SUMMARY

Trends in Social Protection in Finland 2000-2001. Helsinki 2001. 145 pp. (Publications of the Ministry of Social Affairs and Health, ISSN 1236-2050, 2001:7
ISBN 952-00- 0992-2

Finland operates a broad and comprehensive system of social protection. In addition to earnings-related forms of income security, the Finnish social protection system also guarantees minimum income security and basic services for the entire population. As a proportion of GDP, Finland spent less on social protection in 1998 than the EU average, and since 1998 GDP this proportion has fallen still further. In most EU countries social protection is less comprehensive than in Finland, but expenditure is higher.

Almost all social cash benefits were cut during the economic recession in the early 1990s, and there were also cutbacks in benefits in kind. In recent years, the rise in the level of benefits has lagged well behind the general level of earnings or productivity. Concern has been expressed over the quality of services, especially in mental health and care for the elderly.

Post-recession growth has improved the financial position of the municipalities, but there are still considerable differences from one municipality to another. Internal migration is altering the population structure of the municipalities and exerting pressures of various sorts on municipal expenditure. The employment situation varies from one municipality to another, and it is primarily those municipalities with a high employment rate which have benefited from increased corporate taxes. This is effectively polarizing the country into successful and unsuccessful municipalities.

Since 1993, the system of government grants towards municipal expenditure on social welfare and health has been changed from a cost-based scheme to a calculation-based scheme. The municipalities have subsequently experienced difficulties in financing more expensive special services such as taking children into long-term institutional care in the context of child welfare, or the provision of psychiatric care. This has brought pressures to supplement government grants for social welfare and health with additional financing earmarked for special items. An alternative solution would be to raise the level of grant and introduce norms to target resources at tackling the worst defects in the service system.

Economic dependency ratio may not come down

The decline in employment and widespread unemployment caused a rapid rise in the economic dependency ratio in the first half of the 1990s. Entering the new decade, Finland still suffers from low employment, high unemployment and widespread uptake of early retirement. Thus, the economic dependency ratio threatens to remain

permanently at its present relatively high level. It could be brought down to a more acceptable level by helping older workers stay on longer at work before retiring, preventing long-term unemployment and reinforcing the opportunities of all sections of the community to find work.

Health expenditure below the EU average

Total health care expenditure in Finland in 1998 was below the EU average both as a proportion of GDP (6.9%) and in terms of per capita spending, which totalled 81 per cent of the EU average. Total expenditure on health care rose 72 per cent in real terms in Finland during the 1980s. In the 1990s, growth was virtually zero.

There was, however, a change in the financing structure of health expenditure during the 1990s. Government grants to the municipalities were cut, causing a corresponding rise in the financing contributions made by the municipalities themselves. The direct contribution by households also rose.

Public health generally good

Taken as a whole, the Finnish population is in fairly good health. Life expectancy is continuing to rise for both men and women, and there has been a slight narrowing in the differences between the sexes. Much of the difference in mortality rates between men and women is explained by differences between the sexes in accidental or violent deaths.

The National Public Health Committee has drafted a new health policy programme based around the key concepts of health equality, functional capacity, personal responsibility and intersectoral cooperation. Besides the service system, other important factors for improving public health include the home, the school, the workplace and economic structures. Health should be a mainstreaming theme in decision making.

An estimated 30,000 people in Finland regularly use illegal drugs. Most are aged between 20 and 30. Experimenting with drugs and more serious drug abuse are still relatively rare compared with other EU Member States. However, Finland is one of the countries currently experiencing a rapid increase in experimenting with drugs among young people. The problem was previously limited to the Helsinki area and other major centres of population, but is now spreading to other parts of the country as well.

The considerable reduction in hospital beds in psychiatric care was supposed to be compensated by an increase in outpatient services. There has admittedly been some increase, but not nearly enough. There is also a major shortfall in the supply of mental health services for children and young people. To remedy this situation, additional funds have been set aside for psychiatric care of children and young people.

Extension of public dental care

A rolling reform of public dental care will come into effect in April 2001. National health insurance refunds of dental treatment expenses will be extended initially to cover all people born in or after 1946. A phased extension of municipal dental care will also begin in April 2001. The entire population will be brought within the scope of public dental care in December 2002. The reform will be financed primarily from existing resources by tighter targeting of municipal dental care services. Routine annual check-ups will be discontinued for those who can manage with a less frequent check-up.

Growing challenges for rehabilitation

Rehabilitation has in recent years focused increasingly on the over-45-year-olds in working life. This trend has been influenced both by the reform of the employment pension to encourage those nearing retirement to stay on longer at work, and by Social Insurance Institution (Kela) rehabilitation measures aimed at older workers. The volume of vocational rehabilitation provided by Kela grew throughout the 1990s. A return to work is more likely the earlier rehabilitation begins.

In addition to amendments to the pension laws, the pension reform which came into effect at the beginning of 2000 also involved other measures designed to help ageing workers stay on longer in working life. One of these is the phased introduction of the right to early examination of rehabilitation need for those insured under the employment pension scheme. Rehabilitation is one of the means available for pursuing an active approach to social policy and can be used to enhance the working and functional capacity of the population as a whole.

The challenges facing rehabilitation of the working-age population in the early years of the 2000s cover a wide range of issues, including ageing disabled employees, the long-term unemployed, young people in danger of social exclusion and the severely disabled. The need for rehabilitation is to an increasing extent caused by mental problems or alcohol and drug abuse.

Rehabilitating work experience a new form of service

There is to be closer cooperation between the labour administration and municipal social services to ease the predicament of the long-term unemployed and those who have been receiving social assistance for long periods because of unemployment. This will involve the authorities working together with the client to draw up an ‘activation plan’ to serve as the basis for rehabilitating work experience, a new form of service designed especially for young people who are having trouble finding a job. The relevant legislation will come into effect in September 2001. The new service, arranged by the municipality as a part of social welfare provision, will be compulsory for unemployed job-seekers aged under 25. For the over-25s, participation will be voluntary.

Promoting employment for people with disabilities

The employment rate for people with disabilities is much lower than for the population as a whole. Despite the general improvement in the employment situation, disabled people still find it hard to get a job. Moreover, a considerable proportion of disabled people of working age are not available for work at all. The proportion of unemployed job-seekers with a disability has risen as the general employment situation has improved, and in 1999 one job-seeker in ten was disabled. A growing proportion of disabled job-seekers are in the older age brackets, which further lengthens the average duration of unemployment periods among the disabled.

The Rehabilitation Allowance Act and the National Pensions Act were amended as of August 1, 1999 to guarantee all disabled young people aged 16—17 the opportunity of vocational rehabilitation and a higher level of rehabilitation allowance. A condition for the granting of rehabilitation allowance is the drawing up of an individual training and rehabilitation plan for the young person concerned. The reform has reduced the uptake of disability pension among the young.

Another reform which went into effect on August 1, 1999 offers those who receive only disability pension under the National Pensions Act the opportunity to temporarily suspend their pension for a minimum of six months and a maximum of two years while they go out to work. The reform has not so far increased the numbers of disabled people going out to work.

With a view to removing barriers to employment and raising the employment rate among people with disabilities, a rapporteur appointed by the Ministry of Social Affairs and Health has proposed amendments to the Employment Act, changes to the regulations governing the role of the social welfare services in preparing people for employment, and reform of social insurance legislation. Several projects have also been launched to promote entrepreneurship by special groups and examine the employment potential of social entrepreneurship.

Disability pension and unemployment pension still common paths out of working life

The employment rate for the over-55s has risen at almost the same rate as among the young. The higher employment rate among older workers is due above all to their staying on longer in working life. However, older workers who become unemployed still experience trouble finding another job. Unemployment becomes more common from age 55. Use of this avenue to a pension via unemployment is most common in industry and the building sector.

The employment problems facing older workers make it all the more important to help those in work cope with their present jobs by improving their working capacities and working conditions and providing early access to rehabilitation.

They also underline the need for more effective action to help those who become unemployed find another job. From 58 onwards, a pension becomes the most common path out of working life.

More services for the disabled — but with regional differences

The number of people receiving services for the disabled grew throughout the 1990s, as did the costs of service provision. Between 1994 and 1998 the costs of providing services and assistance under the Services and Assistance for the Disabled Act grew in real terms by over a third. However, there are considerable regional differences in expenditure.

Differences in size between the municipalities make it hard to assess how well the supply of services for the disabled matches the needs of people with disabilities in different areas. There seem to be considerable differences in application of the Services and Assistance for the Disabled Act from one municipality and region to another.

National framework for care and services for the elderly

During the last ten years the structure of services for the elderly has changed, and there has been a marked fall in provision of services in proportion to the number of elderly people in the population. The coverage of home help services and old people's homes has been reduced and provision of these services now focuses on the oldest people and those in the poorest condition. Old people's homes have been replaced primarily by service housing. Finnish expenditure on social services for the elderly is well below that of the other Nordic countries. There is a danger of neglecting the need to anticipate, prevent and solve problems at the stage when the health and fitness of an elderly person are such that s/he does not yet need large amounts of expensive help to cope with the demands of everyday life.

In addition to improving the quality of institutional care, giving elderly people a better chance of coping and a better quality of life also requires reinforced prevention and rehabilitation and more provision of a greater variety of non-institutional services. Quality services for the elderly can only be guaranteed by the recruitment of additional professionally competent personnel on a permanent basis.

The Ministry of Social Affairs and Health and National Research and Development Centre for Welfare and Health (Stakes), have now begun drafting national framework for care and services for the elderly in cooperation with other interested parties. The first recommendations were issued at the beginning of 2001 and cover both institutional and non-institutional care.

Falling demand for daycare

Most municipalities have successfully provided daycare according to their obligations under the legislation on daycare provision. Child care arrangements tend to vary depending on

the age of the child. The majority of children aged under three are cared for at home on either home care allowance or parenthood allowance, with just one in four being cared for outside the home. Two out of three children aged 3-6 are in municipal daycare. In recent years, some municipalities have closed afternoon care places for school children in order to cope with their obligation to provide daycare for children of pre-school age.

There will be a fall in overall demand for daycare over the next few years, particularly in sparsely populated municipalities. As a result of internal migration, additional demand for daycare places will focus primarily on just a few major urban centres. Demographic forecasts indicate that the number of children under school age will fall by about 26,000 over the next five years.

Unequal income development

Recent years have seen a rapid growth in disposable household income in real terms. Income development has, however, been uneven, with incomes growing most favourably at the upper end of the scale. Real disposable income in the top tenth with highest incomes rose by an average of 6 per cent per annum between 1994 and 1998. Over the same period, growth in the lowest two tenths was under one per cent per annum in real terms. Differences in household income have been widened by the considerable growth in capital income in recent years, as this tends to be concentrated in the highest income groups. The balancing effect of income transfers has been weakening since the mid-1990s, partly as a result of the improving employment situation.

The economic recovery has been reflected in income development in working-age households. This has been particularly clear in the incomes of the youngest households. Even so, real income for young people in 1998 still lagged behind the situation at the beginning of the decade.

There was a rise in real disposable income for elderly households throughout the 1990s. The maturation of the pension system means the pensions of newly retired cohorts are larger than those of earlier cohorts, a development which raises the average income of elderly households as a whole. Income development among existing old-age pensioners has been more moderate.

Development has been even across the different family types among households of working age, with the exception of single parents, whose incomes have developed poorly in recent years. Reintegration into the labour market after the recession has not been as easy for single parents as for other groups.

There was a growth in relative poverty during the second half of the 1990s. This was primarily due to the general growth in household incomes, causing a rise in the relative poverty line.

FOREWORD

Despite the generally good prospects for the Finnish economy in 2001, a worrying social feature for society as a whole is the intractability of the problem of exclusion caused by long-term unemployment. Overall, there has been a fall in the relative level of public expenditure on reducing social and health-related inequalities. In 1998, Finland's social protection expenditure as a proportion of GDP had fallen below the European Union average. Per capita expenditure was the sixth lowest among EU Member States. The quality of services has become a cause for public concern. Special concern has been expressed over services for the most vulnerable, including the elderly and the mentally ill. There has also been discussion on the levels of some benefits.

The social protection system and the public economy as a whole have in recent years had to adapt their resources to meet the extra costs caused by the ageing of the population and the potential costs of another economic recession. There are good grounds for taking such a long-term approach. But it is just as important to avoid short-sighted and excessive cuts in expenditure, as the under-resourcing of welfare policy would have social and health care repercussions reflected in an unnecessary rise in social protection and overall public expenditure in only a few years.

Helsinki, December 2000

Kari Välimäki, Director-General

There are still clear structural problems in the labour market. Besides raising the level of wellbeing at work, the key objectives for social policy over the next few years must be to cut long-term unemployment and raise the employment rate among the oldest workers and the young. This will require a highly efficient service system, adequate resources and effective cooperation between different authorities. There is a clear need for support for regional cooperation in service provision between the individual municipalities.

We have endeavoured in this report to raise issues which are likely to be the focus of debate on social welfare and health care policy over the next few years. The section on services deals with the role of the private sector in providing social welfare and health care services, possible new models for financing health care services, and the various grounds for reimbursement of the costs of hospital care and doctors' services.

Trends in Social Protection in Finland 2000-2001 is primarily the responsibility of the Finance and Planning Department of the Ministry of Social Affairs and Health. The experts involved in production of the publication are listed on the next page overleaf.

TRENDS IN SOCIAL PROTECTION IN FINLAND 2000-2001 EXPERTS

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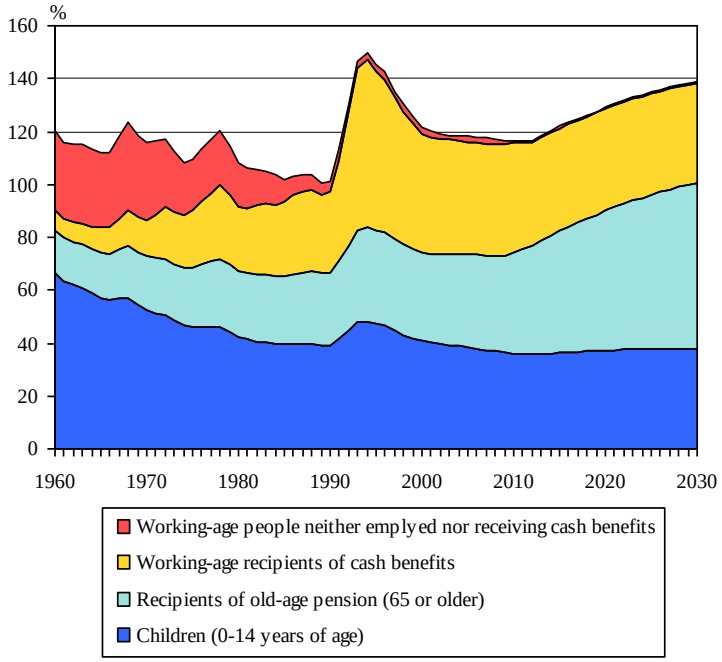
1. SOCIAL PROTECTION FINANCING AND OPERATING ENVIRONMENT

1.1. Development of the economic dependency ratio

The development of the economic dependency ratio is the biggest single challenge facing the financing of social protection in the decades ahead. The economic dependency ratio indicates how many non-employed persons are supported by one employed person. The fall in the employment rate and widespread unemployment caused a significant deterioration in the economic dependency ratio in the first half of the 1990s. The system of income security is facing major pressures, because since the 1990s almost everyone aged 18 or over who is not gainfully employed has been entitled to some sort of cash benefit.

Figure 1. The economic dependency ratio and its components: the trend from 1960 to 1998 and a projection until 2030



The economic dependency ratio is affected by changes in the age structure of the population. Until 1990, there was a sustained rise in the working-age population as a proportion of the population as a whole. This was accompanied by a fall in the proportion of children and a slow rise in the proportion of old-age pensioners. Demographic forecasts suggest a rapid rise after 2010 in the proportion of old people in the population caused by the retirement of the baby-boom generation and increases in life expectancy. The overall proportion of children in the population as a whole is expected to remain stable over the next few decades, but at a relatively low level.

The economic dependency ratio is weakened further by the combination of a low employment rate, high unemployment and a tendency to take early retirement. The employment rate among the over-55s is one of the lowest in the OECD. Only one in three of this age group is employed. The economic dependency ratio can be improved by preventing long-term unemployment and helping older workers stay on longer in working life.

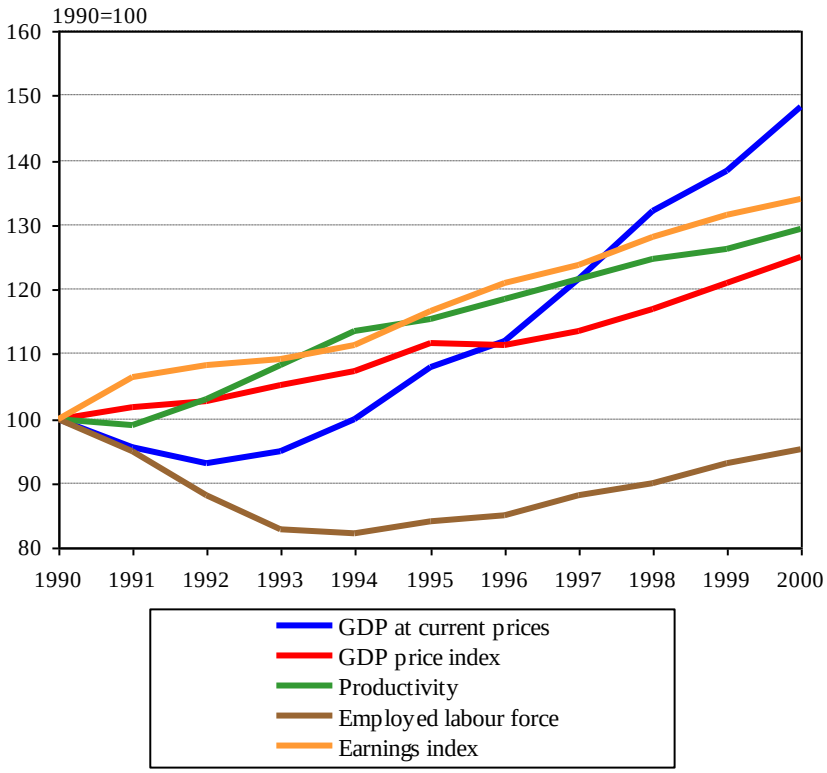
The economic inheritance from the 1990s

Finland joined the European Union in 1995. The third phase of European Economic and Monetary Union (EMU) began on January 1, 1999, covering now twelve of the European Union's fifteen Member States. The core of EMU is the internal market with its four freedoms: the free movement of goods, services, labour and capital. Within EMU, it is vital to be competitive, with stress lying on factors such as employee competence and entrepreneurial skills. Structural policy, including social welfare and health, remains the responsibility of Member States.

Finland has recovered from the economic slump of the early 1990s by rationalizing the economy and strengthening the financial solidity of companies in the business sector. These achievements have been helped by moderate incomes agreements and the reforms to corporate taxation implemented during the course of the decade. The public economy has been stabilized by cuts in social protection expenditure. However, restoring economic competitiveness has had a price in the dramatic drop in the employment rate. This was at its lowest in 1994, but by 2000 the rate employment had still not returned to the level of 1990. And it took until 1996 for GDP to regain the level of 1990 (Figure 2).

The 1990s were characterized by deregulation in many sectors of the economy — including the telecom sector, transport and electricity production — and extensive restructuring in the banking and insurance sector. Increasing competition has boosted productivity and ensured moderate price development. Free international movement of capital has forced companies to improve their performance in order to compete for risk capital on the capital markets. This has been reflected in the development of labour productivity at a faster rate than real wages.

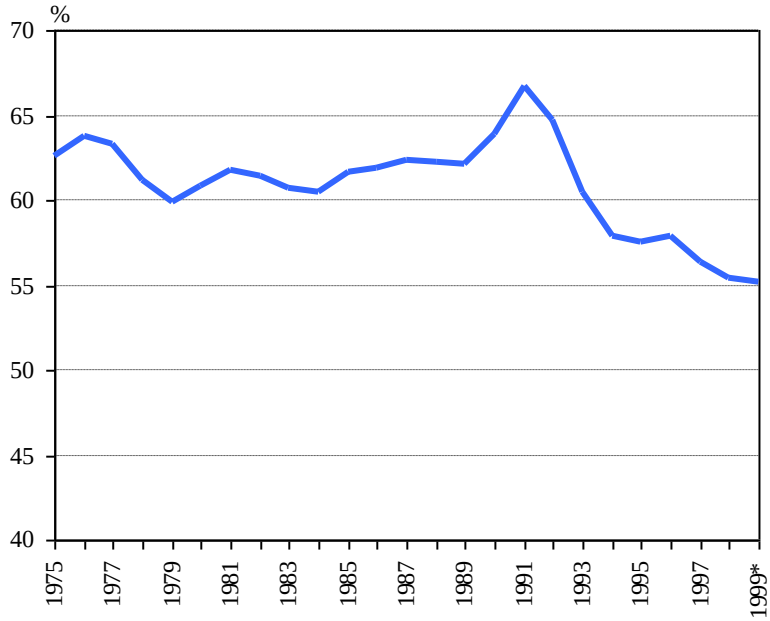
Figure 2. Adjustment of the economy to the economic slump of the early 1990s



Capital income takes a bigger share of national income

During the 1990s, there was a clear shift in the functional distribution of income in favour of capital income. As a proportion of added value, salary costs and employers' social security contributions fell by 10 percentage points, to 55 per cent. This is the lowest figure since the 1950s (Figure 3). Besides the low employment rate and high productivity, this shift in the functional distribution of income is also partly a consequence of the 1993 reform of corporate taxation. This coupled a major extension of the corporate tax base with a reduction in the statutory tax rate.

Figure 3. Functional distribution of income 1975-1999[1)]



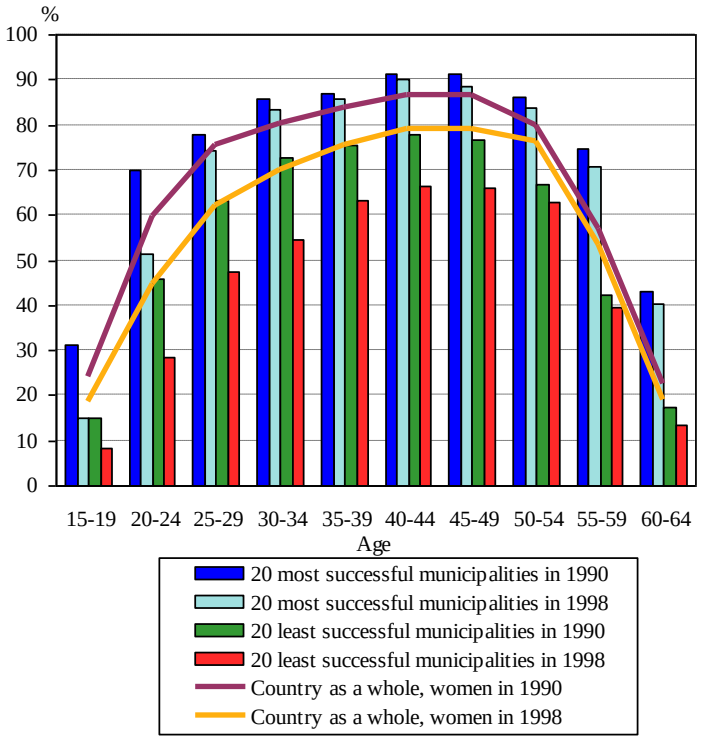
[1)] Salary costs and employers' social security contributions as a proportion of gross value added at basic prices

The shift in the functional distribution of income affects the financing of social protection expenditure, as social insurance is based on social security contributions deducted from wages and salaries. As the employment rate falls, the rate of contributions has to be raised in order to bring in the same amount of resources. Many social benefits are dependent on the development of wages and salaries, although social welfare and health care services and last-resort support are financed primarily from tax revenues.

