollon, keskinäisiä vaikutusvaltaan liittyviä suhteita, yhteistyön kannalta, puuttuvien tutkimusten vuoksi.

5. Avainroolit sosiaali- ja terveydenhuollon yhteistyössä

Raportissa viitataan SOPUKKA-projektissa esille tulleisiin havaintoihin yhteistyön kannalta merkityksellisistä yhteyshenkilöistä ammattinimikkeiden perusteella. Esimerkiksi terveydenhuollossa tärkeimmiksi yhteistyön avainhenkilöiksi tulevat terveydenhoitajat, sairaaloiden sosiaalihoitajat sekä terveyskeskuspsykologt ja puhe- ja lääketerapeutit. Samoin lääkärin rooli on merkityksellinen. Toisaalta tutkittaessa yhteistyön suuntautumista havaittiin, miten useimmat yhteistyökontaktit ovat horisontaalisia sikäli, että lähipitäen samalla tasolla olevat työntekijät ovat yhteydessä toistensa kanssa eikä esimerkiksi sosialitarkkaaja terveyskeskuslääkärin kanssa tai vastaavasti sosiaalijohtaja terveydenhoitajan kanssa. Toteutetun työnjaon tilanteessa vaakasuorat yhteydet ovat ilmeisesti aivan luonnollisia, mutta tällöin vaaditaan myös, että tieto kulkee kunkin organisaation sisällä mahdollisimman hyvin eri tehtäviä hoitavien kesken. Vasta tällöin ongelmat toisessa organisaatiossa sen eri portailla voivat välittyä toiselle organisaatiolle.

Kansallisissa raporteissa tuli lisäksi kiinnittää huomiota yhteistoiminnan ja yhteistyön tuloksellisuuteen. Toisaalta tuloksellisuuden mittausta ei juurikaan oltu suoritettu osallistujamaissa. Sikäli kuin mittauksia oli, nämä lähinnä rajoittuivat kokemuksille eivätkä olleet ns. panos-tuotosmallien kaltaisia. Vaikka Suomessa kolmella paikkakunnalla on yhdistetyt sosiaali- ja terveydenhuoltolautakunnat sekä vastaavat sosiaali- ja terveysvirastot niiden tehokkuudesta määrällisin kriteerein ei voida esittää lukuja. Sen sijaan on kyllä osoitettavissa, että siellä missä yhteistoimintaa on "institutionalisoitua", niin sitä myös tehdään vakiintuneesti osana jokapäiväistä työtä.

6. Tulevaisuuden näköaloja

Suomen raportissa kiinnitetään erityisesti huomiota valmisteilla oleviin sosiaalihuollon hallintolainsäädännön uudistuksiin samoin kuin esityksiin valtionapujärjestelmän uudistamiseksi kattamaan nykyistä suuremmassa määrin myös kunnallisen sosiaalihuollon. Tämän n.s. VALTAVA-uudistuksen oletetaan edesauttavan tasavertaiseen asemaan pääsemistä terveydenhuoltosektorin kanssa. Tasavertaisuuden oikeuksissa ja velvoitteissa on samalla katsottu muodostavan erään perusedellytyksen vastuualueiden menestykselliselle yhteistyölle.
Samoin oletetaan tietoisuuden medisiinisten ja sosiaalisten tekijöiden keskinäissuhteista lisääntyvän sosiaali- ja terveydenhuollossa toimivien keskuudessa. Uudenlainen "kokonaisvaltainen" näkemys varmaankin edesauttaa omalta osaltaan yhteistyötä. Toisaalta alati lisääntyvä työnjako ja ammattien spesialisoituminen uhkaavat vaikeuttaa kognitiivisia yhteistyön edellytyksiä. Keinoina yhteisen "kielen" löytämiselle viitataan yhteistoimintaa edesauttaviin rakenteellisiin ja hallinnollisiin järjestelyihin. Yhteiset lautakunnat samoin kuin virasto-organisaatiot ovat eräs esimerkki rakenteellisista uudistuksista. Toinen ja ilmeisesti vielä merkityksellisempi on yhteensovitettu koulutus. Tällöin yhteiset jatko- ja täydennyskoulutustilaisuudet samoin kuin yhteinen ongelmakeskeinen team- ja projektityöskentely tulevat kysymykseen. Lisäksi vastuu- ja käskyvaltasuhteiden hajauttaminen muodostaa keinon

lisääntyvälle mielekkääksi koettavalle yhteistyölle niin organisaatioiden sisällä kuin niiden välillä. Varsin lähelle "ihanteellista" mallia tulee yhdistetty terveys- ja sosiaalikeskus, mihin vielä kytkeytyy tutkimus- ja koulutustoimintaan.

