# Health, Social Protection and Gender Equality

Survey 2004–2006

MINISTRY OF SOCIAL AFFAIRS AND HEALTH
Finland

# MINISTRY OF SOCIAL AFFAIRS AND HEALTH IN FINLAND

***Tuula Haatainen***
Minister of Social Affairs and Health
***Leila Kostiainen*** State Secretary

***Liisa Hyssälä***
Minister of Health and Social Services
***Terttu Savolainen*** State Secretary

***Markku Lehto*** Permanent Secretary

## SEPARATE UNITS WITH SPECIAL TASKS

## DEPARTMENTS

***Arto V. Klemola***
Director-General

The **Administrative Department** is responsible for the ministry's overall administration and personnel policy.

***Aino-Inkeri Hansson***
Director-General

The **Department for Family and Social Affairs** attends to social services, promoting social welfare, family policy, policy lines concerning intoxicants, as well as social and healthcare planning and matters concerning central government transfers to local government.

***Klaus Halla***
Director of Development
The **Advisory Staff Unit** assists the Permanent Secretary.

***Helena Puro***
Director of International Affairs

The **International Affairs Unit** coordinates the international affairs of the administrative sector.

***Eeva Larjomaa***
Director of Information and Communication

The **Information and Communication Unit** coordinates the ministry's internal and external information and communication.

***Tarmo Pukkila***
Director-General

The **Insurance Department** directs and guides insurance policy and develops legislation on social and other forms of insurance.

The **Pharmaceuticals Pricing Board** works with the ministry to affirm the wholesale price of pharmaceuticals and the special reimbursement status of medicinal products.

***Kimmo Leppo***
Director-General

The **Health Department** directs and develops preventive healthcare, health services, occupational healthcare and health protection, and prepares legislation in these areas.

***Mikko Hurmalainen***
Director-General

The **Department for Occupational Safety and Health** develops and prepares legislation and national policy, coordinates research and handles international co-operation in the area of occupational safety and health.

***Kari Välimäki***
Director-General

The **Finance and Planning Department** coordinates planning and monitoring and attends to payment transactions and bookkeeping. The department also develops performance guidance and is responsible for carrying out the government's gender equality policy.

## OMBUDSMEN

The **Ombudsman for Equality**
***Päivi Romanov*** monitors the implementation of the Act on Equality between Women and Men.

The **Ombudsman for Children**
***Maria Kaisa Aula*** promotes the interests of children and realisation of their rights.

For Health and Social Protection

# MINISTERS

The Ministry of Social Affairs and Health has two ministers, the Minister of Social Affairs and Health and the Minister of Health and Social Services. The ministers direct the preparation of policy. They are assisted by state secretaries, special advisers and the whole organisation of the ministry under the leadership of the Permanent Secretary (see inside cover).

***Tuula Haatainen***
Minister of Social Affairs and Health

"Welfare cannot be generated without a strong economy, and the economy does not work without health and social security."

***Leila Kostiainen***
State Secretary



***Liisa Hyssälä***
Minister of Health and Social Services

"Social welfare and security are generated by good social and health services."

***Terttu Savolainen***
State Secretary

# Health, Social Protection and Gender Equality

# Foreword

The Ministry of Social Affairs and Health is responsible for directing Finnish social, health, gender equality, and occupational safety and health policy. It carries out the government programme: preparing legislation and overseeing the implementation of reforms. It is backed up by the expertise of the whole administrative sector.

Comprehensive social protection and broad welfare services are an essential feature of the Finnish welfare society. All people resident in Finland are entitled to social security and social and health services. The system is universal and nearly all residents use at least some form of benefit or service during the year.

The ministry has a long experience of planning and steering social protection. At present we give central importance to activities that reinforce people's working and functional capacity, support continued involvement in working life and ensure that they have well run social and health services. We want to prevent social exclusion and assure people a reasonable income.

"Health, social protection and equality are mainstays."

The importance of social and health policy as a basis of a cohesive society is widely recognised. Finnish people are fairly satisfied with their welfare state. The system of social insurance has been reformed and social and health services are being developed under wide ranging programmes. The challenges we face are population ageing, the development of the economy and employment, securing financing, sufficient personnel and regional development. The European Union increasingly reflects national activity.

This publication gives a concise overall picture of the extent of the ministry's activities, its points of emphasis and of the way we do things in Finland.

***Markku Lehto***
Permanent Secretary

# Finnish MODEL

## The Ministry of Social Affairs and Health increases welfare

The preconditions for the development of the welfare society and economic growth are a prosperous and able labour force and as full as possible participation in working life. A key aim of the government is to develop the welfare society. To do this it is improving employment, cutting unemployment and upholding people's working capacity. Statutory social and health services and income security reinforce and even out this development regionally.

The Ministry of Social Affairs and Health works to ensure that everyone has the same opportunities for a secure and healthy life.

The ministry's administrative sector advances the population's health and working capacity, healthy working and living environments, and guarantees sufficient social and health services as well as adequate income for people at different stages of life. The ministry also promotes equality between women and men.

The ministry has drawn up the long-term strategic framework, titled *Strategies for Social Protection 2010*, which gives the guidelines for developing the welfare of the Finnish people.

## Acting on four policy lines

The policy activity under the ministry's responsibility is outlined according to four integrated strategic approaches. These are: the promotion of health and working capacity, increasing work attraction, the care and prevention of social exclusion, and well-organised and efficient services and adequate income security. The strengthening of gender equality and the welfare of families with children are also specific areas of activity.

The ministry's aims and its implementation of the government programme are configured by the integrated character of these strategic lines.

The ministry's most important instruments are the preparation of legislation, implementation and monitoring as well as nationwide development. Practical work is distributed among different undertakings, projects and programmes. The central development programmes of recent years have been the National Project

to Secure the Future of Healthcare, known as the National Health Care Project, the Development Project for Social Services, the Alcohol Programme, the Health for All 2015 public health programme, equality projects and the Veto work attraction programme.

### Work carried out with the administrative sector

The Ministry of Social Affairs and Health and its administrative domain pursue common aims. The ministry draws up four-year plans with the agencies and institutes within its sector. They carry out the ministry's aims of affecting social and health trends in society and take part in the projects of the government programme. The implementation of objectives and the four-year performance agreements are assessed annually.

Population ageing is proceeding faster in Finland than in other EU countries. At present numerous broad-based programmes are underway concerning the availability and quality of social and health services and the development of working life. In recent years the ministry's administrative sector has put emphasis on effectiveness, productivity and cost effectiveness. Productivity is one way to ensure the efficient use of society's resources in the years ahead as the population ages and the labour force gets smaller.