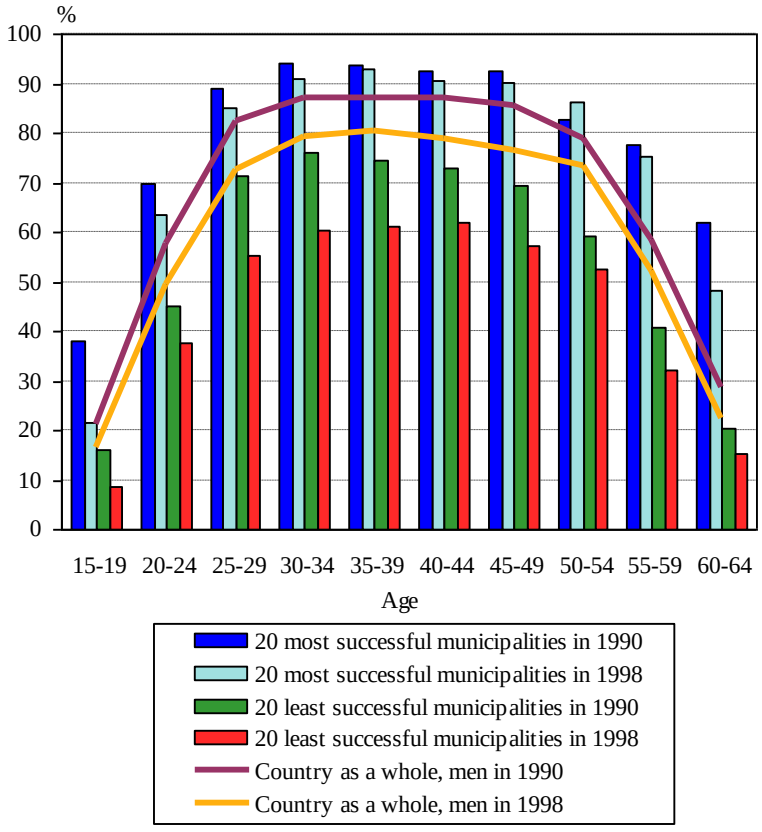
Tax revenues as a percentage of GDP remained unchanged throughout the 1990s, but increases in taxes have been concentrated mainly in municipalities with high employment. Finland is becoming polarized into high-employment and low-employment municipalities. In those municipalities which are doing well, employment rates have returned to the levels of 1990 for almost all age groups. Only in the 15-19 and 60-64 age groups has the employment rate remained at a much lower level (Figure 4).

Figure 4. Employment rates by age group in the twenty most and least successful municipalities in 1990 and 1998

Women



Men



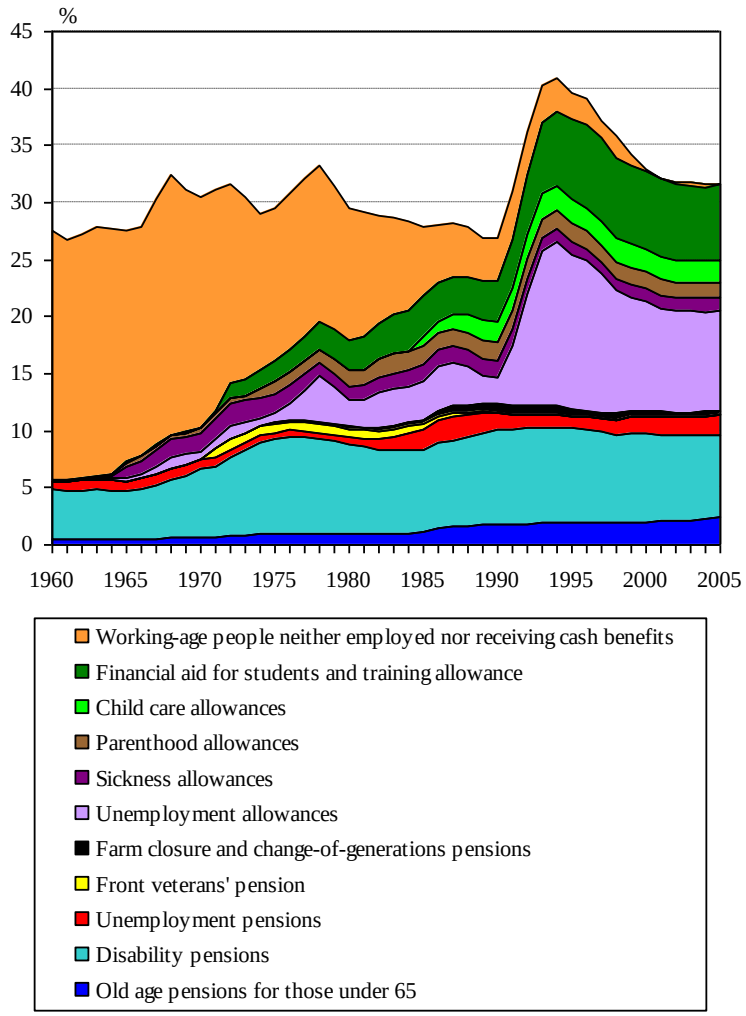
Reduction of structural unemployment proving difficult

The average number of people unemployed in Finland in 1999 was 261,000 (10.2%). This was 22,000 less than the previous year. There has been no evening out in the regional employment trends. In northern and eastern parts of the country and also in many municipalities in central Finland unemployment is well above the average for the country as a whole. The numbers of long-term unemployed in 1999 averaged 98,000. The relative drop in long-term unemployment was faster than the average drop for unemployment as a whole. There are groups among the long-term and repeatedly unemployed and unemployed people nearing retirement age for whom it is not possible to find a job using the normal methods of economic and labour policy. Rehabilitating work experience has been developed as a new form of service to activate the under-25s; the new service will be launched at the beginning of September 2001.

Unemployment led to increased demand and uptake of social benefits during the 1990s. By 2000, the category 'working-age people neither employed nor receiving cash benefits' had disappeared entirely from the statistics (Figure 5). Unemployment is the main reason for simultaneous and long-term receipt of more than one benefit at a time. Social benefits, in principle intended to help individuals and families through temporary crises, have for some people become long-term sources of income. The economic recession also led to a considerable increase in the number of recipients of financial aid for students and training allowance. Compared to the 1980s, the numbers remain relatively high.

With the economic recovery and reductions in unemployment, the demand for social benefits has gradually begun to ebb. However, long-term and repeated unemployment have remained a problem especially for the oldest age groups. This has increased the flow into early retirement, especially on unemployment pension, while there has simultaneously been a fall in the numbers on disability pension.

Figure 5. Working-age benefit recipients as a proportion of the working-age (15-64 yrs) population 1960-2005, %



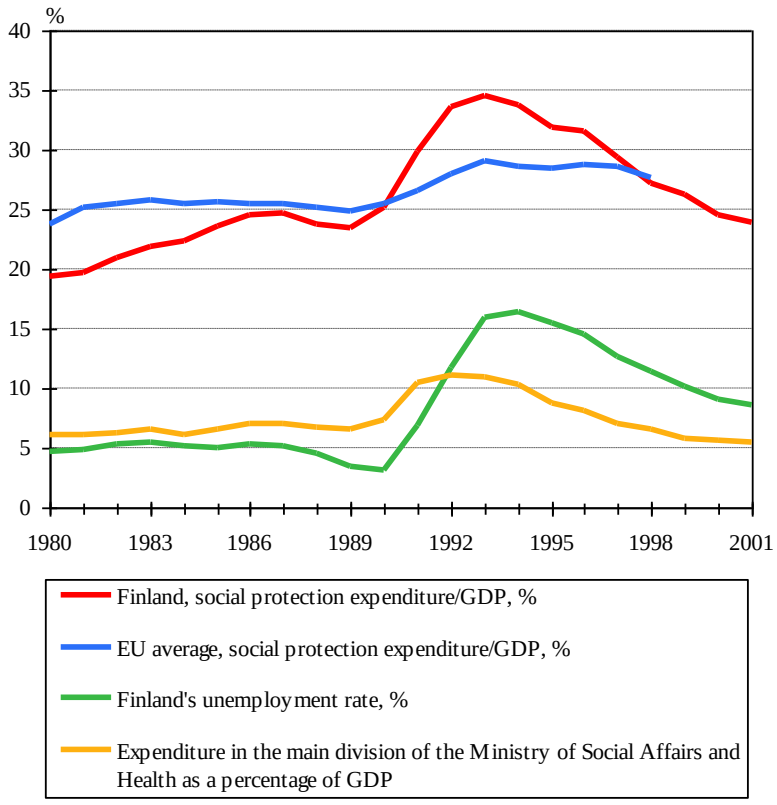
1.2. Trends in social protection expenditure

Decisions to cut expenditure and simultaneous rapid growth in GDP have led to a rapid fall in social protection expenditure as a percentage of GDP since 1993. Social protection expenditure in 2000 was an estimated FIM 193 billion, or 24.5 per cent of GDP. This represents an increase of FIM 2.0 billion on 1999, due mainly to a growth in expenditure on pensions and health care. In real terms, social protection expenditure rose 2.3 per cent in 2000, much less than real growth of GDP. In 2001, social protection expenditure's relative share of GDP will fall further, to 23.9 per cent. GDP share has thus returned to, or even below, pre-recession levels (Appendix 1, Figure 6).

The Government's budget proposal includes a nominal decrease in spending in the main division of the Ministry of Social Affairs and Health in 2000, but an increase in 2001. The latter is due primarily to statutory adjustments to government grants for municipal social welfare and health care, reductions in

the health insurance contributions payable by pension recipients, an increase in the national pension and index-linked increases in social benefits. In 2001, sectoral spending will amount to just under a quarter of all social protection expenditure, compared to almost a third at the beginning of the 1990s. As a proportion of GDP, sectoral spending has fallen over the same period from 11 to five per cent. (Figure 6)

Figure 6. Social protection expenditure in Finland and on average in EU Member States plus the unemployment rate in Finland and budgeted expenditure in the main division of the Ministry of Social Affairs and Health in relation to GDP in 1980-2001, %

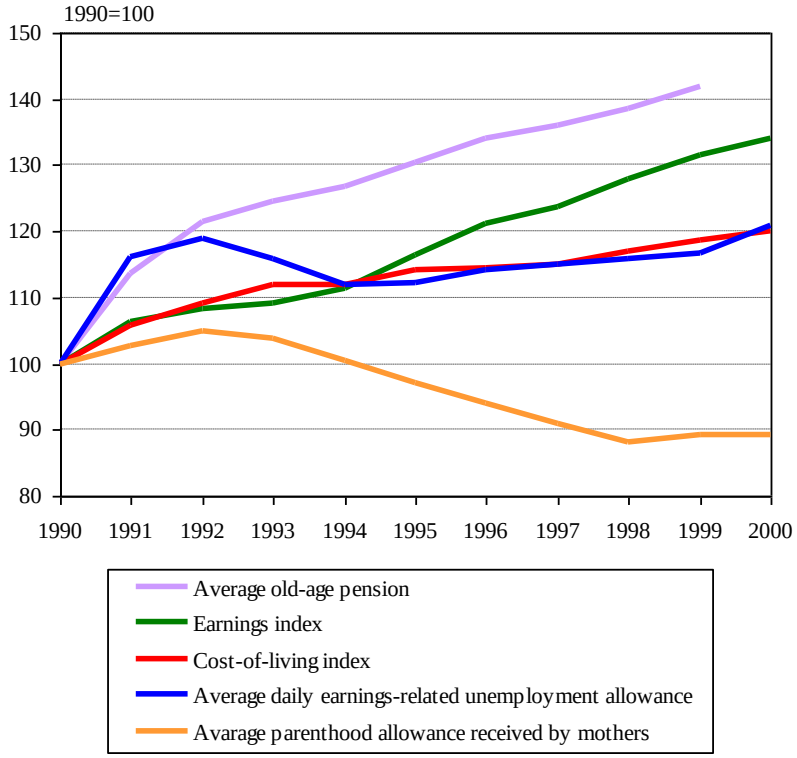


In 1990, services accounted for 38.5 per cent of social protection expenditure. In the depths of the recession this figure came down as low as 31.5 per cent, returning to an estimated 35.5 per cent in 2000. Meanwhile, the GDP share of social protection expenditure as a whole was the same in 2000 as in 1990. The GDP share of services is thus approximately 3 percentage points lower in 2000 than in 1990. If relative expenditure on services had stayed the same, we would now be spending FIM 7 billion more than at present on services.

During the recession years, there was a rapid rise in the proportion of social protection expenditure going into the various forms of cash benefits, as high unemployment more than tripled expenditure on unemployment benefit. At the same time, most types of benefit suffered cuts and some index-linked increases were implemented only in part or not at all. These changes were

reflected in slower growth, or even a fall, in the real level of benefits. For example, there was a noticeable reduction in the average level of parenthood allowance received by mothers. Some changes in the average levels of benefits stem from changes in the target group of benefit recipients. For example, the average level of old-age pension has risen faster than the level of earnings because of the higher level of new pensions. In contrast, the average pension of those receiving old-age pension throughout the 1990s has developed slightly better than the cost-of-living index. (Figure 7)

Figure 7. Trends in some pensions and allowances 1990-2000



International comparison of social protection expenditure is difficult

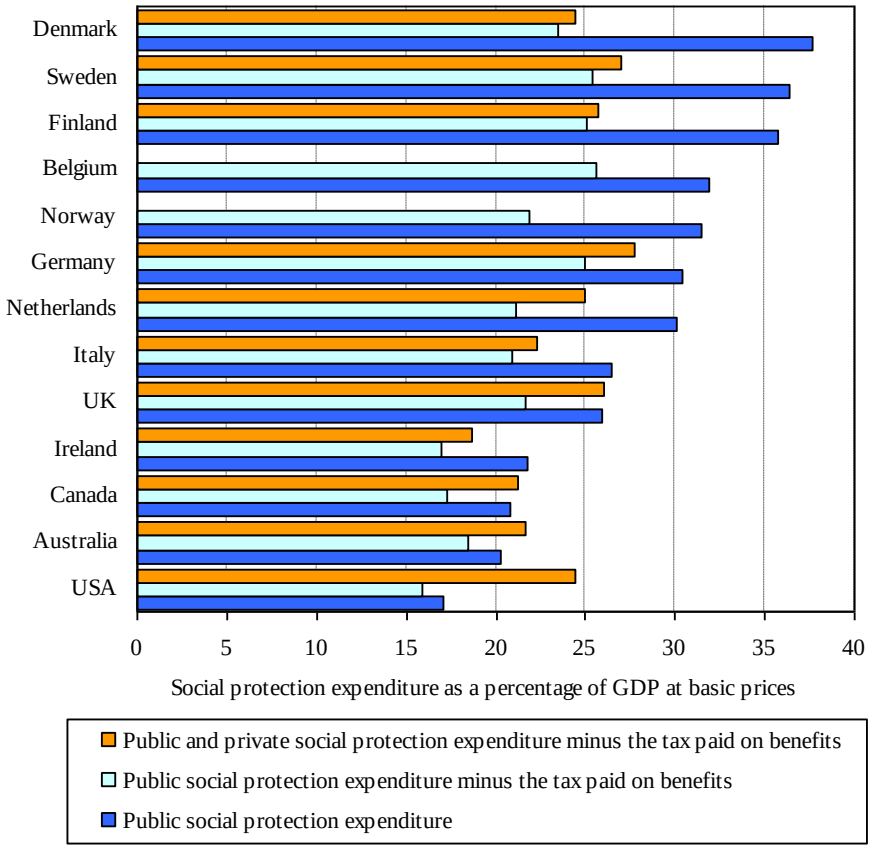
There is no simple way to compare the GDP shares of social protection expenditure in different countries. In countries where benefits are taxable income, their gross levels will be higher than if they were tax-free or if benefit recipients were entitled to special tax deductions. Instead of direct income transfers, support can also be channelled through social tax relief. In Finland, the 1994 reform of family support replaced tax relief for children with higher levels of child allowance. However, as the increase was not as large as the previous level of tax relief, the reform was effectively a cut in the overall level of support for families with children. Despite this, the reform represented an increase in social protection expenditure, as tax relief is not taken into account in calculating social protection expenditure.[1]

[1] The reform also raised the gross tax ratio.

Similar problems are faced in comparing social protection expenditure in different countries. And the differences are not only in respect to direct taxation. Part of the consumer expenditure by benefit recipients returns to the public sector as indirect taxation. Just as with direct taxation, the levels and bases of assessment for indirect taxation vary from country to country.

Taxation is not the only factor which makes it difficult to compare the social protection expenditure of different countries. The borderline between public and private social protection is not always clear. A similar level of social protection can be organized in many different ways, while different ways can be adopted in providing for the same sorts of social risk. In countries where public social insurance is either non-existent or insufficient, private citizens provide against the same risks by taking out private insurance. The OECD has published preliminary estimates of the effects of different methods of calculation on the GDP share of social protection expenditure in different countries.

Figure 8. Social protection expenditure relative to gross domestic product at basic prices under different concepts of social protection expenditure in some OECD countries in 1995



Source: OECD

Figure 8 presents three different ways of calculating social protection expenditure as a percentage of GDP at basic prices in 1995. Public social protection expenditure per se is the traditional way of measuring social protection expenditure. Another approach involves subtracting from public social protection expenditure the direct and indirect taxes paid on benefits. Particularly in the Nordic countries, expenditure calculated in this way produces a much smaller figure than the traditional method of calculation. Taking taxation into account reduces the level of expenditure in the Nordic countries to 25 per cent of GDP or less.

When the private sector is introduced into the equation, the Nordic countries are still in the leading group, but Germany rises to first place. Private social protection expenditure has a particularly significant effect in raising the GDP share of expenditure in the Anglo-Saxon countries. If private expenditure is taken into account, the level of spending in the USA is almost the same as in Finland. In 1995, Finnish social protection expenditure as a proportion of GDP was still unusually high. However, if we take into account the cuts in social protection expenditure during the 1990s as a whole, the current level of expenditure cannot be considered high in international comparison.

In figure 8, social protection expenditure is expressed relative to gross domestic product at basic prices, which results in higher proportional expenditure than using gross domestic product at market prices.[2] The OECD's concept of social protection expenditure differs slightly from the definitions applied by Eurostat. But despite these problems of definition, figure 8 clearly indicates that it can be misleading to draw comparisons purely on the basis of public social protection expenditure. It would be particularly dangerous if differences due purely to statistical practices were to begin to guide decision-making. Similar problems attach to comparison of tax rates in different countries.

1.3. The financing of social protection expenditure

Employers' contribution to financing social protection declined during the recession with the cuts in employers' social security contributions and the simultaneous decline in both the employed and the total payroll, which serves as the basis for calculating contributions. The subsequent improvement in the employment situation and the related rise in the total payroll has correspondingly raised the proportion of expenditure covered by employer contributions. There has also been a slight rise in the employers' contribution to employment pension. The share covered by the insured has grown considerably since 1992, with the introduction of employee contributions to unemployment insurance and the employment pension. Central government contributes mainly to basic security. During the recession in the 1990s, there was a rapid rise in central government's share of financing as a result of unemployment.

[2] Gross domestic product at basic prices does not include indirect taxation or subsidies.

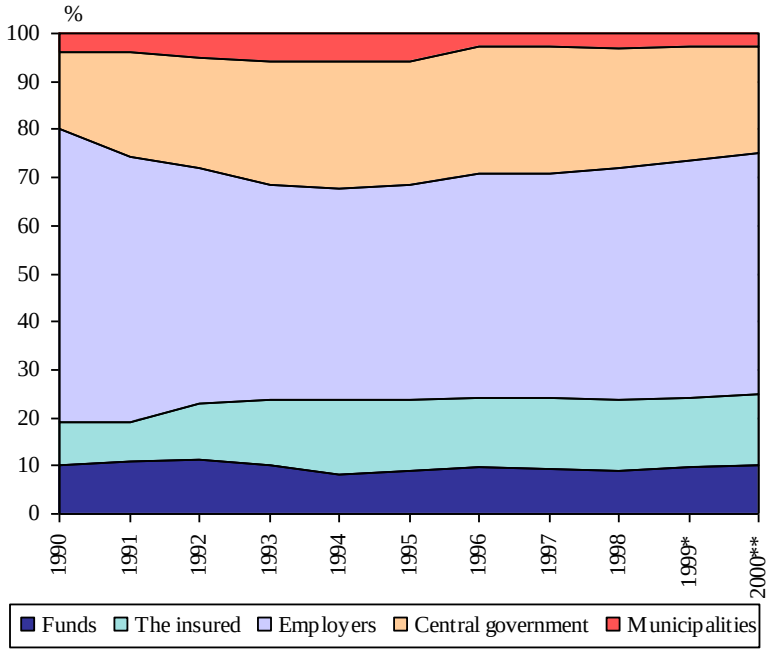
Table 1. Financing of social protection expenditure 1990-2001, FIM billion

	1990	1992	1994	1996	1998	1999*	2000**	2001**
Central government	38,5	52,5	60,3	58,9	54,5	54,4	55,1	56,1
- budget expenditure	36,8	50,5	40,0	37,5	37,1	37,4	36,6	36,3
- government grants to the municipalities	0,0	0,0	18,2	18,7	13,2	13,0	13,5	14,2
- items outside the budget and guarantee payments	1,7	2,0	2,1	2,7	4,1	4,0	5,0	5,6
Municipalities	24,0	27,2	31,2	33,8	38,9	38,4	40,2	42,2
Employers	67,7	64,5	67,1	73,1	78,5	81,1	84,9	90,7
- insurance contributions	54,8	49,0	52,0	56,5	61,4	64,8	68,2	73,0
- tax payments	4,0	9,2	8,4	8,6	8,8	7,7	7,5	8,1
- contributions unconnected to work	8,9	6,2	6,8	7,8	8,3	8,7	9,2	9,6
The insured	12,3	18,5	28,0	27,1	27,6	28,7	29,3	29,2
- insurance contributions	3,8	4,9	12,2	14,6	17,3	18,3	19,6	20,3
- tax payments	8,4	13,7	15,8	12,4	10,3	10,4	9,6	9,0
Interest and other capital income	10,4	14,7	12,8	14,9	15,6	18,1	18,8	21,2
Total	152,9	177,3	199,5	207,8	215,0	220,8	228,3	239,4
Client fees	5,6	6,9	7,6	8,5	8,9	9,1	9,6	10,1

