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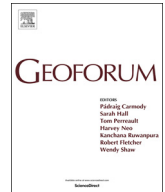
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The gradual city-ness and town-ness of public service locations: Towards spatially sensitive sector policies

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ABSTRACT

Location policies of public services such as health care have a great impact on urban and regional structures. Hence, we criticise the general failure of national public sector policies to account for regionally unequal conditions. Conversely, we question the sufficiency of current regional planning concepts for a spatially sensitive location policy of public services. In this theoretical-conceptual contribution, we review the literature on public service provision and the logics of public facility location systems, especially concerning their explanatory value under different regional urbanisation conditions. We reinterpret the conceptual limits of the prime planning concepts of ‘central places’ and ‘polycentricity’ – represented by their underlying spatial logics of hierarchy and complementarity – by employing the ‘central flow theory’ of Taylor, Hoyler, and Verbruggen. With the help of the ‘territory-place-scale-network (TPSN) framework’ of Jessop, Brenner and Jones, we perform a conceptual shift to ultimately outline an integrative ‘central places and flows planning approach’. It accounts for unequal regional conditions for public service locations, and thus manages to integrate economic, political, and spatial components of service provision. We illustrate the feasibility of the central places and flows planning approach using the case of the Finnish social and health care sector. The (failed) Finnish governance reform plans of 2015–2019 for the health care sector are a telling example of spatially un-sensitive sector policies. The reform plans wanted to advance free market elements and enhance the free choice of clients. These aims implicitly reinforced centre-favouring conditions at the expense of peripheral regions.

1. Introduction: context and research questions

This article analyses a recent attempt of rescaling the Finnish social and health care sector, which is an example of welfare state restructuring in the Nordic context. However, reaching beyond the case analysis, our contribution develops a theoretical-conceptual argument against the lack of cross-sectoral integration between social and health care policy and strategic urban and regional planning. Integrating the logic of public service provision into research on functional urban systems, the article arrives at a ‘central places and flows planning approach’, which will add the missing spatial component to the provision logic. This approach informs both future sectoral planning and urban and regional planning. In this section, we will first elaborate the context and then explain the methodological steps towards answering the research questions.

1.1. Regional rescaling and welfare state restructuring in the Nordic context

The territorial governance structure of the Nordic welfare states has

traditionally been unitary and bipolar, with a strong nation state and even stronger local authorities, while a regional level in-between has only been of marginal importance (Nadin and Stead, 2008; Kristjansdottir, 2018). However, government-rescaling reforms have recently been initiated in the Nordic states, for example in Denmark, Norway, Sweden, and Finland (Moisio, 2010). They concentrate on sub-national levels of government to re-negotiate sectoral policy competences, for instance in social, educational, and health care sectors, between national, new regional, and local levels – at times accompanied by municipal mergers. Despite this, the regional level remains an immature tier of political experimentation, alternating between re-sizing, empowerment, and dismantling (Blom-Hansen et al., 2010). The fading of the clearly bipolar Nordic system corresponds to the general trend of urban, regional, and national state space rescaling in Western Europe (Brenner, 1999, 2004; Bäcklund et al., 2018). Baldersheim and Rose (2010, 2) interpret such rescaling and resizing of sub-national administrations as a continuous struggle “to achieve a better fit between the scale of governance and the scale of problems in the field of local and regional government in European countries”. Major state economic

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rationales behind the Nordic rescaling reforms include limited public budgets coupled with a neoliberal state agenda oriented towards competitiveness. The latter has superseded Keynesian models that aimed to achieve equality in local living conditions and welfare service provision across state territory (Jauhiainen, 2008; Kivelä and Moio, 2017; Martinelli et al., 2017).

In this transformation of the welfare state, social and health care services have become prime objects of rescaling and governance reforms (Kazepov, 2010; Kivelä, 2018). However, the spatial implications of such reforms are rarely considered. While attention is given to socio-economic inequalities in service provision, territorial inequalities are much less debated (Martinelli et al., 2017). Social and health care policy also lacks institutional cross-sectoral integration with spatial planning, among other sectors, although the organisation of social and health care service provision and its locational policies is peculiar in a spatial sense (Colomb and Santinha, 2014; Humer, 2014; Santinha, 2016). Furthermore, the health care sector represents a crucial aspect of the regional economy, labour market, and identity (Williams, 2017) and is a key part of the foundational economy that stabilises cities and their hinterlands (Bowman et al., 2014; Engelen et al., 2017). Therefore, we call for a deeper consideration of the spatial aspects of social and health care sector development and reforms.

We draw attention to the spatial aspects of social and health care sector reforms by discussing the ongoing and protracted social and health care sector (SOTE) reform in Finland. Until March 2019, when the core content of the reform quite suddenly changed with the election of a new government, its central aim was to rescale the SOTE service organisation from the local to the county level, which is to be created in the course of the reform, and to increase flexibility on both sides of service provision, that of provider and patient. This paper discusses the SOTE reform plans of the Government which were operational from 2015 to 2019. Its political rationale reflected the Finnish state transformation from a welfare-oriented cartel model to a corporate state model concentrated on competition (Ahlqvist and Moio, 2014).

Although the existing socio-spatial structures of the state were to be reconstructed during the SOTE reform, (Kivelä, 2018, 161), much of the debate around the reform plans focused on the reshuffling of public, private, and third sector roles as well as on financing and administrative duties of the to-be-established counties. However, deeper spatial implications have remained undebated, despite the fact that governance reforms in other Nordic countries were found to have significant spatial-conceptual implications and to result in a “radical shift away from the idea of service provision and the logic of hierarchical territorial positioning towards [...] networked territorial dynamics” (Galland and Elinbaum, 2015, 81). Moio and Paasi (2013) have illustrated that the territorial service provision logic of the welfare state, which was built on a hierarchical system of central places, has been replaced with the logic of economisation of space in Finland, too. This new logic emphasises competitiveness as well as networking of the largest urban regions and some corridor-like economic zones in-between (cf. Luukkonen, 2012; Kalliomäki, 2012). However, Kivelä (2018, 163) argues that the hierarchic, harmonised, and equity-oriented health care system established during the 1970s and 1980s has largely resisted such change, despite restructuring efforts. Indeed, the emerging networked territorial understanding seems to be in unresolved tension with traditional state-territorial politics of health service provision (Moio, 2018, 4). We argue that the planned major state-orchestrated SOTE reform was about to introduce an economically oriented, networked territorial logic into the social and health care system, and that the spatial implications of such a reform should be heeded.