On kuitenkin ilmeistä, että Suomessa niinkuin muissakin kansainväliseen hankkeeseen osallistuvista maista, yhteistoiminnan ja konkreettisen yhteistyön tie on vaikeakulkuinen. Yhteistoiminta ja -työ eivät sinänsä ole ratkaisuja sosiaali- ja terveydenhuoltoa askarruttaviin moninaisiin ongelmiin ja haasteisiin. Voidakseen vaikuttaa laajemminkin yhteiskuntapolitiikkaan ja ihmisten jokapäiväiseen elämään näiden vastuualueiden on myös kyettävä tuomaan julki ongelmansa edustavasti ja riittävän painokkaasti. Tässäkin suhteessa yhteistyöllä on oma voimia kokoava merkityksensä.

LITERATURE

Aer J. & Rokka S. (1975), "Terveyskeskus toiminnallisena kokonaisuutena" (in: Aer J. (toim.), Kansanterveystyön käsikirja.Helsinki. Tammi.

Alkoholipolitiikka (1980), "Alkoholin käyttöön liittyvät kustannukset vuonna 1978" (in: Alkoholipolitiikka no. 45. 1980).

Asetus sosiaali- ja terveysministeriöstä 1968/405.

Asetus lääninhallituksen sosiaali- ja terveysosastosta 1971/119.

Byckling T. (1978), "Terveys- ja sosiaaliturvan haastattelututkimus 1976: tutkimusaineisto" (in: Kansaneläkelaitoksen julkaisuja M:28).

ECSW (European Centre for Social Welfare Training and Research). (1979; 1980), Primary Health Care: Cooperation Between Health and Welfare Personnel. Research Workshop Reports from Uppsala 8-10 May, 1979 and Dalfsen 27-28 May 1980 (Unpublished).

ECSW (1979), Primary Health Care: Cooperation Between Health and Welfare Personnel. An international investigation of the structure and methods of interprofessional cooperation from the point of view of assessing their outcome. Guidelines for the Preparation of National Reports. Compiled by Gaits G.M. et.al. (ECSW R 10 (1979) 31) (Unpublished).

Hallituksen esitys Eduskunnalle sosiaalihuoltolaiksi 12.5.1981.

Health Services in Finland (1979) Published by The Ministry of Social Affairs and Health and The National Board of Health. Helsinki.

Heikkilä M. & Karjalainen T. & Lihr S & Niinivaara R. (1980), Perhekustannusten tasausjärjestelmä Suomessa. Sosiaalihallituksen julkaisuja 4/1980. Helsinki.

Jussila A. (1975), "Sosiaalihuollon ja terveydenhuollon tehtäväjako ja yhteistyö" (in: Aer J. (toim.), Kansanterveystyön käsikirja. Helsinki.

Kaipainen O. (1975), "Kansanterveyslain keskeiset periaatteet ja terveyspoliittinen merkitys" (in: Aer J. (toim.), Kansanterveystyön käsikirja. Helsinki.

Kaitalo H. (1977), Sosiaali- ja terveydenhuollon kuntatason yhteistoiminta. Projektisuunnitelma. Sopukka 1. University of Tampere. Department of Social Policy. Research Reports 44/1977. Tampere.

Kaitalo H. (1979), Hallintoratkaisut ja työnkuvat sosiaali- ja terveyshuollon yhteistoiminnassa. (English summary) Sopukka 3. University of Tampere. Department of Social Policy. Research Reports 53/1979. Tampere.

Kaitalo H. (1979), (toim.), Kuntatason sosiaali- ja terveydenhuollon yhteistoiminta. Sopukka 4. University of Tampere. Department of Social Policy. Research Reports 54/1979. Tampere.