### Basic elements in Finnish social protection

In Finland, all residents are covered by social security schemes that govern basic pensions (national pensions), sickness and maternity benefits and unemployment benefits. In addition, all employees are entitled to benefits based on employment, such as earnings-related pensions and benefits for employment-related accidents.

A distinctive characteristic of the social insurance system in Finland is that a large proportion of it is managed by private insurance institutions, although the system is obligatory and statutory. Social expenditure is financed by employers, employees, central government and the municipalities.

The basic elements in the Finnish social protection system are preventive social and health policy, social and health care services, and social insurance. The main aim of social protection is to safeguard people's income by providing a comprehensive system of basic security and income-related benefits to guarantee a reasonable level of consumption in different risk situations. An important element in the Finnish social protection system is the comprehensive social and health services it provides. The country's municipalities are responsible for arranging social and health services. The system is characterized by universality of benefits. As in other Nordic countries, it is primarily residence in the country that qualifies a person for social protection.

The social protection system has guaranteed social cohesion, fairness and equality. The income distribution system has been effective in reducing income differences. The poverty rate is one of the lowest in the EU. The vigorous development of the day care system for small children has enabled women to participate widely in working life, and about 70% of mothers of young children do so. All children under school age (7 years) have the right to municipal day care.

The promotion of health and welfare is an essential aspect of social protection in Finland. Its aim is to forestall a range of risks and problems so that use of the more expensive services and forms of assistance can be minimized. People are encouraged to look after their own health and to cut their use of tobacco and alcohol. The main areas of preventive action are environmental healthcare, primary health care, occupational healthcare, maternity and child welfare services. The aim is to tackle poverty and social exclusion preemptively.

### Gender equality and safety at work

Finland has a long tradition of equality work to improve the situation of women. Equality between men and women is a fundamental right enshrined in our constitution. The aim of the Act on Equality between Women and Men is to prevent gender-based discrimination and promote equality.

The Finnish government is committed to promoting equality by its Action Plan on Gender Equality. In addition to reforming legislation, the programme aims to promote equality in working life and facilitate the harmonisation of working and family life. The aim is also to increase the numbers of women in economic

**The Ministry of Social Affairs and Health is responsible for:**

- Social and health policy
- Social protection and health promotion
- Environmental healthcare
- Social and health services
- Social insurance (pension, health and unemployment insurance)
- The development of private insurance
- Occupational safety and health
- Gender equality promotion
- Consistency in sectoral research and development
- International cooperation

and political decision-making positions and to promote equality in regional development and international cooperation.

Like other EU countries, Finland is committed to equality mainstreaming. This aims to develop the promotion of equality within administrative and working practices as part of the usual activities of ministries and authorities. The 'equality barometer' monitors the state of equality policy at three-yearly intervals.

The key goals of occupational health and safety are the maintenance of employees' working and functional capacity and the prevention of workplace accidents and occupational diseases. This now puts special emphasis on people's wellbeing and coping at work, and the consequent requirements in the way workplaces are run. The goal is for a leadership and safety culture in workplaces that promotes a safe work environment.

In recent years the GDP share of social expenditures has increased steadily in almost all EU countries. Finland's expenditure is of average level for the EU.

The occupational health and safety administration supports the preconditions of employers in taking care of health and safety at work. This includes investigating the economic impact of working conditions and creating economic incentives and guidance to develop good work environments.



## The European Union as an operational environment

Under the principle of subsidiarity, social policy belongs to the competence of Member States. Nevertheless, the European Union is increasingly the environment in which social policy has to operate. EMU and the revised Stability and Growth Pact now cover 12 countries, including Finland. The main impact of EMU is clearly positive, as it has stabilised the economy and reduced Finland's previously fairly high and unstable interest rate. Demographic change, structural change in labour markets and globalisation bring about pressures that require a robust economy to assure social expenditure.

The role of internal markets and competition law in designing and to some extent challenging the institutional structure for Member States' social and health policy has become increasingly important in several areas, including free movement of persons, labour and health services, products that impact on health, such as tobacco, and the services of general interest.

The Lisbon strategy – the EU's growth strategy for 2000–2010 – has become an increasingly important tool of policy making in different policy fields, including economic, employment and social policies. From 2000–2005 the Member States have set common objectives and agreed on follow-up indicators, reporting and benchmarking by means of the Open Method of Coordination (OMC).

Health is one of the main pillars of employment and the economy. EU health policy is first and foremost focused on promoting people's health and preventing disease. The Union carries out its policy by such things as the Public Health Programme, which funds joint projects among Member States. There is increasingly better understanding that the factors influencing health are largely beyond the immediate scope of action of the health sector. The Union therefore influences health matters through policy work on foodstuffs, agriculture, chemicals and research activity.

The UN and the EU give equality policy and legislation a firm basis of norms. Attention to income equality in the EU goes back to the founding of the European Community.

Finland plays an active role in drawing up EU legislation on work on health and safety at work. The Community's policy lines and directives support such initiatives as preventive action and risk mapping by workplaces.

## The health and social welfare of Finns in statistics

The population is now healthier and has a better working capacity than earlier. Traditional widespread diseases and accidental deaths have decreased, but their place has been taken by illnesses related to standards of living, such as diabetes, asthma, allergies, drug and alcohol problems and mental health disorders. There is also a clear link between levels of education and health.

Life expectancy is now higher than before and people's functional capacity has improved. Working conditions have improved and the age at which people retire is rising continually.

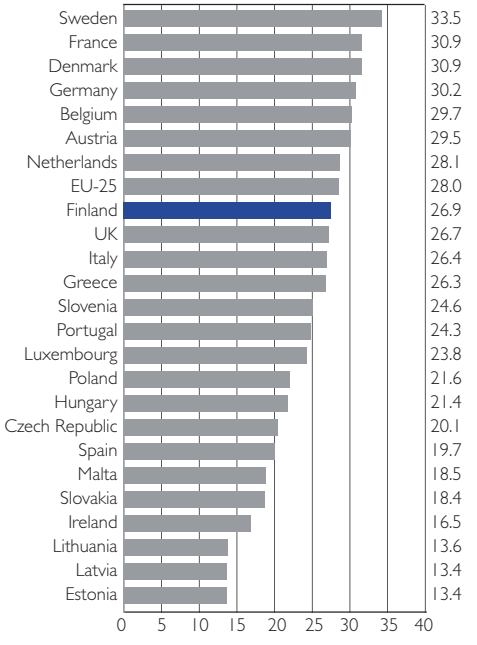
There is less need nowadays for social assistance and equality has increased. Economic growth has continued to be stable and

has boosted employment. Unemployment has dropped to 7–8%. Youth unemployment remains high, but people over 55 are tending to remain longer in working life. Unemployment is for the most part structural and is not eradicated by labour shortages. There are large regional disparities. Long-term unemployment remains a prominent cause of social exclusion.