1.2. Sectoral governance and its spatial aspects

Considering the extreme territorial diversity of Finland, this paper has the immediate aim of drawing attention to the lack of an urban and regional planning perspective in the previous Finnish health care and

social sector governance reform plans. However, the broader aim of the paper extends well beyond this particular case. While sector policies can be criticised for being spatially blind, strategic spatial planning can also be criticised for not addressing spatial implications of sectoral policies adequately. Therefore, we question the impact of sector policy under regionally distinct rural and urban conditions, and conversely, we question the way in which spatial planning concepts comply with different sectoral governance modes. Recognising the communicative and transformative power of strategic spatial planning concepts (Albrechts et al., 2003, 128; Dühr, 2007; Throgmorton, 2003), we ultimately aim to enhance public sector policies by incorporating a spatial conceptualisation. In order to achieve this, we seek to answer one theoretical and one normative question:

Q1: How does the spatial organisation of social and health care services theoretically relate to (a) state/market governance rationales and (b) different types of regional urbanisation?

Q2: What spatial implications do the Finnish social and health care provision reforms entail?

To approach these questions, we closely examine regional science literature related to questions of service locations (Section 2). On this basis, we develop a theoretical conceptual framework (Section 3). Taylor, Hoyler, and Verbruggen's (2010) ‘central flow theory’ and its inherent nuanced understanding of the ‘city-ness’ and the ‘town-ness’ of a place will be of particular importance. Furthermore, the ‘territory-place-scale-network (TPSN) framework’ of Jessop, Brenner, and Jones (2008) supports a shift in conceptual perspective towards an integrative ‘central places and flows planning approach’. Equipped with this framework, we analyse the Finnish SOTE reform plans and their spatial implications (Section 4). We conclude that the ‘central places and flows planning approach’ may also work for sector policies other than social and health care, such as transport, education, and housing. Generally, it supports spatially sensitive sector policies but also sector sensitive spatial policies (Section 5).

2. Theoretical-conceptual background

In this section, we will discuss the theoretical background of public service provision and its spatial logic. The section starts by introducing public services and their distinct logic of state provision – in opposition to the market-driven provision of goods and services – which alters the preconditions of the spatial location of services. Subsequently, we discuss health care services as public services and the applicability of the logic of state provision. We then turn to discussing the location systems of public services, and the location theories that have come to instruct public policies of service provision, especially that of health care services.

2.1. Public services: (non-)market logic, spatial locations, and planning

The organisation of public services, including their location in space, is different from that of commercial services, the location of which is determined by the market. According to Teitz (1968), the principal difference in location choice between public and market-based services is that the location of each service on the market is a single decision by one profit-seeking entrepreneur while the location of public services is a systemic decision by the state, which decides on the location of multiple services. Furthermore, a satisfactory supply of public services for the population is not provided by a single service facility but by a whole system of different service facilities of an identical or similar type.

Speaking geometrically, the catchment areas of these public or private service facilities commonly take the form of a network or a point pattern (Teitz, 1968, 39). Nevertheless, flows and dependencies are also present in point-representable systems through the networks of

supply and demand. These networks, the costs of services, and the variety of functions they perform, all add a hierarchical property to systems (1968, 40). For example, in a health care system, primary treatment facilities should be equally dispersed across a given territory because of their being permanently demanded by ‘everybody’. A facility offering a highly specialised service, instead, is most efficiently located where it serves closest to a maximum of clients and where it enjoys synergies with other services. Therefore, it serves a much wider catchment area than a facility that offers basic treatment. Nevertheless, the public budget and eventual clients’ costs of access ultimately define the availability and density of the public facility system. On this basis, the location of service facilities appears to be an economically rational decision, based on considerations of optimal service design.

In advancing Teitz’s (1968) theoretical foundation, Dear (1978) claims that the objective of efficiency is in a trade-off with considerations of equal provision of services for the population. Therefore, the location of public services is ultimately a political decision, as “equity is high and efficiency is low in a system of closely-spaced centers; and equity is low and efficiency high in a widely-spaced system” (Dear, 1978, 95 with reference to McAllister, 1976). Further, Dear (1978, 96) argues that in order to grasp this political dimension, a ‘procedural’ component, which refers to political and administrative considerations, should be recognised alongside a ‘substantial’ component, which builds on the inherent character of differences in supply and demand of a given service. For example, services offered by hospitals have a different substantial character than that of services offered by schools, given the differing needs of their clients and the nature of their service delivery. However, the substantial supply and demand patterns of hospital or school services are not defined by provision systems alone. Political decision making, which is normative and ideological, also plays a role. The question whether a regulative or a liberal understanding of governing public service sectors prevails is an example of such political influence. Indeed, political considerations might be in tension with finding a system of locations just on grounds of substantive or objective considerations. Dear’s important critique of Teitz’s theory activates the social and political realm. Nevertheless, they both argue that assigning public facility locations requires a theory different from the location theories of private market services.

2.2. Health care services: a hybrid of public and private provision

The question whether health service provision ought to have public facility (procedural) or private market (substantial) location designation is not easy to answer. Today, in the European context, social and health care services are included in the notion of Social Services of General Interest (SSGI) and thus exempted from European single market conditions on the EU level. Nevertheless, this notion does not automatically declare them as ‘public services’, since it is not defined whether SSGI should be organised exclusively through public or through (partially) private provision. The social and health care services in many member states nevertheless are still primarily of a public nature, however with shared public-private contributions in terms of finance and provision (Humer et al., 2013). If an EU member state decides to allow SSGI provision by private providers, the service becomes subject to the EU competition rules, which are already imposed on services under the category of Services of General Economic Interest (SGEI). The latter includes transportation, postal, and telecommunication infrastructure (Colomb & Santinha, 2014). Then, state aid and non-discriminatory procurement rules apply to every service provider, regardless of its public or private/for-profit character.

Today, in practice, the organisation of services increasingly follows both the market and state-controlled logic, in terms of ‘hybrid governance’ modes of public-private partnerships. According to Johanson and Vakkuri (2017), the level of a hybrid public-private organisation of services depends, in managerial terms, on type of ownership, goal-orientation, as well as funding and control mechanisms. In spatial terms,

the location of services under hybrid governance modes is likely to be different from that of purely public services, as described in Section 2.1. Concerning the location of public services, Humer (2016, 182) – studying the primary health care organisation in Austria – found that service locations are organised hierarchically when public sector strategic planning aims for the equal distribution of services for the population across the territory. Contrarily, Meijers (2007a) found that in a case of comparably liberalised SSGI of tertiary education and hospital care in the Netherlands, efficiency is sought through a network model that offers complementary services in a clustered, polycentric system. Goodman and Smith (2018) furthermore showed that in a liberalised system it is the sum of individual, private decisions of health care professionals on location that results in a network system of service locations – one that is different from the system that would emerge under a common public rule. These studies suggest a correspondence of pure public services with the aim for equal distribution of services whereas the liberalised systems correspond with a network logic of efficiency. To deepen our understanding of the different spatial organisation models, we now continue to explain the location theories that have informed these policies, namely the central places theory and the city-network theory.