Kaitalo H. & Walls G. (1978), Sosiaali- ja terveydenhuollon yhteistoimintaprofiilit. (English summary) Sopukka 2. University of Tampere. Department of Social Policy. Research Reports 49/1978. Tampere.

Kansanterveyslaki 1972/66.

Kansanterveysasetus 1972/205 sekä asetus kansanterveysasetuksen muuttamisesta 1972/368.

Karvala J. (1974), Sosiaalihuolto-odotukset. Tampereen sosiaaliviraston asiakkaiden sosiaalinen tausta ja sosiaalihuoltoon kohdistuvat odotukset. M.A. thesis. University of Tampere 1974 (Unpublished).

Kiiskinen P. (1972), Käsitykset huoltoapujärjestelmästä ja sosiaalihuollon asiakkaiden oikeusturvasta. M.A. thesis. University of Tampere 1972 (Unpublished).

Komiteamietintö 1960:A4. (1960), Kuntien yhteistoimintakomitean I osamietintö. Helsinki.

Komiteamietintö 1969:A3. (1969), Kansanterveystoimikunnan mietintö. Helsinki.

Komiteamietintö 1971:A25. (1971), Sosiaalihuollon periaatekomitean mietintö I. Yleiset periaatteet. Helsinki.

Komiteamietintö 1971:B4. (1971), Terveydenhuollon suunnittelukomitean mietintö. Helsinki.

Komiteamietintö 1974:64. (1973), Sosiaalihallintokomitean mietintö I. Helsinki.

Komiteamietintö 1974:32. (1974), Sosiaalihallintokomitean mietintö II. Helsinki.

Komiteamietintö 1976:22. (1976), Sosiaali- ja terveysministeriön hallinnonalan tehtäväjakotoimikunnan mietintö. Helsinki.

Kuusi E. (1931), Sosialipolitiikka I-II. W.S.O.Y. Helsinki.

Kymen läänin kansanterveystyön neuvottelukunta. (1975), Yhteistyöjaosto, Sosiaali- ja terveydenhuollon käytännön yhteistyö. (Mon.) Kouvola.

Kähkölä A. (1981), Etelä-Pohjanmaan keskussairaalapiirin alueellinen täydennyskoulutus. Tutkimuksen tausta. Suunnitelma Jyväskylän yliopiston Yhteiskuntapolitiikan laudaturseminaarissa 12.2.1981 (Unpublished).

Lund R. (1972), De ansattes indflydelse på ledelsens beslutninger inden for Københavns institutioner. København.

Lund R. & Martini S. (1971), Indflydelse og samarbejde. Socialforskningsinstituttets publikationer 48. København.

Mäkinen P. (1980), Asiakaspalvelun yhteistoiminta viiden sosiaali- ja terveydenhuollon organisaation välillä Tampereella. M.A. thesis. University of Tampere (Unpublished).

Niemelä P. & Laurinkari J. & Elo O. (1979), Terveydenhuollon hallinto, talous ja suunnittelu. Kuopio.

Niemi A. (1979), "Pitkäaikaissairaanhoidon ongelmat ja ratkaisumahdollisuudet" (in: Sosiaalinen aikakauskirja 73. 1979)

Nieminen - Kurki T. (1974), Työpaikkademokratiaa sosiaalivirastoihin. Tutkimus työpaikkademokratian toteuttamisedellytyksistä ja työntekijäin vaikutusmahdollisuuksista Kotkan, Kouvolan ja Lappeenrannan sosiaalivirastoissa. M.A. thesis. University of Tampere (Unpublished).

NOU (Norges Offentlige Utredninger). (1976), Levekårsundersøkelsen: Sluttrapport. NOU 1976:28 Oslo.

Nykänen S. (1975), Sosiaalihuollon täydennyskoulutus. Tutkielma suomenkielisten kuntien sosiaalijohtajien, osastosiihteerien, sosiaalitarkkaajien ja sosiaalilautakunnan puheenjohtajien suhtautumisesta täydennyskoulutukseen sekä eräisiin muihin seikkoihin vuonna 1971. M.A. thesis. University of Tampere (Unpublished)

Nyman K. (1980), "Terveyspalvelusten käyttöön vaikuttaneet tekijät Suomessa vuosina 1964, 1968 ja 1976" (in:Sosiaalivakuutus, 18. 1980).

