

The Absent Minority in Welfare Planning: Entitling or Overburdening Citizens with Responsibility?

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Abstract

In Finnish health care and social welfare legislation, a shift towards strengthening the individual's right to participate has been significant during the past two decades. While the traditional presumption of citizen involvement and developing of deliberative democracy lies on normality and social activism, it is becoming apparent that the substantial amount of Finnish social and healthcare expenditure is used by one tenth of citizens who do not fit into this category and can be considered as large-scale consumers of the services. We refer to this group, identified by high service consumption and low participation, as the absent minority. In this paper, we illuminate the legislative and participative possibilities of involving and acknowledging this group in communal welfare service development.

Keywords: deliberative democracy, minority absence, welfare planning, social rights.

Introduction

This article discusses the legislative and participative possibilities of involving and acknowledging the group of service users referred to as “marginal” in communal welfare services development. Our research task is to propose a conceptual framework for “marginal” user involvement in the context of welfare services. We begin by presenting the theory of deliberative decision-making emphasizing the context of welfare services. Thereafter, we present Finnish legislation of the actors and their responsibilities in welfare planning, then outlining the marginalized group of customers in welfare services. Having discussed the attributes of legitimacy, we suggest the directions of practice and theoretical approach in order to advance the legitimacy of welfare policy.

In a wider spectrum, the concept of social exclusion can be used to describe the part of societies not capable of meeting the demands of dominant norms and requirements. In this delineation, “policies” are generally constructed with an objective of fitting in the deviant by offering them opportunities for social cohesion. (Young, 2000). The policy construction usually takes place in a highly biased setting of voluntary participation, where the well-off are overly represented (Fung, 2003). It is also challenging to define the societal common good as a primary aim without oppression or exclusion of the less privileged and their experiences (Young, 2000).

While the traditional presumption of citizen involvement and developing of deliberative democracy lies on normality and social activism, it is becoming apparent that the substantial amount of Finnish social and healthcare expenditure is used by one tenth of citizens who do not fit into the category and can be considered as large-scale consumers of the services. In addition to geriatric patients and expensive somatic illnesses, resources are expended in groups embodying the deviant or marginalized group of citizens with the backgrounds of substance abuse, mental challenges and child protection. Many – though not all – of these groups can be described as *vulnerable*, dependent on the help of others. One of the key identifiers in determining small and vulnerable groups is the possibility and probability of the emergence of their agenda in the democratic system. Some vulnerable groups, e.g. children and older people, are large in number and associate with positive and familiar images, which help them to acquire advocates and representatives.

Others are small minorities and defined by unfamiliar and rare characteristics, such as substance abuse, which drifts them further away from the ideal of active citizenship (Nurmi-Koikkalainen, 2006).

The definition of good governance from the participative perspective has developed Finnish municipal counseling bodies and policy planning processes in order to meet the manifold claims of participation and minority representation. It is yet criticized of seeking consensus by addressing the questions apposite for the dominant (Pykkänen, 2004). Welfare organizations, balancing between their difference tolerating, multiple values and a strain of efficacy, not only smooth away deviant voices but “assume the right to define and diagnose normality and deviance” (Riikonen, Makkonen, Smith, 2004, p. 312).

Finland is rearranging its welfare services by making considerable changes in social services and health care structures. It has been stated that the past Finnish health care reforms have so far failed to meet their objectives due to the disconnection between issues addressed and the challenges of the society (e.g. Vartiainen, 2010). Emphasizing individualism and the neoliberal consumerist mindset has distanced welfare policies from the communitarian values that should fundamentally steer decision-making (Mooney, 2009; 2012). With reference to internationally numerous, substantial and yet unsuccessful efforts to cut back health care costs by deliberating the troubled tenets of prioritization (see Oberlander, Marmor, Jacobs, 2001), we find it essential to guide the inspection of welfare arrangements towards the special characteristics of a community, emphasizing the “heavy user” perspectives in service design.

In Finnish health care and social welfare legislation, a shift towards strengthening the individual’s right to participate has been significant during the past two decades. However, the right to participate in the planning of health care and social services does not implicate a substantive right to certain benefits or services. Despite their relation to constitutional and human rights, the provisions regarding the patient’s and client’s right to participate are merely procedural and aimed at strengthening the ideal of an active citizen.

These new procedural rights produce new kinds of subjectivities with emphasis on active citizenship and the ethical responsibilities that come with it. An active citizen is an ethical subject who is responsible not only for his own well-being but that of the community as well. What about those who refuse to become responsible or are unable to do so? The highly normative comprehension of deviancy

approaches it from administrative supremacy, focusing on controlling the menace to society while a new type of perspective to deviancy could be their divergent interpretations and construction of society and its services.

We suggest the directions of practice and theoretical approach in advancing the legitimacy of welfare policy by proposing a conceptual framework for service user involvement. In our conceptualization, special attention is given to the challenges of marginal participation and its legislative preconditions.

Deliberative democracy and welfare services

The theory of participative decision-making arises from the deep roots of political theories, particularly democratic systems and their advancement of deliberative decision-making (e.g. Pateman, 1970). The *Deliberative democracy theory* is a normative theory focusing on the objective of policy legitimation by means of communicative processes (Chambers, 2003; Dryzek, 2010). The Finnish Institute of Deliberative Democracy (DDI, 2016) defines the conception of deliberative democracy as follows: “...*political decisions can be seen as legitimate if they are based on discussion in which different views and population groups have been equally represented. Deliberative democracy is therefore a question of reciprocity and respect for different opinions*”.

The conception of deliberative democracy can be perceived as a wider, umbrella term covering, for example representative democracy, implementing the “Madisonian” ideal of political participation and electoral, representative decision-making. Contemporary administrative sciences have, however, embraced the term emphasizing its participative (e.g. citizen, service user, inhabitant) attributes. From the deliberative theory perspective, without ignoring other attributes or methods of democracy (such as the rule of law or voting) a political system’s democratic status can be appraised by the state of their deliberative practices (Dryzek, 2009).