2.3. Location systems of (public) services: a question of hierarchy and complementarity

Developing his ‘central places theory’, Christaller (1933) enquired why cities of differing size and importance are distributed in a certain urban system. He defined a systematic positioning of cities, which assures the best accessibility to services (for consumers) and the best reach of services into the hinterland (for providers). The services themselves display different levels of ‘centrality’ based on demand, which varies from basic, daily demand to less frequent, yet specialised, demand. Based on the full catalogue of basic and specialised goods and services – and their respective level of centrality – a certain ‘central place’ level can be assigned to a place within an urban system. Thus, centrality is a question of range and thresholds of services, and, respectively, the level of specialisation and complementarity of service providers (Van Meeteren and Poorthuis, 2018, 130).

Lambooy (1969, 141) further developed the conceptualisation of a central place. Instead of a single place or core city, an urban region may increasingly be designated as a central place. Furthermore, he addressed the complementarity of services of various central places, which is a by-product of advanced suburbanisation and of the specialisation of sectors. Thus, one central place might be understood as a (supra)local network of service facilities in space or as an urban region. Nystuen and Dacey (1961) accordingly speak of ‘nodal regions’, which are defined according to the flow amongst places and not on the basis of administratively pre-defined regions (cf. Parr, 2014, 1927f). They state that “the nesting of cities defines the organization of networks of cities and the position of each city within the network” (Nystuen and Dacey, 1961, 32).

Christaller’s central places theory has mutated to inform public governments’ planning for public service location systems with the highest possible degree of equity. For regional planning purposes, his analytical theory was interpreted for normatively prescribing a hierarchical system of cities. It became widely applied in European spatial planning practice. In Finland, for example, the central places concept became an important instrument for spatial planning at regional and national levels in the 1960s. It was used as a device for distributing public services and as a result, for shaping the spatial structure of the state territory until the 1990s (Moisio, 2012, 148–150). However, it was used as a *normative concept*, which departed significantly from the original theoretical premises. As a normative concept, central places prescribe the centrality of cities and the catalogue of services these cities should offer on different hierarchical levels. From a planning viewpoint, the central places concept has been criticised for being

ineffective, centralizing, hierarchic, inflexible, and averse to private investment. Despite some incremental adaptations and innovations, the instrument is called into question for being unsuitable for addressing contemporary challenges, particularly in environments predominantly characterised by neo-liberal policy making (Meijers, 2007a).

In addition to the criticism of the normative central places planning concept, regional science literature has extensively discussed the theoretical shortcomings of the *original* central places theory with its neoclassical orientation (see for example Berry et al., 1988; Coffey et al., 1998; Parr, 2017). Points of criticism included, from a consumer viewpoint, the nearest-centre and the single-purpose-shopping hypotheses, and from a provider viewpoint, the monopoly-market-search and the dependent-location-finding hypotheses (Deiters, 1996). Blotevogel (1996) acknowledges all the main points of criticism but finds valid arguments in favour of the central places concept. It is at least integrative in character and enables the effective, non-redundant distribution of public services, particularly for general services on low hierarchy levels (Blotevogel, 2002; see also Taylor et al., 2010, 2807–9). Indeed, according to Parr (2017, 151), the central places theory only “represents one component of a more extensive urban system” and thus, as a location theory, it cannot alone fully explain contemporary urban systems.

Regardless of its being called a paradigm shift or not (Meijers, 2007a; Shearmur and Doloreux, 2015), the ‘city network theory’ aims to explain the other components of contemporary urban systems and respond to the theoretical criticism against the central places theory. Indeed, according to the city-network theory, the character of city relations is complementary, non-hierarchical, flexible, and market-efficient – in the sense of economic geography, comparable to firm networks on the market (Camagni and Capello, 2004; Camagni and Salone, 1993). Nodes of the network specialize in certain services and interact with each other, confirming arguments of agglomeration advantages. For Capello (2000), the networked city is a consequence of innovation and the rapid technological transformation of the economic world, summarised in the concept of ‘globalisation’. While greater metropolitan areas inherently function as hubs of the globalised world, cities of intermediate size increasingly also aim at joining the globalisation process and gaining regional externalities by increasing their critical mass through networking with other cities and by doing so, dissociating themselves from their immediate hinterland (Castells, 1996).

Whereas Christaller’s central places theory came to inform the normative planning concept of central places aiming for a hierarchy of service locations, city network theory came to inform the normative planning concept of polycentricity. It is a planning concept that prescribes sharing service functions between locations in a clustered, complementary manner. After the European Spatial Development Perspective (CEC, 1999) introduced such a polycentricity concept, it was adopted by many national spatial planning agendas in Europe, aiming for polycentric development on national, regional, and city-regional levels (Waterhout et al., 2005; Schmitt, 2013; Granqvist et al., 2019). Davoudi (2003) explains that the normative content and application of the concept vary by degrees at intra-urban, inter-urban, and inter-regional scales; three scales which Van Meeteren et al. (2016) confirm in their scientometric review. To some extent, the concept shares the transdisciplinary fate of central places: polycentricity becomes an ambiguous term that serves (i) as a normative aim for the future in regional development and at the same time (ii) as an analytical model to describe urban-regional structures (Rauhut, 2017). That resembles the differences in the logic of ‘substantial’ and ‘procedural’ components (cf. Dear, 1978).

Analytically, the distinction between morphological and functional regional polycentricity is important (Burger and Meijers, 2012). The former concerns the internal centrality, ‘nodality’, or absolute importance of a city, while the latter additionally concerns the external ‘centrality’ or relative importance of a city compared to other cities of a

region. A solely morphological polycentric structure does not reveal the degree to which the cities of a region are connected. Functional economic, governance, and cultural integration form the prerequisites for a well-performing polycentric urban region (PUR) (Meijers et al., 2018). Regarding complementarity as a key feature of polycentricity, Meijers (2005, 769; 2007b, 891) declares two preconditions. The centres must differ in terms of services offered, and their geographic market area must at least partly overlap. Thus, there is a conceptual limit to polycentricity in terms of density and accessibility. Confirming this, Vasanen (2012) found that the polycentric network does not reach far into the hinterland, even in the largest Finnish urban agglomerations.