* preliminary data
** estimate

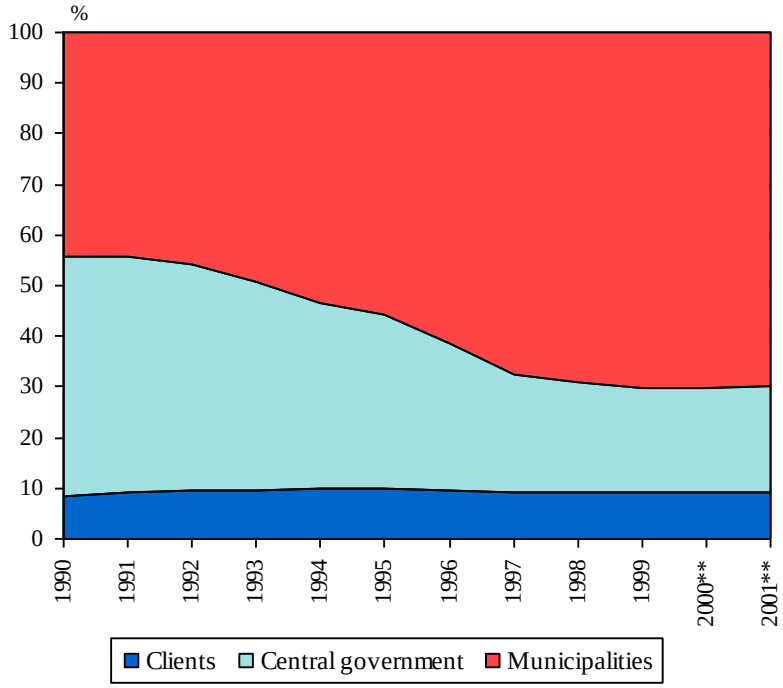
The financing structures of cash benefits, on the one hand, and social welfare and health care services, on the other, are markedly different. The bulk of income-tested cash benefits such as housing allowance and labour market support are financed by central government while income-adjusted cash benefits are mainly financed by employers and employees. The municipalities' contribution to financing cash benefits is minor and their role has even been reduced in recent years. The only area where the municipalities make a major contribution to financing cash benefits is in social assistance and the various forms of support for the care of very young children. (Figure 9)

Figure 9. Financing of cash benefits 1990-2000



The municipalities, in turn, play a major role in both the production and the financing of social welfare and health care services, contributing around 70 per cent of total financing. Some 20 per cent of expenditure is financed by the grants paid to the municipalities by central government, and around 10 per cent by client fees. The relative contribution from central government has fallen as a result of the 1993 reform of the grant system, while the share covered by the municipalities themselves has risen. (Figure 10)

Figure 10. Financing of municipal social welfare and health care services 1990-2001



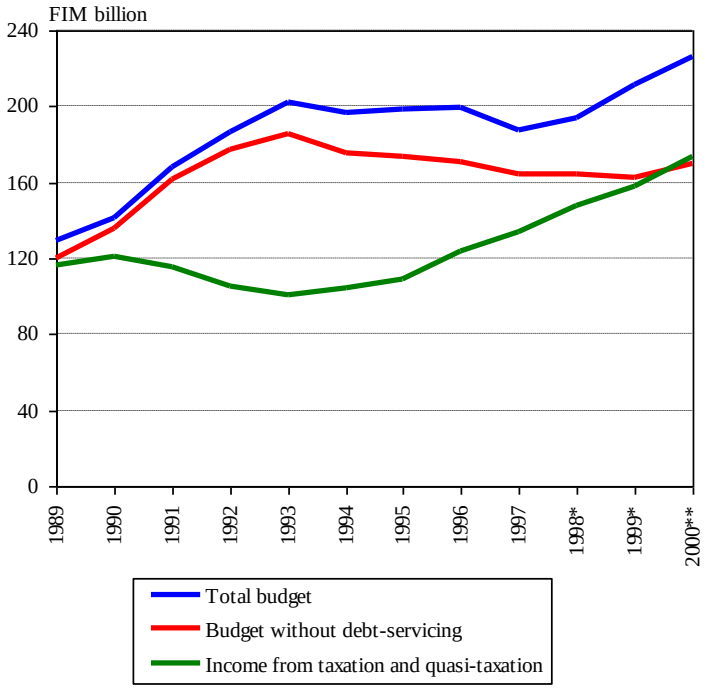
1.4. Social policy and developments in the public sector

The consolidation of general government finances continued in 2000, with the financial surplus rising to 4.5 per cent of GDP. This positive trend is set to continue through 2001. Some of the increase in revenues is due to one-off increases in corporate tax revenues and government income from dividends as a result of corporate restructuring. Municipal finances are expected to enter the black in 2000, and to strengthen further in 2001. The surplus in the social security funds will remain at around 3 per cent of GDP in 2000 and 2001. According to Ministry of Finance estimates, the debt ratio of the total public sector will be down to 42.5 per cent by the end of 2000, and will decrease further to 39 per cent in 2001.

The budget proposal for 2001

The bulk of spending in the budget proposal for 2001 will be financed out of income from taxation and quasi-taxation. In the early 1990s almost 90 per cent of expenditure was covered by taxation. The recession brought a considerable falling off in tax revenues, and at their lowest point they covered less than 50 per cent of the still expanding total of public expenditure. As a result of steps taken to cut public expenditure, budget expenses per se (expenditure excluding debt-servicing) have begun to fall. Since 1993, budget expenses have remained under FIM 200 billion despite rapid growth in expenditure on debt-servicing.

Figure 11. Government spending and central government income from taxation and quasi-taxation 1989-2000 at current values



* 1989-99 according to the final accounts
** 2000 budget proposal and addenda to budget proposal

The total sum for the 2001 budget proposal comes to FIM 197.7 billion (excluding debt-servicing). The main division of the Ministry of Social Affairs and Health accounts for FIM 45.1 billion of this total. This represents a rise of approximately FIM 1.6 billion on the previous year.

The Ministry of Social Affairs and Health's budgetary funding will cover a good fifth of all social protection expenditure in 2001. Expenditure will also be partly financed from expenditure under the other main divisions. Altogether around one third of social protection expenditure will be financed through the budget.

The main changes affecting social welfare and health care in the 2001 budget proposal lie in the areas of active social policy and the extension of public dental care. New legislation on 'rehabilitating work experience' will come into force in September 2001, providing a means for activating the long-term unemployed and those facing the threat of social exclusion. All told, over FIM 200 million per annum has been designated for rehabilitating work experience and measures to combat poverty and exclusion under Ministry of Social Affairs and Health and Ministry of Labour items in the budget.

The budget also provides for the extension of publicly supported dental care to 10 new population cohorts in 2001 and to the entire population in 2002. There will also be an increase to the maternity grant, an extension of adult training allowance to cover employed people, rehabilitating work experience, a rise in the level of national basic pension, an expansion of mental health services, increased use of preventive social assistance and stricter means testing in granting social assistance.

In organizing municipal social welfare and health care services, special attention will be devoted to supporting mental health work, organizing services for the elderly, improving services for children and young people and developing social work and community care. The shortfall in government grants will be gradually restored in 2001 and 2002, in addition to which there will be an across-the-board increase of 1.2 per cent in the level of government grants in 2001 to take account of rising costs.

The 2001 budget makes no change to the level of employers' national health insurance and national pension contributions. There is also no change to the level of standard national health insurance contributions by the insured, although supplementary contributions by pensioners are reduced. Unemployment insurance contributions by both employers and employees are reduced. Employment pension contributions in the private sector remain unchanged. (Appendix 2)

Municipal finances

According to the 1999 financial statements, there was an improvement in the financial position of the municipalities and joint municipal boards. The aggregate annual margin was FIM 9.4 billion. The margin for

2001 is forecast to reach over FIM 13 billion as a result of the growth in tax revenues and government grants. The improvement will be particularly strong in the larger municipalities, whose contribution to the annual margin for the country as a whole is considerable.

The economic crisis of the early 1990s forced the municipalities to adapt their economies by raising the rate of municipal taxation, taking out loans and cutting expenditure. Total outstanding loans to the municipalities rose by over FIM 11 billion in just a couple of years to stand at FIM 31.6 billion in 1993. The municipalities cut their staffing levels by approximately 10 per cent during the recession. In 1998, there were 410,000 officials and other employees working in local government, of whom 220,400 were employed in social welfare and health care.

Table 2. Key indicators of the municipal economy in FIM billion at current prices

	1993	1995	1997	1999	2000	2001	2004
Operating margin	...	-76,4	-73,2	-77,5	-81,1	-84,9	-96,2
Tax revenue	47,8	57,9	65,4	72,0	78,0	81,0	91,2
Central government grants for current expenditure[1)]	40,7	38,0	19,8	19,0	20,1	21,6	23,6
- of which, administered by the Ministry of Social Affairs and Health	21,1	17,9	13,6	12,7	13,0	13,9	15,1
Other expenses, net	...	-4,0	-4,5	-4,1	-4,5	-4,8	-5,4
Annual margin	10,3	13,1	7,4	9,4	12,5	12,9	13,1
Investments, net	6,6	5,6	10,8	9,4	12,5	12,0	13,1
Total outstanding loans	31,6	25,8	25,9	24,9	23,3	22,0	18,0
Cash assets	12,2	19,0	15,7	16,0	17,1	17,9	20,6
Net liabilities (total outstanding loans - cash assets)	19,4	6,8	10,2	8,9	6,2	4,1	-2,6

The figures in the table are based from 2000 onwards on preliminary data or forecasts
[1)] According to the municipalities' own accounts
Source: Advisory Board for Municipal Administration and Economy, September 5, 2000

Although the overall picture is of an improvement in the financial standing of the municipalities as a whole, there is a great deal of variation between different municipalities and regions. The annual margin for 1999 was negative in 87 municipalities, while over 2000 reported an accounting deficit. Increasing internal migration is reflected in both the demand for services and the municipal economy. Towards the end of the 1990s, migration approached the peak figures recorded in the late 1970s. A new feature is the net population loss experienced in many urban areas.

Approximately 70 per cent of demographic growth in the 1990s was concentrated in Uusimaa, and particularly in the Helsinki area. Other important growth centres were the areas in and around Tampere, Turku, Oulu and Jyväskylä. In social welfare and

health care, net population gain is most clearly reflected in a growing demand for children's daycare and a need for new investment. In municipalities experiencing net population loss, the average age of the population rises and spending on children's daycare falls. However, expenditure does not fall at the same pace as the ageing of the population. At the same time, local taxes contribute less to municipal income and the redistribution of tax revenues becomes increasingly important.

Central government's contribution to social welfare and health care funding

There was a considerable contraction in the contribution of central government to social welfare and health care spending during the 1990s. While, in 1990, government grants covered an average of 48 per cent of municipal expenditure in this area, by 1999 this figure had fallen to just 21 per cent (Table 3). By 2000, the figures had begun to creep upwards again, and in future grants are to be held at statutory levels. The absolute level of grants in monetary terms will rise primarily as a result of increases in local population and index increments.

In December 1999, the Ministry of the Interior appointed a rapporteur to produce an overall assessment of the economic relationship between central and local government, the effectiveness of the system of government grants and the growing economic disparity between individual municipalities, and to produce proposals for action in these areas. The rapporteur's brief included producing a separate report on the grant system. The rapporteur's work was to be completed by the end of 2000.

Table 3. Government grants to the municipalities, current expenditure, FIM million

	1998	1999	2000	2001
Grants within the regular system of government grants based on estimated expenditure, plus equalizing items	22 500	22 602	23 473	25 749
of which, on social welfare and health	12 900	12 690	13 035	13 868
Other government grants	2 137	2 041	575	2 331
of which, EVO funding	770	770	778	778
Total government grants	24 637	24 643	26 048	28 080
Grants as a percentage of operating costs	21,4	21,7	22,4	22,4

EVO funding = Government payments for research activities under the Act on Specialized Medical Care and reimbursements of expenditure arising from the training of doctors in health care units

Source: Local government finances 2000-2004. Advisory Board for Municipal Administration and Economy, September 5, 2000.

1.5. International pressures on social protection

The main effects of the European Union's treaty on Economic and Monetary Union are in the area of economic policy, and particularly budgetary and monetary policy. But EMU also has implications for social protection, as economic decisions inevitably influence social policy, and particularly the financing of social protection. The different systems of social policy and financing models in the different Member States have emerged for historical reasons. Within the European Union, cooperation on social protection and powers to act in this area at Union level of have been limited, cooperation being restricted primarily to issues relating to the supply of labour and the functioning of the labour market. In economic questions, decisions are taken which are binding on Member States and which also have an effect on social policy. There has, however, been no wish for direct harmonization of social protection.

New ground was broken in cooperation on social policy during the Finnish Presidency of the EU. On November 29, 1999, the Social Affairs Council agreed to endorse the Commission's previous Communication on a concerted strategy for modernizing social protection. In line with the Council's Conclusions, a group of high-level officials was appointed to prepare the strategy, beginning its work at the end of 1999. It was subsequently decided to set up a committee to prepare the strategy, and this held its first meeting in December 2000.

Four broad objectives were adopted for cooperation:

- to make work pay and to provide secure income
- to make pensions safe and pensions systems sustainable
- to promote social inclusion
- to ensure high quality and sustainable health care

The high-level group initially concentrated on issues relating to the promotion of social inclusion, charting the efforts of Member States to combat social exclusion and using the results to produce guidelines for cooperation. During the French Presidency, efforts were made to develop a model for cooperation whereby the common strategy could be implemented through action plans at national level.

Issues relating to social welfare and health policy have also been added to the agenda at negotiations on trade. There has been a wish to extend efforts towards global trade liberalization to include the production of services, which in this context have been understood broadly to include such areas as cultural services and social and health care services. The OECD spent several years in talks on the Multilateral Agreement on Investment (MAI). These eventually ended in stalemate, primarily because of disagreement over services.

The talks were then transferred from the OECD to the World Trade Organization (WTO). In respect of these talks, the Ministry of Social Affairs and Health has considered it important to ensure that any international agreements which may finally emerge neither prevent nor hamper in any way the implementation

of broadly based national policies on social welfare and health care. For instance, Finland opposes the attraction of foreign companies into the country by lowering the level of social protection or tinkering with international norms on labour relations. International Labour Organization (ILO) conventions and recommendations present core norms relating to issues such as freedom of association, use of child labour and equality.

It is still unclear how broad the area to be included in the round of talks at the WTO will eventually be. Talks on services have begun in line with the General Agreement on Trade in Services (GATS). As the talks began, no service sector was ruled out. Comprehensive public services and statutory insurance are examples of the type of question to which the Finnish social welfare and health authorities will attach particular attention during the talks.

2. Social protection expenditure by target group

The largest single category of social protection expenditure is old age, while the second largest is sickness and health. Together, these account for over half of all social protection expenditure, rising to 55 per cent in 2001. The improving employment situation has led to a sharp reduction in percentage expenditure on unemployment, which will fall to 10 per cent in 2001. Expenditure on families and children will remain at 12 per cent, and expenditure on disability at 13 per cent.

Figure 12. Distribution of social protection expenditure in 2000

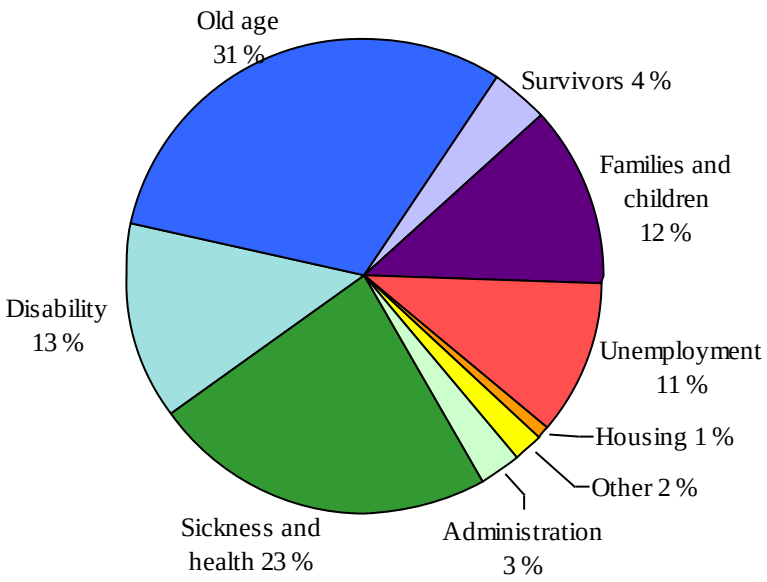
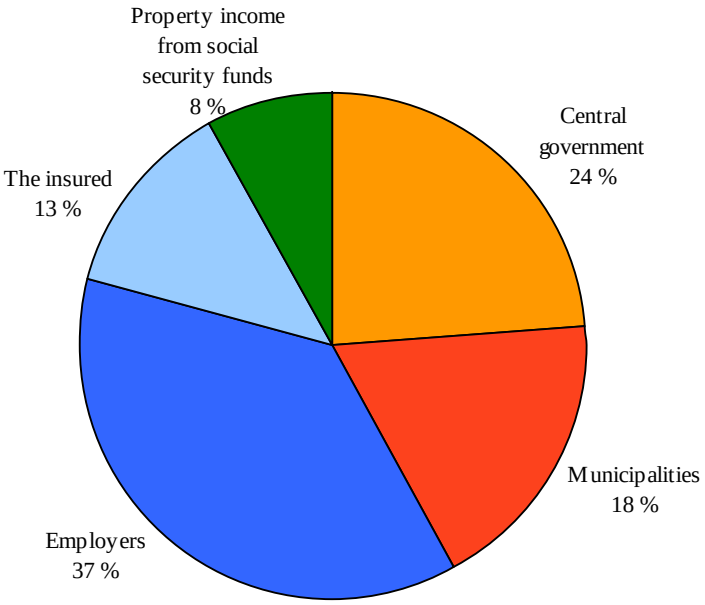


Figure 13. Financing of social protection expenditure in 2000



Employers are the largest single source of finance for social protection expenditure. They contribute to pensions, unemployment security and health insurance. The insured themselves also contribute to these benefits. Central government contributes mainly to basic security, i.e. national basic pension, basic unemployment security, child allowance and government grants to the municipalities for social and health care services. The municipalities bear the primary responsibility for financing social and health care services.

There will be no major changes in the financing of social protection expenditure in 2000–2001. The percentage covered by employers will rise slightly due to the improving employment situation, while the percentage from the insured will fall due to the reductions in their unemployment insurance contributions. The improving employment situation will also be reflected in further reductions in the proportion of expenditure covered by central government, while that covered by the municipalities will remain more or less unchanged. Meanwhile, accumulation of the social security funds will increase the proportion of social protection expenditure financed out of interest and dividend income from the funds. (Appendix 2)

2.1. Sickness and health

	1998	1999*	2000**	2001*
Expenditure on main category (FIM million)	41 300	42 700	45 200	47 800
- of which, cash benefits (FIM million)	7 950	8 600	8 900	9 500
% of social protection expenditure	22,0	22,5	23,4	23,7
% of GDP	6,0	5,9	5,7	5,7
Life expectancy				
Men	73,5	73,7	..	..
Women	80,8	81,0	..	..
Persons receiving sickness allowance during the year	278 100	286 900	296 950	304 400
Primary health care				
medical and health care visits/1,000 inhabitants	4 934	4 898	4 900	4 920
dental care visits/1,000 inhabitants	961	951	955	960
bed days/1,000 inhabitants	1 592	1 568	1 6570	1 580
Specialized medical care				
outpatient visits/1,000 inhabitants	1 148	1 140	1 150	1 160
bed days/1,000 inhabitants	1 093	1 049	1 130	1 110

* preliminary data
** estimate

Expenditure on sickness and health is estimated to total FIM 45.2 billion in 2000 and FIM 47.8 billion in 2001. This represents almost a fifth of all social protection expenditure and just under 6 per cent of GDP. The share of social protection expenditure attributable to sickness and health has grown rapidly in recent years and is still growing. The expense items which have shown a particular increase are primary and specialized medical care plus sickness allowances and refunds on medicine paid under national sickness insurance.

Health situation generally good

Taken as a whole, the Finnish population is in fairly good health. Life expectancy is continuing to rise for both men and women, but the differences between the sexes remain unchanged. The main factor contributing to the increase in life expectancy is the fall in the mortality rate from arteriosclerosis in middle age. There has also been a fall in the mortality rate from other chronic diseases. Much of the difference in mortality rates between men and women is explained by differences between the sexes in accidental or violent deaths. A particularly significant factor is the prevalence of alcohol-related deaths among men, which substantially reduces their average life expectancy.

The percentage of the population who feel their health to be good or fairly good has in recent years stayed around 70 per cent, while the percentage who would classify their health as poor has fallen slightly. In contrast, headaches, insomnia and other stress-related symptoms have become common. Circulatory diseases account for the deaths of approximately half of all

Finns. Arteriosclerosis remains the most common of these diseases, although male mortality from arteriosclerosis has fallen by as much as 70 per cent over the past 30 years. Cancer morbidity has remained more or less unchanged in recent years, but there has been a rapid rise in cases of asthma and allergy, and also in mental health problems. Musculoskeletal disorders remain the most important causes of impaired working and functional capacity, and accidents the most important causes of premature death and disability.

Health inequality presents a challenge

Despite the generally positive trend in national health, health inequalities appear to be on the increase – in particular, there has been an increase in health differences according to socioeconomic status. The better educated and better off live longer and become ill less than those in a poorer socioeconomic position. Most of the difference can be attributed to differences in lifestyle. The better educated and more aware are clearly better placed to adopt a healthy lifestyle than the less well educated and more passive. Equality in health can be best promoted through preventive measures such as environmental health care, mother-child clinics and school health care. However, change will inevitably be slow and will require determined and sustained efforts.

The National Public Health Committee has drafted a new health policy programme based around the key concepts of health equality, functional capacity, personal responsibility, sustainable development and intersectoral cooperation. Besides the service system, other important factors influencing health include the home, the school and the workplace.

Increased problems from abuse of alcohol and drugs

In 1999, Finns spent a total of FIM 20 billion on alcohol. This represents FIM 3,920 per person. Alcohol accounted for 5.6 per cent of expenditure on private consumption, and alcohol consumption is continuing to grow throughout the country. In 1999, Finland consumed nine litres of absolute alcohol per person. An estimated 250,000—500,000 people, around 6—12 per cent of the adult population, can be classed as heavy drinkers. Increased alcohol consumption has led to an increased demand for social work services in the general area of substance abuse, as alcohol problems are often accompanied by abuse of both medicines and illegal drugs.

Early intervention vital in helping drug addicts

An estimated 30,000 people in Finland regularly use illegal drugs. Most are aged between 20 and 30. Experimenting with drugs and more serious abuse of drugs are still relatively rare compared with other EU Member States. However, Finland is one of the countries currently experiencing a rapid increase in experimenting with drugs among young people. The problem was previously limited to the Helsinki area

and other major centres of population, but it is now spreading to other parts of the country as well.

Over the past two years there has been an increase in the number of special units in Finland providing treatment for drug addicts, but replacement therapy is not yet available throughout the country. There is also inadequate provision of low-threshold services. The situation is changing at a rapid pace, and many municipalities which have suddenly found themselves facing a drug problem have set up advice centres for users of intravenous drugs. These also provide the opportunity to exchange used needles and syringes for clean ones.

The social and health care services have an important role to play in providing treatment for drug addicts. However, this often places personnel in an entirely new situation in which their existing skills and knowledge do not equip them to recognize and tackle drug problems. It is particularly important to reach young drug users as early as possible, and more resources need to be devoted to working with the families of young addicts. It is vitally important to create local networks and tightly knit, dependable support groups to help young people and their families.