There are also other challenges. The population is getting fatter and continues to consume alcohol copiously, with the result that the damage to health is increasing. There are problems in the area of child welfare and there are large numbers of people on disability pensions. These problems increase the risk of social exclusion and health disparities between population groups.

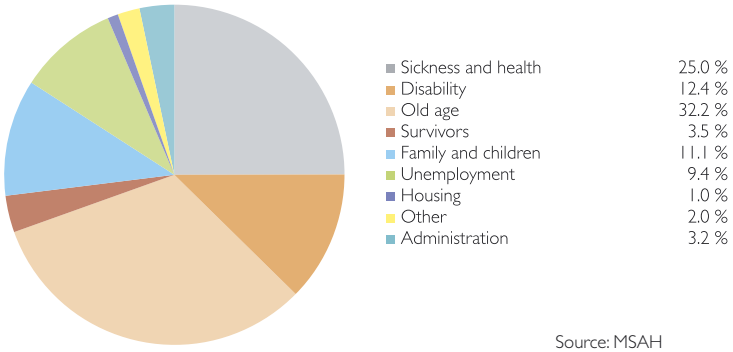
In 2005 social expenditure was 42€ billion, of which a third came from the state budget. In relation to GDP social expenditure was the same as the previous year, 27.4%. The biggest portion of expenditure was in the form of pensions, municipal social and health services, unemployment security and health insurance.

**Figure 1.**
**Social expenditure in 2003 as a share of GDP in the EU.**



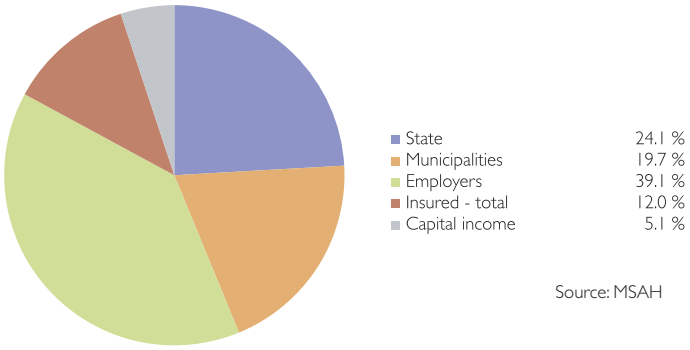

Source: Eurostat

**Figure 2.**
**Social expenditure in 2005 classified by target group.**
(% of total expenditures, EUR 42.0 billion).



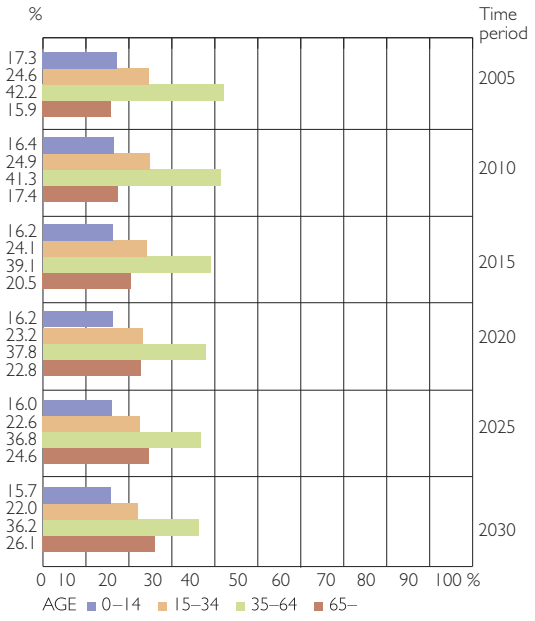

Source: MSAH

**Figure 3.**
**Overall funding of social protection in 2005.**




Source: MSAH

**Figure 4.**
**Demographic development by age groups, %.**

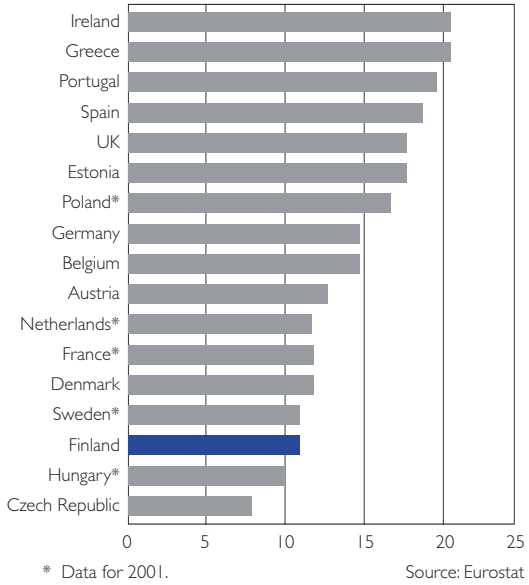



Source: Statistics Finland

**Figure 5.**
**Employment.**



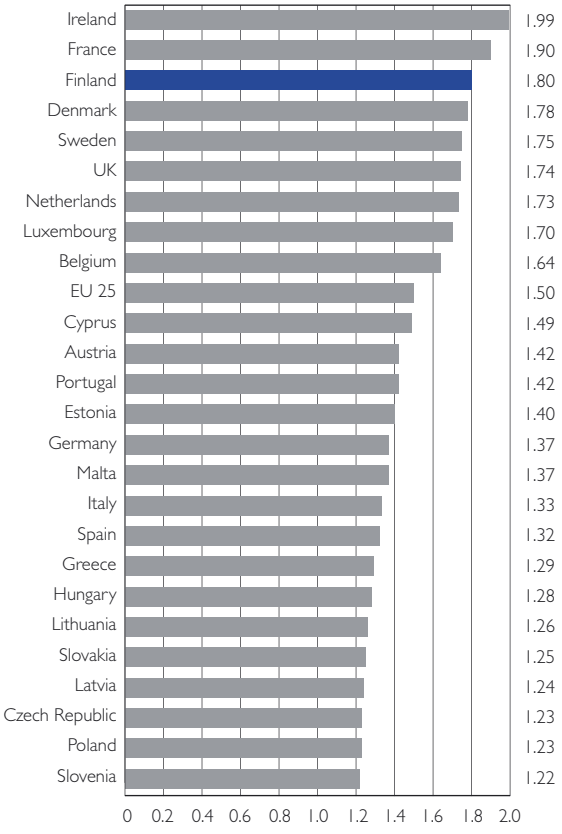

**Figure 6.**
**The poverty rate in the EU in 2002 by percent.**




* Data for 2001.