These limits have also been acknowledged regarding the normative concept of polycentricity. Humer (2018) and Luukkonen (2012) for instance accentuate the conceptual limits of the normative spatial planning concept of polycentricity towards the periphery. In their study of peripheral Eastern Finland, Eskelinen and Fritsch (2009, 617) conclude: “some peripheral and genuinely rural areas are beyond the reach of polycentricity-based strategies, since they do not belong to any urban region’s sphere of influence.” Indeed, it seems that a functioning polycentric network would need a certain minimum degree of urbanisation and accessibility. In the next sub-section, we turn to discussing these qualities, relating the provision logic and location systems of public services to different regional conditions.

2.4. The correspondence of the (non-)market character and location systems of public services: a question of the type of region

The previous sub-sections suggest a connection between the market logic of service provision and the degree of urbanisation of a region; the link between these two is the form of a service location system, which refers to density, equality, and complementarity of point-patterns in a network. Many studies explicitly highlight the connection. For example, Humer and Palma (2013) found that state-protected SSGI – such as education and health care – are of relatively higher importance to less-urbanised regions than to urbanised regions. Conversely, liberalised, technical network SGEI – such as transport and ICT infrastructure – perform relatively more efficiently in densely urbanised regions. Not surprisingly, densely urbanised regions therefore are attractive for profit-seeking private providers (Colomb and Santinha, 2014, 471). Consequently, a clustered, polycentric network model will be more likely in urban regions, while the equal distribution of basic services under public auspices is of higher value in rural, peripheral locations (Burger and Meijers, 2012, 1130; Taylor et al., 2010, 2807).

Indeed, in non-urban regions, service providers face critical-mass problems and seek for non-redundant minimum provision, often through a systematic distribution over a given territory. As such, public service provision would follow the logic of the normative central places concept. However, a central places-oriented planning practice can also only provide public services sufficiently in rural regions if there are (small) urban centres with fair transport accessibility (Maly, 2018). Regarding a polycentric network model, metropolitan areas with a dynamic, urbanised character can exploit the complementary, competing nature of a variety of service locations. This implies a higher variety of services and more – as well as more unevenly distributed – service locations that complement each other’s spectrum of services. Nevertheless, a polycentric, networked model does not automatically guarantee an efficient provision of services, but rather needs integrated regional governance for exploiting network advantages (Meijers et al., 2018). On these bases, substantial and procedural aspects of locating public services (cf. Teitz, 1968; Dear, 1978) to a serious degree seem to be conditioned by the regional type of urbanisation.

3. Towards a gradual concept for locating public services

It became apparent that neither of the two theoretical extremes – hierarchy and complementarity – provide a convincing spatial vision

for organising public services across a state territory displaying diverse regional conditions. A combination of the two – depending on the degree of urbanisation of the regions and on the degree of liberalisation of their social and health care service sectors – appears to be the most fruitful. Therefore, we will now offer a solution to the contradictions of the traditional location theories. For this purpose, we shift our conceptual perspective towards the role of service locations within a provision system.

3.1. Limits and potential of hierarchy and network thinking

Central places and polycentricity have proved unsatisfactory as prescriptive normative planning concepts. Their limitation lies in their respective extreme positions. A fully functional polycentric region would display no hierarchy of places, but only equally important, complementary cities with exclusive special functions. This theoretical extreme case would, however, not be desirable, for ecological and organisational reasons (Green, 2007, 2089). Given that extreme case, functional polycentricity is connected argumentatively, though as an ideal-typical counterpart, to the theoretical opposite extreme situation of central places, the ‘successively-inclusive hierarchy’ (Parr, 2017, 5f). In such a hierarchy, every central place of a higher order would contain all types of the services that are offered by a central place of a lower order, or more. This theoretical extreme becomes increasingly irrelevant in advanced urban economies (Van Meeteren and Poorthuis, 2018, 131). Therefore, instead of pointing to the theoretical extreme poles, a search for the relation of hierarchy and complementarity promises new insights.

One such attempt to re-link central places to city network theory, approaching them rather as two complementary poles than as opposing poles, is the ‘central flow theory’ of Taylor et al. (2010). Drawing on Castells’ (1996) distinction of places and flows, they suggest a theory that distinguishes the external relations of an urban centre (central place) into two features: ‘town-ness’ and ‘city-ness’. Whereas town-ness refers to the function of a central place towards its hinterland, the city-ness of a place stands for the hinterland-dissociating relations and positions in inter-urban networks. While all urban places carry both features, the former is predominantly of constitutive value for small places, and the latter for larger urban centres (Taylor et al., 2010, 2810). From this, Taylor et al. (2010) derive their interlocking network model, building not only on nodes (i.e. cities) and networks (i.e. flows), but also on sub-nodes. Sub-nodes are network agents (i.e. service firms) that interlock the nodes (i.e. cities) dyadically, for instance connecting them directly to each other through their various international offices. Thus, Taylor et al. ultimately see city networks – expressed as central flows – and central places as complementary to each other. Their difference is a matter of “analytical priority: in central place theory, places make flows; in central flow theory, flows make places” (Taylor et al., 2010, 2815).

3.2. City-ness and town-ness: a re-conceptualisation of (public) service locations

On a theoretical level, Taylor et al. (2010) complement central place theory with central flow theory. Likewise, on a normative conceptual level, this supports a spatial, integrated vision – arriving at a ‘both-and’ normative spatial planning concept of vertical hierarchies and horizontal complementarity. For our purposes, the ‘sub-nodes’ referred to by Taylor et al. are the (public) service providers. These providers have a certain location, a certain relation to the hinterland as well as non-local relations in a network. Thus, they enable the integration of two inherently opposite planning ideals, hierarchy and network, into one ‘both-and’ integrated planning concept through the socio-spatial conceptual lens of ‘place’.

The theorizing of Jessop, Brenner, and Jones (2008, 395) on polymorphic, socio-spatial relations offers us a set of heuristics to interrelate

and re-interpret the city-ness/town-ness-related dimensions of hierarchy, complementarity, and location through the TPSN (territory, place, scale, and network) framework. The TPSN framework is a grid and presents the vertical axis T, P, S and N as ‘structuring principles’ that impact the horizontal axis T, P, S and N as ‘fields of operation’. The original purpose of the TPSN framework is twofold: first, to point out – not to resolve – one-dimensionality in socio-spatial thinking (for example, container-like scalar thinking). Second, it aims to point out eventual contradictions among complex socio-spatial conditions. In such conditions, one structural principle affects one field of operation. Thus, conditions become two-dimensional.

