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

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Abstract

The provision of health care in contemporary developed societies has become a so-called "wicked problem." Tackling the many important challenges is a daunting task—so much so, in fact, that it may prove to be a "mission impossible." This reality has significant implications for the crafting of health care reforms and policies. Moreover, and more fundamentally, there exists no widely accepted standard by which to generate, evaluate, and prioritize reform and policy proposals. In view of these difficulties, turning to the public for guidance may be the wisest course of action. Specifically, a democratic mechanism is needed by which the public can consider a range of policy directions and can deliberate the consequences and trade-offs in view of people's values and priorities. In short, some form of deliberative democratic exercise is called for. The chief aim of the present article is to highlight the possibilities for bringing the principles and methods of deliberative democracy to bear on health care in Finland, and in particular on developing proposals for reform and policy. The essay consists of four parts. First, I offer a theoretical perspective on deliberative democracy and its potential for dealing with "wicked problems." Second, I situate the theory in the context of the crisis of the Finnish welfare state. In part three, I consider the relative dearth of existing forms of deliberative democracy in Finland, and present an upcoming Finnish experiment on public deliberation. Finally, in part four, I examine the views of two groups: representatives of Finnish patient and disability NGOs, and a group of Finnish citizens. I ask whether they see the need for or value in increased citizen involvement in the planning of health care reforms and policies.

Keywords

health care, Finland, complexity, deliberative democracy

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Introduction

The provision of health care in contemporary developed societies has become a so-called "wicked problem." Responding adequately to the health care needs of a large population, and doing so at a sustainable cost burden to society, is a task so complex, or "wicked," that it cannot be solved completely (e.g. Rittel & Webber 1973; Glouberman and Zimmerman 2002).[1] We can only try to manage it the best way we can (see Pacanowsky, 1995; Hookins 2005).

Tackling the many important challenges of health care is a daunting task—so much so, in fact, that it may prove to be a "mission impossible." This reality has significant implications for the crafting of health care reforms and policies. Moreover, and more fundamentally, there exists no widely accepted standard by which to generate, evaluate, and prioritize reform and policy proposals.

Simply put, even in developed societies it is not possible to organize equal and optimal care for everyone at a feasible cost. For example, populations are growing older; chronic diseases are increasing; medical technology is becoming ever more expensive; citizens continue to expect and demand more and better care; and resources available for health care are diminishing relative to other social priorities. In these circumstances, it is not humanly possible to build a health care system that affords all the best care medically possible (see e.g. Gaylin 1993). Yet this is precisely what most health care reforms and policies try to achieve. They are searching for the elusive (perhaps even mythical) "Holy Grail" of health care (see e.g. Alban & Christianson 1995).

The preceding conclusion suggests the need for a new approach to setting health care policy and crafting health care reforms (Raisio 2009a; 2009b). If it is not possible to find the one perfectly right solution, what is the best feasible or

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[1] Wicked problems are highly complex, ambiguous and divergent problems. Specifically, Rittel and Webber (1973) attribute ten characteristics to such problems. Conklin (2005),without losing the essence of the concept, condenses the ten to the following six attributes:

- *"You don't understand the problem until you have developed a solution."* Every proposed 'solution' increases understanding of the problem, with the result that understanding of the wicked problem and its 'solution' evolve interdependently, basically forever.
- *"Wicked problems have no stopping rule."* A criterion which tells when the problem has been solved is missing.
- *"Solutions to wicked problems are not right or wrong."* Individuals can judge the solutions from their own viewpoint and all of them are basically equally right. For some the solutions are good, for others bad, and maybe to someone else good enough.
- *"Every wicked problem is essentially unique and novel."* There are similarities, but even the smallest of differences can override these.
- *"Every solution to a wicked problem is a 'one-shot operation'."* Every attempt to solve the problem has consequences which cannot be undone.
- *"Wicked problems have no given alternative solutions."* Continuous creativity is needed to generate possible solutions to wicked problems.

practicable solution? And how do we arrive at it? Can politicians, government officials, and health care professionals make this determination? In my view, they cannot—at least not by themselves. A technocratic, institutional approach will fail, as it frequently has (see, e.g. Yankelovich 1995; Mihályi 2008; Raisio 2009b). Instead of proceeding straightaway to the concrete, detailed provisions of a policy, we must—as a society—confront the inescapable hard choices with which health care presents us. We must seek a rough consensus about what we value and what our priorities should be (see Conklin 2005). This is something a technocratic elite alone cannot achieve. Experts possess no authority in the matter of allocating and prioritizing social values. In a democracy, only the citizenry may do so. And in order for the citizenry to carry out this difficult responsibility, institutional decision-making concerning the details of policy must be guided, supported, and preceded by the deliberative construction of a societal consensus.

Many modern societies have already started to realize the importance of public deliberation in the planning of health care reforms and policies. For example, the UK has been experimenting with Citizens' Juries since 1996 (Lenaghan 1999). However, in Finland deliberative democracy is still in its infancy, not only in the field of health care, but in every policy field. Concern about the lack of deliberation in Finland lies at the heart of this essay. As major problems and challenges in Finnish health care continue to resist solution, it is worth asking whether it is time for the public to grapple with the need to offer policy-makers clear guidance at the level of principles and priorities. Instead of creating a raft of new reforms and policies even before previous ones have been finished and evaluated (see Vartiainen 2005), perhaps we ought to find out what the public thinks when it has a chance to consider its options and the inevitable trade-offs (see Raisio 2009a).

Below, I begin with a perspective on deliberative democracy and its potential for dealing with "wicked problems." Second, I situate the theory in the context of the crisis of the Finnish welfare state. In part three, I consider the relative dearth of existing forms of deliberative democracy in Finland, and present an upcoming Finnish experiment on public deliberation. Finally, in part four, I examine the views of two groups: representatives of Finnish patient and disability NGOs, and a group of Finnish citizens. I ask whether they see the need for or value in increased citizen involvement in the planning of health care reforms and policies.

Part 1: Deliberative Democracy and Wicked Problems

In this section I will give reasons for considering deliberative democracy as the first, indispensable step toward the crafting of coherent, effective, and widely supported health care policy in Finland. I will do this in three stages. Each stage highlights a problem with a certain level of complexity and the implications for

citizen involvement. The stages are problem tameness, problem messiness, and problem wickedness (Rittel & Webber 1973; King 1993).

Tame problems[2] and habitual performance

If problem complexity were placed on a continuum from simplest to most complex, "tame" problems would be situated at one pole. A tame problem is easy to define and also easy to solve (Rittel & Webber 1973). It is a "convergent" problem (King 1993). There is almost no ambiguity in it. Solving the problem is straightforward—in time, a "linear" approach yields a solution. An example is repairing a machine (e.g. Roberts 2000). From their training and experience, technicians easily identify the problem and routinely apply standard procedures to solve it.[3]

Tame problems in matters of public policy and public administration could be solved without involving the public in the process. A small number of experts with the requisite training, experience, and specialized knowledge could readily identify the nature of the problem and the solution, neither of which is likely to occasion disagreement. (Weick & Roberts 1993).

For example, if the development of a national health care system were viewed as a tame problem – as often might be the case (see Vartiainen 2005; Raisio 2009a) – it would be assumed that a solution exists that could be devised by scientific or managerial experts. The solution would enable the system to respond effectively to growing and changing patient demands. Unfortunately, resources are always scarce relative to wants—everybody cannot be provided with everything. As Grint (2010) puts it, in the end there is a need for a political decision and, more specifically, for politically-charged health care priority-setting.

Even though health care as a whole will not yield to solutions suitable for tame problems, it includes tame parts. For example, in the case of surgery it is realistic to think (and certainly to be hoped, if one is the patient) that the problem to be solved by the surgical procedure is a tame one (Grint 2010).