World Health Report is criticized

In the World Health Report 2000, the World Health Organization rated French health care as the best in the world, with Italy in second place. Finland was ranked 31st, with Norway in 11th place the highest ranked of the Nordic countries. For the first time, the 2000 report presents index data on the performance of the health care systems of the different countries in achieving the three general objectives of good health, responsiveness in relation to public expectations and fairness in the financing of services. The assessment is to be repeated annually.

National Research and Development Centre for Welfare and Health (Stakes) reviewed the World Health Report on behalf of the Ministry of Social Affairs and Health. According to Stakes, it is not possible to draw conclusions on health care in Finland solely on the basis of this report. The information on Finland presented in the report is reliable only in respect of the general health of the population, while the comparison of health care systems leaves much to be desired. The greatest weaknesses are in the comparisons drawn between the health care systems of different countries and the research data used in these comparisons. The report has not used data gathered in Finland, the Finnish situation being merely deduced from data gathered in other countries.

Reginal differences in access to health care

A basic requirement of Finnish health care is efficient delivery of primary health care. Almost two-thirds of the population have been assigned their own personal physician responsible for their primary health care. The system of personal physicians has meant more people gaining quicker access to treatment, but the target has not yet

been achieved in all municipalities. Service provision has been hampered by a shortage of health centre doctors.

In the area of specialized medical care, there has been a steady reduction in hospital beds. This has been accompanied by a reduction in the length of stay, but an increase in their number. There has been a particular increase in the use of outpatient surgery. Waiting periods for treatment nevertheless remain fairly long and vary in length from one part of the country to another. There has been considerable development in the methods of examination and treatment used in specialized medical care, which has often led to a need to introduce more up-to-date equipment. This has in turn contributed to rising costs.

The considerable reduction in hospital beds in psychiatric care was supposed to be compensated by an increase in outpatient services. There has admittedly been some increase, but not nearly enough. There is also a major shortfall in the supply of mental health care services for children and young people. To remedy this situation, the Ministry of Social Affairs and Health granted a targeted subsidy of FIM 70 million for 2000 to the municipal boards running the hospital districts for projects to develop psychiatric services for children and young people. A further FIM 45 million has been set aside for 2001. On top of this, further support of FIM 25 million has been earmarked from the beginning of 2001 for psychiatric services for children and young people. This is to be paid through the system of government grants to the municipalities and will be directed into mental health care work for children and young people and social services which support this work. Special additional funding of FIM 20 million has also been set aside for psychiatric rehabilitation for children and young people.

Gradual extension of public dental care to cover the entire population

The scope of public dental care is to be gradually extended from April 2001. During the transitional period of April 1 – December 31, 2001, municipal dental care will be extended to all those born in 1956 or later, and during the period January 1 – November 30, 2002, to all those born in 1946 or later. From the beginning of December 2002, age limits will no longer apply. Access to care will not, however, become a subjective right, but will depend on the need for treatment. Many municipalities already provide dental care for their residents. The reform will primarily improve the situation of people in the larger municipalities. In addition to direct provision, municipalities will also be able to purchase services from outside: for example, from another municipality or the private sector.

National health insurance refunds of dental treatment expenses will also be extended in April 2001 to cover those born in or after 1946. All age limits will cease to apply in December 2002.

The extension of public dental care will be funded primarily from existing resources by reviewing the amounts patients will themselves be expected to pay for treatment under the health

insurance scheme and by tighter targeting of municipal dental care services. For example, routine annual check-ups will be discontinued for those who can manage perfectly well with a less frequent check-up.

Lab tests and costings

In Finland, most lab tests are carried out by the hospital districts and health centres. The costs of lab tests in hospitals and health centres are included in the daily fee for hospital care and the fee for health centre doctor visits. In the private sector, national health insurance covers approximately 38 per cent of the charge for tests prescribed by a doctor. The past decade has seen a rapid introduction of automation in lab tests, and the Ministry of Social Affairs and Health has therefore appointed rapporteurs to study the carrying out of lab tests in the health service and the costs involved. A report is due by June 30, 2001.

Finnish health care costs below the EU average

Overall health care expenditure in Finland in 1998 was below the average for EU Member States both as a proportion of GDP (6.9%) and per capita. Per capita expenditure was 81 per cent of the EU average.

Overall expenditure grew by approximately 72 per cent in real terms in the 1980s. In the 1990s, growth was almost zero. This marks a considerable break with the past and will have major implications for the emphases and solutions adopted in the health service.

Once again a sharp rise in medicine costs

A number of legislative amendments came into effect in 1998 which slowed the rise in medicine costs and related expenditure on refunds. Expenditure on refunds rose in 1998 and the first quarter of 1999 by only two per cent, against an annual rate of increase since 1994 of around ten per cent. Since the second quarter of 1999 the rate of increase has returned to pre-1998 levels. This is due both to the extension of health insurance refunds to cover certain important and expensive drugs which were not previously covered, and to the use of more expensive drugs. As in earlier years, an average of 60 per cent of the cost of prescription drugs was refunded. The average price of a prescription covered by national health insurance in 1990 was FIM 145 (1999 prices) against FIM 229 in 1999.

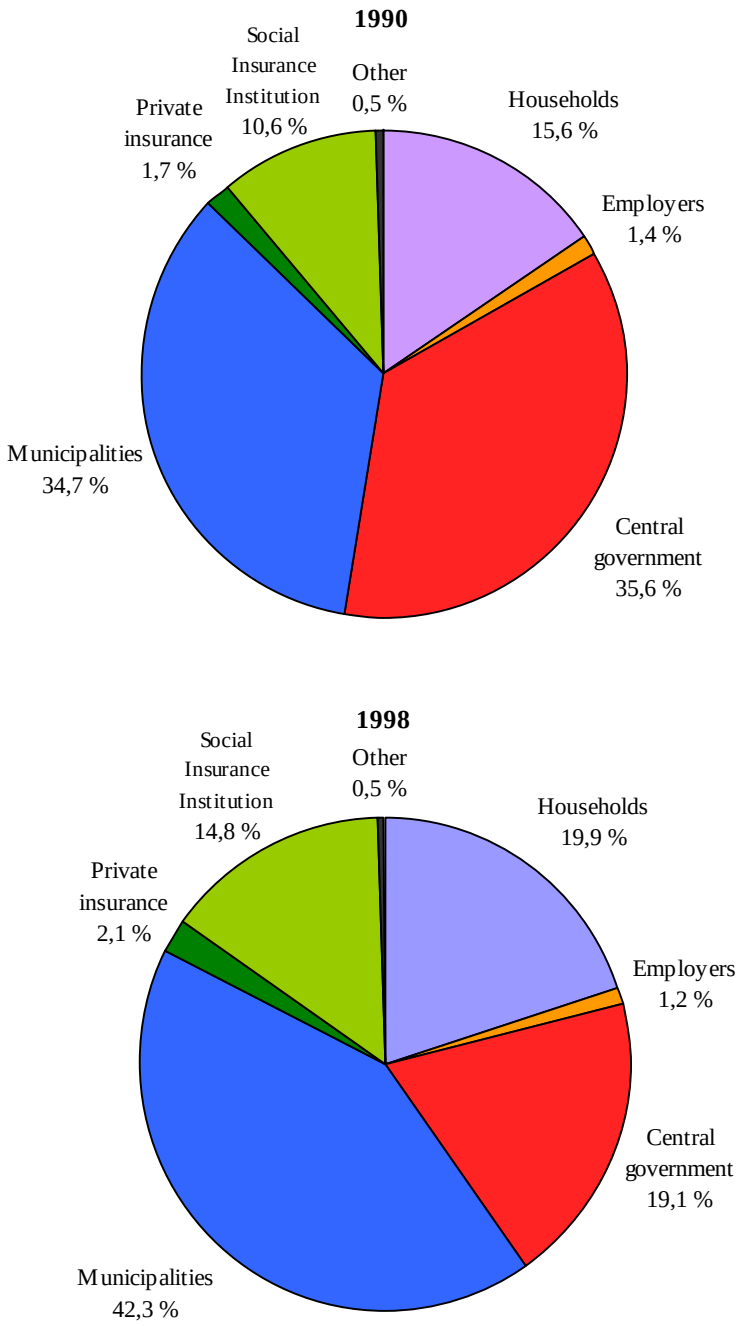
Of the population as a whole, 63 per cent received refunds on medicines in 1999. Slightly over one million people are entitled to special reimbursement on the costs of medicines on the basis of chronic or serious illness. Hypertension is the most common disease that is entitled to special reimbursement. Additional refunds were paid in 1999 to approximately 90,900 people whose medical expenses had reached the personal annual limit of FIM 3,282. This represents an increase of 10 per cent on the previous year, and the number of recipients continues to grow.

Households pay a greater share of health care costs — a ceiling is set

The financing structure for health care expenditure as a whole went through considerable changes during the 1990s. Government grants to the municipalities were cut, while the proportion of expenditure borne by the municipalities themselves correspondingly rose. The burden on households also rose. This was due both to increases in client fees and to increases in the proportion of medicine costs and private health care services paid for by the insured themselves.

Client fees for social welfare and health care services were raised on January 1, 2000. Fees for outpatient surgery were particularly affected. At the same time, a ceiling was fixed for health service fees. Where these exceed FIM 3,500 within a twelve-month period, subsequent outpatient services are provided free of charge and the charges for inpatient services are considerably reduced. The reason for the ceiling is to prevent unnecessary hardship for frequent users of health care services. On January 1, 2001, the twelve-month qualifying period was changed to a calendar year.

Figure 14. Sources of finance for health care expenditure as a whole in 1990 and 1998



Financing expenditure on health

The municipalities receive a block grant from central government for the provision of health care services. In 1999, the grant covered approximately one fifth of expenditure. In straight cash terms, there was a dramatic fall in the size of the grant between 1990 and 1999. From 2000 on, there will be a gradual increase. In 1999, client fees covered around 12 per cent of the cost of primary health care and around 6 per cent of the cost of specialized medical care. The proportion of costs covered

by client fees has remained more or less the same for several years.

Health insurance is funded mainly by contributions from employers and from the insured themselves. Since 1998, the central government has made a special payment to guarantee the liquidity of the health insurance fund, and since 1999 part of the revenue from value added tax has been channelled into financing health insurance.

Statutory accident insurance is financed entirely from premiums paid by employers, and third party liability motor insurance from premiums paid by the insured.

Estimated sources of finance for expenditure on sickness and health in 1999 (preliminary data)

	Expenditure (FIM million)	Financing contribution (%)				
		Central government	Municipalities	Employers	The insured	Clients
Health insurance [1)]	7 955	15	0	35	50	0
Statutory accident insurance[2)]	950	0	0	100	0	0
Third party liability motor insurance [2)]	360	0	0	0	100	0
Primary health care [3)]	11 700	21	67	0	0	12
Specialized medical care [3)]	17 100	23	71	0	0	6

[1)] Includes sickness allowance, but not parental allowance
[2)] Excludes pensions and continuous payments
[3)] Includes client fees

2.2. Disability

	1998	1999*	2000**	2001**
Expenditure on main category (FIM million)	26 150	25 700	25 400	25 800
- of which, cash benefits (FIM million)	20 900	20 300	19 750	19 800
% of social protection expenditure	13,9	13,6	13,1	12,8
% of GDP	3,8	3,6	3,2	3,1
Recipients of disability pension on December 31	288 050	282 050	276 700	271 500
Recipients of disability allowance on December 31	11 600	11 700	11 700	11 800
Disabled people in institutional care on December 31	3 200	3 000	2 800	2 700
Recipients of transport services during the year	58 600	61 700	61 000	61 000
Disabled households receiving home help during the year	6 290	6 580	6 600	6 600
Disabled recipients of informal care allowance during the year	7 640	7 700	7 700	7 700

* preliminary data
** estimate

No major changes in expenditure on disability

In 2000, social protection expenditure on the various categories of disability came to an estimated FIM 25.4 billion. This represents a slight fall in overall expenditure in this area. Share of GDP at a little over 3 per cent, is decreasing slightly.

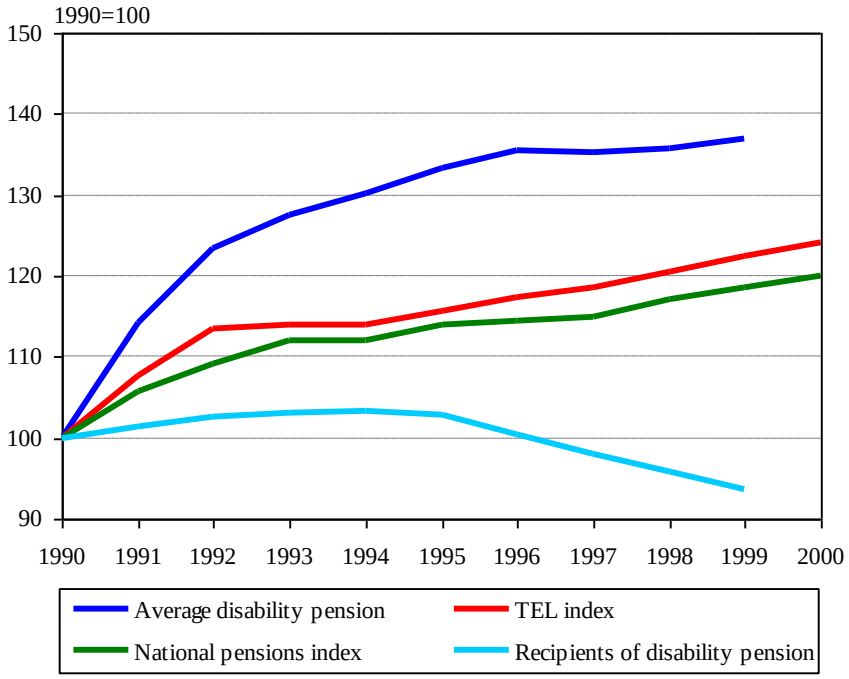
The bulk of expenditure on disability, almost FIM 16 billion, went on pensions. The proportion of 16-64 year-olds on early retirement pension for health reasons reached a peak in the early 1990s, but has fallen again over the past few years. In 1998, 8.1 per cent of 16-64-year-olds were on disability pension or individual early retirement pension. Expenditure on disability allowance, paid to people with disabilities who are not receiving a pension, was an estimated FIM 165 million in 2000, a mere one per cent of the expenditure of disability pension. Services for the disabled accounted for approximately FIM 5.6 billion.

The average disability pension rose up to the 1996 pension reform. Since then, change has been more gradual. Increases in the level of existing pensions have been tempered in recent years by a phased reduction in the basic amount of the national pension. The remaining basic amount of the national pension will be withdrawn from the beginning of 2001. The level of new disability pensions has been undermined by the full deductibility of the national pension and the changes introduced in the procedure for calculating the 'future period' (the estimated period from the onset of disability for work until eligibility for old-age pension). Otherwise disability pensions are following the general trend of the pension indexes (Figure 15).

Tax relief for pensioners has partly compensated for the cuts in pensions. At the end of 1999, the average total disability pension was FIM 5,322 a month. Average disability pensions for

women amounted to less than 80 per cent of the average for men. 54 per cent of people on disability pension received a total pension of less than FIM 5,000 a month, while 16 per cent got over FIM 7,500.

Figure 15. Trends in disability pensions 1990-2000



Low employment rate for the disabled increases social protection expenditure

The employment rate for people with disabilities is much lower than for the population as a whole. Despite the general improvement in the employment situation, disabled people still find it hard to get a job. Moreover, a considerable proportion of disabled people of working age are pensioners. Pensions form the main source of income for approximately three out of four recipients of disability-related benefits, while wages and entrepreneurial income are the main source of income for less than one in five.

Disability allowance is a form of financial support intended to help people with disabilities who do not receive a pension to manage in their daily life, at work and in their studies. It is paid at three levels, depending on degree of disability, need for support and any special costs. In 2001, the three levels of support are FIM 441, FIM 1,029 and FIM 1,912 per month. The number of recipients of disability allowance has remained stable for many years, at around 12,000. The percentage of unsuccessful applications has been remarkably high (34—37% in 1997-1999), and even higher than average in the 16-34 age group.

The Employment Services Decree defines a disabled person as someone whose chances of finding suitable work, holding down a job or progressing in his or her career are considerably reduced by a properly attested injury, illness or other disability. The number of disabled job-seekers has risen in recent years by 4,000 — 5,000 persons per year. Over 1999 as a whole, there were a total of 80,070 disabled job-seekers registered with the labour administration, of whom 66,575 were unemployed. The annual average number for 1999 was 38,800. The proportion of unemployed job-seekers with a disability has risen as the general employment situation has improved, and in 1999 one job-seeker in ten was disabled.

People with disabilities are generally unemployed for much longer than average. The average duration of periods of unemployment which ended in 1999 decreased from 34 to 33 weeks for disabled people, and from 21 to 19 weeks for the unemployed as a whole. The proportion of older people among disabled job-seekers is rising, which serves to lengthen the average duration of unemployment among the disabled. The most common causes of disability are musculoskeletal disorders, respiratory diseases and mental problems.

There were a total of 3,000 people in sheltered work at the end of 1999, with 10,300 people participating in work activities for the mentally handicapped. Work activities means work carried out in a context other than an employment relationship. Net expenditure on sheltered work and work activities for the mentally handicapped totalled FIM 575 million.

The Rehabilitation Allowance Act and the National Pensions Act were amended as of August 1, 1999 to guarantee all disabled young people aged 16—17 the opportunity of vocational rehabilitation and a higher level of rehabilitation allowance. The amendment was primarily targeted at those severely disabled young people who would previously have gone directly on to a pension at 16 without the benefit of intensified assessment of working capacity and rehabilitation. Disability pension can now be granted to a young person under 18 only when it has been established that vocational rehabilitation is not possible, or when rehabilitation has been suspended due to sickness or otherwise ended without result. A condition for the granting of rehabilitation allowance is the drawing up of an individual training and rehabilitation plan for the young person concerned. Rehabilitation allowance is payable up to the age of 18. If the young person concerned is in rehabilitation on turning 18, rehabilitation allowance is paid until the end of the ongoing period of rehabilitation. In 2000, rehabilitation allowance for a disabled young person is FIM 2,139 per month.

At the end of 1999, a total of 813 young people aged 16—17 were receiving disability pension or rehabilitation subsidy (formerly fixed-term disability pension). A total of 445 new recipients were granted disability pension or rehabilitation subsidy during the course of the year. The reform which came into force in August would appear to

have reduced the numbers of young people going on to a pension or rehabilitation subsidy. In January—October 2000, a total of 156 new people were granted disability pension or rehabilitation subsidy, 110 of these being granted disability pension. At the end of June 2000, a total of 441 young people were receiving rehabilitation allowance.

Another reform which came into effect on August 1, 1999 offers those who receive only disability pension under the National Pensions Act the opportunity to temporarily suspend their pension for a minimum of six months and a maximum of two years while they go out to work. The aim is to encourage disabled people to seek work. In order to make working a better option for a disabled person than drawing a pension, a disability allowance is payable for the duration of the period the pension is suspended equal to the level of special-rate disability allowance, which is set at FIM 1,912 per month for 2001. The reform has not so far had as great an effect as expected on increasing the numbers of disabled people going out to work: in July 2000 there were just 25 pensions currently suspended. The low uptake could perhaps be partly due to the fact that a person whose pension is suspended is not entitled to employment subsidy from the labour authorities.

Studies on employment among the disabled

The Ministry of Social Affairs and Health commissioned Rapporteur ad int. Matti Marjanen to study the obstacles confronting disabled people seeking employment. The rapporteur's proposal, delivered in autumn 2000, seeks to provide people with disabilities an equal chance of finding employment and to raise their employment rate. The proposals include amendments to the Employment Act, changes to the regulations governing the role of the social welfare services in preparing people for employment, and reform of social insurance legislation.

The social welfare sector under the Ministry of Social Affairs and Health will be affected above all by the proposed reform of the system of sheltered work based on the provisions of the 1978 Care of Invalids Act. The other sections of the Act were repealed by the entry into force in 1988 of the Services and Assistance for the Disabled Act. Under the proposal of the rapporteur, sheltered work would remain the responsibility of municipal social welfare departments. This would involve amendment of the Social Welfare Act to include new provisions on action to help people find employment and work activities for the mentally handicapped. The reform is not expected to have significant cost effects. The proposal also envisages development of the activities of the work centres run by the municipalities and NGOs. One idea would be for the Social Insurance Institution (Kela) to be able to purchase vocational rehabilitation services from the centres.

The proposed reforms to social insurance legislation involve setting the income limit for temporary suspension of the disability pension at FIM 3,500 a month and extending the maximum period of suspension from two to five

years. Further proposals are to extend the payment period for rehabilitation allowance for disabled young people by two years, to the age of 20, and to give employed people in receipt of disability pension under the National Pensions Act the right to sickness allowance. Extending the period of rehabilitation allowance for young people would produce savings in pensions expenditure. The costs of extending the right to sickness allowance are estimated at just under FIM 1 million per 1,000 pension recipients. In addition to the above reforms, the package as a whole also includes several proposals relating to the labour administration.

At the beginning of 2000, the Ministry of Trade and Industry launched a two-year project on entrepreneurship in line with the Government Programme. This will be implemented in broad cooperation between several sectors of government, NGOs, entrepreneurs and other participants. The project has been divided into five broad areas. One of these deals with becoming an entrepreneur, and part of this focuses on promoting the business activities of special groups, including people with disabilities. A preparatory project on this was launched to run through to March 31, 2001. Its main brief was to report by the end of the year on possible new forms of support to replace value added tax relief for seriously disabled entrepreneurs. It was also charged with taking a broader look at social entrepreneurship as one potential means of finding employment for those difficult to place.

Rehabilitation as a tool of active social policy

Rehabilitation is one of the means available for pursuing an active approach to social policy and can be used to advance the working and functional capacity of the population as a whole. Rehabilitation can be justified on both human and economic grounds. The challenges facing rehabilitation of the working-age population in the early years of the 2000s cover a wide range of issues, including ageing disabled employees, the long-term unemployed, young people in danger of social exclusion and the severely disabled. Behind the need for rehabilitation there are often mental problems or alcohol or drug abuse. As new problems emerge, new methods and approaches need to be developed, and the effectiveness of these new approaches must be constantly monitored by research. Studies on rehabilitation need to focus on both individual measures and organizational approaches, longer-term processes, and the effectiveness of the system as a whole.

Rehabilitation has in recent years focused increasingly on those aged over 45 in working life. This trend has been influenced both by the reform of the employment pension to encourage those nearing retirement to stay on longer at work, and by Kela rehabilitation measures aimed at older workers. Maintaining the working capacity of older unemployed people was the objective behind a joint survey by the labour authorities, the social welfare and health authorities and Kela to chart the service needs of long-term unemployed people in this age group.

The volume of vocational rehabilitation provided by Kela grew throughout the 1990s. In 1999, rehabilitation was provided for 3,900 people at a cost of FIM 103 million. Almost half (41%) of rehabilitees were in the 45-54 age group, while only 7 per cent were over 55. The typical employment pension rehabilitee was a 35-44 year-old employee suffering from a musculoskeletal disorder who was given training for a new line of work. Of those completing rehabilitation in 1999, 44 per cent went back to work, while 30 per cent took their pension. A return to work is more likely the earlier rehabilitation begins. Of those who were on neither a pension nor rehabilitation subsidy when they began rehabilitation, over half (54%) returned to work, compared with less than a third (30%) of those on a pension.