In the study at hand, we certainly encounter the problem of two-dimensionality. We have identified two structuring principles, not one, which creates a lack of conceptual clarity. We have elaborated complementarity (which is of a ‘network’ dimension in TPSN terms) and hierarchy (which is a ‘scalar’ dimension in TPSN terms) as two mutual structuring principles. Both identify public service location systems through node or point patterns (which is a ‘place’ dimension in TPSN terms) as one field of operation. By introducing central flow theory, we add the dimension of sub-nodes, which is represented by the TPSN dimension of ‘place’. That might appear as another increase of complexity; however, we additionally change the direction of perspective within the TPSN framework. We choose ‘place’ – i.e. location, (sub-) node – as our singular structuring principle that operates, through the two fields of city-ness and town-ness, in the fields of ‘network’ and ‘scale’. Fig. 1 illustrates the shift, which ‘downgrades’ scalar and network thinking from structuring principles to fields of operation. Instead, place-thinking is ‘upgraded’ from a field of operation to a structuring principle. In doing so, we no longer think according to the two different structuring principles of network and scale. For this interpretation, Jessop et al. (2008, 395) exemplarily suggest analysing divisions of labour (place → scale) and forms of governance (place → network), which are likewise relevant to the procedural and substantial (Dear, 1978) questions of organizing public service locations in space.

A city/central place is the location of service provision, characterised by the organisational modes of its sub-nodes/agents, which are the actual service providers. In fact, places harbouring service facilities carry features of both: city-ness and town-ness. Taylor et al. (2010, 2815) describe agents as advanced producer and service firms that dyadically interlock the service places. In the particular case of social and health care service provision, the sub-nodes/agents would be providers of various, mostly hybrid, kinds of services of commercial, public, or other non-profit character that together create a certain governance mode for a place.

3.3. Components and character of a ‘central places and flows planning approach’

Fig. 2 concludes the theoretical-conceptual elaboration of Sections 2

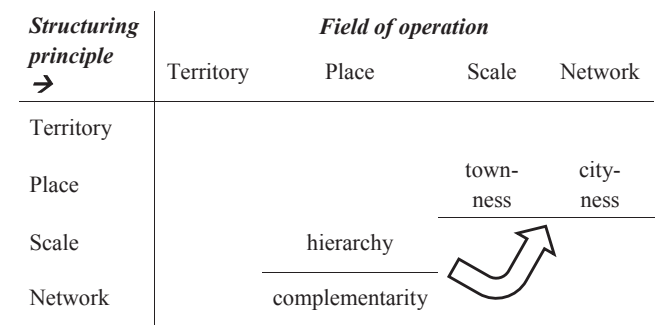


Fig. 1. Changing conceptual perspectives from two opposing structuring principles (scale versus network) to one common structuring principle (place). Source: own elaboration, modified after Jessop et al. (2008) and inspired by Taylor et al. (2010).

Components of service provision		Gradual character of service places	
		<i>Town-ness</i>	<i>& City-ness</i>
↑ ↓ ↑ ↓	Substantial/ economic	Public	& Private
	Hybrid market forms	Basic	& Specialised
	Procedural/ political	Equal	& Efficient
	Normative goal orientation	Regulative	& Liberal
	Spatial/ urban-regional	Hierarchic	& Networked
	System logic of locations	Place/point	& Node/flow

Fig. 2. Components of service provision, related to the character of service places. Source: Authors' own elaboration.

and 3. It presents a framework for analysing the provision of public services under their known substantial and procedural components (cf. Teitz, 1968; Dear, 1978; Johanson & Vakkuri, 2017), and newly adds a spatial system component to them (cf. Christaller, 1933; Green, 2007; Parr, 2017 in Sections 2.3, 2.4 and 3.1). The conceptual glue between the three components is the gradual town-ness and city-ness of service locations, as elaborated above in accordance with Taylor et al. (2010) and re-conceptualised in the TPSN-framework of Jessop et al. (2008). This conceptual approach that ties the substantial, procedural and spatial components together through the character of service places, we call the 'central places and flows planning approach'.

The central places and flows planning approach, summarised in Fig. 2, helps us to deconstruct the components of a particular sectoral service system; in this study, it will be the Finnish social and health care system. We can comprehend its spatial implications (on a regional systemic level) through the metaphor of town-ness and city-ness. The spatial component of service provision that we add alongside the substantial and procedural components is sensitive to urban-regional settlement conditions. How 'wide' a service location system is, and which absolute and relative position its points/nodes have, depend on population density and distribution – in other words, on the degree of urbanisation of a region. A service location system with a 'town' character thereby accentuates the absolute importance of places, that is, the internal centrality of a place in a region directed towards its hinterland. A service location system with a 'city' character accentuates a nodal, functional (polycentric) understanding and the flows between nodes, that is, the external centrality of a service location. The latter is typical for dense, possibly clustered service location networks in highly urbanized regions (cf. Burger and Meijers, 2012). Furthermore, vertical and horizontal relations between service locations as well as between a service location and its hinterland develop within local, but also supra-local/city-regional levels (cf. Lambooy, 1969) and are likewise subject to the degree of urbanisation of a region. Ultimately, the components of service provision and their various features, as summarised in Fig. 2, do add to the gradual town-ness or city-ness of a service location. The conceptual link between town-ness and city-ness ties the substantial, procedural, and spatial components together.

4. Case analysis: spatial implications of the previous regional governance and social and health care (SOTE) reform plans in Finland

Equipped with the theoretical-conceptual framework (Fig. 2), in this section, we interpret the spatial implications of the previously proposed Finnish SOTE reform plans. These deeper spatial implications of the reform that go beyond territorial rescaling in terms of establishing SOTE counties, (i) derive from the components of service provision; concretely, the hybrid market form, the normative goal orientation, and the system logic of locations; and (ii) culminate in the gradual town-ness and city-ness of a service place.

The case analysis includes the SOTE reform plans of the government, in office between 2015 and 2019. The aim of the reform plans was to provide equal accessibility and availability of SOTE services,

reduce inequalities in the health and wellbeing of the population, and to reduce costs of the SOTE service provision. Although consecutive governments of Finland have been preparing the SOTE reform for over 15 years with rather similar aims, we focus on this particular period for two reasons.

First, the government elected in 2015 started to pursue a supra-local, county-based SOTE reform, and supplemented it with a broader state-regional administration reform (Government of Finland, 2015). This introduction of a county-based SOTE and governance reform presented a significant change in comparison to the preceding plans, which had aimed to reform the provision of public services by creating stronger and larger municipalities (e.g. HE 324/2014vp, 2014; Law 169, 2007). The new reform plans foresaw, instead, a formal rescaling of competences for organising and providing social and health care services away from the 190 municipalities (or, occasionally, joint municipal cooperation) to 18 new county governments (Government of Finland, 2018). These county governments were to be established as a third tier of elected government between the local and the national level in the course of the reform. Until the reform, regional governance has not been independent, and the regional hierarchy of health care has consisted of the nation-wide network of municipal health centres alongside the previously developed network of hospitals comprised of university, central, and district hospitals (Kivelä, 2018, 163–4). Thus, the reform presents a significant change to the existing system of the public social and health care sector, characterised by the withdrawal of competences from local governments, considered as a unit too small and weak to organise SOTE services in the context of contemporary state economics (HE 15/2017vp, 2017).