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[2] Solving tame problems can be compared to puzzle solving or solving a mathematical equation. Firstly, in tame problem there is then a well-defined and solid statement of the problem and a definite list of objectively evaluated right solutions and permissible operations, e.g. chess. Secondly, there are rules according to which certain groups of problems can be solved, e.g. equation groups. When solving tame problems it is possible to start all over if failed, no harm has been done by failing. Also, there exists stopping point for a tame problem, a point of closure. (Rittel & Webber 1973; Conklin 2005.)

[3] Solving tame problems has also been characterized as using the "waterfall model" (see Conklin 2005); as "normal science" (see Funtowicz & Ravetz 1994); and as "routine management" (see Grint 2005).

Messy problems and the collective mind

In "messy problems," complexity increases, but the problem remains a convergent one: even starting from different perspectives, problem-solvers can reach agreement concerning the nature of the problem and may eventually "converge" on a small range of solutions or even on a single one. Although tame problems can be solved by focusing on individual parts of the problem, a more systemic approach is needed to deal successfully with messy problems. In the latter case, the parts are interrelated in a manner and to an extent that requires close attention to interactions between the parts both in the present and in the future (King 1993). Hence the importance of an approach that sees "the big picture".

It is easy to understand why the involvement of citizens might be necessary for the solution of messy public problems. The messier a public problem is, the greater is the need for application of the "collective mind," the process by which many actors construct a collective view of the problem and respond to it through complementary actions (see Weick & Roberts 1993). According to Weick and Roberts (1993), the more heedfully[4] the interrelating between actors is carried out, the more developed and more capable of intelligent action the collective mind will be. And the more diverse the participation, the more comprehensive the "big picture" will be.

Weick and Roberts (1993) envision the importance of collective mind especially in situations where almost continuous operational reliability is needed. The presumption is that as collective mind (i.e., heedful interrelating) strengthens, the actors in the system begin to understand better the complexity they are faced with. The comprehension of unforeseen events grows, and as a result the incidence of errors within the system decreases. Conversely, when the collective mind weakens—i.e. when the interrelating deteriorates—actors grow more isolated, comprehension declines, and interrelating becomes more and more difficult. Individual mind begins to replace collective mind and problem wickedness begins to emerge: "As people move toward individualism and fewer interconnections, organizational mind is simplified and soon becomes indistinguishable from individual mind" (Weick & Roberts 1993: 378).

Messy problems are difficult largely because of their epistemic uncertainty. But with time and effort by people acting as a collective mind, they can yield to shared analysis and understanding. Citizens may make an important contribution to solving the problem by being part of the collective mind. Conventional institutional structures and processes, such as public hearings, may lead to

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[4] "Heedfully" means "critically," "attentively," "purposefully," "consciously." (Weick & Roberts 1993).

efficient "solutions," but fail to produce effective, sustainable policies that require public acceptance and continued support.

Wicked problems and co-intelligence

When a problem gives rise to sensitive socio-political and moral-spiritual issues with respect to which people hold many divergent opinions, it becomes much more resistant to solution. Familiar examples are global warming, terrorism, and health care priority setting (see Raisio et. al. 2009). These are so-called "wicked problems," i.e. problems that are both very hard to define in a clear and widely acceptable way, and extremely difficult—even impossible—to solve to the enduring satisfaction of the contending stakeholders (Rittel & Webber 1973). The major difference between messy problems and wicked problems is that the eventual consensus that can be expected in messy problems gives way to stubborn dissensus. Instead of coherence, fragmentation prevails (Roberts 2000; Conklin 2005). This thwarts attempts to "engineer" solutions. Making progress toward solving wicked problems approaches in which every stage of planning must be viewed as an opportunity to enhance understanding of the problem and possible solutions (Jentoft & Chuenpagdee 2009; Conklin 2005; Funtowicz & Ravetz 1994). If tame and messy problems can be compared to unassembled pictures the outlines of which are known or readily discovered, wicked problems are akin to pictures that cannot be readily drawn, because they differ substantially in the minds of different stakeholders. Thus solving wicked problems is more about learning than knowing, and more about responding to something that has never happened than dealing with something that has occurred and been experienced previously (Conklin 2005; Grint 2005).

For example, the problem of long waiting lists in health care systems – an issue that has received considerable attention in discussions of Finnish health care –is a wicked problem (see Raisio 2009a). It is highly complex: myriad factors influence both demand and supply. Kenis (2006) mentions a few of these factors:

> "…the need for care or cure, the population structure, epidemiological factors, the way the insurance companies assess future needs, the number of personnel, the efficiency of the cure and care process, changes in the emancipation of citizens, the situation on the labor market, technological developments in the medical sector, existing capacities for child care etc."

Procedural attempts to decrease waiting lists – such as enacting time limits for accessing care, as has been done in Finland – generate "waves of consequences" (see Weber & Khademian 2008) that can and do prove unexpected. Shorter waiting times for surgical procedures, for example, might result in longer waiting times of psychiatric care (see Raisio 2009a). This is a form of "cannibalism"—

one part of the health care system is prioritized at the expense of the others (Bruni et. al. 2007). As one interviewee in a previous study (Raisio 2009a) observed, "Guarantee for care (i.e. patient is guaranteed to get the care in a certain time limit) is not a simple problem, and it most definitely wasn't seen as such. Rather so that it was seen as a problem that is impossible to be solved. In the middle of this jungle of the need for resources, how do we find a consensus which everybody commits to and is content about?"

Citizen involvement in the effort to solve wicked problems is important because such problems can be understood as "problems of interactions" (van Bueren, Klijn & Koppenjan 2003). In such problems, everyone possesses some portion of "the truth" (Roberts 2000). Lack of coherence creates a need for communication—for dialogue and deliberation—to "piece together" both the picture of the problem and its solution. The "collective mind" cannot be brought to bear if there is no foundation on which to build. "Co-intelligence"—"the ability to generate or evoke creative responses and initiatives that integrate the diverse gifts of all for the benefit of all" (Atlee 2003: 3)—is required simply to make sense of the problem.[5]

In a world that is highly fragmented, many problems become wicked ones. Understanding what is at stake and what the impact on others will be of adopting different possible solutions is crucial. That is precisely why the principles and practices of deliberative democracy are needed.

Deliberative democracy: Definitions, prospects and challenges

"Deliberation" is "debate and discussion aimed at producing reasonable, well-informed opinions in which participants are willing to revise preferences in light of discussion, new information, and claims made by fellow participants" (Chambers 2003). "Deliberative democracy" can then be defined as "an association whose affairs are governed by the public deliberation of its members" (Cohen 1991).

Although it may culminate in voting, public deliberation is not the same thing as voting.[6] Traditional voting is a purely private act, not public (Parkinson 2004). So are polls and surveys (Tenbensel 2002; Ralston 2008), which are a form of

[5] In the context of wicked problems, where blaming, dissensus and fragmentation prevail (Conklin 2005), co-intelligence has an important role to play. According to Hartz-Karp (2007), co-intelligence can help us to be the best we can be. In her view, there is a clear need for co-intelligence. In a world which has become so divided, the understanding of the life situations and the opinions of others is more important than ever. People can no longer afford (if they ever could) to concern themselves solely with their strictly personal interests, but must instead take into account the experiences, needs, concerns, and priorities of others.

[6] According to Cohen (2009), the results of voting based on aggregation of uninformed and unconsidered views are likely to differ from the results based on "voting among those who are committed to finding reasons that are persuasive to all…."

informal, unofficial “voting.” All voting lacks the opportunity for interpersonal dialogue and deliberation among individual decision-makers (Lenaghan 1999). In contrast to public deliberation, which may result in a collective view shared to varying degrees by the deliberators and not identical to the individual views of any, voting merely aggregates, or adds up, the preferences (or opinions, desires, etc.) of the individual voters. (Warren 2008; Fishkin 2009).