Source: Eurostat

**Figure 7.**
**Overall fertility rates in EU 2004.**




Source: Eurostat

The birth rate, as shown by the overall fertility figure, has remained fairly stable in Finland, even increasing a little in recent years.

# Welfare
## YESTERDAY, TODAY, TOMORROW

## The ministry promotes health and functional capacity

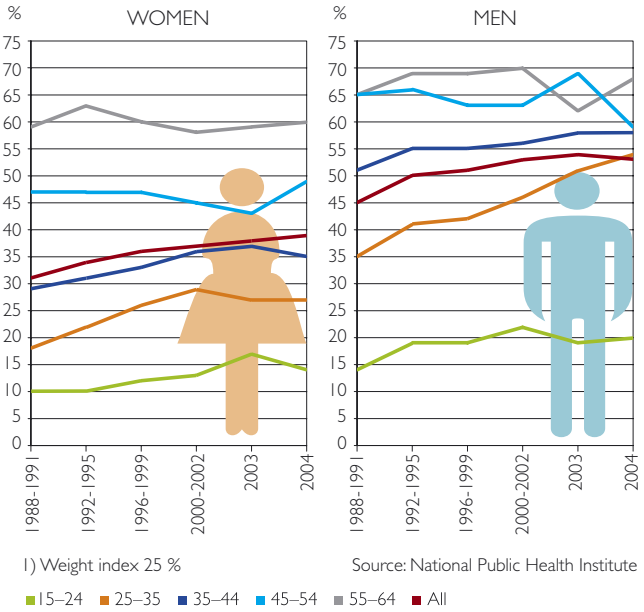
*The main aims of health promotion are described by the Health 2015 public health programme. The aim is to shrink health disparities between population groups, to reduce deaths due to accidents and violence, especially among young men, and to diminish the harm done to public health by alcohol. At the same time, the goal is to improve employment and working capacity among people of working age, increase the functional capacity of people over 75, improve the possibilities for older people to live and manage at home, and advance the possibilities for people with disabilities to take part in working life.*

People's life expectancy has increased and their years of functional capacity have grown. The life expectancy gap between men and women is seven years, but still large internationally. Health trends among men and women of all age groups have been mainly positive.

The wellbeing of the population is undermined by obesity, growing alcohol consumption and lack of exercise. Social exclusion is also a significant threat to public health. The biggest health gaps between population groups even appear to be growing.

2004 was an exceptional year for *alcohol policy*, because import restrictions were dropped and the tax on alcohol lowered. Overall alcohol consumption increased to 11 litres per person. The harm caused by alcohol has risen palpably, most dramatically in the numbers of alcohol related deaths. Deaths due to drug abuse have increased lately. The suicide rate and accidental death among young men have markedly decreased.

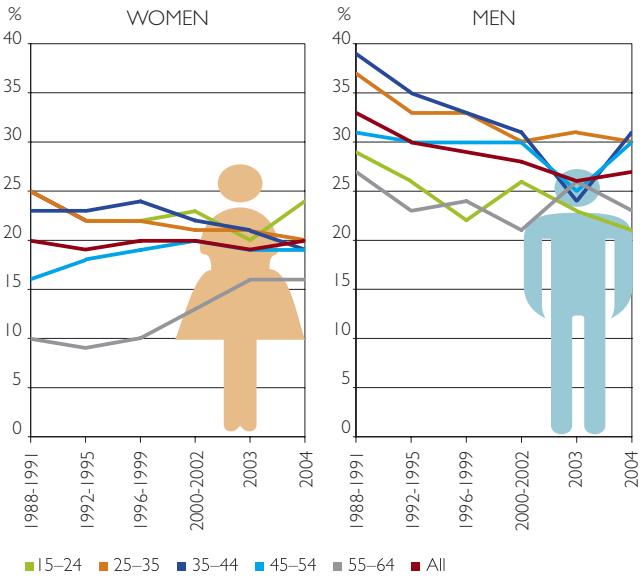
**Figure 8.**
**Obesity in the population**




1) Weight index 25 %

Source: National Public Health Institute

**Figure 9.**
**Adult daily smokers 1990–2004.**

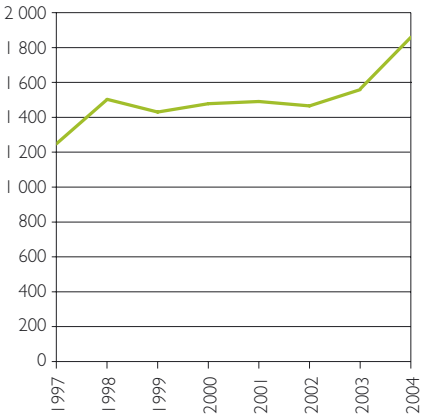



Source: National Public Health Institute

The proportion of smokers is low in international comparison.

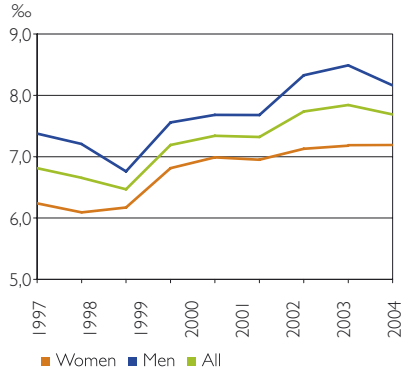
Obesity as a public health problem is being tackled.

**Figure 10.**
**Deaths due to alcohol 1997–2004.**




Source: Stakes/ Statistics Finland

**Figure 11.**
**Disability pensions granted to 35–54 year-olds between 1996–2004, per thousand.**




Constant population = people with occupational pension insurance not people on pensions

Source: Finnish Centre for Pensions

The health of people of working age has generally improved, and special attention has been given to occupational health. There are fewer incidences of illnesses and injuries affecting the employment and working capacity of older workers nowadays than in the past. A great number of disability pensions are granted due to mental health problems.

The functional capacity of people aged between 75 and 84 has clearly improved. The proportion of older people living in their own homes is almost unchanged. The participation of people with disabilities in working life appears to be improving.