Second, the government elected in 2015 introduced the aim of significantly increasing the diversity of service provision by opening the provision of services currently provided mainly by the public sector to private and third sectors as well as entitling the citizens to choose freely between these different providers (HE 15/2017vp, 2017). As such, while the public sector would continue to be responsible for organising the services, it would not continue as the main provider of the services. While the political aim of the government was to pass the legislation before the end of its term (Government of Finland, 2015), the law proposal failed, primarily because of constitutional complications surrounding the opening of the provision to private and third sectors and increasing the freedom of health care choice. Consequently, the government resigned just ahead of regular elections in April 2019. While the left-centre majority government elected in 2019 has continued to pursue the central objectives of the preceding centre-right majority government, it abandoned the controversial plans of liberalising the provision of services and increasing health care choice. Instead, government now focuses on improving the current system based primarily on public provision (Government of Finland, 2020). Therefore, the reform plans of the period between 2015 and 2019 can be seen as a bold historical attempt to reshape the logic of service provision that failed – for the time being.

We examined official documents related to the SOTE reform for the period 2015–2019. These included seven communications on government policy during the preparatory phase, ten government proposals,

six draft legal bills related to social health care reform with their supporting material, as well as four other official reports and evaluations related to the reform. We thus identified content in which the spatial implications of the reform were explicitly discussed as well as content with implicit spatial implications, dealing with the positioning of different service facilities. These were organised under the categories of the ‘central places and flows planning approach’, presented in Fig. 2. The categories included the three components of service provision, namely the substantial component (hybrid market forms), the procedural component (normative goal orientation), and the spatial component (system logic of locations). In the next sub-section, we separately discuss each of these three components contributing to the character of service places, which will reveal the spatial implications of the SOTE reform. Furthermore, we conclude the section by summarising these implications and discussing the gradual town-ness and city-ness of service places in SOTE counties.

4.1. Underlying spatially relevant features of the SOTE reform plans of 2015–2019

(a) Substantial component: hybrid market forms

For the substantial component, the assumption is made that the location of service facilities is determined by the economic service design, which varies for basic and specialised services and forms of service provision (cf. Teitz, 1968). Therefore, attention will be given to the public and private, that is, hybrid forms of service provision that the SOTE reform envisaged for the whole range of services, from basic to specialised.

The Finnish government of 2015–2019 assumed that competitive elements should be introduced into SOTE provision to increase the availability and quality of basic services while ensuring cost efficiency (HE 15/2017vp, 2017). The intention was that public, private, and third sector operators would provide publicly funded SOTE services. Opening service provision more broadly to private and third sector organisers would diversify and increase the number of service providers of basic health care and certain specialised care services (HE 16/2018vp, 2018).

In terms of the substantial component of service provision, the reform plans favoured the private provision of services, especially regarding basic services. According to the initial proposal (HE 47/2017vp, 2017), all publicly funded basic services were to be opened to competition so that public providers, namely the counties, could participate through their particular provision enterprises, operating on market principles. According to a government proposal (HE 16/2018vp, 2018), all providers were to participate in the competition on equal terms. They would have been required to offer the same selection of basic services in health centres that would have been the operational units of provision, and receive equal compensation on services provided. Nevertheless, there had been concerns that the provision would concentrate in “the hands of large multinational health companies, who focus on profit-seeking rather than on producing good health and well-being”, as Kivelä (2018, 165) summarises. The realisation of this concern was perceived to be dependent, on the one hand, on the criteria, specifications, and compensations which the counties pre-decide for service providers, especially small businesses (HE 47/2017vp, 2017). On the other hand, it would depend on the capacity of public providers to present their services as more effective and attractive for the patients (cf. HE 16/2018vp, 2018, 106, Kivelä, 2018, 165).

The reform related the diversification of service providers to the plan of extending citizens’ rights of free choice to providers from different sectors. Concerning basic care, this meant that patients would have been able to choose basic health service providers from among public, private, and third sector providers. In practice, clients would have signed up with the health centre of their choice (HE 16/2018vp, 2018). Although the formal purpose of the freedom of choice was

supposed to increase the equal accessibility and availability of services in a cost-efficient manner, it had also been interpreted as a political project to further the privatisation of the health care provision (Kivelä, 2018, 164–5). The strong emphasis on privatization revealed that the plans had favoured the city-ness of service places.

Although these aspects all favour the private provision of public services and the city-ness of service places, there is an argument for public provision, too. That, on the contrary, supports the ‘town’ character of service locations. Regarding basic services, the law proposal HE 16/2018vp (2018) stipulated that unincorporated county enterprises could provide services directly through public health centres, contrary to the initial proposal of subordinating them to the market. The amendment introduced the possibility of direct public provision in order to ensure service availability in counties where a SOTE market with private and third sector providers would fail to develop. Indeed, according to the assessment of the law proposal on freedom of choice (HE 16/2018vp, 2018, cf. National Institute of Health and Welfare, 2016), there was a risk that the market would fail to develop in some remote and sparsely populated counties. Overall, the opening up of service provision would have increased the number of providers and provision units, thus positively affecting the service network. These effects however probably would mainly concern urban regions where a network of private and third sector service providers as well as a large demand for services already exist. Thus, the role of counties as service providers would have been prominent especially in counties with poor prospects of establishing diverse service networks, and in remote or sparsely populated areas within counties (HE 16/2018vp, 2018). The public provision of basic services in these counties accordingly would favour the town-ness of service localities, although this was not intended in the earlier version of the plans.

As far as specialised medical and social services are concerned, public provision of services was to remain more prominent across and within counties. While the counties through their unincorporated county enterprises would have been the main providers of these services, the patients’ freedom of choice of these services would have increased. First, the patients would have been enabled to choose their unincorporated county enterprise nationwide and second, attain certain special medical and social services from private and third sector providers (HE 16/2018vp, 2018). For attaining services from private, third sector, or county providers, the counties could grant patients with so-called service vouchers and/or a personal budget. In addition to that, the private and third sector could participate in service provision in the role of a sub-contractor (HE 16/2018vp, 2018). Therefore, the role of private providers would also have increased in special medical and social services and thus, again, the decisions would have favoured the city-ness of service places.

(b) Procedural component: Normative goal orientation

The procedural component (cf. Dear 1978) concerns the normative goal orientation on a political level. The pursuance of goals, here equality or efficiency goals, also involves a decision concerning regulative or liberal policy approaches. The question of the quantity and uniformity of the distribution of public services among the population is a principal government decision. A liberal policy approach leads to a higher degree of diversity and complementarity of services, yet may lower the equity of service provision.