Compared to a post-deliberation “public voice” (see Mathews 1999), aggregate opinion has at least three weaknesses. The first is its static character. Aggregation produces a static “snapshot” of a dynamic phenomenon: not the evolution of a stable “public judgment.”[7] Aggregate opinion has “shallow roots” and is prone to change. The second weakness is that aggregate opinion is superficial. It consists of respondents’ “off the top of the head,” unreflective, immediate responses to a particular question or statement posed by a pollster or survey-taker. Aggregate opinion differs substantially from a considered *judgment*: what citizens *would* think—what they *will* think—after having adequate opportunities to consider other perspectives, explanations, evidence, and options for action. Finally, in contrast to a post-deliberation public voice, aggregate opinion lacks nuance. It does not reveal where the public agrees and where it disagrees, or the reasons why. It gives no indication of what underlies people's views or what might change them. (see e.g. Yankelovich 1991; Atlee 2004; Fishkin 2009; Kim et.al. 2009).

Conventional public meetings provide little opportunity for deliberation. Typically, time is short (Rawlins 2005); the issue is narrowly framed as one of approving or rejecting a specific policy proposal; the purpose is either to inform the audience or to gather comments (or worse, simply to defend the proposed policy against criticism); and members of the public are neither encouraged nor aided to deliberate among themselves in order to work through their differences in order to set a public priority. Public meetings frequently are dominated by persons or groups who have the largest stake in how the issue is resolved and who therefore bring intense passion to the issue, with the result that they are usually more intent on in making their own views known than listening to others’ views. Public meetings can even be staged or “hijacked” for partisan political advantage. (Gregory, Hartz-Karp & Watson 2008; Fishkin 2009).

In contrast to traditional forums of public participation, deliberative forums offer “safe public spaces” for all citizens (or a representative sample thereof)—not just those having special interests—to meet and to “truly discuss and listen to each other.” Fishkin (2009: 51, 33-43) has defined five conditions for a high-quality deliberative process. These are presented in Table 1.

[7] Yankelovich (1991: 6) defines public judgment as “the state of highly developed public opinion that exists once people have engaged an issue, considered it from all sides, understood the choices it leads to, and accepted the full consequences of the choices they make.”

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

Table 1. Five conditions for a high-quality deliberative process (Fishkin 2009: 33-43)

In practice, deliberative public processes and events remain relatively rare (Herne & Setälä 2005). But the number and variety of methods and tools for achieving public deliberation continue to grow, each having particular strengths and weaknesses. Some of the most common approaches are the National Issues Forums, Study Circles, Participatory Budgeting, 21st Century Town Meetings, Citizens' Juries, Planning Cells, Consensus Conferences, and Deliberative Polling (Rowe & Frewer 2000; Fung 2003).

Theoretical justifications for public deliberation are numerous. Deliberation, it is argued, is an aspiration implicit in all conceptions of democracy. Whether members of a parliament or merely of a local council, elected public officials are expected to engage in reasoned debate that improves the prospects for sound and equitable public policy. Insofar as politics falls short of that ideal—as it seems increasingly to do—deliberation is seen as an antidote to excessive influence by organized pressure groups, to partisanship, and to the self-interested desire to remain in office and to accumulate political power (Fishkin 2009). Similarly, public deliberation is considered desirable to counter the susceptibility of contemporary large-scale popular initiatives to manipulation by special interest campaigning (Ferejohn 2008; Warren 2008). It is unlikely, of course, that public deliberation will ever drive self-interested, power-based competition from democratic politics. But the more harmful practices of such competition might be curbed and the more damaging consequences might be limited if deliberation, with its implicit focus on the common good, could be more deeply and broadly institutionalized. (Cohen & Fung 2004.)

Table 2 sets out some of the other aims and benefits of deliberative practice. Viewed, though, from the perspective of problem "wickedness" described above,

the promise of public deliberation lies chiefly in its potential to mitigate the problem of "separateness" (see Fishkin & Farrar 2005). Wickedness stems in part from the diversity of viewpoints people bring to the problem and from the fact that those viewpoints typically are rooted deeply in different "worldviews," i.e., systems of connected factual and evaluative beliefs that are not readily bridged (e.g. Roberts 2004). The problem with "separateness" is that inhabiting different worldviews makes it difficult for people to comprehend fully and, more important, sympathetically, each other's experiences, perceptions, concerns, priorities, and so forth. It is not easy for people to accept, as Mary Parker Follett suggests with her analogy of piano keys, that "value comes not in separateness, but in relating" (Morse 2006: 10). When people are separated by worldviews, and when problems have roots in multiple worldviews, mutual comprehension becomes essential to analyzing the problem accurately and to creatively generating potential solutions (Briand 1999; Atlee 2008).

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

Table 2. Purposes of deliberative public engagement (Friedman 2006: 17-20)

In deliberation something happens that typically fails to occur during ordinary political discourse. Much political discussion takes place within groups of persons having similar beliefs and values. Deliberation, in contrast, with its intentional commitment to inclusion, diversity, and equality of participation, makes possible a "moral discussion"—"a kind of ideal role-taking"—in which participants are asked to view issues from the perspectives of others (Fishkin 2009: 125). Deliberation enhances moral perception and facilitates empathy,

which make possible decisions that are not only sounder but also morally better (Fouke 2009). Precisely because self-interest is acknowledged and given its due, it can be transcended and the common good can emerge as an idea with concrete attributes (see Murphy 2005). Fishkin (2009) points to tentative empirical proofs which support the notion that public deliberation leads citizens to focus more on the public good.

To be sure, public deliberation has its critics. For example, Sanders (1997) argues that the principle of "mutual respect"—i.e. deliberators treating each other as equals and demonstrating respect by offering reasons that offer the other an opportunity voluntarily to assent to the proposition being argued for—is difficult to achieve, and achieve consistently. There will always be those who speak more, are more persuasive, and whose ideas count more than others. Similarly, there will always be people who speak less, are less likely to be listened to, no matter how well-reasoned and well-presented their ideas may be. Paradoxically, instead of promoting mutual respect, public deliberation can lead to unequal participation and influence.

Young (2003) highlights the challenges of deliberative democracy by juxtaposing the ideal types of a deliberative democrat and an activist. The practices of deliberative democracy, she argues, cannot make activism an unnecessary form of influencing political decision-making. In reply, Fung (2005: 399) writes of "deliberative activism," i.e. activism to achieve deliberative democracy: "I call this perspective deliberative activism because it holds that widespread inequality and failures of reciprocity can justify nonpersuasive, even coercive, methods for the sake of deliberative goals."

Not every issue requires or permits a deliberative approach. Deliberation demands time, resources, and commitment to seeing the process through. Yet even as we recognize the practical constraints on deliberation, we must bear in mind the often-unrecognized costs of failing to deliberate (see Cookson & Dolan 1999; OECD 2001; Roberts 2004; Bruni et. al. 2007). The main question then is whether the problem is "hot" or wicked enough to justify the use of resources for public deliberation (Atlee 2004; Roberts 2004). According to Yankelovich (1995) public deliberation is needed when an issue meets one or more of three criteria: the issue is significant to people's lives; there is a need for sacrifice; or special interests adopt positions that, even if amenable to compromise, would fail to address the needs and concerns of the great majority of ordinary citizens. Many wicked problems meet these criteria. Health care is one (see e.g. Raisio 2009a; 2009b). It may prove illuminating, therefore, to consider public deliberation in the context of the crisis of the Finnish welfare state.

Part 2. The Crisis of the Finnish Welfare State

Esping-Anderssen (1999) sees the construction of modern welfare states as a spectacular reformist achievement. He divides these welfare states into three types of regime: liberal, conservative, and social democratic. Finland belongs to the family of social democratic regimes. More specifically, Finland is a “Nordic welfare state” (see Kosonen 1998). It has a wide-ranging social policy, a high degree of equality between sexes, and low income inequality. Most social programs are supported by general taxation revenues, and out-of-pocket expenses for welfare services are moderate.