An essential feature of deliberative democracy is its requirement of collective argumentation preceding the decision-making (Chambers, 2003). By means of various deliberative arrangements (e.g. citizens’ juries or panels, deliberative polling) an equal discourse is reached: viewpoints are articulated and valued without diminishing or denying discrepancies between the perspectives presented. Ideally, after introductions given by various experts, exchanging views and profound reflection of the issue addressed, a final conclusion,

in which all members of the deliberation can engage, is reached and presented (e.g. Raisio and Vartiainen, 2015).

The majority of the deliberative theorists of deliberation accentuate – embracing the Habermasian idea of “public sphere” – the heterogeneity of the group involved in deliberative discussion to ensure the diversity of arguments presented in the aspiration of optimal decisions (Sunstein, 2002) as well as to advance coherence in disunited societies (Dryzek, 2005). The legitimacy of the conclusions and decisions reached through deliberative arrangements is based on the participant’s ability to reason their perceptions (Fung, 200; Young, 2000).

While acknowledging the constricted participative capabilities of the disadvantaged or underprivileged, the true equity, and therefore the objective of legitimacy, can be challenged (Raisio, Valkama, Peltola, 2014). While evolving into a more applicative theory, the idea of deliberative democracy has become more “sensitive to pluralism” (Chambers, 2003, p. 321), yet still criticized for inability to resolve the questions of injustice (Sanders, 1997; Karpowitz, Raphael, Hammond, 2009). Widely cited, the Chambers’ revised definition of deliberation envisions the questions of inequity: *“Although consensus need not be the ultimate aim of deliberation, and participants are expected to pursue their interests, an overarching interest in the legitimacy of outcomes (understood as justification to all affected) ideally characterizes deliberation”* (2003, p. 309).

The advantages of deliberative decision-making concepts are eminent particularly approaching an inevitable discrepancy between increasing demands of welfare services and respectively diminishing resources. Internationally observed there is a strong shift towards emphasizing service users’ perspectives in service planning and welfare policy decision-making (e.g. Martin, 2008; 2011; Vigoda, 2002; Rosen, 2006). In Finland, there is a slow awakening to the significance of service users’ expertise of the services while the methods of public, deliberative policy guidance are still sketching their outlines (Raisio, 2010; Möttönen, 2012).

The shift is somewhat perceptible in documents concerning service planning and reforming; e.g. the Ministry of Social Affairs and Health (STM) is framing customer orientation in its strategy as “an offset of developing services as well as a strategic choice aimed to shift emphasis towards preventative and achievable care”. Reforming of services is implemented through “the active participation of service users”, yet assigning the communities (municipalities, regions) to determine their means of

citizen involvement (STM, 2011). Despite the efforts of Finnish ministries and public offices in developing citizens’ engagement and municipal democracy (e.g. Open Government Action Plan 2015-2017), experiments in participative, deliberative democracy have remained local and relatively small-scale.

The actors and their responsibilities in welfare service planning

The responsibilities of the authorities

There is no specific mention of participatory welfare planning in Finnish law. The duty to plan and develop welfare services on a general level is divided between different authorities: the Ministry of Social Affairs and Health, communities as service organizers and “the centres of excellence on social welfare” (Government decree on the activities of social welfare know-how centres 1230/2001), state-financed regional development networks in the social sector. In health care, the responsibilities in planning and development work are respectively divided between the Ministry, research agencies under the Ministry’s administrative branch and the organizing authorities, i.e. municipalities and hospital districts.

The legal framework of welfare planning concentrates on the responsibilities of service organizers in collecting and utilizing both professional expertise and empirical data concerning social problems and welfare. In the context of social services, this activity is called structural social work and is divided into three parts:

1. Providing client work-based information about client needs and their social connections as well as the impacts of the services responding to these needs
2. Target-oriented actions for preventing and correcting social problems and improving the living environment of the inhabitants of the municipality.
3. Bringing social welfare expertise into the planning of other sectors of municipal services as well as co-operating with private service providers and organizations in developing local social work and services (Social Welfare Act (hereinafter SWA), 1301/2014, §7).

Officials’ responsibility to mediate the needs and views of clients is regulated in both general and specific laws in the welfare sector, e.g. in the SWA §8, which obliges officials to pass on information regarding the needs of people with special support needs, and paying special attention to these needs in service development. The obligations of officials regarding welfare planning culminate in various obligatory plans, which must be conducted as part of municipal strategic planning. Such plans

include, e.g. municipal welfare report, welfare plan for children and youth as well as a plan for supporting older population. Municipal citizen councils, which are statutory for the representation of older people and persons with disabilities (Local Government Act (hereinafter LCA) 410/2015, §27, §28), have the right to participate in drafting these plans at least in the form of comments. Requests for comments are usually sent to all relevant client and patient organizations but these requests are neither mandatory nor any reaction to the received comments.

Clients have no legally recognized way to participate directly in the planning of welfare services. They are represented by: 1) professionals as information collectors and mediators and 2) client organizations as reference group-based forms of social activism. From the viewpoint of social margins and large-scale service consumers, the latter form of representation is of weak significance, since a high level of needs in support and services tends to correlate with a low level of social activism, which, in fact, makes the participatory and empowering efforts of the professionals the very essence of social work with marginalized clients (see e.g. Fook, 2000; Parton and O'Byrne 2000).

The participative rights of the service-users

Finland has passed two groundbreaking laws on patients' and clients' rights. The Act on the Status and Rights of the Patient 785/1992 (hereinafter Patient Act) was the globally first law on patient rights in health care and The Act on the Status and Rights of the Clients of Social Care 812/2000 (hereinafter Client Act) provided similar rights for the clients of social care. These laws focus on the individual's right to self-determination and access to information regarding the planning and implementation of their own services. The laws do not include any collective rights or set any obligations for the service organizers regarding welfare service planning on a general level. The individual's right to participate in their own matters is relatively strong, however, including the right to decline any services (Patient Act §6; Client Act §8), the right to co-operate in the planning and implementation of social of services (Client Act §7) and express or decline 'mutual understanding' regarding the statutory service or treatment plan (Client Act §7; Patient Act §4a). As these plans obligate the service providers, the right to participate in formulating service or treatment plans is the weakest of these individual rights, reducing the individual's actual right of decision to the *right to accept or decline* the offered services.