Piirainen V. (1958), Kylänkierrolta kunnalliskotiin. Savon ja Pohjois-Karjalan maaseudun vaivaishoitotoiminta vaivaishoidon murroskautena 1800-luvun jälkipuoliskolla. Helsinki. W.S.O.Y.

Pitsinki P. (1981), "Sosiaalihuollon taloudelliset edellytykset ja mahdollisuudet". (Esitelmä "Tavoitteet ja todellisuus sosiaalihuollossa" -seminaarissa Forssassa 27.5.1981) (Unpublished).

Raitasalo R. (1978), "Lääketieteellisestä psykologiasta" (in: Kansaneläkelaitoksen julkaisuja E:102/1978) Helsinki.

Rintanen E. -L. (1975), "Terveyskeskuksen henkilökunta ja sen työnjako" (in: Aer J. (toim.), Kansanterveystyön käsikirja. Helsinki. Tammi.

Saarenpää M. (1982), "Eräiden Tampereen sosiaali- ja terveydenhuollon organisaatioiden yhteistoiminta asiakkaiden kannalta" M.A. thesis. University of Tampere (Unpublished).

Sairaalaliitto. (1977), Sairaalahallinnon kehittäminen. Julkaisu 5/77. Helsinki.

Salo R. (1962), Kunnallinen huoltoapu yhteiskunnallisena ja yksilöllisenä ongelmana. Vaasasta koottuun paikallisaineisto on perustuva tutkimus huoltoavun tarpeen syistä. Vaasa. Omakustanne.

Sauli H. (1979), Kuolleisuus ja ammatti. Tilastokeskus, tutkimuksia n:o 54. Helsinki.

Savolainen E. & Klaukka T. (1980), "Väestön terveydentila" (in:Sosiaalivakuutus 18. 1980).

Sihvo T. (1980), "Yhden aikuisen ruokakunnat eniten kotiavun tarpeessa" (in: Sosiaaliturva 20. 1980).

Siivola J. & Ylätalo K. (1981), "Sosiaali- ja terveydenhuollon yhteistoiminta Jyväskylän kaupungissa" (Unpublished manuscript).

Social Insurance in Finland. (1981), Published by the Ministry of Social Affairs and Health. Helsinki.

Social Welfare in Finland. (1980), Published by the Ministry of Social Affairs and Health. Helsinki.

Sosiaalihallitus 68-78. (1980), Helsinki.

Sosiaali- ja terveysministeriö. (1978), Ehdotus sosiaali- ja terveydenhuollon suunnittelu- ja valtionosuusjärjestelmäksi (VALTAVA) Helsinki.

Sosiaalitoimiston kehittäminen. (1981), Sosiaalityötä ja sosiaalitoimiston työn organisointia selvittäneen työryhmän muistio. Sosiaalihallituksen julkaisuja 1/1981. Helsinki.

Sosiaaliturvan Keskusliitto. (1974), Raportti. Sosiaali- ja terveydenhuollon yhteistoiminta. 1973. Helsinki.

Sosiaalivakuutus n:o 5-6. 1980

SVT (Suomen Virallinen Tilasto). (1979), XXI B:19, Sosiaalihuolto. Sosiaalihuoltotilaston vuosikirja 1977. Sosiaalihallitus. Suunnittelu- ja tilastotoimisto. Helsinki.

SVT (Suomen Virallinen Tilasto). (1979), Terveydenhuolto. Tilastokeskus. Helsinki.

Tainio E. (1976), "Sosiaali- ja terveysministeriön hallinnonalan valtionapulainsäädännön historiaa ja tulevaisuuden näkymät" (in: Sosiaalinen aikakauskirja n:o 5. 1976).

Tampereen kaupungin Tilastollinen Vuosikirja. (1979). Tampere.

Tannenbaum A., Control in Organizations. New York.

Tilastokeskus (Central Statistical Office of Finland). (1981), Suomen Tilastollinen Vuosikirja 1980 (Statistical Yearbook of Finland 1980). Helsinki.

Townsend P., The concept of poverty. Working papers on methods of investigation and life-styles of the poor in different countries. London. Heinemann.