But things are changing. Kajanoja (2007) points out, for example, that disparity in incomes is growing, child poverty is increasing, and needs-based monitoring of expenditures for the disadvantaged is toughening. The impact of income transfers and taxation on income inequality is declining; low-income citizens are seeing their socioeconomic position relative to the well-off worsen. Moreover, public sector collaboration with the private sector is decreasing and privatization is increasing (e.g. Koskiaho 2008). Significantly, as the population ages, the dependency ratio is growing, causing a major challenge to the Finnish welfare state.

When the Finnish welfare state began to develop soon after the Second World War, conditions were favorable. Finland was an agricultural society with liberal values. The national division created by the Finnish civil war of 1918 had been healed by the Winter War with the Soviet Union during WWII, which unified the population. People were optimistic about the ability of government to improve the conditions of life (e.g., George 1996). Political support was strong, unemployment low, and economic growth robust.

The Finnish welfare state was at its peak in the 1980s. During the recession of the 1990s, challenges started to emerge. As economic growth began to diminish and unemployment rose, taxes were lowered in response. As a result, cuts in social expenditures were initiated (see Niemelä et. al. 2007).

Today, as we face a recession of unprecedented depth and breadth in the post-War period, and with one of the fastest “graying” populations in the world, the challenges to the Finnish welfare state are more severe than ever. This is especially clear in health care (e.g., Teperi et. al. 2009). With growth in GDP what it is now, the saturation point has been reached, and the public sector cannot expand further to meet the still-growing needs of citizens. Raising taxes remains a policy option, but it would be as politically unpopular as cutbacks in services (Jallinoja 1993). Policymakers are thus caught between a rock and a hard place. But something must be done. The question is, which values and priorities should determine how we go forward? This issue can be viewed from two perspectives.

First, at the core of the Finnish welfare state there is a major tension. This is between the elite striving to develop the welfare state and the citizenry wanting to

sustain it as it now is. According to surveys, citizens still strongly support the existence of the welfare state. A majority remain agreeable even to raising taxes if needed, especially if these are used specifically for health care services (see Forma et.al. 2007). The elite, on the other hand, urge cutting both taxes and public expenditures (Kajanoja 2007; Koskiaho 2008).

In its urge to make changes, the elite appeals to three facts.[8] The first is to globalization. The argument is that a closed and regulated welfare state doesn't work in the contemporary conditions of a globalized world: "The world around us has changed. Thus we also need to change...." A specific fear is that Finland cannot compete with the rising new economies. The second appeal is to the changing age structure, i.e., the "dependency ratio." Third, the perennially high unemployment rate is emphasized. It is argued that high taxation cannot be the salvation of the welfare state. Without more fundamental changes, it is said, the welfare state begins to regress. (Ruokanen 2004.)

Supporters of the continued development of the welfare state accuse its critics as stubbornly trying to sustain the status quo (see also Esping-Andersen 1996), and not seeing the reality as it now is.[9] They even treat the welfare state as sacrosanct—something not to talk about in a negative tone (e.g., "the modern day Soviet Union"). Discussion is defensive and open-mindedness, constructive engagement, and innovativeness are lacking. The way forward is to be shown us by elite leaders, who warn us that hard choices must be made, and the solutions may conflict with the public's views. Yet at the same time political leaders are accused of "Gallup-leadership"—instead of making bold choices for society, they slavishly follow the results of opinion polls. (Ruokanen 2004.)

The popular desire for continued development of the Finnish welfare state is recognized. It is thought that "defending and implementing the basic values of Finnish people is a common challenge to which every Finn has the responsibility to respond. In Finland, a shared outlook on the common values to which all the actors can commit must be found. After that the discussion of the implementation of these values and their practical realization will be easier than it now is" (Ruokanen 2004: 82). It seems, however, that such a shared outlook is not on the horizon (e.g., Julkunen 2005).

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[8] This outlook is based on a report of Finnish Business and Policy Forum EVA (Ruokonen 2004). For Report 57 notable Finnish decision-makers in the fields of science, business, and public policy and administration were interviewed.

[9] According to Ackoff (1974), the public behaves as an *in*activist, but the elite willing to reform the welfare state would like the public actually to take the role of *inter*activist. Inactivists believe everything is fine and thus don't see a need for a major change. They may even strive to block any changes. In contrast, interactivists believe we should seek a better future and should fulfill our potential as a nation to forge our shared and desired future, not settle for "good enough."

The second perspective on the question of which values and priorities should determine how we go forward begins with the contention that a fairly homogenous society, which Finland was at the founding of the welfare state, has become increasingly heterogeneous. The social values that were in the ascendancy—solidarity, equality, and fairness—have been challenged by rival values, such as liberty, competition, self-reliance, and risk-taking (Andersson 1993). The old values grew out of conditions that have now changed. Solidarity, for example, has been undermined by social fragmentation, globalization, and immigration (Andersson 1993; George 1996). The welfare state itself has been blamed for changing conditions. The argument is often heard, for example, that personal responsibility for one's family, neighbors, and community has been weakened by the knowledge that the state will step in to meet people's needs (see Einhorn & Logue 2003).

The tension then is between, on the one hand, equality and social solidarity, and on the other hand, individual freedom and greater income disparities. Wallgren (2007) believes it is unrealistic to think that the rich can still get richer, while at the same time, the position of the disadvantaged would also improve. The welfare state is thus facing an ethical choice: between social support for the disadvantaged and the promise of greater wealth for the educated, skilled, and capable. Wallgren (2007) calls for a public discussion marked by argumentation and the encouraging of social learning, resulting in a purposefully created social consensus. For him the desire for individual prosperity is neither constant nor independent of social conditions. The things citizens value can and do change.

The two preceding outlooks are partly parallel. The first criticizes the welfare state status quo and argues for radical development plans. The second stresses diminishing solidarity, equality, and fairness, and the ethical choice we are now facing. Both outlooks welcome change, but in addition it might be argued that both require a deliberative democratic process. This argument is based on the contention that the crisis of Finnish welfare state is a wicked problem.

Problem wickedness can be understood as characterized by two incoherencies, epistemic and axiological (see Conklin 2005). Epistemic incoherence is reflected in the uncertainty surrounding the causes of the crisis of the welfare state and, more fundamentally, disagreement over whether there even *is* a crisis. This uncertainty extends to the solutions offered in response. There is no objective knowledge which could tell us how to solve the problem. It is not only that we don't have the knowledge needed to define the problem or to devise the solution, but also that we also lack consensus on the values that should guide us.[10]

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[10] The crisis of the Finnish welfare state might be characterized as a "super wicked problem" (Levin et.al. 2009; see also Lazarus 2009). A "super" wicked problem adds three additional features: 1. Time is running out. 2. No central authority. 3. Those seeking to end the problem are also causing it. As for the first of these, it might be, as some have argued (e.g., Ruokanen 2004)

There are two specific reasons why the wickedness of a problem would be mitigated by citizen involvement. First, by including citizens diversity increases. As "experts" in their own lived lives, they know the reality of the problem in a concrete, personal way. Their contribution deepens the understanding of the problem and provides insights that may lead to solutions previously not contemplated (see Clarke & Stewart 2000). More important, changes in the way people behave are more likely when people are involved directly in identifying solutions (APS 2007). The welfare state is highly valued by a large majority of Finns, but it cannot be sustained without changes in the way they live. As Clarke and Stewart (2000) write: "The wicked issues by their nature will be enmeshed in established ways of life and patterns of thinking; they will only be resolved by changes in those ways of life and thought patterns." Clark and Stewart argue further that traditional means for solving wicked problems, such as legislation and regulation, are by themselves inadequate to the task of achieving sustained behavior changes (e.g. APS 2007). Such changes will occur only when problems are widely understood, discussed and, most importantly, "owned." "Top-down" coercion will be resisted unless citizens willingly accept the changes they need to make (Clarke and Stewart 2000). Effective responses to wicked problems must be co-produced by policy-makers and citizens (e.g. Harmon & Mayer 1986).