The normative-political goals of the SOTE reform were to provide equal accessibility and availability of SOTE services, reduce inequalities in the health and wellbeing of the population, and to reduce costs of the SOTE service provision. While the former two correspond with the normative goal of equality, the latter corresponds with efficiency. The central means towards attaining these goals were to be the shifting of responsibility, concentrating it in the counties (HE 15/2017vp, 2017), and the opening of publicly funded service provision to market dynamics, as discussed above. In governance terms, the reform fostered

devolution and liberalisation.

The SOTE and regional governance reform would have given a single administrative body at 'county' level responsibility for a number of currently predominantly municipal competences and would have equipped it with an own public budget through the national tax redistribution system (Government of Finland, 2018). These larger organisational units were to reduce regional disparities in service provision (HE 15/2017vp, 2017, 14). Those organisers who serve a larger population base and harbour more skills and knowledge were considered to have a greater capacity to assess service needs and to organise an appropriate service network, for example, by converging special services or distributing basic services in order to reach customers locally (National Institute of Health and Welfare, 2016). The larger organisational units were also to ensure greater efficiency, because they arguably would have utilised complementary specification better through creating service networks and economies of scale in service provision. The larger scale of production was meant to enable equalising the quality and content of services when higher service provision volumes enabled managing regional and local variations (HE 15/2017vp, 2017, 16–18).

Questions arose whether establishing counties in fact would help to diminish the disparities in access to basic health and social services (e.g. HE 16/2018vp). An evaluation of the law proposal (National Institute of Health and Welfare, 2016) pointed out that the counties were in different positions for organising equal access to services, because they varied not only in terms of their existing SOTE infrastructure, but also in terms of geographical size, settlement structure, and population development. All of this implied different service needs and varying potential degrees of service provision. Therefore, due to these differences, the disparities in access to basic services were likely to remain between and within counties (HE 16/2018vp, 2018).

The attainment of the cost-reduction goals would largely have been dependent on how the counties managed the organisation and steering of the service network, as well as on digitalisation. These factors would have been difficult to assess (HE 15/2017vp, 2017, 14–16). The counties had differing preconditions for attaining the efficiency goals because of the differences in private and third sector providers in their SOTE market. Furthermore, the differences in SOTE markets, which were likely to persist, would decrease the equality between citizens in access to services and attaining freedom of choice. Indeed, although the freedom of choice was likely to improve the equality between clients from different income groups, spatial equality was not likely to be achieved (HE 16/2018vp, 2018). Therefore, whereas from the perspective of the procedural component, the SOTE reform plans with their equality goals aimed at being supportive to service places with a 'town' character, those with a high degree of city-ness would have profited more from the reform plans. This is because the main tool for achieving the equality goals was to be the opening of publicly funded services to market dynamics. A liberal governance approach such as this favours the city-ness of service locations.

(c) Spatial component: System logic of locations

The spatial component of service provision concerns the urban-regional system of locations. Service places are situated in vertical hierarchies and horizontal network relations in a region and beyond (cf. Fig. 2). Service places of absolute importance directed towards their hinterland, thus with an orientation towards internal centrality, are considered to have a 'town' character. Service localities understood as nodes of a network and with a relative centrality also beyond their region are considered to have a 'city' character (cf. Burger and Meijers, 2012).

In principle, the autonomous counties would have been equipped with tools to plan the location of basic services systematically (HE 16/2018vp). A system abundant with private providers however is likely to favour central locations also beyond the region, and thus favour the

city-ness of service places. Indeed, it has been assessed (HE 16/2018vp, 2018) that the increase in private provision of services, in conjunction with the freedom of choice, entails the risk of cherry picking when service providers specialise to serve only certain population groups and as a result, cluster to locations where the network of providers is diverse. Such diverse, well-connected networks can be found in urban areas. Consequently, only five of the 18 counties were assessed to have the preconditions for the development of a diverse network (HE 16/2018vp, 2018). The most favourable conditions for organising an accessible basic service network are encountered in the most populous counties, which also host a university hospital. In remote and sparsely populated areas, counties could stimulate the private provision of services by compensating for location-specific conditions, thus allowing companies to invest in the renewing of premises and the updating of equipment in more remote and less profitable areas as well – to increase the absolute importance of a service location with 'town' character.

As discussed previously in connection with the substantial component of provision, the public provision of basic services would have been likely to play a significant role in less-urbanised areas with less diverse provider networks. Nevertheless, the counties would have had a high degree of autonomy (HE 15/2017vp) in defining the location systems of the services they would have provided. While the proposed reform pursued increased digitalisation and use of e-services (Government of Finland, 2018), the counties could integrate them with social and health services to provide the SOTE services equally and in full coverage (National Institute of Health and Welfare, 2016) despite a 'wide' service network. This would potentially have increased the connectivity, flows, and relative centrality beyond the own region, and thus the city-ness of a service place.

The location system of the special medical and social care, which would primarily have been provided by the public sector, would have followed a predominantly vertical location logic, typical for service places with a 'town' character. The counties were to centralize the provision of fewer, larger units with a wide reach on clients when the provision of these services required specific investments and skills. The number of hospitals was consequently expected to decrease, which would have led to a 'widening' of the location system (HE 16/2018vp, 2018; HE 15/2017vp, 2017; National Institute of Health and Welfare, 2016). The most demanding specialist emergency care would have been concentrated in 12 hospitals, whereas the remainder of the central hospitals would have continued to provide complementary specialised and basic health care as supplementary centres of the network beyond single SOTE regions. Formally, the reduction was to improve the quality and accessibility of services because centralisation would ensure the long-term availability of services (HE 15/2017vp). However, Rehunen et al. (2016, 4) have illustrated that the accessibility of hospitals would have been significantly poorer than currently is the case. This would particularly have affected remote areas and counties without specialist emergency hospitals.

Overall, from a spatial/urban-regional perspective, the SOTE reform plans principally allowed for a gradual degree of town-ness and city-ness of service locations. Yet, it becomes evident that a single-component view does not offer an exhaustive perspective on the complete situation. For example, it depends on the public or private dominance of service providers whether a predominantly hierarchic or horizontal network approach emerges in a SOTE county. Section 4.2 will therefore combine the three points of analysis.