These individual rights are based on two separate constitutional rights: the right to life,

personal liberty and integrity (The Constitution of Finland 731/1999 §7) as a basis for the right to self-determination and the right to social security as a basis for necessary care and income as well as sufficient welfare services (§19). Furthermore, the equality of all people (§6) and the public authorities' obligation to protect basic rights and liberties (§22) serve as a backbone of Finnish constitutional thinking, defining justice in welfare as equality in terms of access to and the content and quality of services (Paunio, 2001). These constitutional social rights, in turn, implement international treaties on human rights. This mechanism turns individual rights into equivalent responsibilities of the state and the municipalities. The subjective constitutional social rights have effects in all aspects of the legal system: in the justification, making, interpretation and application of law (Tuori & Kotkas 2008; Hänninen 2010). For this reason, is it not relevant to make a distinction between the right-based and regulatory approach to user participation in the context of welfare planning, as the two mechanisms are integrated (cf. Tritter, 2009).

A major concern, however, has been expressed over the increasingly procedural nature of the individual social rights in the Finnish social and health care legislation. The above-mentioned participatory rights do not protect the access to certain services or benefits as *substantive rights* do. In contrast, they protect the right to proper procedures in applying for and implementing the services, and thus they can be described as *procedural rights* (Kotkas, 2010). The individual's right to participation in the decision-making concerning one's own welfare supports the fulfillment of the right to self-determination, but in the same time it gives the individual new responsibilities. Instead of being automatically entitled to certain services, the client or patient is obligated to participate actively in order to obtain and retain a better standard of service. This can be seen as a manifestation of the ideal active citizen taking responsibility for one's own well-being (see Kotkas, 2010). There are no sanctions for neglecting one's participatory duties, but the quality and individuality of the services may diminish. This is alarming, considering the characteristics of large-scale service consumers.

The right to participate, especially in the context of deliberative democracy, has some fundamental tensions in relation to the basic values of public welfare and social care. The client has traditionally been regarded as a passive care-receiver and object of services, whereas the professional personnel have an active role of caregivers and benefit providers. This has led to the dominance of the authoritative

perspective in the guidance and counseling of the client (Government Bill 137/1999). Welfare services are provided considering the patient's or client's *best interest*, which is determined by the professionals. This *paternalistic* way of thinking, originating in the Hippocratic oath, is manifested in medicinal ethics and the welfare personnel's ethical code (Tuori & Kotkas, 2008; Beauchamp & Childress, 2012). The *principle of safeguarding and protection* is closely linked to paternalism, obligating the welfare professionals to protect individuals from harm against others and against themselves (Mäki-Petäjä-Leinonen, 2003). On the other hand, the rise of consumerist welfare models has gradually developed the Finnish welfare system towards implementing activating measures as preconditions for providing social benefits and in many ways encouraging the clients to take more responsibility in the planning and provision of their own services, thus prioritizing the right to self-determination over paternalism (Kotkas, 2010; Tuori & Kotkas, 2008).

According to the national RAI database, only 10-50 percent of older people within long-term care participate in the assessment of their own capacities and service planning. The lowest percentage of participation, 10-17 percent, was among the residents of nursing homes and institutions, i.e. people with largest service needs (Finne-Soveri & Noro, 2012). The ideal of the active citizen cannot be applied to these large-scale service consumers with diminished capacities and functional restrictions. However, the ideal of active, responsible and interested citizen has effects on the services they receive. The welfare system promises a sufficient amount and good quality of services (SWA §1; HCA §2) but in return it requires individual participation in the assessment of service needs and planning of service content. If the client does not have enough interest or capacity or participate, there is a severe risk of a poor quality of service or even abuse. Recently, the National Supervisory Authority for Welfare and Health (Valvira) reported the results of an enquiry addressed to the personnel in social welfare units providing 24-hour care for the elderly. Results show that 93 percent of the respondents had noticed some kind of abuse (Valvira, 2016). The findings were mainly associated with stressing working conditions or shortcomings in supervision and management, but the clients' vulnerable position and incapacity to participate are among the known risk factors of elder abuse (Caste, Ferguson-Rome & Teresi, 2015).

Citizen participation in Finnish welfare

Citizen participation on a more general level is protected by the recently revised Local Government

Act §22. According to this paragraph, the inhabitants of the municipality have the right to participate in and influence the activity of the municipality. This right may be promoted especially by:

1. Organizing public hearings and citizen juries.
2. Surveying public opinion before decision making.
3. Electing service user representatives into municipal governing bodies.
4. Organizing opportunities to participate in the financial planning of the municipality.
5. Planning and developing services together with clients and service users.
6. Supporting the unprompted planning and preparation work done by citizens, organizations and other local communities.

It is noteworthy that the actions listed in the paragraph are merely informative in providing examples of efficient citizen involvement. The implementation of these actions is voluntary to the municipalities – in the realm of their autonomy they may use some of these methods or perhaps none at all (Government Bill 268/2014, p. 150). However, the citizens' right to participate is legally binding and the municipal council is obligated to provide diverse and effective means to exercise this right. Section 5 of the above listed paragraph is entirely new. Planning and developing services together with clients and service users can be applied in all varieties of public service planning: small sections or large systems, in narrow or broad topics, in long-term or short scale projects. In the reasoning of the government proposal, there are listed numerous methods of conducting such user-oriented development. They include collecting client feedback, measuring client satisfaction, events of brainstorming and envisage, service experiments, collaborative planning and service design. The new Local Government Act also recognizes service development via citizen activity in projects, campaigns and networks together with client organizations or other communities. In addition, the new act also gives citizens the right to make initiatives concerning service innovations, i.e. suggesting more efficient or client-friendly ways of producing public services. Execution of this right, however, requires a decision by the municipality to apply the service initiative model (Government Bill 268/2014, p. 151-152).