In sum, then, there are three basic responses societies might adopt when confronted with "wicked welfare state" problems such as universal healthcare. First, public leaders could attempt to follow aggregate public opinion (Blum & Manning 2009). But by their nature wicked problems are such that people's opinions are apt to rest on insufficient and imperfect information. In order to provide meaningful guidance to policy-makers, people must work through the many complex issues involved (see Fishkin 2009).

A second approach would be for public leaders try to impose their views on a divided and potentially recalcitrant public. Such an attempt is unlikely to be sustainable, however. Emphasizing technocratic values such as fiscal restraint and efficiency is unlikely to prove popular when officials run for re-election (e.g. Randma-Liiv 2008). Moreover, technocratic knowledge has no democratic authority independent of that which the public accords it. Even if elected, policy elites lack the democratic political authority to prescribe values and value-priorities for the public. At some point, substitution of elite judgments for the

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that Finland is running out of time and soon will fall behind other countries. A regression could start that would be highly difficult to stop or reverse (analogous to climate change). As for the second feature, the issue of welfare state development is not an issue that could be handled solely within national boundaries. For example, the regulations of the EU and EMU have to be accommodated. Also, globalization is making is less and less likely that a single central authority will emerge to reduce the wickedness of the problem. Lastly, all of us who are trying to solve the perceived crisis of the welfare state are also causing it through our behavior towards others, our life habits, our use of welfare services and benefits, or our material affluence.

democratic judgment of the public threatens the legitimacy of a regime (Rawlins 2005). Because the issues of welfare, and especially of health care, are about the priority that should be assigned essential human values, only the public has the democratic political authority to resolve them. Finally, the public is the current and future consumer of health care. They are stakeholders as well in virtue of being taxpayers (Rawlins & Culyer 2004; NICE 2004; Rawlins 2005).

A third approach, then, would consist of public leaders enabling and encouraging citizens to engage in unhurried, well-informed public deliberation for the purpose of reaching a collective judgment about basic values and priorities. Wicked problems in societies suffering from symptoms of a declining consensus about the traditional aims and policies of the welfare state must intentionally reconstruct a workable consensus by recommitting themselves to democratic values, and to the values of deliberative democracy in particular. Only by doing so will they come to recognize that it is up to them, and them alone, to make the difficult choices and accept whatever uncomfortable changes must be made. They must see that it is irresponsible of them to "hide behind the mantra of 'cutting waste, fraud, and abuse'" (Yankelovich 1995: 16). The practice of deliberative democracy offers societies a chance to rebuild a broad consensus upon which coherent policy can be developed. In Finland, regrettably, such a practice remains much more theoretical than actual.

Part 3. Deliberative Practices in Finland

Unlike, say, Denmark, Finland lacks a tradition of deliberative democracy (see Table 1). Less-deliberative forms of public participation have been implemented. For example, so-called "near democracy" is found in Finland at the local level of government. "Near democracy" encompasses city forums, youth councils, and elder councils, among others. So-called human impact assessments and environmental impact assessments also strive to increase the involvement of citizens, permitting them to evaluate in advance the effects of proposed health and welfare or environmental policies (see e.g. Hokkanen 2008; Nelimarkka & Kauppinen 2004). But while they bring municipal decision-making closer to citizens, these forums fall well short of the deliberative ideal; for example, limited information provided to participants, uneven substantive balance, and less-than-full diversity of the participants have often characterized forums (see table 1). The relative brevity of the events also impedes adequate deliberation.

Finland has implemented various forms of online citizen participation, such as the knowledge society program "eTampere"[11]. Most of these are organized and conducted locally, giving inhabitants of municipalities an opportunity to comment on policies being considered or constructed in municipal councils. At the national

[11] See http://www.etampere.fi/english/.

level, Finland's Ministry of Justice maintains a website called Otakantaa[12]. This website, started at the beginning of 2000, can be viewed as the Finnish government's platform for citizen deliberation. Basically it is a place where citizens can offer their opinions about policies under preparation. Discussions usually last from two to four weeks, after which a summary is written and published. This summary is supposed to be used as a guide to decision making. Otakantaa has also organized internet-chats for citizens in which, for example, the ministers of the government have participated. However, Otakantaa has received criticism as a participatory mechanism. This criticism includes complaints that there are no guarantees that expressed opinions have little impact on decision-making; that participants are not representative of the population; that forums are not publicized adequately; and that the discussion can be intemperate or even uncivil (see Raisio 2009c).

Instances of genuine deliberative democracy with the goals of inclusivity and deliberativeness, such as Citizens' Juries and Deliberative Polls, are rare in Finland. To my knowledge only five of such have been implemented. These practices and an upcoming youth jury experiment will be described briefly below.

The first Finnish deliberative citizen forum was organized in Turku by Åbo Academi University in November 2006 (Setälä, Grönlund & Herne 2007). This deliberative forum was undertaken as a research experiment and, as such, has been described more fully than the other events. The event didn't adhere strictly to any particular deliberative format. It consisted of 135 participants who deliberated about the construction of the sixth nuclear plant in Finland. Even though this is a national-level issue, because of time and costs a random sample was taken from the populations of the municipalities of an electoral district of southwest Finland. The original sample was 2500 voters. Each received a survey and an invitation. Of these, 592 responded, and 244 were willing to participate to the event. After a final random sample to ensure representativeness with regard to age and gender, 194 people were invited, of which 135 arrived. Travel expenses, food, and a 100€ gift voucher were offered to the participants.

The deliberative event lasted one day and included time for two surveys (pre- and post-deliberation), reading the information material, hearings and questioning of four experts, small group discussions, and decision-making in small groups. Also, one survey was conducted afterwards. Small-group discussions were moderated. These included altogether twelve groups, of which ten were conducted in Finnish and two in Swedish. Two different kinds of decision-making procedures were used for purposes of comparison. Half of the small groups concluded with a secret ballot, the other six generated a final statement formulated jointly by members of the group. Because the purpose of the experiment was to

[12] "Voice your opinion". See www.otakantaa.fi.

gather research data, no direct influence on the decision-making was examined (Setälä, Grönlund & Herne 2007).[13] [14]

The other four Finnish examples are segments of wider international and European projects. They are summarized in table 3. Taken together, the foregoing five instances of deliberative democracy in Finland constitute a positive development. Even though none attained the deliberative ideal—whether because time was too short or participants were not representative or for other reasons—they contributed significantly to the discussion of the possibilities of deliberative democracy in Finland. Moreover, they support the contention of this article that in Finland citizen deliberation could take place more widely. For example, in the 2006 event addressing construction of a nuclear plant, the opinions of participants on the deliberative method used were surveyed (Setälä, Grönlund & Herne 2007). The scale ranged from 1 (disagree completely) to 4 (agree completely). The average responses were as follows: to the question whether participants thought that the experiment was pleasant, 3.8; to the question whether participants would participate again in a similar kind of forum, around 3.65; and to the question whether in policy decision-making methods like the deliberative citizen forum should be used, 3.37. Similarly, in the 2007 event on citizens' perspectives on the future of Europe, 93 percent of participants indicated that they liked the event very much; 89 percent said they would participate again in a similar event; and 11 percent said they might (ECC 2007b). Also, in the 2009 event on climate issues, 93 percent of the participants thought that the time spent in the event was worthwhile, and all of the participants concluded that similar events should be organized in the future (Lammi & Rask 2009).