Health promotion in the municipalities is run according to the *Health 2015 public health programme*. This emphasises efforts to reduce health disparities between population groups and cooperation within the administrative sector in promoting health. Particular attention is given to promoting physical exercise among the ageing population, smoke-free lifestyles and healthy nutrition.

A long-term Alcohol Programme was launched in spring 2004. This is carried out by partnerships involving municipalities, NGOs, churches and central and regional administrative state organisations. 2004 also saw the start of the Drug Policy Action Programme, the core aim of which is for drug users to receive proper treatment.

Alcohol-related deaths have increased dramatically.

The importance of preventing communicable diseases has been stressed in recent years, particularly due to the threat of disease pandemics. Such disease prevention is provided for by extensive international cooperation. Regional units monitor municipal environmental healthcare.

## Good social and health services and social environment enhanced

*One prerequisite of a welfare state is that there are functioning social and health services and adequate income security. Because of this, efforts are underway to improve the availability and quality of services. The aim is to ensure the availability of services in Finnish and Swedish and sufficient staff to run them. The structural organisation of services will be reformed and regional cooperation strengthened. The sustainable funding of services and social insurance will be secured. The opportunities for people with disabilities to take part in society will be promoted. Everyone is to be guaranteed sufficient minimum security and adequate income security.*

According to the services' quality barometer, residents rate the municipal child day care system highly. Healthcare scored slightly less well. There was little change in the results compared to the previous year. Finnish residents' level of satisfaction with healthcare services has remained good by comparison with other EU countries, according to international studies.

### Access to care guaranteed

*The National Health Care Project* was started in 2003 and will continue until 2007. It aims to secure access to healthcare, and it puts special emphasis on preventive treatment, increasing work sharing in medical treatment, collaboration between hospital districts and the need to reorganise primary healthcare into larger units.

The project includes the reform of access to non-emergency treatment, which took effect 1 March 2005. One aspect of ensuring access to healthcare is the criteria drawn up on non-emergency treatment. Access to treatment is also being monitored. Deadlines for access have clarified the work of municipalities and hospital districts and have led to an improvement in services. Waiting lists of over six months had been reduced by the end of August 2005, but queues have not been eliminated altogether. Work practices, too, still need to be better developed.

An extensive field study is being carried out to investigate problems and solutions concerning the running of *health centres*. Special emphasis is being put on intensifying regional collaboration. The aim is also to improve the effectiveness of the organisation of laboratory, imaging and information technology services as a larger entity. The reform of the structural organisation of services and regional cooperation is being continued, for instance with the administrative experiment run in the Kainuu Region. The national projects on safeguarding healthcare and developing the social service sector, referred to earlier, variously promote the introduction of new technology. However, their impact can only be assessed in years to come.

In spring 2005 the government started on a wide-ranging programme to reform the municipal and service structure, which is collecting organisational models of regionally broader welfare services. These can secure savings and the funding of services as the country's population ages. The policy lines of this reform will be made in spring 2006.

In 2004, there were more doctors than ever before and there are now fewer residents for each doctor than at any time in the past. But the shortage of doctors is felt especially in small localities. There is also a lack of dentists to some extent. However, by international comparison Finland has plenty of physicians.

**Time limits on access to treatment**

- Immediate attention given to patients in need of urgent treatment.
- Immediate telephone access to health centres during their opening times.
- Non-emergency treatment needs to be assessed by health centres within three days of being contacted by patients.
  The treatment assessment can be made over the phone and done by a healthcare professional other than a doctor.
- In hospitals, non-emergency treatment assessments have to be made within three weeks.
  If a doctor states that a patient needs hospital care, treatment has to start within six months at the latest.

By 2007 the healthcare sector will have a nationwide system of electronic patient and client records, and by 2011 this will be extended to the social care sector. These will improve work efficiency and the administering of patient and client data.

### Better social services

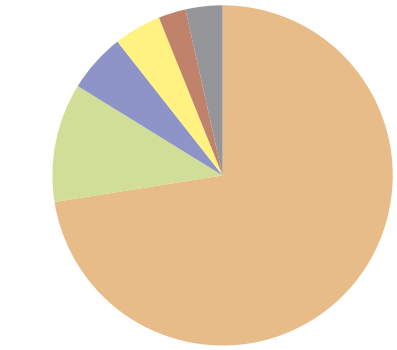
*The Development Project for Social Services* started in 2003 and will continue until 2007. At the same time, the Welfare 2015 programme has been launched together with the long-term development of the social sector.

The Development Project for Social Services is part of a comprehensive nationwide reform of social services. The project supports municipalities in this work and seeks permanent forms of service organisation. It is being conducted in close collaboration with the National Health Care Project. The project on social services comprises four main projects and 23 sub-projects. The municipalities have over 400 regional projects linked to the programme.

The Development Project for Social Services is currently focusing on regional circuits. It aims to secure an equal level of services for clients regardless of which municipal area they live in, particularly by increasing regional collaboration. The project compiles information on the availability of services and the deficiencies that need priority attention.

Efforts are made to ensure that older people and people with disabilities have as homely living conditions as possible. Increasingly more clients are offered service or residential housing. Their living at home is eased by home service, home nursing and informal care support. The demand for personal assistants and transport services for people with disabilities has increased, and accordingly a greater number of assistants have been employed and transport services enhanced.

**Figure 12.**
**Housing and services for older people 2004.**



- 72.5% live at home without regular services
- 11.3% live at home and receive home services or nursing care regularly
- 5.6% live in service housing
- 4.5% live in old people's homes
- 2.6% receive long-term care in a health centre ward
- 3.5% cared at home by informal care allowance

Source: Stakes

Spending on social and healthcare as a proportion of total municipal expenditure has risen each year. In 2004 it was about 47%. Municipalities receive central government transfer for their social and healthcare operations from the national budget. This covers about a third of municipal expenditure in this area, and has increased markedly in recent years. The numbers of individuals and families on social assistance fell in 2004, though they are still high: 7.7 percent of families received social assistance in 2004. This portion has clearly decreased in recent years.

### *Insurance gives security*

The numbers of *health insurance* reimbursements paid out for visits to private doctors as well as tests and treatment have remained about the same for many years. There has been an increase in reimbursements for private dental treatment as the whole population is entitled to them.

In line with a government decision, the financing of health insurance has been under reform from the beginning of 2006. Health insurance is divided into earned income insurance and medical care insurance. Earned income insurance will be funded by employees and employers, and medical care insurance will be funded by insurance payments and the state.