One of key expectations of the law is that it ensures the enforcement of values that otherwise might not be taken into account in societal practices such as organizing services. Laws can be set up to assure that proper tools are used in order to ensure the protection of predetermined values (Larsson, 2013). The values which steer welfare planning

can be found in social and health care legislation, from the paragraphs stating the law's purpose (SWA §1; HCA §2; Client Act §1). The central values from the viewpoint of welfare planning are 1) client-orientation, 2) equality and 3) participation. The above-mentioned LCA §22 which regulates municipal inhabitants' right to participate is a juridical safeguard for the enforcement of these values but it does not guarantee proper implementation of the law in local welfare policy.

The legal framework governing Finnish welfare planning can be regarded as up-to-date, flexible and responsive to the needs of clients and patients as it enables all forms of citizen involvement and participatory planning. However, the administrative activity in the welfare sector does not take full advantage of the options enabled in the law. Socio-legal scholars have analyzed reasons for dysfunctions of laws in their social context using American sociologist Robert Merton's functionalist theories as a starting point (Merton, 1968). One reason for dysfunctional laws is that the legal norms are ill-fitted to the social norms and the societal context that they try to regulate, which leads to unintended consequences of legal implementation (see Mathiesen, 2005). In the context of welfare planning, the values of health care and social work are not always easily reconcilable with the values of deliberative democracy. When we consider the needs of large-scale service consumers, the right to care and protection becomes the first priority leaving involvement and participatory efforts as a secondary concern.

The hidden significance of the disadvantaged

From welfare policy point of view, one of the biggest challenges in deliberative deliberation executing lies in strengthening equity by fortifying the voice of the quiet marginal. By increasing societal inequity, the theme of welfare equity can be estimated to grow substantially. Individualistic, market oriented mindset has already significantly shaped Finnish health care services: the growth of private welfare services in the 2010s has been stronger than public services. In a study executed in 2004, 11 percent of Finnish population sought to get help in private health services and only 10 percent stated to have bought private health insurance¹, whereas in a similar study executed in 2013, the

¹ All Finnish people are insured by the state, entitling the inhabitants to seek services in public, primary healthcare centers and (through a referral system) specialized healthcare. Private healthcare services, including specialized physician services, can be purchased by private health insurance coverage or private settlements partly supported by the state. Occupational health care services are provided for all employed people.

possession on private health care insurance amongst adults was already 22.7 percent and amongst children – as much as 52 percent (Kallio, 2008).

The socio-economic demography of private health insurance purchasing shows them to be polarized strongly in the favor of wealthy households and, respectively, the underprivileged to be uninsured. This group consists partly of a population group referred to as “marginal” or “disadvantaged”, yet found to create a noteworthy proportion of Finnish social and welfare expenses. In a study implemented in Oulu (northern city with 190 000 inhabitants, placed within the five biggest cities in Finland) 10 percent of inhabitants were discovered to accumulate as much as 81 percent of the total expenses in municipal welfare services. In addition to geriatric patients and with expensive somatic illnesses, resources are expended in groups embodying the deviant or marginalized group of citizens with the backgrounds of substance abuse, mental challenges and child protection (Leskelä, Komssi, Sandström, Pikkujämsä, Haverinen, Olli, Ylitalo-Katajisto, 2013). The study resonates with earlier study made in Helsinki and its surroundings (Kapiainen, Seppälä, Häkkinen, Lauharanta, 2010), wherein a similar distribution of costs was found.

Results in the research on children's well-being in Finland (e.g. Tähtinen, Broberg, Forssen, Hakovirta, 2004) predict the continua of welfare challenges and polarization of wellbeing due to multiple problems of a small part of children suffering from weak domestic resources. Also a study by the National Institute for Health and Welfare (THL) and the Network of Youth Research (subordinate to the Ministry of Social Affairs and Health) indicates high costs of the marginal customers of welfare services (Aaltonen, Berg, Ikäheimo, 2015). According to the study, the gross expenditures of “chronically marginalized” youth's health care services are sevenfold and pharmaceutical costs as much as tenfold compared to youth, secondary school graduates, without an imminent threat of marginalization. The correlation between chronic marginalization and high healthcare costs was shown to interconnect strongly through mental problems. The study also indicated a general discontent with meeting youth's needs in healthcare services, which was estimated to be paramount amongst the risk factors of marginalization.

Ambiguous inclusion

The variety of solutions to include demographically reflecting population in policymaking has been present since introducing the ideas of inclusive democracy. Deliberative democracy theory

efforts to increase legitimacy claim of decision-making have produced a variation of mini-publics, consisting of citizens' juries, consensus conferences and deliberative polling. Whether or not the practical strategy of using microcosmic deliberation fulfills a requirement for participation as one of the major values of deliberation it has been widely discussed (see Lafont, 2015). Yet it has also been questioned if a randomly selected group of ordinary people, at the end of the deliberative process, after engaging in a "deliberative filter" of adequate expert introduction and good quality deliberation, can indisputably be considered as a mirror (see Fishkin, 2009) of population as a whole (Lafont, 2015; Parkinson, 2006).

One of the main principles of constructing mini-publics in a legitimate fashion is to include participants "from the target population in miniature" (Raisio, Valkama, Peltola, 2014, p. 83). Whilst compressing the public sphere into a smaller constitution, *mini-publics* are presented as ways "... to capture the otherwise-missing voices and [mini-publics] provide opportunities for organised interest groups and hyper-interested individuals to attend as expert speakers" (Raisio, Carson, 2014, p. 77). Mini-publics are suitable for considering general issues such as "issues of energy or economy" (Ibid., p. 79).