In order to maintain and improve working capacity, and particularly the working capacity of those still in work, Kela has developed a form of early rehabilitation in a vocationally oriented medical rehabilitation programme called ASLAK. Most work under ASLAK is carried out in the form of workplace-specific or vocation-specific courses, but activities are also to an increasing degree open to all. ASLAK is one of the main channels for Kela's work in rehabilitation, and funding has steadily increased year on year. In 1999, a good 14,000 people took part, of whom 8,600 were aged 45-54, and around 1,000 were over 55. Studies indicate that ASLAK has been particularly effective in raising the working capacity and quality of life of women participants.

Training designed to maintain and enhance working capacity (TYK training) is meant particularly for older employees with many years of experience in working life. It is organized in cooperation with the employee, the workplace and the rehabilitation centre concerned. In 1999, TYK training was organized for approximately 7,000 people, of whom 4,000 were aged 45-54, while around 2,600 were over 55. The results of a study into the effectiveness of TYK training was due to be ready before the end of 2000.

The service needs of older long-term unemployed people were surveyed as part of Finland's National Action Plan for Employment 1996-1999. The purpose of these surveys was to boost the effectiveness of employment services, training, rehabilitation and working capacity assessment provided for this group, explore adequate pension alternatives and generate data on long-term unemployment among older workers. According to the survey, those who benefited most from rehabilitation measures were on the one hand those in fairly good condition whose return to working life could be advanced through rehabilitation, and on the other hand those with weakened working capacity who were granted disability pension after examination of their capacity to respond to rehabilitation. In 1999, approximately 5,500 older long-term unemployed people took part in rehabilitation need surveys, rehabilitation examinations or courses of rehabilitation. Originally introduced as an experiment, service need surveys have now been adopted throughout the country.

In addition to amendments to the pension laws, the pension reform which came into effect at the beginning of 2000 also involved other actions to help ageing workers stay on longer in working life. One of these is the phased introduction of the right to early examination of rehabilitation need for those insured under the employment pension scheme. The Insurance Rehabilitation Association (VKK) has been commissioned by the Federation of Employment Pension Institutions to implement a project (KUTVE) on a rehabilitation and working capacity evaluation network. This project, to be implemented during 2000-2002, has two objectives: to develop means whereby the authorities responsible for employment pension rehabilitation can support people whose health makes it hard for them to stay on at work, and to help older employees stay on longer in working life. The project will concentrate on developing two distinct forms of cooperation: (1) Activities at local level relating to early identification of the need for rehabilitation and the launch of evaluation in response to the threat of disability. An aspect of this will be to provide training for occupational health care personnel in cooperation with the Institute of Occupational Health. (2) Cooperation between the purchasers (the employment pension institutions) and suppliers (occupational health care providers and rehabilitation centres) of rehabilitation services in organizing research into rehabilitation and workplace trials. This will also involve the development of procedures and criteria for measuring functional capacity. This work will take place in working groups of physicians from Kela and the employment pension institutions. A study is also currently in hand to assess the content of the medical certificate which must be attached to applications for disability pension.

The budget proposal for 2001 includes the raising of the minimum level of rehabilitation allowance for periods of vocational rehabilitation from the present level of around FIM 1,500 to FIM 2,139 a month from September 1, 2001. The Social Insurance Institution will also begin to pay a discretionary tax-free maintenance allowance to participants in vocational rehabilitation. The daily allowance of FIM 30 would be paid primarily for the duration of rehabilitation examinations, open courses, workplace trials and similar measures to people who face unavoidable costs on account of factors such as the rules governing personal contributions to travelling expenses, and who otherwise receive the minimum level of rehabilitation allowance. It has been estimated that the increase in the level of the rehabilitation allowance will benefit around 1,500 people. The estimated cost of these reforms has been put at FIM 7 million a year.

Disability pension and unemployment pension as exit routes from working life

When older workers leave working life it is normally to take up a pension. Amongst the over-55s this is more than twice as common as leaving working life via the intermediary stage of unemployment. During the 1990s, however, the proportion of over-55

year-olds receiving early retirement pension has fallen while the proportion unemployed has risen. The proportions of both the 55-59 age group and the 60-64 age group on disability pension have also fallen. In 1998, the respective proportions were 21 per cent (55-59-year-olds) and 41 per cent (60-64 year-olds).

Unemployment is the main exit route from working life for those under 58 years of age, becoming more common from age 55 onwards. Use of this avenue to a pension via unemployment is most common in industry and the building sector. There is little difference between the sexes.

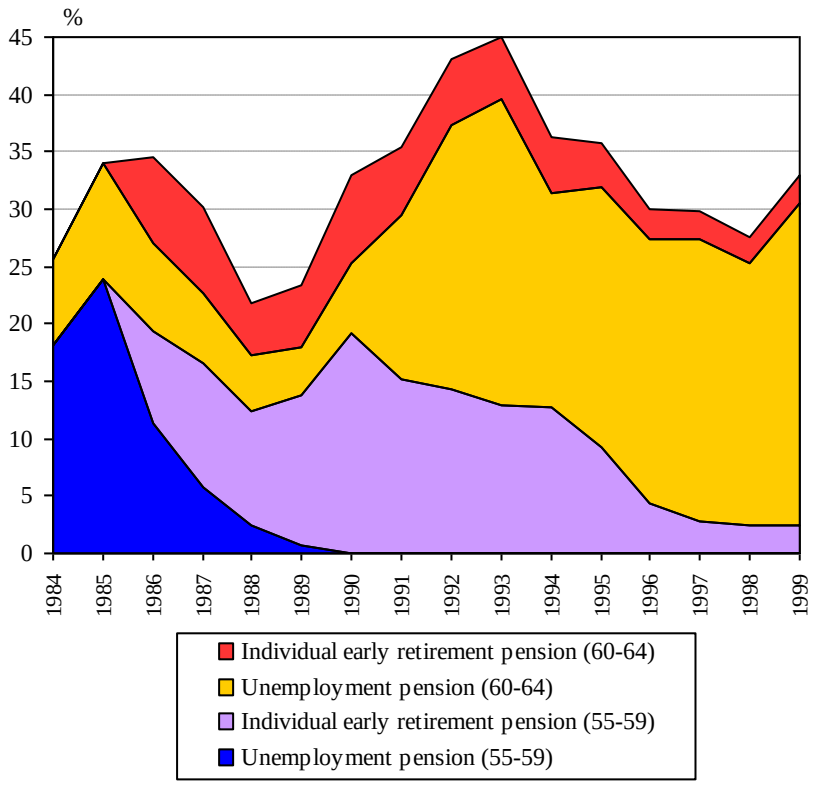
It can be considered positive that the employment rate among the over-55s — those in work as a proportion of the age group as a whole — rose in 1999 at almost the same rate as employment among the young. The improvement was particularly noticeable among women. The higher employment rate among older workers is due to the age group as a whole staying on longer in working life. However, older workers who become unemployed still experience trouble finding another job. These difficulties make it all the more important to support older workers in coping with their present jobs, and also highlight the need for rehabilitation measures to begin early enough to make a difference.

The average age of retirement continued to rise in 1999, reaching 59 years, a higher figure than for any other year in the decade. If older workers were to continue to take early retirement at the earlier rate, the growth in cohort size would mean that within a few years there would be a considerable rise in the numbers retiring before the age of 65.

The number of people receiving disability pension is not an accurate measure of the real loss in working capacity across the workforce as a whole. The numbers on disability pension are affected by the extent of other social protection measures, the definition of disability conferring entitlement to pension and changes in employment and working life. For example, the rise in the relative numbers on disability pension towards the end of the 1980s was due largely to the introduction of individual early retirement pension, for which disability is defined less strictly than for disability pension per se. In 1996, the lower limit for individual early retirement pension was raised from 55 to 58 years, and in 2000 it rose again to 60.

In the 55-64 age group the number of new recipients of individual early retirement pension, in particular, has fallen as the number of people on unemployment pensions has risen (Figure 16). The rise in the lower limit for individual early retirement pension to 60 at the beginning of 2000 will have little impact on the number of new pensions, as the number of new individual early retirement pensions among the under-60s had already fallen to a very low level.

Figure 16. New unemployment pensions and individual early retirement pensions as a proportion of the 55-64 age group in 1984-1999



Mental problems an increasingly common reason for disability pension

The past two decades have seen a considerable reduction in the number of disability pensions granted on the basis of circulatory diseases. The proportion granted for musculoskeletal disorders rose steeply until the early 1990s, since then it has fallen back slightly. The changes in respect of mental problems have been smaller, but in recent years they have become more important as a cause of disability. Figures 17 and 18 show the trend in the private sector, as there are no combined statistics on the private and public sectors before 1996. In 1999, there was an increase in the uptake of both disability pension and individual early retirement pension.

For the employment pension system as a whole, the most common reason for new disability pensions in 1998 were musculoskeletal disorders (31%). They were also the most common reason (49%) for new individual early retirement pensions. There was a slight increase in the proportion taking disability pension as a result of mental problems (29%). The proportion of new individual early retirement pensions granted on the basis of mental problems remained stable at 16 per cent in 1997 and 1998. Among recipients of rehabilitation subsidy, mental problems have remained the most common cause of disability. In 1998, 39 per cent of new rehabilitation subsidies were granted on the basis of mental problems.

Figure 17. Reasons for granting new disability pensions in the private sector in 1986-1999

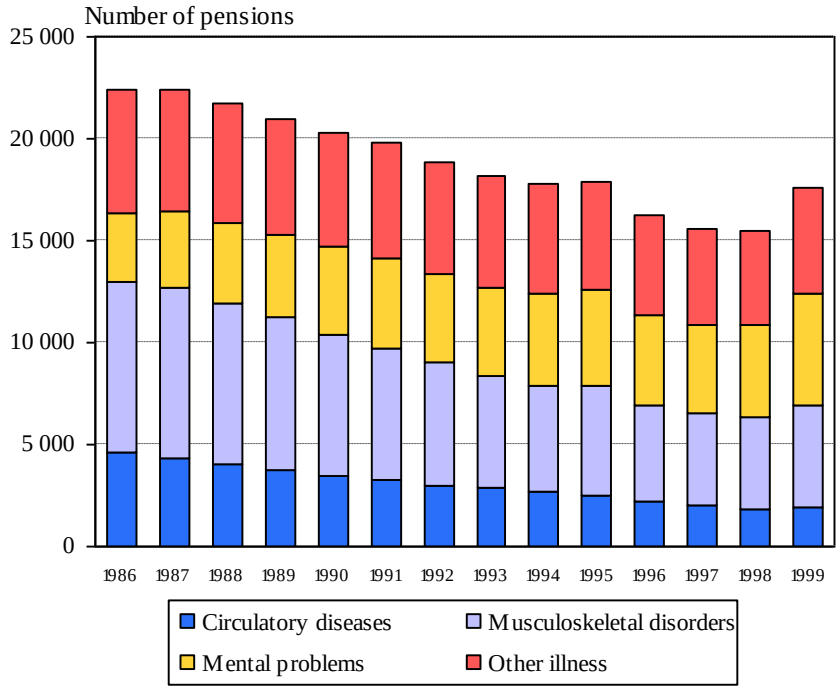
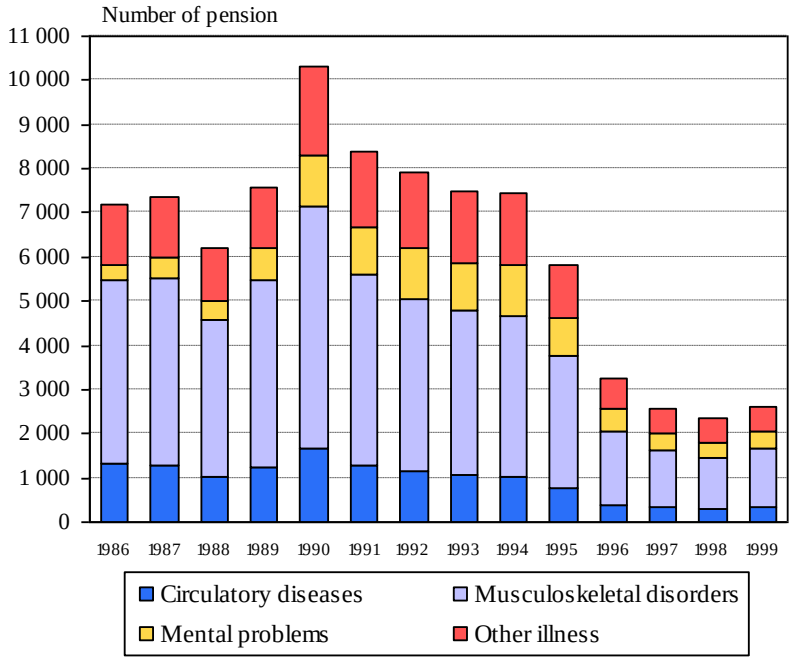


Figure 18. Reasons for granting new individual early retirement pensions in the private sector in 1986-1999

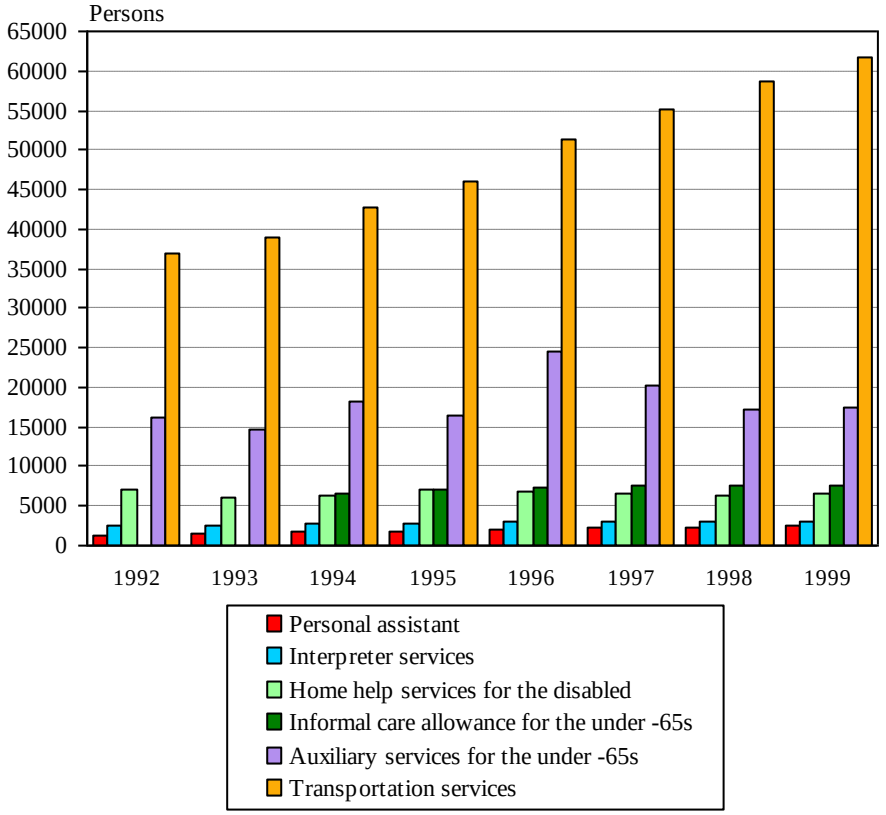


Source: Central Pension Security Institute

More services for the disabled — but regional differences

In 1999, home help services were provided to slightly more people under the age of 65 than in the previous year. There was also an increase in the number of disabled people receiving transportation services, interpreter services, or a personal assistant under the Services and Assistance for the Disabled Act. Transportation is by far the most widely used service among the disabled. The biggest relative rise was in the numbers receiving the services of a personal assistant, with an assistant being provided for almost 2,600 disabled people in 1999. In contrast, there was a slight fall in the number of under-65s cared for with the help of informal care allowance. (Figure 19)

Figure 19. Number of disabled people receiving home help, informal care allowance and other services for the disabled in 1992-1999

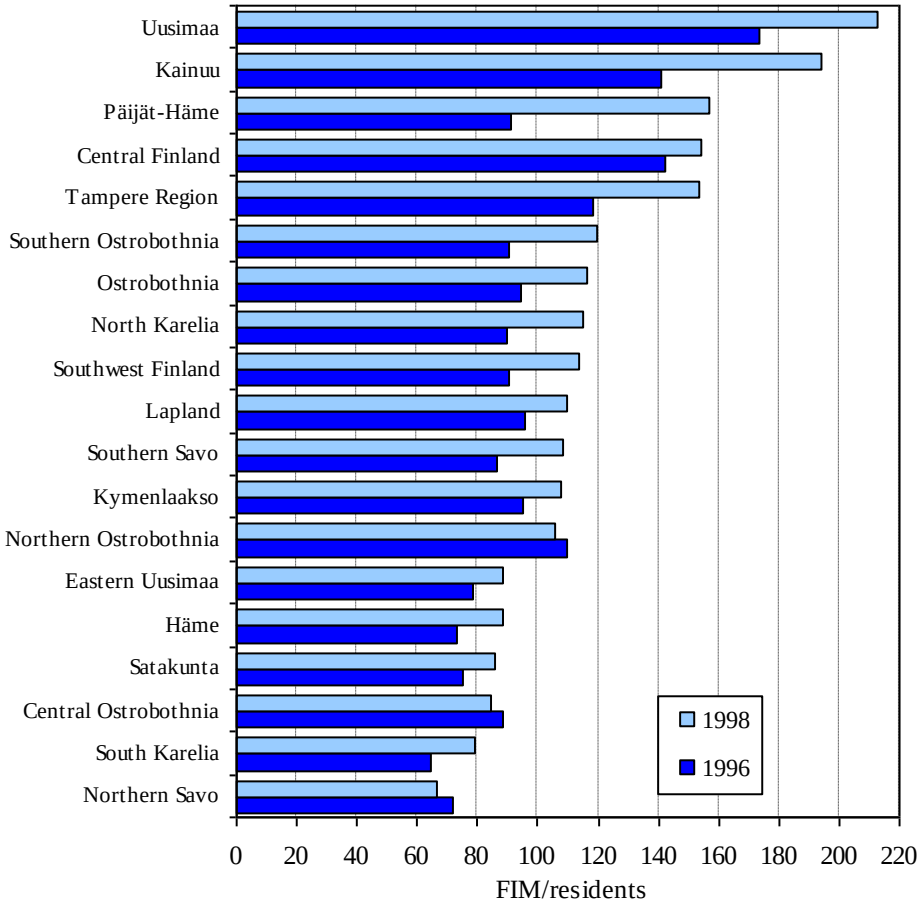


Source: SOTKA

The present Services and Assistance for the Disabled Act has been in force in its full extent since 1994. The services and assistance referred to in the Act are provided only where a disabled person cannot get adequate or appropriate services under some other piece of legislation. The Act applies to an estimated one per cent of the Finnish population. The number of people receiving services for the disabled grew throughout the 1990s, as did the costs of service provision. Between 1994 and 1998 the costs of providing services and assistance under the Act grew in real terms by over a third. The figure for 1998 was FIM 721 million.

Per capita expenditure on services and assistance under the Services and Assistance for the Disabled Act have risen year by year in all provinces of Finland, and in almost all regions within each province. There are nevertheless considerable regional differences in expenditure. In 1996 and 1998, by far the greatest per capita expenditure was in Uusimaa (FIM 210 in 1998) and the lowest in Northern Savo (FIM 70 in 1998). In 1998, per capita expenditure for the country as a whole was FIM 140. (Figure 20)

Figure 20. Per capita regional expenditure on services and assistance under the Services and Assistance for the Disabled Act in 1996 and 1998, FIM



Source: SOTKA

There are two main factors which would seem to explain the growth in both customers and costs in services for the disabled: the ageing of the population, and increased awareness of the services which are available. However, for various reasons, including the wide diversity in the size of municipalities, it is hard to give a precise assessment of how well service supply meets the needs of disabled people in the different municipalities. There would appear to be considerable differences both at municipal and regional level in the practical application of the provisions of the Services and Assistance for the Disabled Act, and this results in

inequalities between disabled people living in different areas. There are particular problems in relation to services and forms of assistance tied to budgetary appropriations, as many municipalities have not set aside sufficient funds to cover them.

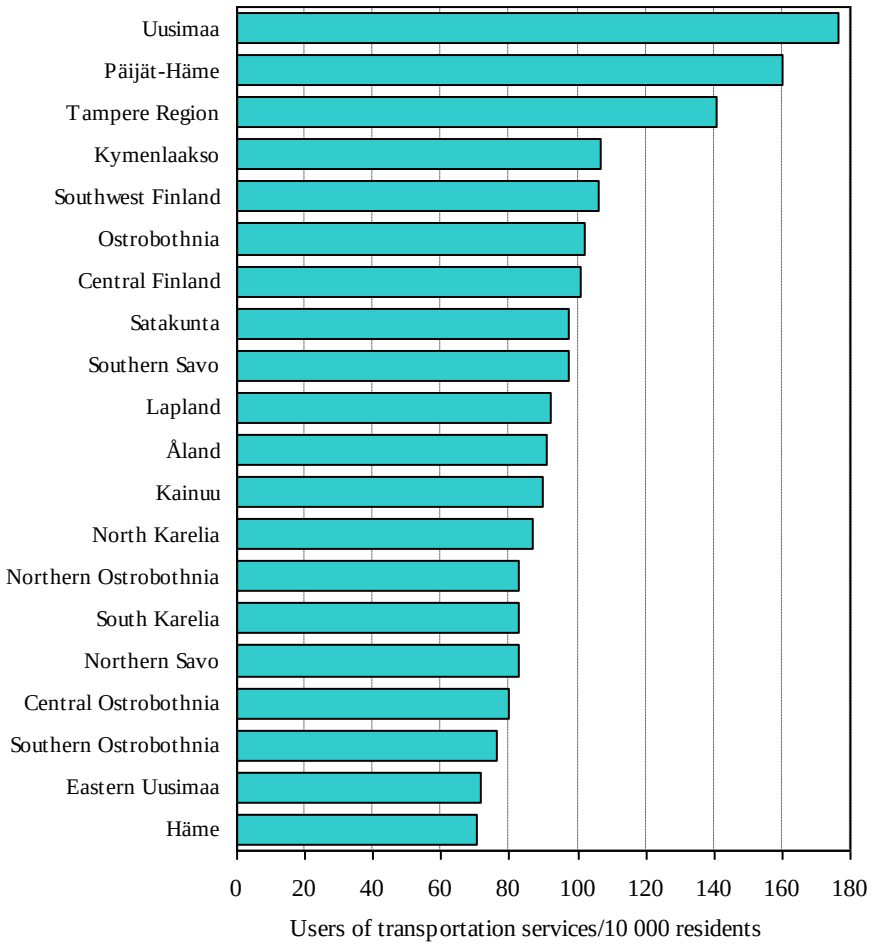
In March 2000, the Ministry of Social Affairs and Health delivered the report on municipal implementation of services for the disabled requested by the Social Affairs and Health Committee of Parliament. In its response to the report, the Committee emphasized that the statutory obligation on the municipalities to provide services for the disabled required each municipality to take steps to establish the content and volume of services and assistance required by disabled people in their area.

There are many reasons for the differences between the municipalities in social welfare and health care expenditure. These include differences in municipal resources and in the needs of local residents, differences in service structure and local policy in the area of social welfare and health, and differences in the efficiency and productivity of service provision. Studies suggest that extrinsic factors such as differences in economic resources or changes in central government supervision are less important than often thought in causing differences in expenditure, while factors specific to each municipality (policies, structures, local ways of working) are more important.