The ministry has defined the key goals of the national policy on medicines for the current decade. The starting point is that the ready regional availability of medicines is guaranteed and that their safety is maintained. In order for medicinal treatment to be developed attention must be given to the requirements of drug research. The rationalisation of the amount and use of medicines aims to promote long-term activity. In addition, the aim is that pharmaceutical expenses are such that they do not weaken the possibilities of receiving medicinal treatment.

The practice, introduced in 2003, of being able to opt for cheaper versions of medicines corresponding to brands prescribed by doctors has brought savings of about 90 million euros a year.

By *making occupational accident and traffic accident insurance* as a full expenses reimbursement system the aim is to ensure that recipients can swiftly receive treatment and return to work. Accident and motor insurance recipients' medical expenses are charged directly from the relevant insurance institution.

Improvements in the unemployment situation are shown by the decrease in the numbers of recipients of unemployment benefits.

## Work attraction in focus

*Occupational safety aims to secure safe working environments and wellbeing at work, and there is emphasis now on occupational healthcare and opportunities for rehabilitation. The national 'Veto' work attraction programme for 2003–2007 aims to increase the appeal of work and working life. The programme seeks to ensure full participation in employment, to influence people's continuation in working life and to strengthen the option of work in all situations. The programme is intended to ensure that by 2010 people remain in work on average for 2–3 years longer than they did in 2002, sickness absences from work are cut by 15%, people start work earlier in life, and that the recurrence of accidents at work and occupational diseases are reduced by 40% and their severity diminished.*

The work attraction programme covers the period 2003–2007. It aims to stimulate debate on wellbeing at work and sharing best practices. The Ministry of Social Affairs and Health, occupational health and safety sector and research institutes have conducted a series of regional information and discussion events on this, funded development projects and given backing to workplace changes in practice.

The mainly positive developments in working conditions have continued. The long term trend concerning workplace accidents and occupational diseases has been positive. Work stress has decreased and the intention is to put even more emphasis on employees' wellbeing. Good work conditions are related to high productivity and work quality.

**Table 1.**
**Developments in working conditions 1996–2004**

| | 1996 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Compensated workplace accidents in millions of working hours, all professions | 30 | 30 | 30 | 29 | 29 |
| Workplace deaths | 47 | 44 | 35 | 40 | 38 |
| Deaths during travel to and from work | 24 | 42 | 28 | 20 | 18 |
| Compensated occupational diseases | 6 399 | 4 836 | 4 646 | 4 326 | 4 300 |

Source: Federation of Accident Insurance Institutions: Occupational accidents and occupational disease statistics.

### *Reform of the pension system*

The numbers of people on old age pensions have increased with population ageing, though there are fewer people taking early retirement than in the past. The significance of the national pension has lessened as more people have had the possibility to accumulate occupational pension payments.

*The reform of the statutory earnings-related pension scheme* came gradually into force from the beginning of 2005. The reform is crucial to the sustainability of the financing of the pensions system. One's entire working life is assessed concerning future pension payments in such a way that a longer lifetime does not automatically increase pension expenses.

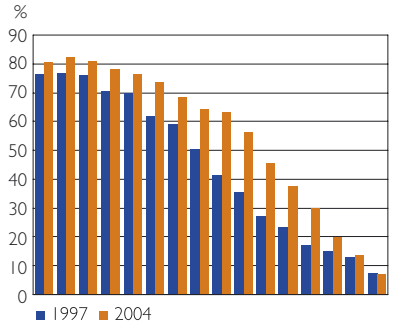
The reform is designed to encourage older employees to remain in work for longer. The retirement age is now flexible. People can retire when they are 63 or remain in work until they are 68. Pension accruement determined by income is assessed throughout people's entire working life. The reform contains various measures and support for sustainable pension funding to encourage people to remain in employment. Municipal and state pensions are being reformed according to the same principles as in the private sector.

Research shows that the effect of the 2005 pensions' reform has further encouraged people to retire later. Disclosures by employees of their intended time of retirement give a later age than current retirement trends. In addition, employers reckon that the opportunities for continuing at work are more than employees intend to use: in about half of workplaces most employees could continue working until they are 65, and a quarter of them until they are 68.

The amount of earnings devoted to *statutory earnings-related pension payments* has remained the same for the last two years, 21.4%. Employee contributions will increase in coming years but not as much as estimated before the pension reforms were introduced. Finland's statutory earnings-related pension scheme secures the long-term financing of pensions better than many other schemes in other countries. Employee pension funds made up some 55.6% of GDP in 2003, a clear increase from the end of the 1990s when they accounted for less than 50%.

*Levels of employment* among older age groups have increased rapidly. Retirement trends are expected to slow a prevalence of disability pensions. Employment among older people is better than before, as the amount of the statutory earnings-related pension no longer depends on the age of the employee, nor in the case of the disability pension does the most recent employer have to spend as much as earlier. The youth employment levels remain lower than they were before the recession of the 1990s.

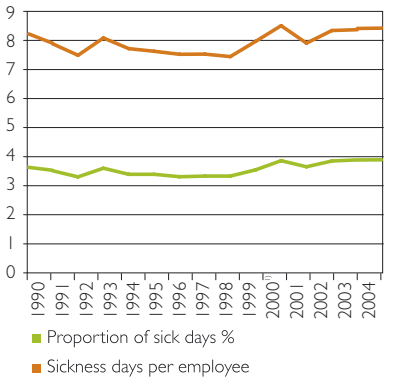
**Figure 13.**
**Employment levels by age group in 1997 and 2004**




Source: Finnish Centre for Pensions

There has been a slight increase in the number of *working days lost to sick leave*, 8.4 for each employee. Mental health problems and musculo-skeletal diseases are responsible for much sick leave and the taking of disability pensions.

**Figure 14.**
**Percentages of sickness days in relation to work days 1990–2004.**




1) Since 2000 data has been compiled by examining all weeks in a month, whereas before it was assessed on the basis of a single week. The new method takes better account of holidays and other absences at different times of the month.

Source: Statistics Finland

The reconciliation of work and family life has been eased by broadening the compensation for part-time care leave improving *parental leave* benefits and by adjusting annual leave expenses reimbursement paid to employers. Compensation for part-time care leave used to be paid only to parents of children under three, but this now covers preschool and the first two grades of primary school.