Tuomi J. (1978), "Sosiaali- ja terveydenhuoltojärjestelmien yhteistoimintamuodot" (in: Isokoski M (toim.), Sosiaali- ja terveydenhuollon yhteistyö. Tampereen yliopiston Kansanterveystieteen laitoksen opetusta koskevia julkaisuja 9. Tampere.

Vainio P. (1981), Päihdehuolto ja sen yhteistoiminta Lappeenrannassa. M.A. thesis. University of Tampere 1981 (Unpublished).

Walls G. (1970), Asiakasdemokratia ja luokkasamaistuminen. Tampereen yliopisto. Sosiaalipolitiikan laitos. Tutkimuksia 14. Tampere

Walls G. (1970), Sosiaalihuolto ja oikeusturva. Raportti sosiaalitarkkaajien ja luottamushenkilöiden käsityksistä eri henkilökunta- ja asiakasryhmien oikeusturvasta ja sen loukkauksista virallisessa sosiaalihuollossa. Tampereen yliopisto. Sosiaalipolitiikan laitos. Tutkimuksia 17. Tampere.

Walls G. (1970), Sosiaalihuollosta kuultuna. Luottamushenkilöiden ja sosiaalitarkkaajien käsitykset suoriutumisesta huollon tehtävistä. Tampereen yliopisto. Sosiaalipolitikan laitos. Tutkimuksia 19. Tampere.

Walls G. (1973), Huolto-organisaatio ja työmotivaatiot. Tampereen yliopiston Tutkimuslaitos. D tiedotteita. N:o 54/1973. Tampere.

Walls G. (1980), " On the Equality Approach and the Problem of Influence" (in: Simonen L. (ed.) Working Papers. N:o 2.1980. University of Tampere. Department of Social Policy. Tampere.
a)

Walls G. (1980), "The Interrelations and Co-operation Practices of Social Welfare and Health Care on the Municipal Level in Finland" (in: Simonen L. (ed.) Working Papers. N:o 2. 1980. University of Tampere. Department of Social Policy. Tampere.
b)

Walls G. (1981), "Yhteistoiminta yhteiskuntatieteiden kehikossa" (in: Kuotola U.et.al. (toim.), Sosiaalihuollon näköaloja. Juhlakirja professori Reino Salolle. (with english summaries) Acta Universitatis Tamperensis. Ser. A. Vol. 127 Tampere.
a)

Walls G. (1981), "Mitä sosiaali- ja terveydenhuollolla on yhteistä" (in: Koskiaho B. et.al. (toim.), Tutkimus yhteiskuntapolitiikan viitoittajana. Professori Leo Paukkuselle omistettu juhlakirja 28.6.1981. Jyväskylä Studies in Education, Psychology and Social Research 42. Jyväskylä.
b)

Walls G. (1981), "Interaction Between Health and Social Service Delivery Systems in Finland" (to be published in: Hokenstad M. & Ritvo R. (ed.), Health Services and Social Services. Vol.5, Social Service Delivery Systems: An International Annual. Beverly Hills (Manuscript).

Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosille 1982-1986. (Luonnos) (Unpublished).

Waris H. (1980), Suomalaisen yhteiskunnan sosiaalipolitiikka: Johdatus sosiaalipolitiikkaan. Porvoo-Helsinki-Juva. W.S.O.Y.

Westrin C-G. (1981), Primary Health Care: Cooperation between Health and Welfare Personnel in Sweden. (Skaraborgs läns landsting. Sjukvårdsstyrelsen. Psykiatriblocket) Skövde.

WHO (World Health Organization). (1976), Expert Committee on Nursing: Fifth Report. Geneva. WHO Technical Report. Ser. n:o 347. Geneva.

V.P. (1980), "Sosiaalihuoltomme kunnallistaminen. Erään merkkipäivän problematiikkaa" (in: Sosiaaliturva n:o 7. 1980)

Vuori H. (1979), Lääketieteen historia - sosiaalihistoriallinen näkökulma. Jyväskylä. Gummerus.