We can expect continued growth in expenditure on services for the disabled for two reasons: the increasing stress on community care in policy on the disabled and the elderly, and the need for further development of services for the disabled.

Transportation services play a vital role in helping people with severe disabilities cope with the demands of everyday life. Measured as a function of the number of local residents, there was an increase in provision of transportation services for the severely disabled across all provinces and regions between 1994 and 1999. In 1999, the level of transportation services was highest in Uusimaa, where transportation was provided for 176 people out of every 10,000, and lowest in Eastern Uusimaa and Häme (Figure 21). The figure for the country as a whole was 119 out of 10,000. There is clearly considerably more demand for transportation services for the severely disabled in the Helsinki metropolitan area and other large towns than in smaller urban municipalities or rural municipalities. The number of people using transportation services under the Services and Assistance for the Disabled Act is influenced to some extent by whether other transportation services are provided in the municipality in question. Cuts in other transportation services have particularly increased the number of elderly people using transportation services under the Act.

Figure 21. Regional breakdown of the number of people using transportation services for the severely disabled in 1999/10,000 residents



A perennial problem with transportation services under the Services and Assistance for the Disabled Act has been how to define 'severe disability' and 'neighbouring municipality' and also the share of the costs to be borne by service recipients. New problems relate to the provision of co-transportation — as for example when different journeys are combined with the aid of a travel dispatch centre — and the introduction of service lines. Disabled access to public transport can also influence whether a particular municipality defines a person as severely disabled as meant in the Act. As a result of increasing access to co-transportation and improvements in disabled access to public transport, some municipalities have limited their individual transportation services for the severely disabled.

New transportation solutions can reduce the need for transportation services under the Services and Assistance for the Disabled Act and release existing resources for use on other services for the disabled. However, severely disabled people will continue to require individual transportation services. A flexible arrangement whereby some transportation is carried out on an individual basis and some using collective or public transport is not possible under the present Services and Assistance for the Disabled Decree.

Under the Services and Assistance for the Disabled Act, municipalities are obliged to provide the services of an interpreter for those severely disabled people who need this sort of service. The minimum annual service has been set at 120 hours per person, or in cases of combined hearing and visual impairment at 240 hours per person. Students, however, must be provided with adequate interpreter services to enable them to successfully cope with their studies. There was a gradual rise throughout the 1990s in the number of people using interpreter services, but there remains considerable local variation in access to services. In 1999, 3,100 people were provided with interpreter services. Relative to population, the highest numbers were in Southwest Finland and Central Finland (8.3/10,000), and the lowest in Lapland (4.2/10,000).

Stakes has carried out a survey on interpreter services for people with severely impaired hearing and speech defects. Services cost FIM 24 million a year, with an estimated FIM 10 million more for student interpreters. An estimated 5,000 people with severely impaired hearing and 700—800 people with combined hearing and visual impairment need interpreter services. There are also several thousand people with severe speech defects. Stakes estimates that around 90 per cent of interpreter services are provided to people with severely impaired hearing, under 10 per cent to people with combined hearing and visual impairment, and only around one per cent to people with speech defects.

The main problems revealed by the survey of interpreter services lay in the following areas: a shortage of full-time interpreters, differences in access to services both regionally and between different categories of disability, quality issues, inadequate provision in terms of time, inadequate instruction for small children and their families on sign language and also on methods to support the use of speech or to replace it, and inadequate access to IT applications supportive of interpreter services.

Some municipalities provide no personal assistants

Provision of personal assistants is a growing area in services for the disabled, but a personal assistant is not a subjective right. In 1999, approximately one in four municipalities did not provide any personal assistants. Overall, assistants were provided at a rate of 2.9—11.3 per 10,000 inhabitants, with the average being 5.0.

According to benefit statistics produced by Kela, there are almost 30,000 people in Finland with some degree of mental handicap. Of these, around 6,000 are severely handicapped. Special services for the mentally handicapped are used by approximately 21,000 people. There has been a drive to reduce the use of institutional solutions in the provision of care for the mentally handicapped, and this has been successful. Institutional care has been replaced with housing services, which have been the fastest improving service for the mentally handicapped over the past couple of years. In 1999, there was a

further reduction in the number of people with mental handicaps in institutional care: there are now around 3,000. The number of people covered by housing services for the mentally handicapped rose to approximately 5,500. Continuation of the success achieved so far in changing the service structure in care for the mentally handicapped will depend on securing the necessary quantity and quality of housing services and the effective functioning of a range of forms of short-term care. The role of the special care districts now lies more clearly than before in the provision of institutional care and serving in an expert capacity to support basic service provision by the municipalities.

Preventing discrimination and providing an obstacle-free living environment are key issues

Prevention and eradication of discrimination and provision of an obstacle-free living environment are key issues in implementing equality for people with disabilities. The importance of these issues will increase further in the future as the ageing population structure brings an increase in the number of people with disabilities.

Under the Finnish Constitution, gainful employment should take precedence over welfare cash benefits for disabled people just as for the rest of the population. If we are to raise the employment rate among disabled people and others whose capacity to work and look after themselves is restricted in some way, prevent selective recruitment and discrimination at work, and improve the opportunities for disabled people to live an independent life, there will have to be a change in attitudes. There will also have to be action by several different branches of government. Besides reforms to the social protection system, it is also vital to develop housing, the domestic environment in general, and the workplace environment so as to allow unrestricted access for people with disabilities. This means an environment free from both physical obstacles and obstacles to communication. If most services for the disabled could be provided using general services and other solutions designed to serve the population as a whole, the Services and Assistance for the Disabled Act would be able to function in its originally intended role of guaranteeing special services for the severely disabled.

Financing expenditure on the disabled

National basic pension is funded primarily by employer contributions and by central government. When necessary, the government also makes a special payment to guarantee the liquidity of the national pension fund. In 1999, FIM 2.4 billion of the revenue from value added tax was also channelled into financing the national basic pension.

Employment pension is funded from contributions by both the employer and the employee. Employees have contributed to employment pension since 1993. In 1999, employee contributions formed a quarter, and employer contributions three-quarters of collective contributions.

The government is solely responsible for the funding of disability allowance and it also pays a government grant towards municipal social welfare and health care services. However, the primary responsibility for financing services for the disabled and other social welfare and health care services used by people with disabilities lies with the municipalities themselves. In its assessment of the state of services for the disabled, the Social Affairs and Health Committee of Parliament has raised the question of whether the current division of financing responsibility between central and local government requires readjustment.

In 1999, client fees in institutional care for the disabled covered approximately five per cent of institutional expenditure. This figure has remained at the same level for several years. Some services for the disabled are provided free of charge, with the result that client fees contribute just one per cent of total service expenditure.

Rehabilitation organized by Kela is covered by national health insurance. Rehabilitation organized by the employment pension institutions is financed in the same way as employment pension.

Financing of expenditure on the disabled in 1999 (preliminary data)

	Expenditure (FIM million)	Financing share (%)				
		Central government	Municipalities	Employers	The insured	Clients
National basic pension	3 960	47	0	50	2	0
Employment pension	12 300	0	0	78	22	0
Disability allowance	160	100	0	0	0	0
Institutional care for the disabled [1)]	790	23	72	0	0	5
Services for the disabled [1)]	750	24	75	0	0	1
Rehabilitation services	1 300	22	0	35	42	0
Sheltered work and vocational rehabilitation	550	21	79	0	0	0

[1)] Includes client fees

2.3 Old Age

	1998	1999*	2000**	2001**
Expenditure on main category (FIM million)	55 500	57 400	59 100	62 750
- of which, old age pensions (FIM million)	47 900	49 600	50 900	53 900
% of social protection expenditure	29,5	30,3	30,6	31,2
% of GDP	81	8,0	7,5	7,5
Recipients of old age pension on December 31	846 900	861 400	863 800	878 200
Residents in old people's homes on December 31	21 400	21 100	21 000	21 000
Elderly households receiving home help services during the year	84 800	84 300	85 000	86 000
Auxiliary service recipients aged over 65 during the year	105 600	103 400	104 000	105 000
Recipients of informal care allowance for the over-65s during the year	12 800	13 180	13 300	13 400

* preliminary data
** estimate

The elderly the biggest single category in all social protection expenditure

Social protection expenditure on the elderly, an estimated FIM 59.1 billion in 2000, forms the biggest single category in all social protection expenditure. This accounts for 31 per cent of social protection expenditure and 7.5 per cent of GDP. Pensions and other income transfers accounted for 90 per cent of expenditure on this main category, while social services accounted for the remaining 10 per cent. These figures do not include expenditure on health care services used by the elderly.

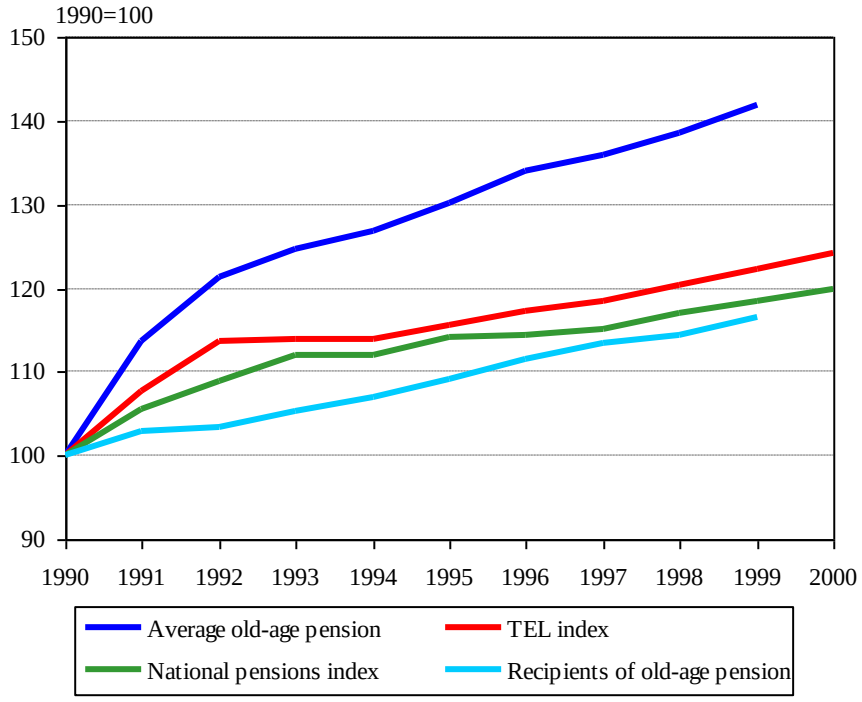
Expenditure on the elderly is increasing year by year. In 2001, it is expected to reach FIM 62.8 billion. The increase in old age pension expenditure is due to both an increase in the number of pensioners and a higher level of pensions. The crucial factors for expenditure on services are old people's health and general ability to cope and the range of public services on offer.

The trend in current pension levels for old age pensions follows the national pension index and the employment pension (TEL) index. The average level of old age pensions is rising all the time, because the employment pensions of people now reaching retirement age are higher than the pensions of earlier pensioners. The changes brought by the 1996 pension reform did, however, moderate the rate of increase in pension levels (Figure 22). The changes brought by the reform include making the national pension fully deductible, and gradually reducing the basic amount of the national pension, and introducing a separate TEL index for the over-65s.

Index adjustments of employment pensions for old-age pensioners are made using an index where changes in price level account for 80 per cent and changes in earnings level account for 20 per cent. Meanwhile, the calculation of

pensionable salary and adjustments to the value of pension rights earned and to payable pensions up to the age of 65 continue to use an index where price level and earnings level each account for 50 per cent. The remaining basic amount of the national pension will be withdrawn at the beginning of 2001. Tax relief for pensioners has partly compensated the cuts made in pensions. At the end of 1999, the average total old age pension was FIM 5,570 a month. At the end of 1999, only about one in ten old-age pensioners depended on national pension alone.

Figure 22. Trends in old-age pensions 1990-2000



Elderly people's ability to cope

The life expectancy of 65-year-old men in Finland is 15 years on average, while the corresponding figure for women is 19 years. An 80-year-old Finnish woman can expect to live for about another 8 years, while the corresponding figure for men is about 7 years. The biggest proportionate increase in life expectancy is predicted for the over-80s. The rate at which people's ability to cope decreases after the age of 75. According to an *Ikivihreät* ('Evergreens') study, only one in twenty women between 83 and 92 can cope with all their daily activities without difficulty, while the corresponding figure for men is one in six.

Very little reliable information is available on how longer lifespans affect the percentage of the population with limited functional capacity. The few cohort comparisons made using the same method seem to indicate that the number of severe disabilities tends to shift slowly towards the oldest age groups. According to the *Ikivihreät* ('Evergreens') study, people in later generations are, on average, healthier

and fitter than people in older generations. The study focused on the functional capacity of people aged 65-69 in Jyväskylä in 1988 and 1996.

The functional capacity of people over 65 will probably continue to improve, though changes are likely to be slight over the short term. The overall functional capacity of old people and their general need for help will therefore probably not grow at the same rate as their numbers. Especially during the 'third age', i.e. 60-80, it is expected that people will become increasingly capable of continuing to lead an independent and active life. If there should be problems, there are many ways to compensate for and restore functional capacity with the help of rehabilitation. Meanwhile, during the 'fourth age', after the age of 80, the situation deteriorates and people no longer have the same capacity for coping. Rehabilitation can, however, still help maintain functional capacity.

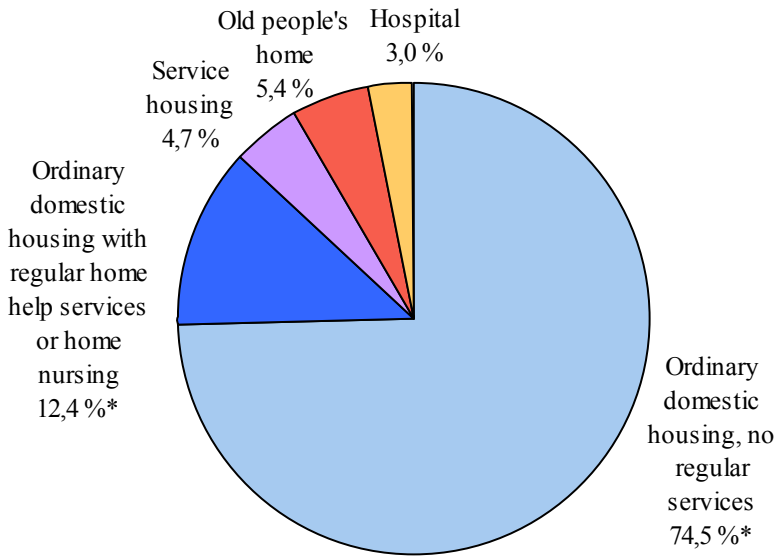
Dementia is one of the biggest challenges for the social welfare and health care services from the economic point of view; treatment of this condition demands increasing resources. The number of elderly people suffering from advanced or severe dementia is about 80,000 at present and it is expected to increase by about 15,000 people over the next 10 years. Conditions which cause dementia are the main reason for long-term institutional care. Other potential risk groups in need of long-term institutional care are patients with brain haemorrhages or broken hips who do not receive enough rehabilitation to manage at home.

Elderly people's housing standards, living environment and access to services are the crucial factors in determining how well they can cope. It is thus possible to give elderly people a better chance of coping and a better quality of life through community planning, physical planning, housing policy and transport policy. The need for social welfare and health care services is less when people's housing and living environments are changed to accommodate their real functional capacity. More extensive use of aids also makes care of the elderly easier.

Need for more non-institutional care

The majority — 88 per cent — of people over 75 live at home in ordinary domestic accommodation. Most of them are not in need of regular social or medical services. Twelve per cent of the over—75s receive regular weekly services in the home (home help services or home nursing). Five per cent live in service housing, while 8 per cent are in long-term institutional care (Figure 23).

Figure 23. People over 75 and their housing type in 1999

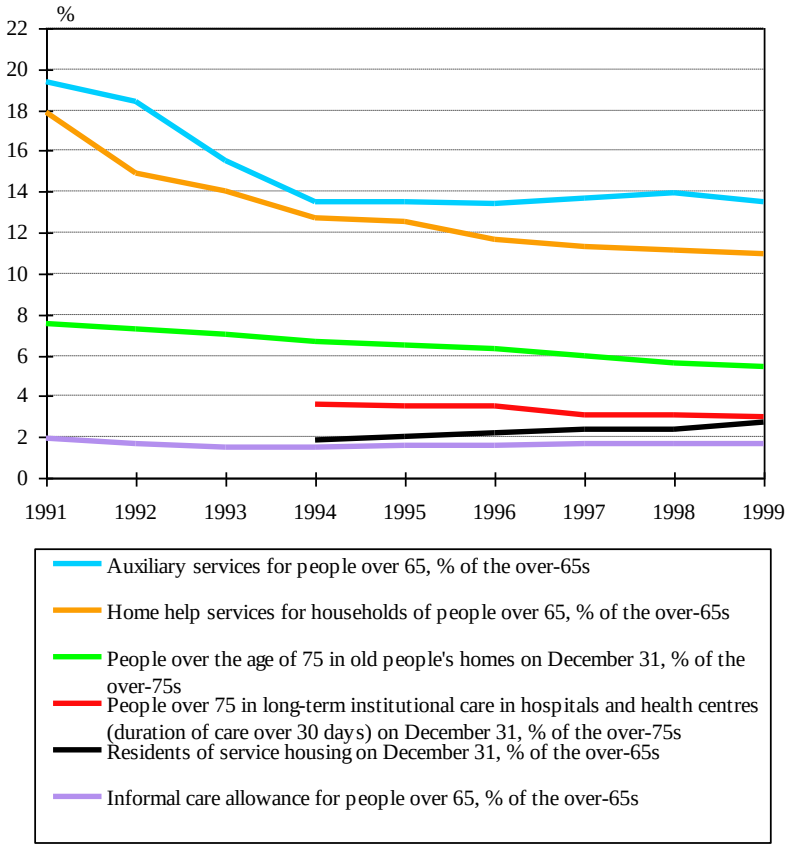


*) The division of those living in ordinary housing into users and non-users of services is based on data from 1999.

During the last ten years, the structure of services for the elderly has changed a great deal and the provision of services in proportion to the number of elderly people has fallen noticeably. The coverage of home help services and old people's homes has been reduced and provision of these services now focuses on the oldest people and those in the poorest condition (Figure 24). Old people's homes have been replaced chiefly by service housing. In 1999, the number of clients receiving home help services for the elderly continued to fall, although only slightly (Figure 25). The number of visits per client has increased, however. There is an imminent threat that problems will be neglected rather than prevented or solved at a stage where deterioration of health and functional capacity do not yet prompt any need for expensive, large-scale help with everyday life.

The expansion of service housing is reflected in many municipalities in personnel cuts in the services available to people in ordinary domestic housing, as former home help staff are transferred to serve elderly people living in service housing. The main problem in services for the elderly is, in fact, that there has been little improvement in non-institutional services for elderly people living in ordinary domestic housing. Over time, this may cause more pressure for more institutional care. Since the recession ended, auxiliary services and informal care allowance have been increased, as has service housing, but when viewed against the increase in elderly people, the increase has been slow. Furthermore, the coverage of auxiliary services appears to have taken a downward turn in 1999 (figure 24).

Figure 24. Percentage of recipients of the main forms of care for the elderly in Finland, 1991-1999



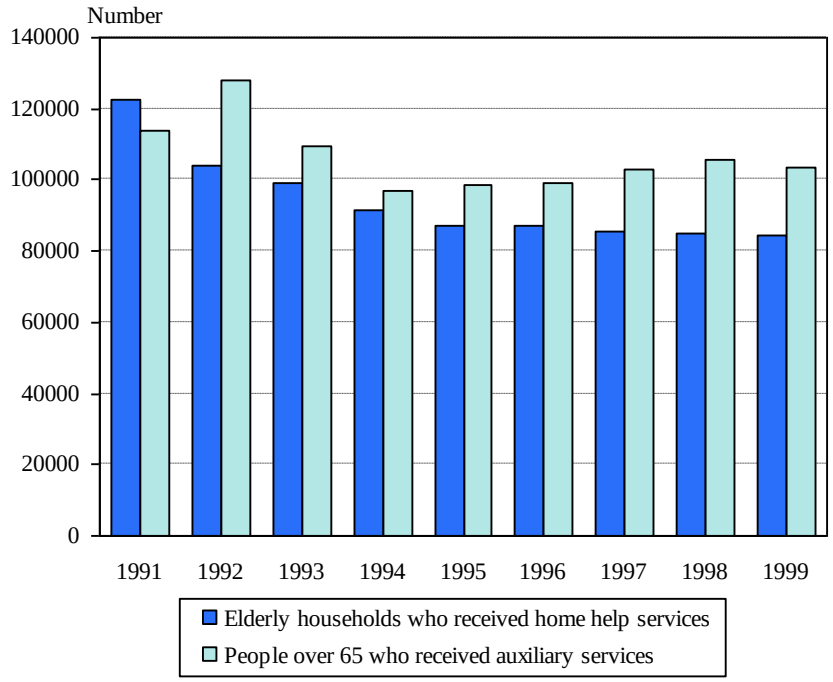
One of the reasons for the trends in the use of service housing and auxiliary services is that municipalities have a fairly free hand in pricing these services. A person living in service housing may also receive various benefits paid by Kela (housing allowance, pensioner's care allowance, health care reimbursements) which are not paid to people in long-term institutional care. Another factor behind the expansion of service housing in the 1990s is the support granted by the Slot Machine Association and the Housing Fund of Finland for the construction of service housing.

Studies show that service housing is an alternative which appeals to the elderly, although there has also been some debate about whether service housing is an appropriate or even safe, form of care for elderly people in poor health. Important issues for the future will be the content and extent of the service housing concept, and also the extent of public support to be granted for construction of such housing units. The present extent of service housing is in keeping with the target set for 2001 by the government committee on policy for the elderly.

In health care, long-term institutional care for the elderly has been shifted almost completely to hospital wards at health centres. Meanwhile, cuts in the provision of psychiatric care for the elderly has raised the question of whether elderly people in need of psychiatric care are getting the care they require.

The structure of services for the elderly varies a great deal between types of municipality and different regions. Most elderly people live in cities, but the service provision there is more one-sided than elsewhere, with more institutional care but less non-institutional care, on offer. In rural municipalities, the situation is the opposite. According to an estimate by Stakes, urban municipalities need development programmes for non-institutional services, especially, if they are going to meet the need for elderly people's services.