However, deliberative forums are expensive. In the report of the Ministry of Finance (2001) it was noted that because deliberative forums are time-consuming and expensive, at that time it did not seem advisable to recommend that deliberative forums be implemented in Finland. As a recent positive sign, the new report of the Ministry of Justice (2010) mentions and even calls for deliberative discussion.

[13] Even though media was invited to the event, it was noted by the organizers that the experiment's purely scientific nature might have influenced the dynamics of the deliberations (Setälä, Grönlund & Herne 2007). Results might have been different if the participants had known their "judgment" would have been introduced into the policymaking.
[14] Event was replicated online in 2008.

Location and duration	Tampere, 24.–25.3.2007	Helsinki 14.–15.3.2009	Helsinki 15.–16.5.2009	Helsinki 26.9.2009
Topic/charge	"Finnish citizens' perspective on the future of Europe."	"What can the EU do to shape our economic and social future in a globalised world?"	To vision desired future by deliberating on the wishes, dreams, worries and threats related to the future scenarios.	To produce recommendations to the negotiators of Copenhagen climate conference 2009.
Organizer/s (national)	The Swedish Study Centre; The Educational Association and Citizens' Forum; Helsinki office of EAEA.	Main organizer the Swedish Study Centre.	National Consumer Research Centre.	Main organizer National Consumer Research Centre.
Participants	Random sampling based on criteria and implemented by market research company; 29 participants.	Random sampling based on criteria and implemented by outside research company; 70 participants.	Invitation sent to the members of the Consumer panel (>100 willing to participate); 29 were chosen according to criteria; 23 participated.	Advertised in magazines; from those willing to participate, a diverse sample was chosen; 107 participants.
Given information	Background information before the event; use of "resource persons"; online connections to European companions.	Use of "resource persons"; online connections to European companions.	Two interviews; information magazine.	Before-hand sent information material; four documentary videos.
Influence	Final report handed over to MP in a closing event; European level synthesis of national outcomes; Presented in the European Summit.	A panel of four candidates for European Parliament examined the results in the ending event; Final report handed over to Minister of Migration and European Affairs.	International expert workshop on the results (April 2010) followed with another round of citizens" juries (2.10.2010).	Results (global and national) handed over to the Minister of the Environment.
Other details	National consultations took place in 27 EU countries.	Open online-discussion preceded the event (generated 10 suggestions for the face-to-face event).	Included seven EU countries.	Around 4000 participants from 38 countries.

Table 3. Finnish experiments on public deliberation as part of wider international and European projects. (ECC 2007a; ECC 2009; Rask et. al. 2009; Niva & Rask 2009).

Encouraged by previous Finnish experiments in deliberative democracy and by the prospect of public deliberation, we at the University of Vaasa[15] are striving

[15] The author of this paper and two colleagues are the chief organizers of the experiment. Master's degree candidates in social and health management will participate in the experiment through different roles. Pedagogically, the experiment then reflects the growing need for teaching

to experiment with deliberative democracy in the fall 2010, and specifically to analyze for the first time in Finland the usability of a youth jury[16] on the topic of youth involvement.[17] The objective is to gather a representative sample of young people in Finnish language upper secondary education in the city of Vaasa. This sample will be a microcosm of the student population. Over three days, 24 young jurors will listen to and question witnesses; deliberate together in small groups and in plenary session; and arrive at a collective judgment on the topic. Local decision-makers will commit to offering a reply to the product of the deliberators. The theme of "involvement in school community" has been chosen by the steering committee. A focus group discussion prior to the jury will allow for a more-specific phrasing of the question.

The main research objective is to ascertain the usability of a specific format of deliberative democracy, i.e. a youth jury, in the context of Finnish schooling and youth involvement. The chief societal objective is to provide information to local decision-makers to support them in increasing youth involvement, and especially to afford young people an opportunity to influence policy with respect to issues important to them.

Part 4. Increasing Citizen Involvement in the Planning of Finnish Health Care Reforms and Policies

It has been argued here as elsewhere (e.g. Vartiainen 2005; Raisio 2009a) that many health care issues are wicked by their nature and therefore need to be approached in a more collaborative manner than is customary. Collaboration means, among other things, including citizens as key stakeholders (Clarke & Stewart 2000). But what do citizens themselves think? Do they want to increase their involvement on wicked issues such as health care policies and reforms? Do they believe they are capable of understanding issues that are highly complex? Do they see an important role for the public in the policy-making process?

Previous surveys on citizen participation and deliberation (e.g. Setälä, Grönlund & Herne 2007; Association of... 2008; Lammi & Rask 2009) have revealed positive responses to participation and deliberation on important social issues. Because it would be useful to find out whether this receptivity extends

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democracy in public administration education (see e.g. Bingham, Nabatchi & O'Leary 2005; Leighninger 2010).

[16] Carson, Sargant and Blackadder (2004: 7) define youth jury as follows: "A youth jury runs along the same lines as a citizens' jury, but the jury is made up only of young people, typically aged between 12-25. We believe that youth juries provide young people with a unique and stimulating way of talking about and being involved with issues that concern them and have an impact on their lives, their community and their country. A youth jury is a way for the wider community to listen to the voices of young people, and for the jury members to be exposed to a variety of different views."

[17] There was a clear call for action from "the field" to improve the involvement of youth.

specifically to issues of health care reform and policy, which are frequently controversial (see Raisio 2009b), a citizen survey on this topic was conducted.

One assertion in this article is that citizens are experts in their own right on matters about which no other expertise is available: their own (individual) values and value-priorities. They are experts in the matter of their own lives, their own lived experience. Representatives of Finnish patient and disability NGOs[18] were asked their point of view on this claim. These NGOs represent citizens who confront wicked health care issues at the point of greatest impact, as patients and clients. Do NGOs acknowledge this expertise? Representatives were then asked how strongly the NGOs believe patients/clients influence the planning of health care policies and reforms, and whether the role of patients/clients in the planning of health care policies and reforms in Finland should be strengthened.

Research methods

Two surveys were carried out. The first was sent to 30 representatives of Finnish patient and disability NGOs. These form a notable part of Finnish patient and disability NGOs working at the national level. The respondents were divided evenly between major national NGOs – the largest having more than 100,000 members– and small national illness-specific NGOs with a few hundred members. The response rate was average (63.3 %), with 19 responding. The respondents are indicated in Table 4.

Position	***n***
Executive director/secretary-general	12
Chairperson	1
Member of executive committee	1
Vice-member of executive committee	1
Development director	1
Specialist of Social Welfare and Health	1
MD, executive	1
Secretary	1

Table 4. The organizational positions of the respondents.

Respondents were asked open-ended questions using a qualitative electronic survey. The responses were analyzed using theory-originated content analysis, where the theoretical concepts are already known (Tuomi & Sarajärvi, 2002).

[18] Finnish patient and disability NGOs can be defined as nation-wide organizations with patients and/or close relatives as members, organized around recognized illnesses, diseases or handicaps (National Research and Development Centre for Welfare and Health [STAKES]). The structure of these organizations varies substantially depending on their size. Similarly, the tasks of these NGOs differ with regard to peer support, information-dissemination, influencing public opinion and lobbying, service-provision, and research (Toiviainen 2005).

Instead of letting the empirical data dictate the content of the theoretical concepts, the empirical data is used to preliminarily test the propositions postulated in this article.

The second survey probed the views of the citizens themselves. Finland's Ministry of Justice supported the survey by agreeing to post it on their website Otakantaa. It was an ideal location to ask citizens their views about the theme of this article. However, because the Otakantaa website is not well-known in Finland, 11 major national patient organizations were asked to promote the questionnaire to their members. Ten of the organizations agreed to do this. Information about the questionnaire was then published on their websites, discussion platforms, internet magazines, and journals.

Clearly, the voluntary nature of participation in the second survey introduced a bias in favor of citizens who are more active than average citizens. They visit government or NGO websites, or read member journals. Also, they find the time to respond to a survey. The responses thus give us no indication of the views of people who are less active, less interested, etc.