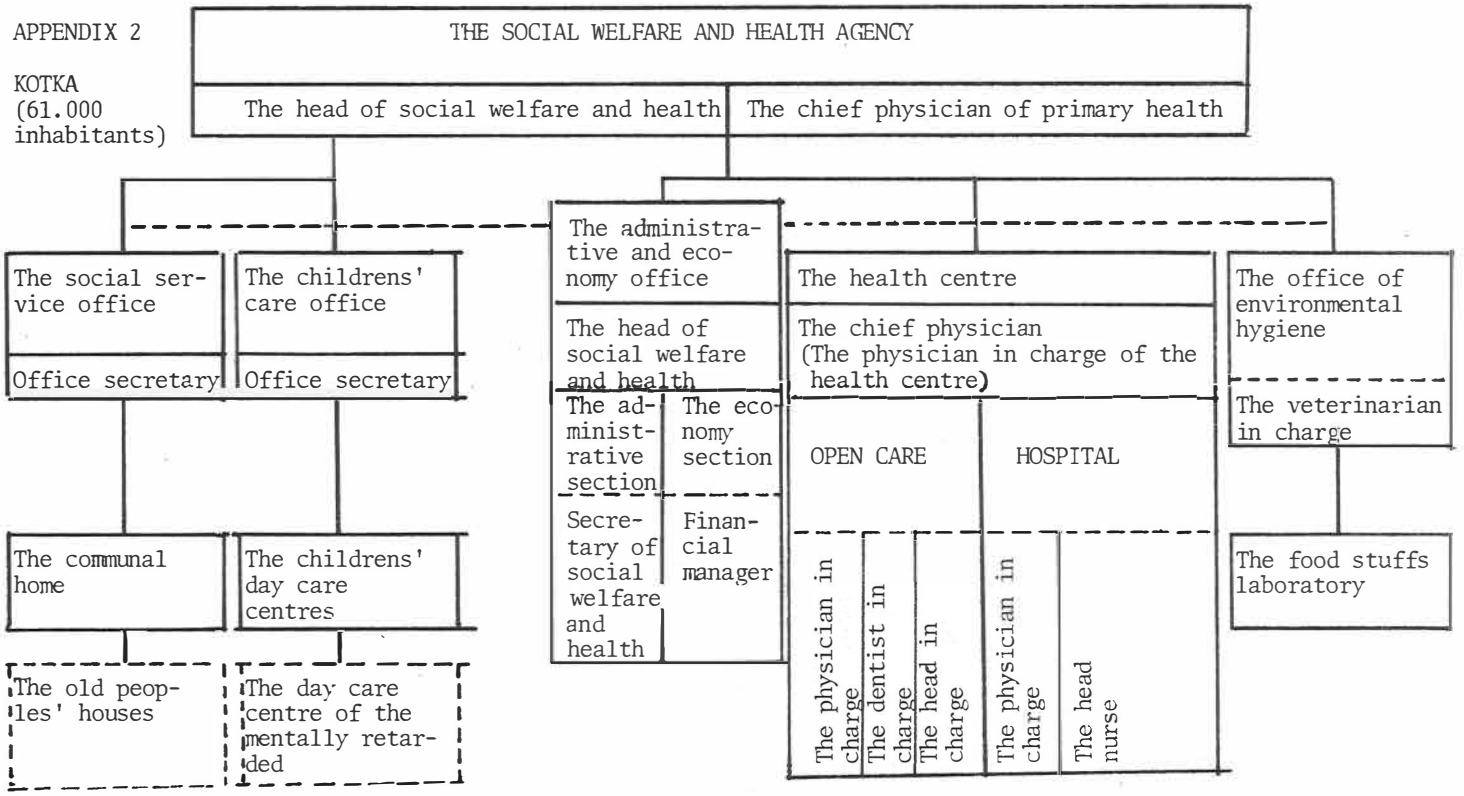
APPENDIX 1

PRIMARY HEALTH CARE: COOPERATION BETWEEN HEALTH AND WELFARE PERSONNEL. An international investigation of the structure and methods of inter-professional cooperation from the point of view of assessing their outcome. (Gaits et.al., ECSW R 10 (1979)