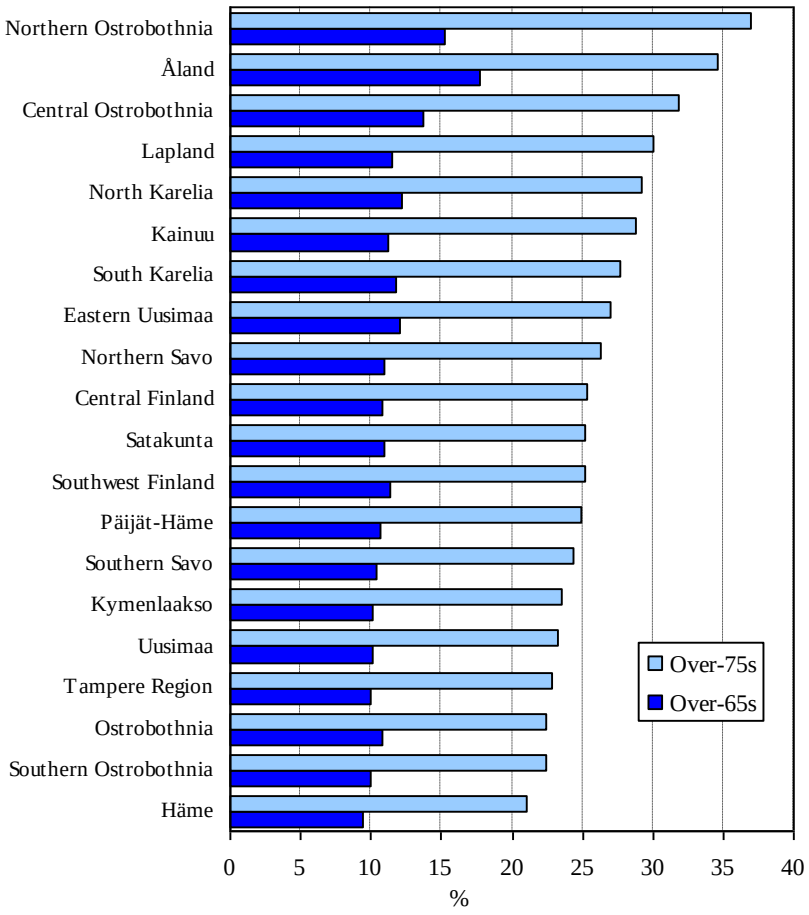
Figure 25. People over 65 who received home help services and auxiliary services, 1991-1999



There are considerable regional differences in the coverage of home help services. In 1999, the percentage of elderly households receiving home help services out of the total number of people over 65 in the province in question varied between 9 and 18 per cent, while the corresponding number for the over-75s was between 21 and 37 per cent. The number of client households for home help services for the elderly in Finland as a whole corresponded to 11 per cent of the over-65s and 25 per cent of the over-75s (Figure 26).

In 1999, an average 8.6 per cent of those over 65 in a municipality were clients of regular home help services and/or medical care at home. Regular clients account for relatively few visits on average, i.e. nine visits a month according to the 1999 home help survey. Only in one municipality in ten was the average over 30 visits a month.

Figure 26. The percentage of elderly households[1)] receiving home help services out of the total number of people over 65 and over 75, by region in 1999



[1)] An elderly household is defined as a household in which the oldest member is 65 years old or more.

Areas of emphasis: prevention, rehabilitation and quality

Public debate about the state of care for the elderly has been dominated by concern about the quality of institutional care. According to the Government Programme, care for the elderly should be developed based on client needs, with special emphasis on providing support for people so they can continue to live at home, and on improving rehabilitation and the quality of services. The Government Programme also states that a functioning set of criteria and quality measurements must be created so that the implementation of equal access to social welfare and health care services can be monitored. The Target and Action Plan for Social Welfare and Health Care for 2000-2003 involves drawing up recommendations for care for the elderly as well as other areas.

The impression that the care provided for elderly people in institutions does not correspond fully with their needs has been validated by empirical studies. The low staffing in certain institutions tends to impede the provision of individually tailored services and implementation of a rehabilitation-based approach. The right of elderly

clients and patients to self-determination is not always fulfilled, nor is their human dignity always respected in an appropriate way.

The general conclusions of a recent Stakes survey on institutional care can be summarized as follows: it has been possible to maintain a reasonable general standard of institutional care. The staffing in public institutions is, however, inadequate in proportion to the needs of clients in poor health, and as a consequence inadequate standards of care may occur. The public sector is responsible for the care of the elderly in the poorest health, and wards and units, especially at older institutions, are too big. There is much room for improvement in the physical premises themselves. The problems are most common in health centre wards.

National framework on its way

In care for the elderly, there are considerable differences between care units and municipalities as a consequence of different operating methods and care practices and also the municipalities' different financial situations. The trend towards growing differentials has also been magnified by the withdrawal of nationwide regulations and recommendations, and the limited resources of regional control, advisory services and monitoring. In accordance with the Government Programme and the Target and Action Plan for Social Welfare and Health Care, the Ministry of Social Affairs and Health and Stakes have now started drafting national frameword for care and services for the elderly in cooperation with other actors. The first framework was issued at the beginning of 2001, and cover both institutional and non-institutional care. Training, guidance and advisory services can also be enlisted in making operating methods and care practices more uniform, for instance by creating working methods based on regional peer review, with the ultimate aim of ensuring the best practices.

In addition to improving the quality of institutional services, development of services for the elderly requires reinforced prevention and rehabilitation and more provision of a greater variety of non-institutional services. Housing and services should be combined to form a functioning whole. The accessibility of various types of local service should receive more attention. The wider the variety of services on offer, the more flexible and appropriate is the help available to elderly people with different needs.

The municipalities must find a balance between providing care for people with severe disabilities or reduced functioning capacity and allocating resources to prevention and early diagnosis of illness and reduced functioning capacity. One of the recommendations of the Target and Action Plan for Social Welfare and Health Care is that the municipalities should offer people over the age of 80 preventive home care visits. Such home visits would provide an opportunity for assessing their functioning capacity, living conditions, and possible need for aids or services.

Issues concerning quantity and quality in working life have significant impact on the quality of services for the elderly. In order to ensure a high standard, these services need more skilled, permanent staff. This would also help ensure that ageing employees in the sector can cope with their work and continue their careers rather than take early retirement. The better the health, motivation and skill of the staff in the sector, the better the services for the elderly. It is important to appreciate the value of permanent staff rather than people on fixed-term contracts, to improve management practices and to give staff in the sector opportunities for maintaining and improving their professional competence. In addition to adequate numbers of staff, care for the elderly also needs new operating models, and further training and guidance will be needed in order to create and establish these.

Quality is directly related to the financial resources available for any given type of operation. About 80 per cent of costs in the social welfare and health care sector relate to personnel. According to a NOSOSKO study, the expenditure on social services for the elderly in Finland was well below the level in the other Nordic countries. In Finland, per capita expenditure on social welfare for the elderly was about 40 per cent of the Nordic average in 1998. Expenditure on social welfare for the elderly as a percentage of GDP was 1.2 per cent in Finland, against 2.7 in Sweden, 2.6 in Norway, 1.8 in Denmark and 1.4 in Iceland. If the long-term care for the elderly provided in health centre wards (something typical of Finland) is included, per capita expenditure on care for the elderly in Finland is still about 30 per cent below the Nordic average.

Financing —expenditure on the elderly

National pensions are financed primarily by employer contributions and by central government. When needed, the central government also makes ‘guarantee payments’ to the national pension fund to ensure its liquidity. Additionally, FIM 2.4 billion of value added tax revenues of 1999 were channelled into the national pension fund.

Employment pensions are financed through contributions by employers and the insured. Employees have contributed to their own employment pensions since 1993. In 1999, employee contributions made up one quarter of the total, while employer contributions made up three quarters.

The main source of financing ——for services for the elderly are municipal tax revenues. Services are further financed by central government grants, client fees, Kela benefits and subsidies from the Slot Machine Association. In 2000, subsidies to a total of FIM 1.4 billion will be granted from Slot Machine Association profits to non-profit associations and charitable foundations for the promotion of health and social welfare; FIM 287 million of this sum will be spent on care for the elderly.

According to a State Audit Office estimate, the financing system for services for the elderly is uncoordinated

in its present form and does not fully support achievement of the aims. The system makes it possible to transfer costs from one party to the next without gaining any significant overall economic benefits.

The problems of the funding system are closely linked with definition of the boundary between institutional and non-institutional care and the fact that the financing systems for these two forms of care are different. According to the State Audit Office, this boundary could be removed without significantly changing the distribution of costs between local and central government. A working group appointed by the Ministry of Social Affairs and Health is studying questions concerning the boundary between institutional and non-institutional care. The working group's mandate will end in April 2001.

The State Audit Office also drew attention to the differences between the client fees for services for the elderly in different municipalities. The client fees paid by elderly people receiving care in different municipalities can differ significantly, even when their care needs and the services they receive are identical. Poverty traps also came to light in non-institutional care, arising from income-related client fees and social welfare benefits. Client fees play a much bigger role in financing services for the elderly in Finland than in the other Nordic countries.

Contributions to financing services for the elderly in 1999 (preliminary data)

	Expenditure (FIM million)	Financing contribution (%)				
		Central government	Munici-palities	Employers	The insured	Clients
National pensions	11 020	47	0	50	2	0
Employment pensions	38 600	0	0	78	22	0
Institutional care for the elderly [1)]	3 550	19	60	0	0	21
Home help services [1)]	1 800	20	64	0	0	16

[1)] including client fees

2.4 Social protection for survivors

	1998	1999*	2000**	2001**
Expenditure on main category (FIM million)	7 250	7 500	7 700	8 100
- of which, survivors' pensions (FIM million)	7 000	7 200	7 400	7 800
% of social protection expenditure	3,9	3,9	4,0	4,0
% of GDP	1,1	1,0	1,0	1,0
Recipients of survivors' pensions on December 31	247 550	250 300	262 400	271 000
Recipients of child's pensions on December 31	28 900	28 250	28 250	28 200

Most recipients of survivors' pensions elderly widows

Expenditure on survivors' pensions and funeral grants will come to an estimated FIM 7.7 billion in 2000 and FIM 8.1 billion in 2001. This is about 4 per cent of total social expenditure.

The main form of survivors' pension is the widow's/widower's pension. At the end of 1999, there were 250,300 people in receipt of widow's/widower's pension; of them, 9 per cent were men. The number of men has been rising steadily since the reform of survivors' pensions in 1990. Most recipients of the widow's/widower's pension are elderly, with 77 per cent of widows being over 65. The number of recipients of this kind of pension has been rising steadily as the population ages (Figure 27).

Survivors' pension is paid to the widow/widower if married to the person through whom the benefit is derived before the person in question was 65 and if the widow/widower has or had a child by the person in question. A widow's/widower's pension expires upon remarriage if the widow or widower is under 50 years old at the time. A childless widow/widower may also be entitled to a pension if he or she is 50 or older or disabled and was married for at least five years to the person through whom the benefit is derived.

In 1998, the average widow's/widower's pension was FIM 2,268 a month. Widows received an average FIM 2,400 a month and widowers FIM 983 a month. Widows' pensions were higher than those of widowers because the pension is based on the pension or pension rights of the person through whom the benefit is derived. The widow's/widower's pension is also coordinated with the recipient's other pensions. The more pension the recipients receives from other sources, the smaller the widow's/widower's pension.

A child receives a survivors' pension if the child is under 18 on the death of the person through whom the benefit is derived. The child's pension ends when the child turns 18. Students under 21 continue to be entitled to their pension, however. In 1999, there were 28,250 children receiving child's pensions. Almost 4,800 of them were under 10, 11,500 were 10-15 and 6,100 were 16-17 years old. The number of recipients of child's pensions has been falling with the declining birth rate.

The average child's pension was FIM 1,573 a month.

The average widow's/widower's employment pension increased steadily throughout the 1990s, as did child pensions. Employment pensions increase year by year due to the maturity of the pensions system and the increase in wage and salary earnings. Meanwhile, the widow's/widower's pension of those who receive only the general survivors' pension remained almost unchanged throughout the 1990s. The general survivors' pension has been raised annually only by the amount of the cost-of-living index (Figure 28).

Figure 27. Age structure of recipients of widow's/widower's pension in 1999

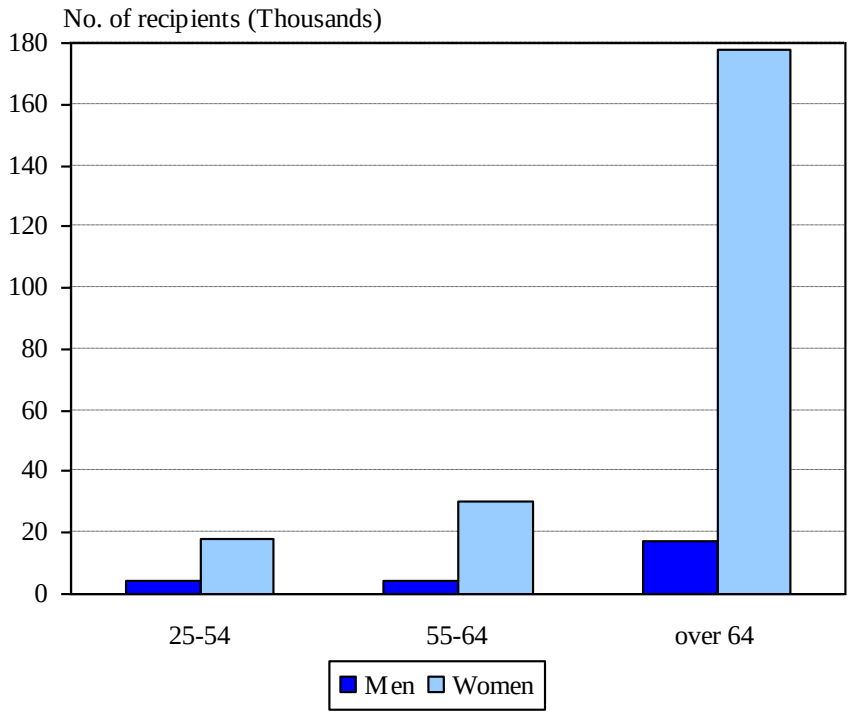
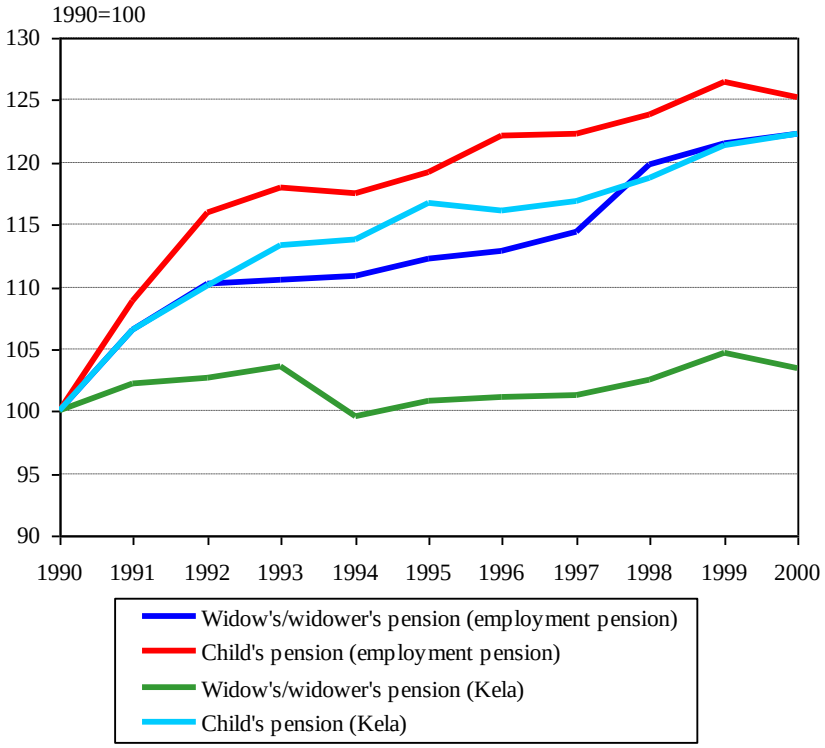


Figure 28. Trends in average survivors' pensions, 1990-2000



Financing

General survivors' pensions are financed entirely by central government. Survivors' employment pensions are financed like employment pensions, i.e. through employer and employee contributions. Employees have been contributing to employment pensions since 1993.

Financing of survivors' pensions 1999 (preliminary data)

	Expenditure (FIM million)	Financing contribution (%)			
		Central government	Municipalities	Employers	The insured
General survivors' pensions	230	100	0	0	0
Employment pensions	6 970	0	0	78	22

2.5 Families and children

	1998	1999*	2000**	2001**
Expenditure on main category (FIM million)	23 300	23 100	23 300	23 800
- of which, cash benefits (FIM million)	14 000	13 900	14 000	14 100
% of social protection expenditure	12,4	12,2	12,1	11,8
% of GDP	3,4	3,2	3,0	2,8
No. of mothers receiving parenthood allowance on December 31	48 400	49 300	48 200	47 800
No. of children in municipal daycare on December 31	218 500	215 100	213 000	210 000
Families receiving child home care allowance on December 31	74 400	73 000	70 000	69 000
No. of children receiving private day care allowance on December 31	12 800	13 800	14 000	14 000

* preliminary data
** estimate

Child allowance and daycare the main forms of support for families with children

The aim of the family policy support system is to cover the expenses arising from providing for children in order to ensure that childcare does not place an overwhelming financial burden on families. In 1999, family policy support[3] came to about FIM 25 billion, or about 3.4 per cent of GDP. Expenditure on family support has not changed much in the last few years. Child allowance and daycare are still the main forms of support for families with children (Figure 29).

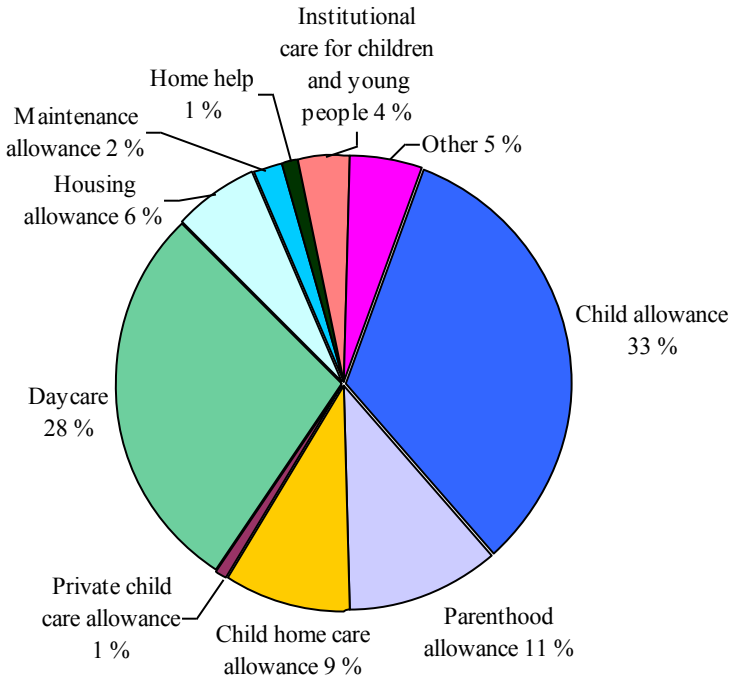
Expenditure on child allowance came to FIM 8.3 billion in 1999. Because the cohort born in 1999 was smaller than that leaving the system the expenditure was FIM 47 million less than the previous year. Population forecasts indicate that this trend will continue. Child allowance payments have not changed since cuts were made in 1995. The purchasing power of child allowances fell by about 9.4 per cent between July 1995 and October 2000.

As of 1994, children in single-parent families have received a higher rate of child allowance. The number of recipients of this supplement for single parents is rising steadily. At the end of 1999, the supplement for single parents was paid on 156,400 children, or 2,400 more than in the previous year. The single-parent supplement is also abused. In 1999, FIM 0.6 million in child allowance was paid out on false grounds. It has become difficult to reliably establish whether a child's parents are in fact living together or separated, as the population register may not always contain the latest data or even an up-to-date address.

3 Family policy support is a more extensive concept than the 'families and children' concept of expenditure in this main category. It also includes benefits such as the general housing allowance paid to families with children under the social expenditure main category 'housing'.

Expenditure on parenthood allowance came to FIM 2.8 billion in 1999, which was FIM 64 million more than the previous year. This was due to higher wages and salaries, though the number of mothers receiving parental allowance fell. The number of mothers receiving minimum parental allowance did not, however, fall to the low level in the pre-recession years, and the percentage has settled at 28. The number of fathers receiving parental allowance has increased steadily. In 1999, 61 per cent of fathers took paternity leave, while only 2 per cent took parental leave.

Figure 29. Distribution of family policy support in 1999



According to advance estimates for 1999, total expenditure on children's daycare will come to about FIM 100 million less than the previous year. The reason for this is that the number of children in daycare has fallen. According to preliminary data, total municipal daycare expenditure in 1999 was FIM 8.3 billion, 15 per cent being covered by daycare fees.

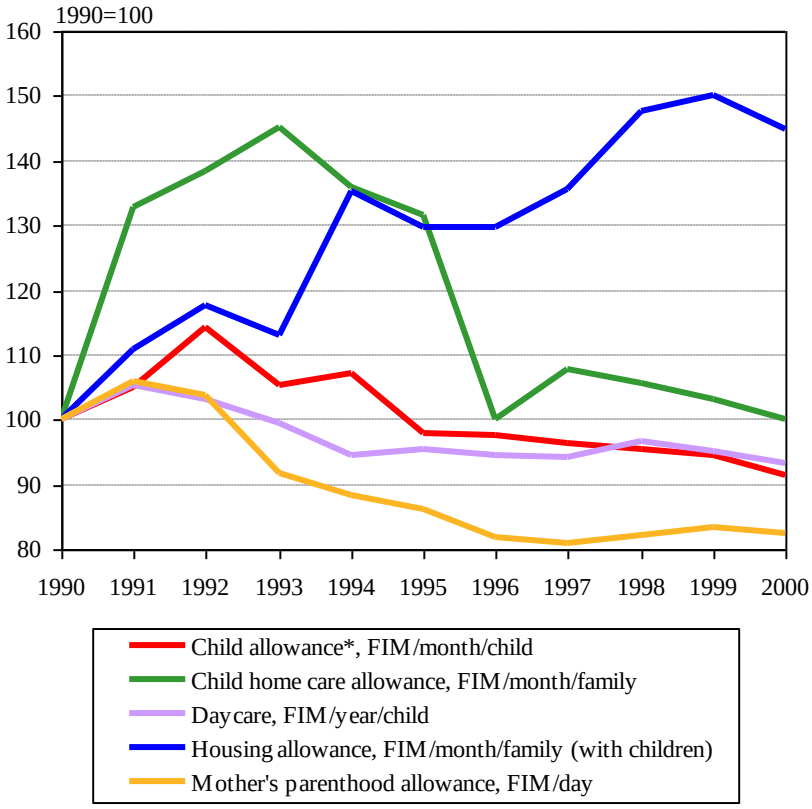
In 1999, expenditure on statutory child home care allowance came to FIM 1.9 billion, which was FIM 80 million less than the previous year. A new form of support, private child care allowance, was paid to a total of FIM 129 million, an increase of FIM 29 million on the previous year. Municipalities may supplement statutory forms of support with municipal supplements. In 1999, a total of FIM 213 million in municipal supplements for home care allowance and FIM 112 million in municipal supplements for private child care allowance were paid out. The municipalities pay municipal supplements in an attempt to reduce the demand for municipal daycare. Municipal supplements have been introduced in the larger municipalities, especially.

In 1999, FIM 1.4 billion in housing allowance was paid to families with children, about FIM 56 million more than the previous year. The increase was due to the increases in the level of housing allowance introduced in 1998. The number of families with children receiving housing allowance fell by 2,000 on the previous year. Housing allowance was paid to 80,000 families with children, 64 per cent of these families being single-parent families.