Deliberation amongst sub-national or marginalized groups (also referred to as in-group or *enclave deliberation*) consisting of a homogenous or "like-minded" (see Fung, Warren, 2011) group of people are more rarely encouraged presuming that they diminish the prospects of reaching a collective view or embracing societal diversity (Walsh, 2007; Miller, 2000) and create group polarization (Sunstein, 2002). However, according to Vasilev (2013), in-group deliberation can serve as a forum of "transformative" deliberation, an identity shifting postulating across-groups deliberation and communicative development in fragmenting societies. Karpowitz, Raphael and Hammond (2009, p. 576) present similar study evidence arguing that in-group, enclave deliberation among disempowered groups offers "some of the same benefits of deliberation found in more heterogeneous groups" by a careful design and proficient facilitators.

Lyn Carson (Raisio, Carson, 2014) illustrates the level of inclusiveness with a continuum: the ideal situation of including the whole sphere of society lies at the other end of continuum, whereas the enclave deliberation is positioned across from it. Mini-publics is situated right next to the public sphere, illustrating it as the next best method considering the realization of inclusion. The concept of *sector mini-publics* is located in between mini-publics and

enclave deliberation and is characterized to address a distinct segment of population. The inclusive objectives of the mini-publics sector differ from the previously described by addressing a section of society "relevant to the specific policy" (Ibid., p. 89) such as youth, elderly or citizens with disabilities (Ibid.).

The practices as well as incentives to encourage the missing participants to involve themselves in policy deliberation have been ruminated to a great extent. The majority of this discussion seems to consider the inclusion of citizens with physical impairment or disability, less attention has been paid to the inclusion of groups with social disparities. Nevertheless, representative selection by representative polling using incentives or the yielding results of participation, or using recruitment processes (e.g. Fung, 2003) would have to be brought to bear the context of marginalized welfare service users.

The legitimacy of welfare planning from the viewpoint of marginal involvement

From legislative point of view large-scale service consumers have no obligation to participate in service planning. However, their views and needs should be collected and mediated for the development and planning of services as a legal responsibility of officials. The LCA §22 as a general provision, and the SWA §7 specifying it in the context of social work clearly state as the duty of officials to provide information concerning client needs when planning services. In Finnish health care legislation, indirect participation has a less binding normative basis than in social care, as the Health Care Act (HCA, 1326/2010) only obligates municipal officials to monitor health and well-being of its inhabitants not collecting information directly from patients.

This procedure of gathering client and patient information represents indirect client participation. The vast majority of involvement activity in the welfare sector is indirect involvement and typically entails information gathering from service users. Direct involvement, by contrast, is based on clients, patients and the public taking part in actual decision making. This includes determining the services that are offered and how resources are used. Indirect participation allows professionals and officials to make final decisions. They can choose to ignore feedback from people if they think it inappropriate or decide what aspects of information they have collected they should take into account (Tritter, 2009).

In other words, the absent minority is not expected to participate and yet their views are

regarded to be the starting point of welfare service planning. However, it can be argued that they may not have the possibility to participate regarding the methods of promoting the right to participate, as the list of means leans heavily on the concept of active citizenship and the ‘ordinary’ citizen with sufficient social capacities (see Raisio, Valkama & Peltola, 2014). The legislator has recognized their role as the main service user group but has it provided them with functioning means of influencing the service planning process?

The legal framework governing Finnish welfare planning can be regarded as up-to-date, flexible and responsive to the needs of clients and patients as it enables all forms of citizen involvement and participatory planning (see Bächtiger et al., 2010). However, administrative activity in the welfare sector does not take full advantage of the options enabled in the law. According to socio-legal scholars, formal citizen participation as it is described in laws does not necessarily mean inclusion in practice. The informal viewpoint to participation must take into consideration both sides of the matter: whether or not a citizen has the formal possibilities to act, or has the actual possibilities to act (Baier, 2010; Larsson, 2013).

A conceptual framework for marginal involvement

The many conceptualizations of public involvement build on the “ladder of participation” proposed by Arnstein (1969), representing the increasing degrees of involvement from non-participation to citizen control. Tritter (2009) has proposed a conceptual framework for patient and public involvement (PPI) in health care, covering five different categories of involvement activities: treatment decisions, service development, evaluation of services, education and training of health professionals and research. In Tritter’s conceptualization, these five categories of PPI activities are differentiated in relation to

three dimensions: 1) individual and collective participation, 2) direct and indirect approaches and 3) proactive and reactive nature of involvement. His model serves to conceptualize PPI activity in the context of health policy. However, Tritter’s model fails to recognize the fundamental differences between legally binding involvement activities and other, optional or spontaneous types of citizen participation. The latter type is closely connected to *consumerist* definitions of user involvement, in contradiction to *democratic* models (Tritter, 2009; Croft & Beresford, 1993).

The Finnish welfare system consists of two normatively separate sectors: health care, which is distributed through treatment decisions, and social care, which is distributed through administrative decisions. At the same time, new legislation (e.g. in elderly care) and political reforms are merging the two sectors into one, more client-oriented and centrally governed field of welfare services. This development raises a distinction between regulated and optional involvement activities into a key position. Some activities of user involvement can be applied according to choice, such as involving the client or a user panel in decision making, or enquiring user opinions prior to the implementation of new services. Other activities, however, are obligatory and based on legal norms, such as requiring client acceptance for service delivery or monitoring the service needs of the inhabitants of the municipality.

In order to conceptualize key characteristics of large-scale service consumer involvement, we propose that Tritter’s analysis of policy drivers should in fact serve as the fourth dimension to his model of PPI involvement (Tritter, 2009; see also the starting point of Tritter’s conceptualization in Oliver et al., 2008). This model provides a framework for specifying involvement activities in relation to: 1) *participatory role* (individual-collective), 2) *degree of involvement* (direct-indirect), 3) *mission* (proactive-reactive) and 4) *the legal drivers* (optional-regulated) (see Table 1).