List of participants of the project:	Report nr (Order form)	
Mo, Linn, Report: NORWAY	ECSW R 10 (1980)	1
Sali, Yehudit, Report: ISRAEL	ECSW R 10 (1981)	2
Wells, Lilian, Report: CANADA	ECSW R 10 (1981)	3
Nuyens, Yvo, Foets, Marleen, Vallons, An, Report :BELGIUM	ECSW R 10 (1981)	4
Westrin, Claes-Göran, Report: SWEDEN	ECSW R 10 (1981)	5
Hallet, Christine, Stevenson, Olive, Report: UNITED KINGDOM	ECSW R 10 (1981)	6
Walls, Georg, Report: FINLAND	ECSW R 10 (1981)	7
Blanken, Karel, Report: NETHERLANDS	ECSW R 10 (1981)	8
Kosanke, Bodo, Report: FEDERAL REPUBLIC OF GERMANY	ECSW R 10 (1981)	9
Bartnik, Maria, Report: POLAND	ECSW R 10 (1981)	10

APPENDIX 2

KOTKA
(61.000
inhabitants)



APPENDIX

ILLUSTRATIONS[x)]

CASE I: COOPERATION DUE TO INVALIDITY PENSION CONSIDERATIONS

Male, 45, a teacher in a juvenile reformatory.

A lot of disorders of the vascular system in the family. Suffers from psychosomatic symptoms: vomiting, ulcer, migraine, psoriasis, etc. Also claudication.
5/78 A student makes an attempt to kill him. Cardiac symptoms.
7/78 infarct and a severe fear of death. Palpations, arrythmias takes nitroglycerin tablets.
7/78 An Invalidity Certificate from an internal specialist. Obvious symptoms of stress.
5/79 Patient requests for an evalution of his ability to work from a Mental Health Care Agency for the State Accounting Office and The Social Insurance Institution. Qualified as old for his age, overweight extremely distressed and weeps frequently. Doesn't concentrate or sleep, overaccurate, poor mental capabilities. Returning to work involves a risk to life. A refusal from the State Accounting Office; a complaint is sent to the Court of Administration. The SII grants a pension for a specified period.
8/79 Examined by an internal specialist; qualified again as permanently disable to work. A pension granted for inspecified period by the SII:
11/79 At the doctors consultation: patient cries, shouts, palpation etc. A new statement made about the pension; a stable pension is recommended, the statement is sent to the Court of Administration as a supplement to the appeal. The Court of Administration asks for statements from two more specialists; both in favor of the case. Lesion of

x) The cases are not "typical" but anyhow based on and selected from the acts of the Social Welfare and Mental Health Agencies of a medium-sized city in Finland. Two criteria were used: that of representativity from the point of view of cooperation and that of extremity in respect of the need of multi-problem approaches.

the brain confirmed. The statement is sent back to the State Accounting office for a new discussion.

Again rejected by the SAO. The patient undergoes a short state of delirium. The disorder of the vascular system impaires, a y-prothesis (arterial reconstruction) prescribed.

12/80 A legal council appointed by the Diet examines the decision of the State Accounting Office. A suggestion for new statement once again. A new permanent statement is made.

4/81 The State Accounting Office grants a pension for a specified period.

CASE II: COOPERATION DUE TO INVALIDITY PENSION CONSIDERATION

Female, 47, a designer in a textile company.

Recieved an Invalidity Pension granted on psychological grounds. Before the pension worked for the company for 18 years. Advanced from the machines to the designing post without special schooling by self-training and artistic capabilities. Has recieved psychoterapic treatment and various kinds of physical therapy. The pension was extended until 1979.

6/79 The Pension Foundation of the company did not accept the continuation statement. A complaint is sent to the Pension Board with an Invalidity Certificate from another psychiatrist as a supplement: patient qualified as permantly disable to work.

7/79 Recieved her tax book from the company while the complaint was in procession. Uncertainty about her housing provided by the employer; according to the employer working relations ended when the pension was granted, since no other work from the company has been recieved.

8/79 Recieved a recommendation for a National Old Age, Invalidity and Unemployment Pension granted for unspecified period. Recieves allowance for the first time in her life, cries a lot, is distressed.

3/80 The complaint is examined by the Pension Board; the decision of the Pension Funds is changed and it is made to grant her an Occupational Pension until 9/80. Plans for a continuation statement made.

4/80 Recieves information: the Pension Fund refuses to pay her regardless of the decision of the Pension Board and makes a complaint about the decision.