4.2. Interpreting the town-ness and city-ness of SOTE service places

In this sub-section, we will take account of the inter-linkages of the three components of service provision – indicated by the arrows in Fig. 2 – and thus provide a combined interpretation. According to the previous sub-section, the SOTE reform plans of 2015–2019 entail various – at times discordant – characteristics of substantial, procedural, and spatial components. Each of these characteristics foster a tendency

either towards the town-ness or city-ness of service places in counties (cf. Fig. 2). The town-ness of a service place is characterised as serving the immediate hinterland with basic, equally distributed services through public-hybrid market forms. The city-ness of a service place, on the contrary, is characterised as efficiently offering specialised services and being complementary with other nodes of a network beyond the immediate hinterland (cf. Taylor et al., 2010). Private involvement in service provision is much broader in this case. Nevertheless, every service place is characterised both by town-ness and city-ness, the extent of which is ‘only’ a gradual matter.

Based on the analysis of its substantial, procedural, and spatial components, the service provision logic of the proposed SOTE reform fosters both the town-ness and city-ness of service locations. As Kivelä (2018, 167–8) has argued, the diversification of service providers, together with the freedom of choice model, at the time represented a “state-led neoliberalisation” of Finnish health care provision. In such provision, the state is not leaving the field to the market but “turns the public sector into an increasingly attractive market space” Kivelä (2018, 167). Patients become ‘entrepreneurial citizens’ and consumers. With its private provision logic, the substantial component of the proposed SOTE reform therefore theoretically would foster the city-ness of service places. From a political perspective, the reform aimed to attain the normative goal of equality, which is associated with service places with a ‘town’ character. The analysis thus suggests that for pursuing equality goals, dense networks in urban SOTE counties that feature service places with a high degree of city-ness should theoretically be complemented with service places with a stronger ‘town’ character, in good reach of the urban area (cf. Lambooy, 1969). In terms of the spatial component, the private provision of (basic) services fosters a horizontal networked logic, where providers are clustering and pursuing complementarity. A diverse and dense nodal network is likely to flourish only in urbanised regions, where the preconditions for ‘city’ type service places are generally better.

In the case of increased private provision, the point-patterned system logic of public provision is likely to disperse, not least because – recalling Teitz (1968) – entrepreneurs offering market services make their own ‘best location’ decisions while disregarding the systemic logics of service facilities. This risks the efficiency and equality goals from the perspective of the system of public services and emphasises the role of counties as organisers and providers of services. Their role is pronounced, especially in the peripheral and sparsely populated counties where the county is the major/sole player in the SOTE market. In these areas, where there are no dense networks of private providers, the counties are likely to promote a regulated, equal distribution of basic services, thus fostering vertical hierarchies in location systems featuring places with a high degree of town-ness that cater for their hinterland.

This interpretation of the results suggests that SOTE counties of various regional types should aim for using their organisational competences to steer towards a town-ness or city-ness dominated service location system. Service providers, as the sub-nodes/agents in the system, add up to each other and thus gradually calibrate a place by being either of a state-provided or for-profit character, or by being a hybrid. While a national sector law would allow liberalisation across the country, the degree of liberalisation of service provision remains in the hands of the SOTE counties, which each involves a different range of service providers and degree of urbanisation. The task of the SOTE counties individually would then be to manage a service provision mix within the range of city-ness to town-ness for the service places of their territories.

5. Conclusions

Based on an extensive discussion and re-interpretation of literature on public service provision and location systems, we made a theoretical-conceptual contribution that adds a spatial logic to the otherwise economic and political logic of service location systems. Building on

Taylor, Hoyler, and Verbruggen (2010) we suggested the perspective of gradual town-ness and city-ness of public service locations and presented this perspective as the key for a ‘central places and flows planning approach’ (Fig. 2). We now close this contribution by returning to the research questions posed earlier and answering them.

Thus, *how does the spatial organisation of social and health care services theoretically relate to (a) state/market governance rationales and (b) different types of regional urbanisation?* Concerning research question Q1, we found that the spatial organisation of social and health care services is theoretically related to (a) state/market governance rationales in substantial and procedural terms. The *substantial component* is the inherent logic of the supply and demand of a particular service. The *procedural component* adds a normative notion of political decision-making, which is influenced by the socio-political model of a state that defines the services provided to a population as well as the way in which they are provided. For example, by political will, some services may be purposely over- or undersupplied – regarding mere substantial reasoning – due to the societal-political value assigned to a service. To the substantial and procedural component, we added the *spatial component*. We showed that (b) the regional location system of a service depends on the level of urbanisation (or density, accessibility) of a particular region. In other words, substantial and procedural components function differently in urban areas and rural peripheries.

Thus, *what spatial implications did the proposed Finnish social and health care provision reforms of 2015–2019 entail?* Concerning research question Q2, we conclude that the actual rescaling of the SOTE system towards a new county scale was just one obvious, though spatially less complex feature of the reform plans. With the help of our theoretical framework that recognises the substantial, procedural, and spatial components of service location systems, which add up to town-ness and city-ness of service places (Fig. 2), we could discern the further spatial implications of the reform. Rural SOTE counties might predominantly have accommodated places with a ‘town’ character, which are inclined to a publicly determined distribution of locations. The counties might have needed to provide a substantial share of services in these areas where the prerequisites for developing well-functioning private markets for SOTE services are sparse. Nevertheless, some service segments might have been attractive for third providers and thus might have allowed a small degree of city-ness. Such third providers might have operated across the country, or even internationally, and thus might have established flows between the SOTE counties and beyond. Contrarily, highly urbanised SOTE counties with well-accessible service locations might have attracted privately provided services, allowing for the development of specialised, complementary, pluralistic, and at times clustered service locations, which result in a dense, polycentric type of SOTE service location system.

Overall, a national social and health care policy framework (such as the SOTE reform plans of 2015–2019) that aims at decentralised implementation (SOTE counties) should regionally allow tailored solutions. Above all, the respective SOTE counties or similar entities should be aware of their high degree of autonomy and actively steer towards a place-based solution, sensitive to their type of region (i.e. the spatial component). Their means for steering is the substantial and procedural components of service provision, which in turn contribute to a location network of gradual town-ness and city-ness. Such a ‘gradual central places and flows planning approach’ can help SOTE counties or similar entities in their strategic planning by providing them with a better understanding of the kind of service system that will emerge and should be developed on grounds of regional population and urbanisation structures.

A benefit of the gradual central places and flows approach is that it accounts for various organisational and market conditions in one sector policy, as well as for various levels of regional urbanisation. Therefore, this contribution not only supports spatially sensitive sector policies but also sectorally sensitive spatial policies. Our case study dealt with health care, but in principle, the approach may also be applied to other

sector policies, such as transport, education, and housing.

CRediT authorship contribution statement

Alois Humer: Conceptualization, Methodology, Writing - Original Draft, Writing - Review & Editing, Visualization, Project administration, Funding acquisition. **Kaisa Granqvist:** Methodology, Investigation, Data Curation, Writing - Original Draft, Writing - Review & Editing.

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Appendix A. Supplementary material

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