Table 1

Model of welfare service user involvement in Finland

	Direct: taking part in decision making				Indirect: information gathering			
	Proactive		Reactive		Proactive		Reactive	
Individual	optional (service planning)	regulated (acceptance/denial)	optional (corrective measures)	regulated (complaint)	optional (planning discussions)	regulated (assessing client needs)	optional (follow-up discussions)	regulated (client feedback)
Collective	optional (planning panels)	regulated (councils, initiatives, comments)	optional (reviewing panels)	regulated (councils, reviewing)	optional (recommendations, comments)	regulated (monitoring service needs)	optional (polls, research)	regulated (collective feedback)

Source: Modified from Tritter, 2009, p. 277.

The model sets the minimum standard of user involvement based on legal norms (the grey area in Table 1) leaving the maximum as an open category (white area). There is no limit to which extent optional activities may be developed, whereas obligatory involvement efforts required from the service organizers are set as statutory duties. Due to our Finnish welfare context, the comprehension of ‘rights-based’ and ‘regulatory’ policies differs here from Tritter’s comprehensions, as Finnish legislation and administrative praxis are highly rights-based. Tritter associates rights-based policies with patient consumerism and primacy of the individual, whereas Finnish policy sets the individual’s constitutional social rights as the basis for special legislation and the services provided according to these statutes (Tuori & Kotkas, 2008). In this conceptualization, the optional policies are equivalent to the rights-based policies in consumerist models (see Tritter, 2009). In Table 1, we have described different involvement activity types with indicative examples from Finnish welfare planning policy and legislation. However, the activities differ significantly between health care and social welfare, and the statutory duties center on social welfare laws.

It is noteworthy that the minimum standard is not limited to the lowest ‘rung of the ladder’, i.e. merely informative indirect participation. Finnish welfare law provides that clients and patients take part in the decision making regarding their own services. Also, municipal disability and elderly citizen councils have become statutory during the 2010s (LCA §27, §28). As a diminishing ability to function is a key characteristic among large-scale service consumers (Leskelä et al., 2013), these citizen councils may contribute significantly to marginal involvement. However, regulated collective involvement activities are distinctively inadequate regarding e.g. child protection and the social services for “chronically marginalized” youth (see Aaltonen et al., 2015). In these service sectors, collective participation is mainly carried out by non-governmental organizations and the regulated measures are limited to making initiatives, comments and complaints.

The statutory, minimum standard of user involvement is distinctively *passive* by nature. Regulated involvement duties include such activities as requesting client acceptance for decisions, giving instructions for making complaints, requesting comments for government bills from client organizations and monitoring client needs and experiences with the help of surveys and statistics. There is no active involvement required by service users in these actions, as the client is not actually

obligated to participate and the impact of these activities does not have to be evaluated. The active forms of involvement are all optional for the service organizers, and therefore the regulatory-optional dimension of this model also corresponds to the scale of presumed user activity of involvement actions.

Finnish public and patient involvement in health care has traditionally been rather passive and largely exercised through local elections (Tritter, Koivusalo, Ollila & Dorfman, 2009). In fact, as social rights as well as individual rights are protected by law, the Finnish welfare system actually discourages both individual and collective participation. There are statutory duties regarding all aspects of welfare service user involvement but as they set only the minimum standard of participation, they must be completed with optional activities. On the other hand, the statutory minimum of participate efforts can be seen as an effective way of strengthening the individual’s engagement and inclusion in the service planning process. Developing the level of participation further is significantly easier with clients engaged in the minimum activities compared to those who are – intentionally or unintentionally – left to the outskirts of the service system.

Few key characteristics of the large-scale service consumers defined in this paper, vulnerability, multiple service needs, the risk of marginalization, are insufficient to serve as identifiers for a participatory group. By dividing this minority into two sub-groups it is easier to conceptualize the factors with effect to involvement activities: 1) those with merely functional disabilities due to e.g. chronic somatic illnesses and 2) those with diminished capacity and high risk of social exclusion. This distinction enables us to define two separate minorities among welfare service users: *the active minority* and *the absent minority*. Regarding the characteristics of “the absent minority”, in addition to their large-scale service consumption, passiveness and a lack of interest are among the most essential (see Raisio & Carson, 2014). Passivity cannot be extracted from the marginals but could it be included in the conception of active citizenship? The passive, statutory individual involvement activities are a preliminary stage of more active forms of participation. The minimum standard is required from the service organizers but the maximum is not set. The activities which require more engagement and personal effort may be applied gradually, paying special attention to the evaluation of the impact of these activities and thus increasing the motivation of the individuals.

We propose a model of the “gear wheels of citizen involvement in welfare services”, which serves to illustrate the methods already available for

promoting minority involvement (see Fig. 1). In the mechanism, the active minority is in a key position being able to influence the service system most effectively. These individuals have user expertise combined with high level activity and interest. The vast majority of citizens are non-users or relatively small-scale users, and their participation is hindered by a lack of both experience and interest. The absent minority has user experience but they lack interest and capacity. The three wheels can also be determined in terms of legal drivers, as the majority of citizens are the potential implementers of the freedom of choice in the opening welfare markets. The active minority has less freedom of choice due to their vast and multiple service needs, and the absent minority is entirely dependent on a predetermined standard

of services as they lack motivation and capacity for competitive tendering of service providers.

The model we propose demonstrates the mechanisms between different participatory activities: each user has an impact on the whole system, however small the contribution may be. Welfare service professionals act as machinists by relaying client views into the service planning process. They have the power of oiling the wheels by increasing the impact of involvement with effective and innovative procedures, or they can cast sand between the wheels by disengaging users from planning.