The representatives of the workers have been contacted about the case before the Fund's meeting. The Fund decides not to pay; makes a complaint to the Insurance Law with the majority of votes from the employers' side.

A complaint is made as a countermove on the patient's behalf, since the pension was granted by the Pension Board as one of specified period.

It has also been noted that the legal security of the patient has been violated, since the company has terminated the pension even though the

patient has shown no recovery.
The company's doctor of Industrial Health Service examines the patient for the first time and mentions that the pension will not be granted. This is done before the fund meeting has taken place. The Inspector of the Ministry of Social Affairs and Health for the Pension Fund has been contacted and the procedures of the Pension Fund has been noted.
6/80 Patient recieves a submission for hospital treatment: does not go.
1/80 Problems regarding the housing situation: 8/79 moved away from the housing provided by the employer to a friend's house, who is now selling her house and moving away. The patient has filled an application for community rental apartments.
4/81 The Insurance Law sends all the complaints to the police, who is to take them to the patient to read. The arrival of the police is a shock to the patient; she is too afraid to sign the notification. An arrangement is made between the patient and the police that the notification will take place at the Mental Health Agency. Impossible for the patient to read through all the papers while the police is waiting. Copies have been taken of the papers of the Pension Board and the patient is sent to the Juridical Office to prepare her own papers.
5/81 A new doctor's statement is sent to the Insurance Law; patient permanently disable to work.

CASE III: A CHILD PROTECTION CASE

4-year-old Matti has been a child protection case ever since he was 6 months old. Before that time he has been taken into custody of the Social Welfare Board and placed into a childrens' home already for two short periods, because the mother had left the family and the unemployed father was not able to take care of the child.

The partners were married close to the time of Matti's birth; the father for the first and the mother for the second time. The mother has three other children, one of which has foster parents, the other is taken care of by the grandmother and the third has been taken to a Social Welfare Board's childrens' home straight from the maternity ward. The youngest child was born when Matti was 18 months; both of these children are retarded. According to the doctor statement Matti's case is not actually mentally retarded, but it is caused more likely by the insufficient relationship and emotional ties between the child and his parents. During fits of rage he beats his head to the floor. As the situation has become better the symptoms have become less violent.

The family has recieved allowance during the years 1977-81. It includes financial and domestic help and day care places for the children. The social workers contact the family regularily and work together with the Newborn Care Centre and the Day Care Centre. The father took care of the boy quite well, however the parents were clearly immature to raise the children and their relationship was distorted.

In the beginning of this year the situation got so bad that the neighbours called for the police suspecting child abuse. The boy was taken to the hospital by the police and later on to a small childrens' home.

According to the doctor's statement the child had obvious injuries: a fracture line on the parential bone and facial injuries. It was confirmed that a small child is unable to cause such injuries himself. The father's explanation of the night's happenings were that the children had been playing together and Matti started beating his head to the floor.

The father was charged with child abuse and regardless of the father's request he was not given custody of the child. During the same time the divorce case was brought before the court.

The father was released of the charge in February by the Interior Court due to insufficient evidence. He recieved a fine for disturbing the neighbours. After the negotiation of the hospital and the social workers the child was taken into custody without the father's consent; later on he submitted. The Social Welfare Board already had the approval of the mother.

The child is now in a small childrens' home, from where he will be moved to a special childrens' home.

CASE IV: DIFFICULTIES IN ACTIVITIES OF DAILY LIFE (ADL)

The patient is a 89 year old widower living downtown in an apartment with accomodations. Her husband died 1971 and her only son lives in another city about 100 km:s away. He visits her and takes her to his home every once in a while. The patient has bad eyesight, biliary symptoms (diet) and organic heart symptoms.

The patient is unable to take care of everyday things. Recieves domestic help from the Social Welfare board 3 x 2h/week. In addition a deaconess visits her regularily. She has only the old-age pension and has applied for a place in a home for the aged (400 other applicants).

The domestic help includes: cooking, personal hygiene, shopping, business, laundry and cleaning. No compensation is collected since she has no tax units.

The patient is lively for her age. Recieves the largest amount of domestic help provided by the SWB and if more care is needed she will be taken to the range of the Home Nursing Service.