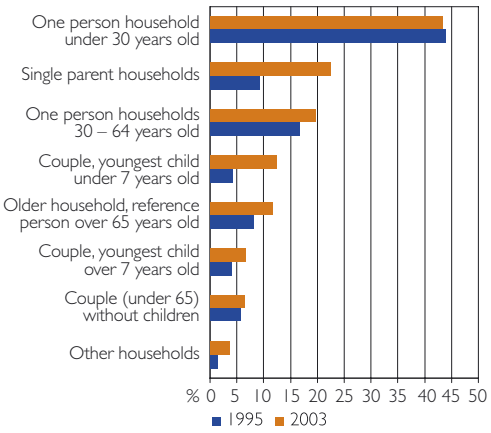
## Combating social exclusion

*The ministry wants to ensure care for the excluded in society and advance provisions to deal with the risks of exclusion. Work is being carried out so that long-term unemployment and structural unemployment decrease, the need for long-term social assistance lessens and poverty among families with children falls. Preventive health services for children and young people are being increased. The same is true of care for substance abusers, mental health and child welfare services. The aim is to ensure that there are sufficient treatment services for drug users, cooperation is intensified in the administrative sector to stop social exclusion and the number of homeless people drops.*

The starting point for preventing social exclusion is the view that work is the best form of social security. People are not excluded when they have work, reasonable income security and sufficient minimum benefits.

*The risk of poverty* in Finland is less compared to in EU 15. Relative income differences between households have increased in recent years. The numbers of people on small incomes and on small incomes of long duration have increased slightly in recent years. The financial problems of people on small incomes have more permanent features than before. The numbers of long-term unemployed have, however, fallen since 2000. Some 60% of long-term unemployed are over 50. Only a small number of them can join the jobs market without special measures to assist them. Young people are rarely unemployed for long periods.

**Figure 15.**
**Percentages of low income according to type of family unit in 1995 and 2003. The low income threshold is 60% of mean annual disposable household income.**




Long-term poverty is still a challenge.

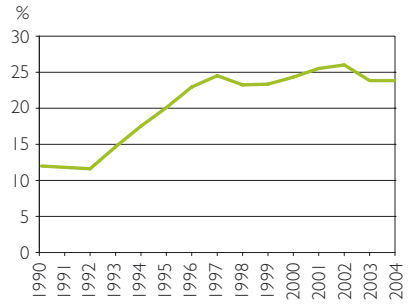
The low income threshold is 60% of mean annual disposable household income.

Source: MSAH, Statistics Finland, income distribution service data.

The demand for *drug treatment services* is increasing, though the number of clients has not changed in recent years. The numbers of people using mental health services have increased slightly, though the number of mentally ill patients being treated in institutions has dropped.

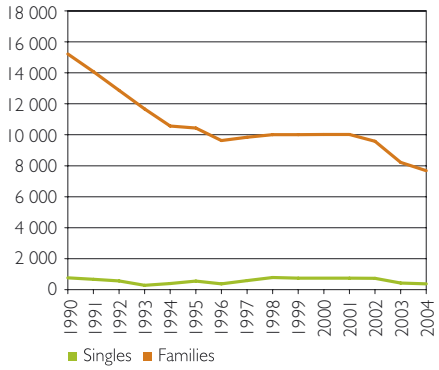
The numbers of people on *social assistance* and of those receiving it for long periods have decreased. The need for long-term support nevertheless represents a crucial challenge. There has been a clear decrease in homelessness.

**Figure 16.**
**Proportions of people on long-term social assistance, 1990–2004.**




Source: Stakes

**Figure 17.**
**Numbers of homeless people 1990–2004.**




Source: Housing Fund of Finland

*Special groups* need tailored services. Key government programmes underway are the National Health Care Project and the Development Project for Social Services, measures to ease access to the labour market, boost employment in the social sector and develop school healthcare and study guidance.

*The programme on homelessness* conducted in the Greater Helsinki area has eased the problem. Key projects on social exclusion include early intervention in the problems of children and young people, support for the integration of immigrants and projects linked to measures in the national programmes on alcohol and drugs and on crime prevention.

In 2006 measures will be taken to ease the situation of all people on low incomes. The national pension will increase by 5 euros from September 2006. Rent arrears and evictions will decrease when social assistance no longer contains a deductible portion of housing expenses. It is estimated that long-term unemployed people will be able to return to work more easily when their housing allowance remains the same for the first three months of gaining employment.

The EU's Open Method of Coordination has tightened national cooperation on tackling poverty and social exclusion. This includes the carrying out of the Union's national action plans for 2004–2005 against poverty and exclusion. Numerous EU funded activities were used to support the employment of people of low employability.

## Supporting the welfare of families with children

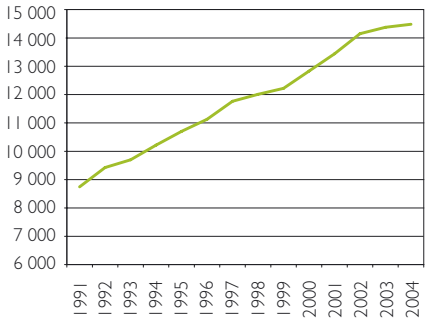
*Support is given to parenthood and family cohesiveness to assist the daily situation of families with children. Expenses derived from raising children are levelled out so that families are not forced into unequal positions in relation to one another or to those without children. Emphasis is given to strengthening children's growth and developmental environments and easing the reconciliation of work and family life.*

Numerous measures have been taken in the field of family policy in line with the government programme. In 2004 the child benefits and single parent supplement were adjusted. In 2005 decisions were made on the flat rate of the child home care allowance and private care allowance. Children's interests were furthered with the creation of the office of the Ombudsman for Children. The Ombudsman started work in September 2005. A key goal is for children's problems to be dealt with at an early stage.

*Work and family life* cannot always be reconciled. This issue has recently received much attention and efforts have been made to deal with the evident imbalances. For instance, attempts are being made to even out the costs incurred by employers by the system of family leave. This is being done so that costs to be paid do not pile up on women's employers.

The annual *divorce rate* has stabilised at about 13,000 and about 20% of children live with a single parent. The majority of children in Finland manage well but the constant increase in numbers of children in need of child welfare is worrying.

**Figure 18.**
**Children cared for outside the home as a child welfare measure 1990–2004**




Source: STAKES

The most important forms of *support in family policy* are the child benefits and day care. Within this policy, support directed at children decreased at the end of the 1990s but in recent years it has been increased. Child poverty is low in Finland compared to other EU countries, but the number of families living below the poverty line has not declined. Families with many children and single parents are in the most difficult position, and 22% of them lived below the poverty line in 2002.

Sufficient *early learning* and primary schooling are crucial from the point of view of children's stable development.