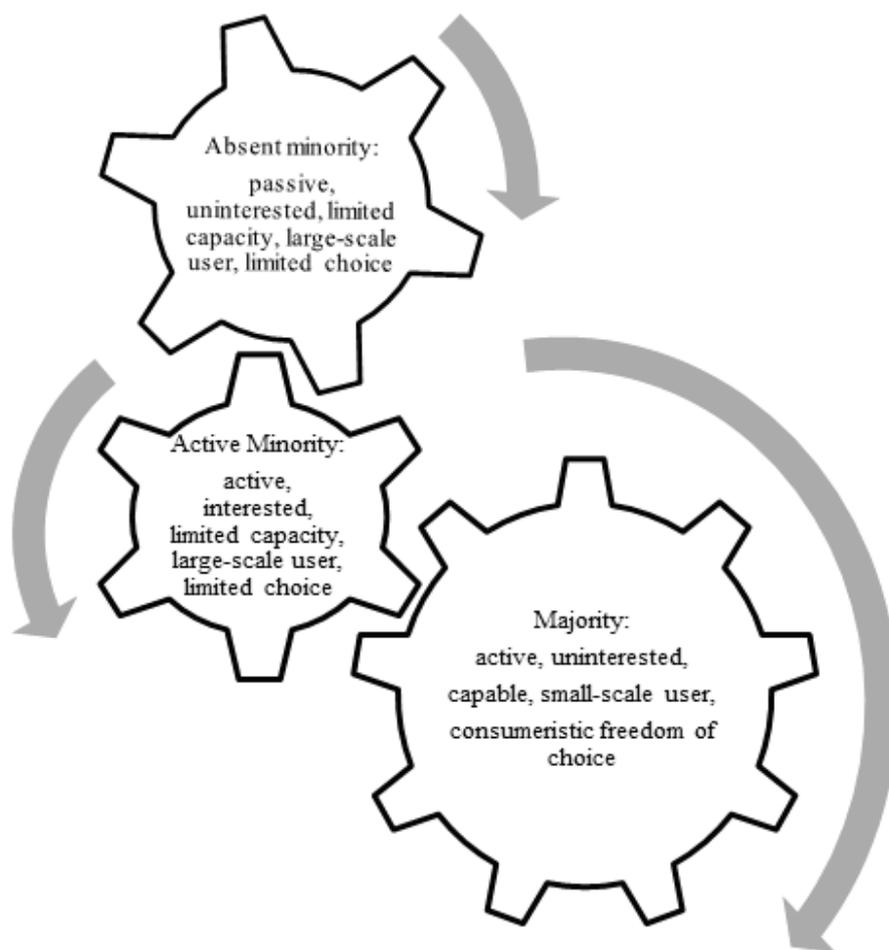


Fig. 1. The gear wheels of citizen involvement in welfare services

Conclusions

Finnish welfare services are entering a new era by making considerable changes in welfare service structures. Goals are ambitious: by subordinating earlier independent (as welfare service organizers) the total of 303 communities under 18 provinces, the state is pursuing better economic capacity

to produce services more rationally and equally. Social and health care services will be united in all levels of services and the freedom of choice in selecting service providers will be increased also by placing public welfare services to market-based competition. Whether furthering welfare policy-making processes to provinces, reasserting private

services or increasing the discretion of service providers will enhance the position of marginalized service users as significant factors of welfare service development remains to be seen.

With reference to internationally numerous, substantial and yet unsuccessful efforts to cut health care costs by deliberating the troubled tenets of prioritization we find it significant to consider the expedients of citizen inclusion in order to rearrange Finnish welfare services more effectively. This requires careful assessment of meeting the fundamental standards of deliberative policymaking as well as the administrative potential to meet them in accordance with the laws and values to be protected.

The traditional representative, also described as an aggregative model of democracy, serves in identifying the majority's preferences without a need or ways of interacting with others with opposing views and, more importantly, social vulnerability. In that sense, the representative decision-making institutions offer support for prolific inequality, particularly noteworthy in decisions serving public well-being. Considering the imbalance between the amount of services used by clients referred as underprivileged compared with general population, we suggest that, in the context of welfare policymaking and the development of welfare services in accordance with the general principles of deliberative decision making, more attention ought to be paid to the structure, inclusion and attributes of designated assemblies.

In Finnish health care and social welfare legislation, a shift towards strengthening the individual's right to participate has been significant. Despite their relation with the constitutional and human rights, the provisions regarding the patient's and client's right to participate are merely procedural and aimed at strengthening the ideal of an active citizen. When a welfare client is not capable or interested enough to participate even in one's own services planning, deliberative efforts appear not as empowering but rather as overburdening.

We approach the conceptualization of marginal involvement with emphasis on the legislative preconditions of social protection. Limited possibilities of engaging the 'absent minority' can be seen as a starting point in an evolving participatory mechanism. In our model, key actors are the active members of the minority. They have the same service needs as the marginalized groups but they possess more capacity and interest for participation. Thus, their involvement can be beneficiary to the absent minority in regards of developing statutory public services. The majority of population, on the other hand, has only small-scale service needs and little

experience or interest as users. Their participatory role is more connected to the client's freedom of choice and the non-regulated, consumeristic service provision. However, involvement efforts in every group have effects on the entire service system, provided that welfare professionals disseminate all relevant information they have received. Thus, engaging the absent minority can be reconstructed from an overburdening responsibility to a part of collective participation in welfare planning.

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Ausschluss einer Minderheit bei der Wohlfahrtsplanung: Ist es gut, den Bürgern das Recht auf Verantwortung einzuräumen, oder überbeansprucht man sie damit?

Zusammenfassung

Dieser Artikel befasst sich mit den legislativen und partizipatorischen Möglichkeiten, die Gruppe von Dienstleistungsnutzern, die bei der Entwicklung der kommunalen Wohlfahrtsdienstleistungen als „marginal“

bezeichnet wird, einzubeziehen und anzuerkennen. Wir beginnen mit der Beschreibung der Theorie der deliberativen Beschlussfassung, wobei der Schwerpunkt auf dem Bereich der Wohlfahrtsdienstleistungen liegt.

Danach gehen wir auf die Systematisierung der finnischen Gesetzgebung ein und betrachten die Akteure und deren Verantwortung bei der Wohlfahrtsplanung. Darauf folgen eine Skizzierung der marginalisierten Kundengruppen bei den Wohlfahrtsdienstleistungen und die Behandlung von Aspekten der Rechtmäßigkeit. Wir schlagen die Richtungen für die Praxis und den theoretischen Ansatz vor, indem wir die Rechtmäßigkeit der Wohlfahrtspolitik voranbringen und einen begrifflichen Rahmen für die Einbeziehung der Dienstleistungsnutzer vorschlagen. Bei unserer Begriffsbildung schenken wir den Problemen der Partizipation der Randgruppen und den legislativen Voraussetzungen dafür besondere Beachtung.