Overall the survey generated 153 responses. Women were over-represented and men under-represented (74 % and 26 %). The working age population was over-represented and the young and the elderly were under-represented (89 % and 11%). Respondents with more education, i.e. college, polytechnics or university education, were better represented than their counterparts with less education (71 % to 29 %). Additional variables were occupational group and place of residence. Among occupational groups the unemployed were under-represented (3 %). As for place of residence, one province is highly over-represented (47 %) compared to the 19 provinces. This is the capital area (Uusimaa). In short, the results of the survey cannot be generalized to the Finnish population as a whole. However, the results provide some preliminarily information about what one small group of citizens think about the questions put to them.

The quantitative questions, which formed the main part of the electronic survey, were analyzed using descriptive analysis, in which the results are presented in simple percentage values. At this stage of the study, the results, due to space limitations and the small size of the sample, will not be presented through cross tabulation. Cross tabulation was used, but since the answers clearly emphasized one view, they did not reveal any findings with major significance for this study.

The qualitative questions from the second survey were analyzed in the same way as the first survey, with theory-originated content analysis. These questions were about different kinds of participation methods. Respondents were afforded space to write comments about the survey at the end. These questions about participation methods will be discussed in another publication, but because

respondents wrote in the free space about their willingness to participate, etc., these comments will be reviewed briefly.

Views of representatives of Finnish patient and disability NGOs

Firstly, most of the NGO representatives surveyed thought that patients and clients had weak and non-existent influence on policy-making decisions. At the level of individual interaction with health care providers, patients and clients have minor input into decisions. But planners and decision-makers of health care reforms and policies take scant account of the view of ordinary citizens.

One common denominator among the responses was the emphasis representatives placed on the role of the NGOs in representing the views of the patients. There was however a slight parting of views between those who believed patients could influence only through NGOs and between those who believed also into a more direct possibility of influencing. For example from the negative point of view one representative remarked that "the ordinary patient doesn't have any other way to influence [health care policy] than through his or her own organization. The voice of an individual patient isn't heard anywhere… I don't believe in the prospects of an individual patient [influencing policy]….". However, negative views such as these can be considered not as a critique to direct influence of patients as such but more as a response to the weak and non-existent possibility for this influence, i.e. as one respondent stated "if real and genuine possibilities to influence would exists, there would hardly be a need for patient organizations to 'defend' the rights of the patients and to oversee their interests".

Respondents noted that, even though many efforts are made to hear the voice of the patients, the results are not usually very good:

> *"Many efforts are made, but if we examine how much the voice of the patients is really heard, the results aren't very impressive. They are listened to but not necessarily heard. Already in the hearing process a decision can be made not to make any more changes."*

Three representatives emphasized economic factors as one reason for the low level of patient participation:

> *"In planning the emphasis is usually given to economical and political actors."*

> *"The nation's and municipalities economic deficiencies and pressures clearly override (the role of the patients)."*

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

One other interesting view emerged. According to one representative the role of the patient can be weak not only because of the actions of government, but also because of "the nature, seriousness, shame, and diverse care possibilities of the illness… The resources of the patients are already diminished [as a result of their focus on obtaining proper care]." So even though patients would like to influence the planning of health care reforms and policies, in some cases the patients just do not have the energy for it.

When it comes to strengthening the role of patients, twelve representatives clearly implied the need to strengthen this role of influencing health care reforms and policies. The rest seven representatives did not have as clear a view about this. For example, they continued to emphasize the role of the NGOs. According to them, by increasing the role of the NGOs, the patients' views would be better heard[19]. One of these representatives mentioned also the internet hearings where individual patients can express their opinions.

"The views of the individual patients are represented in patients' organizations, which bring out these views."

"I don't believe in the prospects of an individual patient, but I hope more for contacts from the individual patients to the organization and in that way increase the circulation of information. This way the organization could more easily advocate the cases of the patients."

One representative asserted that the basic things, like care for all, should take priority and only then would it be justifiable to start thinking about something like patient participation. Basically this means that some organizations already have their hands full with basic tasks and responsibilities, so it is necessary to ensure that they are carried out first.

Another representative observed that we need to remember that "every patient is an individual and one patient's view doesn't necessarily represent all the views

[19] According to Kim et. al. (2009) patient advocacy groups – such as the NGOs examined in this article – should not be confused with deliberative democracy. These groups work as interest groups and thus represent special interests. Deliberative democracy is not about negotiating or bargaining between representatives of special interests, but about reasoned deliberation between equal citizens (e.g. Cohen & Fung 2004). Also, as advocacy groups usually have the disadvantage of focusing intensely on a single issue, they can lose sight of the common good of a deliberative political process (Warren 2008). In contrast, the ideal of public deliberation is that it "focuses debate on the common good" (Cohen 2009). Particular interests must be weighed against the public interest and supported only insofar as they do not conflict with the latter.

in the treatment of some disease." This fact makes the participation of patients in the planning of health care reforms and policies more complex, for example in priority setting. How do we involve patients in the planning processes so that the views expressed are as diverse as they are in the population as a whole?

The views of the representatives who more strongly supported the idea of strengthening the role of patients were more optimistic. But even some of these views continue to acknowledge a role for the NGOs:

> *"... Disabled and long-term ill patients with low-incomes should be heard through organizations about the problems in everyday life in relation to planned decision-making."*

NGO representatives with more optimistic views saw many reasons why the views of the patients should be taken more fully into consideration. Their expertise was acknowledged:

> *"Clients or patients are experts of their own lives. Politicians should get to know their realities before making decisions."*

> *"Patients have a lot of information and experiences that are often missed in reforms and decision-making."*

Some representatives saw other benefits to patient participation: commitment, an understanding of many interrelating factors, and the strengthening of a humane policy:

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

> *"Citizens should have a clear knowledge about the direction in which we are taking our health care. This way it would be possible to evaluate the consequences already in the planning phase. It would make it easier to understand the synergy of many interrelating reforms and complexes."*

> *"Purely medical and economic dominance would then lessen and a life-advocating, humane attitude would strengthen and would be written down."*

Additionally, NGO representatives stated that it is not enough just to hear patients. The views of the patients must be genuinely heard:

> *"Internet-sites like Otakantaa are also good, but only if the suggestions by patients or clients are truly taken into consideration when planning reforms."*
>
> *"According to the constitution, health care is equal and a good for all. It just doesn't come true like that. Clients should be asked more about how they have experienced the services and these enquiries should also be listened to."*

From the foregoing we can infer with some justification that the views expressed by NGO representatives are consistent with a basic theme of this article: that ordinary citizens are "experts in their own lives," and that this is an expertise that is fundamentally important to the formation of sound, effective, and equitable public policy. The humane values and personal interests expressed by consumers of health care do not constitute information that policy-makers may simply assume or take for granted. Nor is it information that can be fully appreciated by the device of opinion polls. Citizens have stories to tell, and in those stories lie details and nuances that policy-makers cannot divine except by listening to people tell their own stories. Deliberative democracy represents a call for a democracy that is more responsive because it is more inclusive, more participatory, and more communicative than any existing mechanism by which the public may inform and guide the decision-making of government officials.

Views of Finnish citizens

The results of the quantitative part of the citizen survey appear below. Table 5 shows how the respondents view their potential, as individual citizens, for influencing the development of health care reforms and policies. Those who thought that their prospects were "quite poor" or "poor" (87 %) clearly outnumbered those who considered their chances to be "quite strong" or "strong" 8 %).

Strong possibilities (%)	**Quite strong…**	**Don't know**	**Quite poor…**	**Poor…**
3.92	3.92	5.24	42.48	44.44

Table 5. How respondents view their prospects, as individual citizens, for influencing the development of health care reforms and policies

To the question of whether the respondents want to influence policy-making more strongly, respondents answered clearly in favor ("yes," 71 %; "Maybe," 27 %). Only 2 % expressed no desire for greater influence.