Fewer children have been in *day care* because the number of children has declined. The proportion of 3–5 year-old children cared for outside the home has remained the same, 68%. The corresponding proportion of 1–2 year-olds is 36%, the remainder being cared for at home with the help of the home care allowance. Nearly all 6 year-olds attend pre-school. In recent years investments have been made in morning and afternoon activities for school learners. In addition, parents of first and second grade primary school children whose working time is at most 30 hours a week receive a small reimbursement for shortening their working time. Children live in a more secure growing and developmental setting, if we consider the numbers of children admitted to hospital due to accidents and the numbers of accidental deaths of under-15-year-olds.

## Using the gender equality action plan

*Equality between men and women still needs reinforcing. All ministries have made preparations for and introduced measures on the Government Action Plan for Gender Equality. The new Act on Equality between Women and Men took effect in 2005. The aim is to narrow wage differentials between men and women and reduce fixed term employment. The aim is also to increase the participation of women in decision making and in the economy, as well as the number of women entrepreneurs. Efforts are being made so that violence against women and prostitution decrease. Issues of gender equality policy also need to be assessed from men's points of view.*

The Ministry of Social Affairs and Health monitors the implementation of the government's equality plan adopted in a government resolution in 2004. The action plan brings together, harmonises and sets in motion nearly 100 equality-promoting projects and measures in different administrative sectors. The equality plan also features equality mainstreaming for all areas of the administration, by which gender equality is taken into account in all ministerial decisions, budget preparations, planning and performance agreements.

Income equality is also pursued separately by the constitution and equality legislation. The new Equality Act specifies the prohibition of discrimination and directs employers and places of higher education to draw up equality plans. It is suggested that equality plans include salary charts.

Women's salaries remain on average smaller than men's corresponding salaries. A main reason for the wage differential is the lower appreciation given to professions dominated by women compared to those dominated by men.

In spring 2005 a three-tier working group proposed *an equal pay programme*, which aims to tackle the inequality of the income situation. The measures proposed in the programme are being followed up by a tripartite working party.

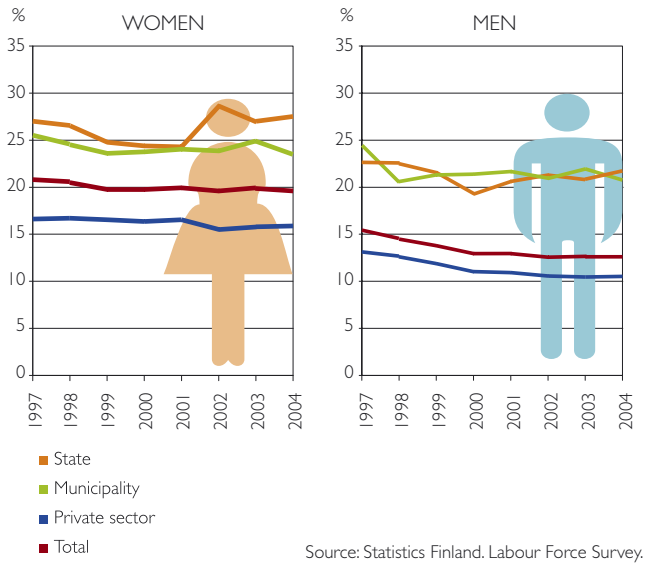
In 2003, some 80% of female wage earners and 87% of male wage earners had permanent employment. Fixed term employment for both men and women decreased slightly between 1997 and 2003.

There are now more women in *decision making* and in the economy than before. The Equality Act requires that there are as many women on municipal boards as men. The law is being carried out in all municipal boards. In 2001, 45.4% of municipal board members were women, up from 24.5% in 1993. Throughout the 1990s progressively more women were elected to local councils. The participation of women at the highest levels of central government has been the lowest in Europe, though the situation has improved noticeably over the past year.

Women have traditionally worked as entrepreneurs particularly in the service sector, and there are more women entrepreneurs than before, notably in the areas of home services and care.

*Fathers have increasingly made more use of family leave* since the 1990s. Some 42% of fathers took paternity leave in 1990, but by 2004 the number was 69%. The parental leave system will be made more flexible so that in future fathers and mothers will make greater use of their leave entitlements.

**Figure 19.**
**Women and men in fixed term employment, 1997–2004.**




Source: Statistics Finland. Labour Force Survey.

# Looking
## AHEAD

**Challenges for social and health policy**

- Population ageing and functional capacity
- National economic development
- European integration
- Employment and long-term unemployment
- Poverty and social exclusion
- Introduction of new technology
- Regional development
- Changes in staffing of social and health care

The most important challenges for social protection are population ageing, securing good quality social and health services, international economic development, closer cooperation in the European Community on social protection, the impact of new technology and regional development in Finland. Also, the debate will continue on the position of the public sector, its tasks and guiding role, and the forms of collaboration between the public and private sectors.

The implementation of access guarantees to medical treatment and pension reform will continue during 2006 under the ministry's direction. The social protection strategies will be reformed and these will be carried out by such activities as the National Health Care Project, the Development Project for Social Services and the Veto work attraction programme, the Health 2015 public health programme, the Alcohol Programme, the Drug Policy Action Programme, all of which continue throughout 2006.

The Action Plan for Gender Equality will also continue. In addition, efforts will be made to find ways to level the costs among employers incurred by parental leave. In 2006 a project on municipal and service structure reform will seek more sustainable structures to improve social and health service productivity. Emphasis will be placed on health promotion.

The development of the EU's internal market brings challenges to national-level social policy. Work will have to pay special attention to collaboration between public and private sectors and flexibility.

Finland is to hold the EU presidency in the second half of the year and the European issues will be given much emphasis throughout 2006.

***Activity emphases***

- Strengthening preventive actions
- Improving the population's working and functional capacity
- Narrowing health gaps
- Reducing obesity
- Reducing harm caused by substance abuse

- Encouraging continuation in working life
- Reducing sick leave absenteeism
- Increasing wellbeing at work
- Follow-up measures on pension reform

- Reducing long-term unemployment
- Reducing poverty among families with children
- Ensuring alcohol and drug treatment services

- Completion of the National Health Care Project
- Improving the quality and availability of services
- Reform of working methods of services and securing their financing
- Ensuring sufficient personnel

- Reconciling work and family life
- Securing special services of families with children
- Ensuring a secure growing environment for children.

- Carrying out the Act on Equality between Women and Men
- Reducing wage discrepancies between men and women
- Cutting violence against women.



For Health and Social Protection

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