In einem weiteren Sinne kann der Begriff der sozialen Ausgrenzung benutzt werden, um den Teil der Gesellschaften zu beschreiben, der die Kriterien der dominanten Normen und Anforderungen nicht erfüllen kann. Bei dieser Beschreibung wird die Politik im Allgemeinen mit dem Ziel geplant, die Abweichler zu integrieren, indem Gelegenheiten für soziale Kohäsion gegeben werden. Die Planung der Politik findet in einem extrem voreingenommenen Rahmen der freiwilligen Partizipation statt, wo die Gutsituierten überrepräsentiert sind. Es ist auch ein Problem, das gesellschaftliche Gemeinwohl ohne die Unterdrückung oder Ausgrenzung der weniger Privilegierten und ihrer Erfahrungen als primäres Ziel zu erklären.

Während die traditionelle Annahme der Einbeziehung der Bürger und der Entwicklung der deliberativen Demokratie von der Normalität und dem sozialen Aktivismus ausgeht, wird offensichtlich, dass ein erheblicher Betrag der Ausgaben für Sozial- und Gesundheitsdienstleistungen von einem Zehntel der Bürger genutzt werden, die nicht in die Kategorie passen und die als ausgedehnte Konsumenten der Dienstleistungen angesehen werden können. Außer für die Geriatrie und teure somatische Krankheiten werden die Ressourcen aufgewendet für Gruppen, die die abweichende oder marginalisierte Gruppe von Bürgern verkörpern, so z. B. für Drogenabhängige, psychisch Kranke und zum Schutz von Kindern. Viele – wenn auch nicht alle – dieser Gruppen können als verwundbar und als abhängig von der Hilfe anderer beschrieben werden. Einer der Hauptindikatoren bei der Bestimmung kleiner und verwundbarer Gruppen ist die Möglichkeit oder die Wahrscheinlichkeit, dass ihre Belange im demokratischen System auftauchen.

Manche verwundbare Gruppen, wie z. B. Kinder und ältere Menschen, sind zahlenmäßig sehr groß, und mit ihnen werden positive und vertraute Vorstellungen in Verbindung gebracht. Dies hilft ihnen dabei, Rechtsanwälte und Repräsentanten zu finden. Andere Gruppen sind kleine Minderheiten, die sich durch unbekannte und seltene Charakteristika auszeichnen, so z. B. Drogenabhängige. Diese driften weiter ab vom Ideal der aktiven Bürgerschaft.

Die Definition der guten Regierungsführung aus partizipatorischer Sicht hat zur Entwicklung der kommunalen beratenden Gremien und der Prozesse der Politikplanung geführt. Dadurch wird den mannigfaltigen Forderungen nach Partizipation und der Vertretung der Minderheiten nachgekommen. Es wird jedoch kritisiert, dass man einen Konsens sucht, indem man die Fragen stellt, die für die Dominanten passen. Wohlfahrtsorganisationen, die einen Ausgleich zwischen toleranten, vielseitigen Werten und einer Form von Effizienz schaffen müssen, beseitigen nicht nur abweichende Stimmen, sondern geben auch das Recht, Normalität und Abweichung zu definieren und zu diagnostizieren.

In der finnischen Gesetzgebung zum Gesundheitswesen und der sozialen Wohlfahrt ist in den letzten zwei Jahrzehnten eine Verschiebung hin zu einer Stärkung des Rechts des Individuums auf Partizipation spürbar gewesen. Trotz ihres Bezugs zum Grundgesetz und den Menschenrechten sind die Bestimmungen bezüglich des Rechts der Patienten und Kunden zu partizipieren bislang rein verfahrensmäßig und zielen darauf ab, das Ideal eines aktiven Bürgers zu stärken.

Diese neuen Verfahrensrechte bringen neue Arten von Subjektivitäten hervor mit einem Schwerpunkt auf der aktiven Bürgerschaft und der ethischen Verantwortung, die damit verbunden ist. Ein aktiver Bürger ist ein ethisches Subjekt, das nicht nur für sein eigenes Wohlbefinden sondern auch für das der Gemeinschaft verantwortlich ist. Was ist aber mit denen, die es ablehnen, Verantwortung zu übernehmen oder keine Verantwortung übernehmen können? Das stark normative Verständnis von Abweichung nähert sich ihr von der administrativen Überheblichkeit her und konzentriert sich auf die Kontrolle der Gefahr für die Gesellschaft, während durch eine neue Sicht auf die Abweichung neue Interpretationen und ein neuer Aufbau der Gesellschaft und ihrer Dienstleistungen möglich wären.

Es ist festgestellt worden, dass die früheren Reformen des finnischen Gesundheitssystems bislang ihre Ziele verfehlt haben, und zwar wegen der Diskrepanz zwischen den angesprochenen Themen und den Problemen in der Gesellschaft. Die Betonung des Individualismus und der neoliberalen, konsumorientierten Denkweise haben die Wohlfahrtspolitik von den kommunitaristischen Werten, die die Beschlussfassung grundsätzlich steuern sollten, abgebracht. Unseres Erachtens ist es wichtig, passende Lösungen für die Inklusion der Bürger zu suchen, damit die finnischen Wohlfahrtsdienstleistungen effektiver reorganisiert werden können. Es muss dabei geprüft werden, ob die fundamentalen Standards der deliberativen Politik erfüllt werden und ob es administrative Möglichkeiten zur deren Erfüllung gibt. Diese müssen natürlich im Einklang mit den Gesetzen und Werten stehen, die es zu schützen gilt.

Schlüsselbegriffe: deliberative Demokratie, Ausschluss einer Minderheit, Wohlfahrtsplanung, soziale Rechte.