Table 6 shows how important the respondents consider the participation of citizens to the development of health care reforms and policies. A strong majority (95 %) stated that citizen participation is "quite important" or "important." Not even one respondent considered the participation of citizens in the development of health care reforms and policies to be not important at all.

Important (%)	Quite important	Don't know	Not that important	Not important
65.36	30.07	3.27	1.31	0.00

Table 6. How important respondents consider the participation of the citizens in the development of health care reforms and policies.

One question in the survey asked whether respondents believe that an individual citizen has the capacity to understand the complex matters that are the focus of health care reforms and policies. The structure of the system of health care provision was given as an example of a complex matter. Table 7 shows a strong belief in citizens' capacities, with 79 % of respondents saying that they believe "completely" or "somewhat" that an individual citizen can comprehend the complex matters of health care.

Believes completely (%)	Believes somewhat	Don't know	Doesn't believe exactly	Doesn't believe
28.76	50.33	8.50	11.76	0.65

Table 7. Do respondents believe that an individual citizen has the capacity to understand the complex matters that are the focus of health care policies?

Respondents were also asked whether they would be willing to participate in a Citizens' Jury. A Citizens' Jury was described in its most demanding form, i.e. with a duration of four to five days. It was expected that respondents would be disinclined to such a time-intensive exercise. Surprisingly, only 12 % said they would not participate. Instead, almost 60 % said "yes" and 28 % "maybe."

From the qualitative portion of the survey, views about the themes of this article emerged. One view was a critique of the planning of health care reforms and policies. Respondents expressed the opinion that decisions are made by a small number of insiders; that there is not enough communication about the planned reforms and policies; that decision making is too lacking in transparency and closed to citizens; and that money is the determining factor in making decisions:

> *"Preparation of reforms should be transparent so that there would be communication as early as in the planning stage, so that it would be possible to have time for genuine influence. Decision-making in public administration (and in municipalities) is too cryptic and closed to citizens. Open debate doesn't take place and the opinions of citizens aren't listened to….."*

> *"If only there were notifications about these reforms somewhere. Seems to be they are only matters for insiders."*

> *"...As an individual citizen, I believe opportunities for influence very small; budget, money and surplus are decisive. That is sad."*

It also became clear that respondents did not have much trust in the knowledge of decision-makers:

> *"The only thing that I have is the experience about living as a disabled person through my life. As a survivor of polio, I have experienced one thing and another in health care through these years. Decision-makers and implementers don't know much about the reality."*[20]

> *"It would be a really good thing if individual people could take part in plans about health care services."*

> *"… Decision-makers are people who don't have even the slightest idea about the conditions and the world view of the people whose issues they make decisions about. That's why it would be important that the voice of the people whom the decisions influence would be heard. As far as I can see, the strength of the many would be the solution."*

There was, however, some skepticism in the answers about the possibility of making changes to increase citizen influence in planning of health care policies. This critique was expressed most frequently in the Otakantaa internet discussion forum:

> *"I really hope that citizens' forums like Otakantaa would yield results and that the opinions of citizens would be noticed, but unfortunately it seems that there is no hope of this happening.…"*

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[20] This reflects with what Thacher (2009) calls "the experiential gap," meaning that public officials constantly "take actions that have implications for people whose experiences they do not share, and they must continually make laws that affect lives they have not lived." As the "direct experience to draw from" stays marginal, the risks of misconstrual in the decisions may increase as a result.

Two additional perspectives of interest emerged. First, some of the respondents stated that they would prefer to exercise influence through third sector organizations. This parallels the views of some NGO representatives. Second, it was interesting to notice that respondents wrote highly personal information as well as voicing common critiques of Finnish health care in the open comments section of the survey. This suggests that many people do not have many chances to express their views, so they do so when they can, even though no one is likely to reply to them.

At the outset of this section it was noted that an important question that needs to be asked is, "what do citizens themselves think about the themes of this article?" viz., do they consider their involvement in the planning of health care reforms and policies important? The citizens who answered the survey clearly believe that at this moment their individual opportunities to influence the development of health care policy are quite limited. In the qualitative answers this sense of powerlessness came out strongly. This is not a state of affairs that respondents are content with. They very clearly want more influence on these issues.

Also, even though health care issues can be highly complex, respondents believed that an individual citizen has the capacity to understand these matters, although they are less certain of their capacity to do so than they are of the importance of having opportunities to express their views. It is possible that more experience with public deliberation would increase their confidence (see e.g. Bennett & Smith 2007). Additionally, respondents regarded the idea of deliberative practices – in this case, a Citizens' Jury – more positively than expected.

In general, then, the views of these citizens who responded to the survey are consistent with the theoretical perspective of this article.

As noted previously, generalizability of the results was not expected, given the limited, unrepresentative sample available for research. However, the results reported here are similar to those obtained from a survey with a more-adequate sample. A recent survey by the Association of Finnish Local and Regional Authorities (2008) of views held by residents of 14 Finnish municipalities on the question of municipal performance and decision-making randomly sampled 11,600 persons between the ages of 18-75, with a final sample of 5,183. Two results are of special interest. First, respondents were asked if the municipal residents' opportunities for participating in decision-making should be improved. On the issue of elder care, 78% of respondents agreed that improvement is needed. On the issues of health care development and planning, 74% favored more chances for participation. In contrast, on the issue of developing and planning for cultural services and libraries, only 39% were in favor of the proposition (Association of... 2008).

Second, on the questions of (1) whether municipalities should develop the feedback processes by which the views of service-users are gathered; (2) whether service-users should be involved more in planning than is customary; and (3) whether municipalities should organize more public hearings and discussion events which would include elected officials and municipal officials, the answers in favor were, respectively, 86%, 77% and 67% (with 26% neither for nor against) (Association of... 2008). Even though these answers are from a survey of views about local level municipal issues, the evident desire for increased citizen involvement is striking, and in line with the results of the health care surveys reported in this article.

5. Conclusions

Five claims have been made. First, there exists no “Holy Grail” of health care policy which those in positions of decision-making authority might discover and then, with perfect reforms and policies, solve the wicked problems of health care. Second, in order to tackle wicked problems effectively, public participation—especially participation of a deliberative nature—is called for. Acceptance of these propositions is a precondition for achieving coherence (i.e. shared understanding and commitment) on wicked health care issues such as the question of how to resolve the dilemma created by increasing health care demands and limited resources. Third, the abstract notion of deliberative democracy can be seen to have practical application in the case of challenges confronting the Finnish welfare state. Public deliberation could transform the discussion on the future of welfare state, and rebuild a broad consensus upon which coherent policy could be developed. Fourth, although only a few examples of Finnish public deliberation are available for analysis, and these few fell somewhat short of the deliberative ideal, they are something that hasn’t been done before in Finland, and as such represent important progress in this crucial area of democratic theory and practice. Lastly, the results from two electronic surveys were presented. One included the views of NGO representatives and the other the views of a group of citizens. Both the NGO representatives and citizens were clearly in favor of increased citizen involvement in the planning of health care reforms and policies.

Overall, we can say that the way certain health care problems are perceived affects respondents’ views of whether citizens should be involved in decision-making. If problems are considered “tame” or “messy,” or if wicked problems are believed to be “tamable,” the favored approaches remain technocratic ones (see Raisio 2009a). Involvement of citizens in planning is a marginal concern. However, if health care problems are perceived through the lens of wickedness – which is the right perspective on many health care issues (see e.g. Glouberman & Zimmerman 2002; Vartiainen 2005; Raisio 2009b) – then acknowledging the expertise of citizens and admitting them to the process is appropriate. This change

of visual angle could then have significant implications for the future planning of Finnish health care reforms and policies.

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