Reduced support for families with children

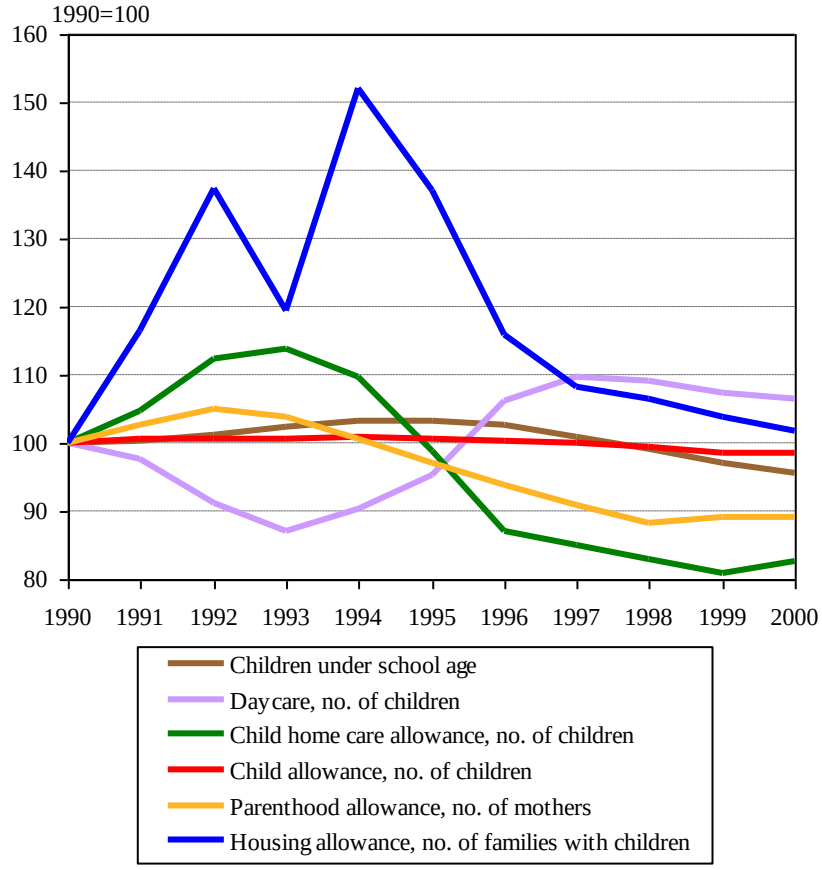
Support from society to families with children is now slightly lower than it was a decade ago. Since 1992, all children under school age have had a right to municipal daycare, child allowances have been both raised and cut at different times, family policy tax deductions have been abolished and the level of home care allowance has been cut (Figure 30). There has been a fall in the number of people receiving family policy support in recent years (Figure 31). Unless changes are made in the level of various forms of family policy support, actual support for families with children will fall in future as the birth rate declines.

Figure 30. Real trends in family policy support, 1990-2000



* includes tax deductions in 1990-1993 (child deduction in municipal taxation, the municipal tax single-parent deduction and child care deduction in government taxation).

Figure 31. Recipients of family policy support, at year end, 1990-2000



Children under three usually stay at home while older children go to daycare

Considerable changes took place in the provision of care for very young children during the 1990s. As of 1990, parents of a child under three years of age have been entitled to either municipal daycare for the child or to child home care allowance. As of 1996, the right to municipal daycare was extended to cover all children under school age. The support systems for the care of very young children were changed on August 1, 1997, with the aim of clarifying and simplifying the systems and reducing the differences between municipalities in daycare charges.

At the end of 1999, 49 per cent of children under school age were in municipal daycare, while 26 per cent received child home care allowance. Private daycare has not been very widely used. About 3 per cent of children under school age were receiving private child care allowance. About 10 per cent, some 44,000 children, were outside the care systems eligible for support. These children are either cared for at home by unemployed parents or are children over three who are cared for at home but have no siblings under the age of three who would be entitled to home care allowance.

Only 24 per cent of children under three are cared for outside the home. The majority (72 per cent) of children were cared for at home on either home care allowance or parenthood allowance. Three per cent of children under three were not covered by any system. These are probably mainly the children of unemployed parents. In such a situation the parent caring for the child at home tends to opt for unemployment benefit, which is generally higher than child home care allowance**.**

Child care arrangements tend to vary depending on the age of the child. Two out of three children aged 3-6 are in municipal daycare (Figure 32).

Most municipalities have successfully arranged daycare according to their obligations under the legislation on daycare provision. The larger municipalities have established new daycare centres, while the smaller ones have increased the provision of family daycare. Sixty-six per cent of the children in municipal daycare were at daycare centres, while 34 per cent were in family daycare (Figure 33).

Falling demand for daycare

At the end of 1999, there were 215,000 children in municipal daycare, which was 3,500 less than the previous year. The number of children under school age in daycare has decreased due to the falling birth rate. Meanwhile, private child care allowance was paid on 1,000 more children than in the previous year.

Demand for daycare will continue to fall for the foreseeable future, as demographic forecasts indicate that the number of children under school age will fall by about 26,000 over the next five years. The reason for this is the fall in the birth rate (Figure 34). The number of children born in Finland this year will be about 8,000 less than the number starting school.

There is continuing discussion on the municipal daycare rights of children whose parents are at home. It has been suggested that their right should be either limited to just half-day care, or removed altogether. If the right were limited to half-day care this would have a very small effect on total daycare expenditure. Parents' long-term unemployment may increase the risk of social exclusion for their children, and in such a situation daycare can be essential in providing children with a secure and stimulating environment.

Figure 32. Care for very young children on December 31, 1999

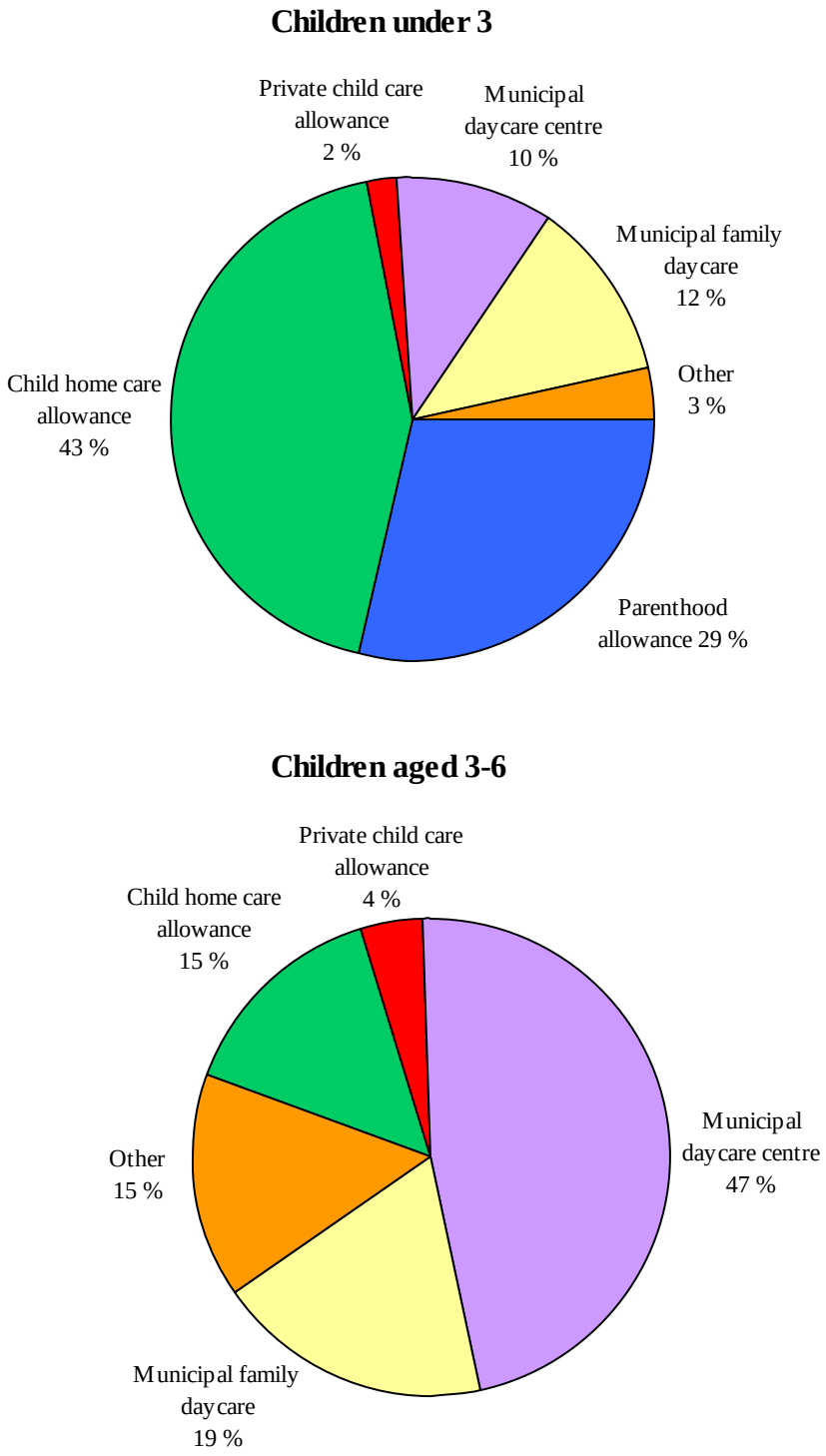
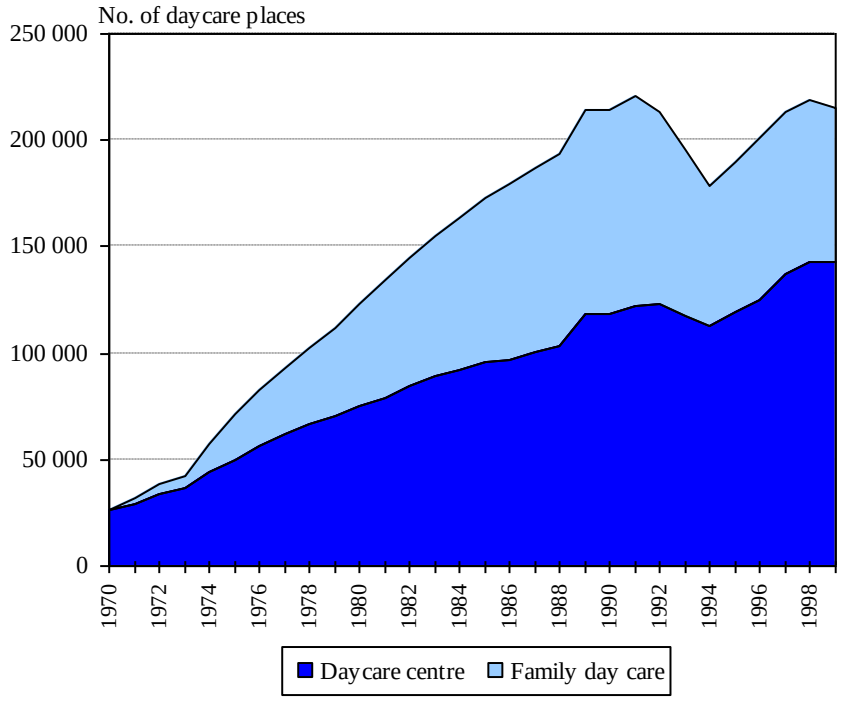
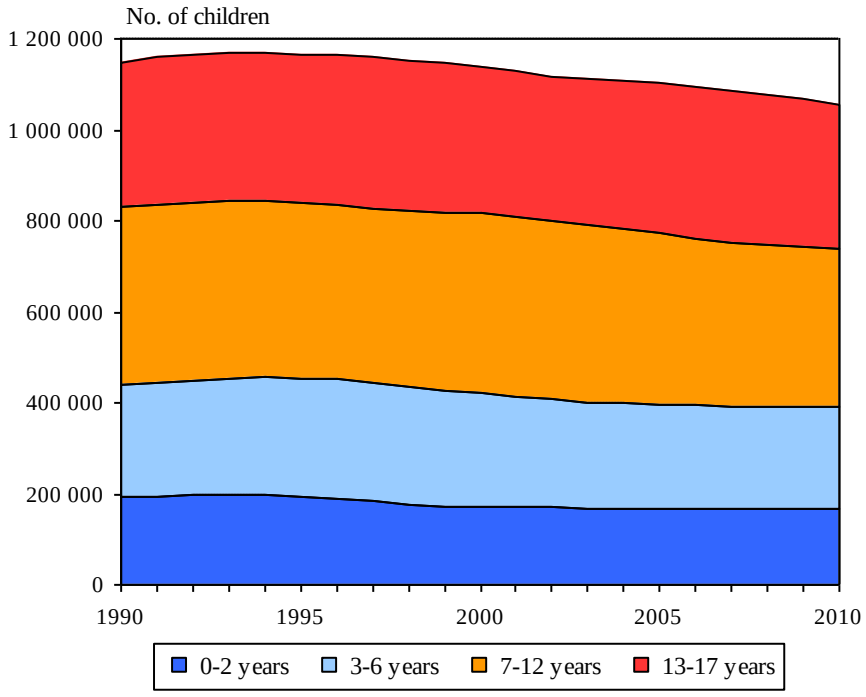


Figure 33. Trends in children's daycare places 1970-1999



For parents to take up options to all-day daycare, there must be alternative services on offer in the municipality. During the recession, drastic cuts were made in open daycare, club and supervised play facilities. Pressure on all-day daycare could be reduced by increasing such facilities once again.

Figure 34. Children aged 0-17, 1990-2010



Cuts in afternoon care for schoolchildren

There were about 6,400 schoolchildren in municipal afternoon care at the end of 1999. This was 1,000 children less than the previous year. The legislation on children's daycare places no obligation on the municipalities to provide afternoon care for school children. In recent years, some municipalities have closed afternoon care places for school children in order to fulfil their obligation to provide daycare for children of pre-school age. Afternoon care for young school children should be developed through cooperation between different administrative sectors and interested organizations. In recent years, church parishes and the Mannerheim League for Child Welfare, in particular, have increased their provision of afternoon care for young school children, but in some municipalities a shortage is still apparent.

The afternoon care provided for schoolchildren by voluntary organizations is often more expensive for the family than municipal care would be. In a situation where there is a shortage of afternoon care provided by the municipality and the afternoon care provided by other organizations is relatively expensive, there is a danger that many young schoolchildren are left without appropriate care.

Changes to daycare fees

In connection with reform of the support systems for the care of small children on August 1, 1997, the grounds for setting municipal daycare fees were also standardized. Under the new system, daycare fees are determined in percentages based on family size and income. In accordance with the Government Programme, client fees in the social welfare and health care sector were adjusted as of the beginning of 2000. The maximum children's daycare fee was raised from FIM 1,000 to FIM 1,100 a month. As of the beginning of 2000, daycare fees can be charged for 12 months for children who use the services all year round. The reform should increase income from daycare fees by about FIM 85 million a year, FIM 80 million of this deriving from raising the upper limit on the fee. The reform will increase daycare fees for families with a medium to high income, which fell considerably in the last reform. According to preliminary information on 1999, total payments received for daycare came to around FIM 1.3 billion. Daycare fees accounted for approximately 15 per cent of total expenditure, i.e. about the same as in the previous year.

No great change in uptake of child home care allowance

The new child home care allowance system has been in use for over three years now, but there have been no major changes in either the number of recipients or the number of children. At the end of November 2000, there were 68,900 recipients of home care allowance, covering 105,800 children. Thus, recipients of the allowance had an average of 1.6 children within the sphere of the allowance. The average amount of home care allowance for an

individual family has been slightly higher (FIM 2,139/month) than payments under the old system, due to the fact that the care supplement covers a slightly wider range of incomes than the earnings-related supplement under the previous system. So far, 79 per cent of the recipients of child home care allowance have also received the care supplement.

Increased uptake of private child care allowance

A private child care allowance was introduced as a new form of support on August 1, 1997. It is paid directly to the service provider. Private child care allowance provides an alternative to municipal daycare for parents who wish to make their own daycare arrangements for their children.

The number of children qualifying for private child care allowance has been growing constantly since its introduction. 13,700 children were covered at the end of November 2000, most of them (75%) over three years old. About half (50%) were in private daycare centres, while 37% were in private family daycare. Private child care allowance also offers the option of hiring a child minder to look after the child at home. This option has not been used much, however, with only 1,700 children being cared for in this way at home. The average level of private child care allowance was FIM 817 a month, against an average fee for private daycare of FIM 2,184 a month. Twenty-six per cent of the children qualifying for private child care allowance also received care supplement.

Parents usually pay a higher fee for private daycare than they would have to pay for municipal daycare. Some municipalities, especially the larger ones, pay municipal supplements for private daycare; the level of these municipal supplements varies considerably from one municipality to the next. According to Kela statistics, 56 per cent of children in private daycare receive municipal supplements.

There is distinct seasonal fluctuation in the use of the private child care allowance, and the number of recipients falls noticeably during the summer months. During that time, recipients of home care allowance increase slightly.

Subjective right to pre-school teaching for all 6-year-olds in 2001

The aim of pre-school teaching is to improve the learning ability of the child and help children make the transition from nursery education to primary school. Pre-school teaching offers the child an opportunity for active personality development through play and other activities based on their individual capabilities. Pre-school teaching is a systematic form of education which bridges the gap between nursery education and primary school.

As of August 2001, municipalities are required to provide pre-school teaching for children in their area in the year preceding the start of compulsory education. In the academic year 2000-

2001, provision of pre-school teaching is voluntary. Pre-school teaching is free of charge.

Most municipalities started providing pre-school teaching in 2000. An estimated 88 per cent of six-year-olds attended pre-school in autumn 2000. Only 33 municipalities did not provide such teaching. These included a number of small localities, notably in Northern Savo and North and South Karelia. About 7,300 children did not attend pre-school.

Pre-school teaching can be arranged at a school, at a daycare facility as laid down in the legislation on daycare for children, or at some other suitable place as decided by the municipality. Municipalities also have the option of buying pre-school teaching from another public or private service provider.

Attendance at pre-school is voluntary, with the child's guardian making the final decision. The extent of pre-school teaching is the same throughout Finland: 700 hours a year, i.e. 3-4 hours a day. The local curriculum must be based on the national core curriculum set by the National Board of Education. Teachers with the qualification of class teacher or pre-primary teacher are mainly responsible for the teaching. During the transition period, daycare staff with the qualification of social educator or a diploma in social sciences are also qualified to teach pre-school. People currently employed in daycare can also complete further training to acquire the competence required of pre-school teachers.

Children at pre-school, with the exception of those whose compulsory education is brought forward, are not entitled to free travel to school. The arrangement of transportation may cause problems, particularly in sparsely populated areas, and could be a deciding factor in parents' decisions not to send their children to pre-school.

Municipalities receive a central government grant for pre-school teaching on a per pupil basis, in accordance with the financing system for education and cultural services. The government grant is thus higher than that for children's daycare.

Working group sees no need for administrative reform in daycare

A working group on the administration of children's daycare expressed certain reservations concerning a proposal to allow individual municipalities to decide for themselves which municipal organ should be in charge of children's daycare, home care allowance and private child care allowance. According to the working group, the criterion for assessing the functioning of the administration of children's daycare should be the viewpoint of children and families. The working group argued that the arrangement of care for small children is part of social welfare and thus part of the social service system, which comes under the body in charge of social welfare provision as a whole. As a consequence, it would be inconsistent to detach a key factor in this service system, namely children's daycare, from social services as a whole, and no action should be taken at this stage. A change of this nature

would be a significant social and family policy statement which demands further consideration. Meanwhile, the representatives of the Ministry of Education, Ministry of the Interior and Association of Finnish Local and Regional Authorities in the working group all felt that the municipalities should be allowed to decide which municipal organ should be in charge of the administration of children's daycare. The main concern was to ensure that expertise in daycare and social welfare services is brought to bear in preparation and implementation of the issues in question.

The working group felt that the complete care system for small children comprises both municipal daycare, and home care allowance and private child care allowance. Decisions on the care system for small children and individual client fees should be dealt with as a whole rather than being split up into different administrative sectors.

Experiences of the system for redistributing the high costs of child welfare

The number of children and young people placed in care outside the home grew throughout the 1990s. In 1991, there were 8,700 children and young people in care outside the home, or 0.7 per cent of the age group. In 1999, the corresponding figure was 12,400, or 1.1 per cent of the age group. Of the children and young people placed outside the home, about 6,800 were in custody. In addition, there were 43,600 children and young people in open care, 4,000 more than the previous year. Open care comprises various support measures taken to create and maintain good conditions for the child by providing support for the family and the family's ability to cope independently.

About half of the children and young people placed outside the home were in family care, while one in three was in institutional care and the remainder were placed elsewhere, for instance, in independent supported housing. The main reasons for placing a child or young person outside the home are the parents' alcohol or drug abuse or mental problems, which often lead to neglect of the child or to domestic violence. Recently, a growing number of children have also been placed outside the home due to the child's own problems, including school-related problems, crime or drugs.

In connection with the 1993 reform of the government grants system, grants for municipal social welfare and health care services were reorganized on the basis of estimated expenditure. This has caused problems for some municipalities in financing expensive special services which cannot be predicted in advance, e.g. long-term institutional care in child welfare cases. This problem is particularly pronounced in municipalities with a small population, where even the cost of a single child welfare case may have a considerable impact on the budget.

A system for redistributing the high costs of child welfare has been in force since March 1, 1999. The purpose of this system is to redistribute the economic burden placed on an individual municipality by high child welfare costs and to channel resources

in such a way that child welfare clients receive appropriate services at the appropriate time, regardless of the finances of the municipality in question.

The joint municipal boards of the special care districts run the cost redistribution system. Municipalities are entitled to be reimbursed through the system for 70 per cent of all costs in excess of FIM 150,000 per family per annum arising from child welfare measures included in the welfare plan referred to in the Child Welfare Act.

According to preliminary data for 1999, expenditure covered by the system for redistributing the high costs of child welfare was higher than expected, reaching FIM 208 million, to which the central government contributed about FIM 60 million. There were considerable regional differences in expenditure; it was lower than predicted in the special care districts of North Karelia, Kainuu and Savo, and higher than predicted in districts with big cities, notably the special care districts of Helsinki, Uusimaa and Southwest Finland. Care for young drug-abusers probably increased the expenditure in these districts. Reimbursements primarily apply to institutional care.

The fact that expenditure was lower than expected in rural areas may be explained by the fact that less child welfare is needed in these areas. It is also easier in rural areas to find family care for children who have to be placed outside the home, and family care is less expensive than institutional care. Furthermore, it is also possible that small municipalities do not provide advanced special care for children who need it, as it would be too expensive.

Experiences during the first year of the new system show that municipalities are paying more attention to fulfilling their duties under the Child Welfare Act. Cooperation between the various sectors involved has intensified and child welfare care plans are drawn up with greater care. On the other hand, municipalities tend to find the detailed monitoring of expenditure in this area both difficult and time-consuming.

Total expenditure by the special social services for children and families comes to about FIM 2 billion a year, with care of children placed outside the home accounting for around FIM 1.2 billion. The total annual cost of the redistribution system in 2000 and 2001 is estimated about FIM 330 million, half of this being covered by a specially earmarked central government allocation.

Improved access to psychiatric care for children and young people

Mental health problems have been on the increase in recent years. Estimates of the frequency of mental disturbances among children and young people vary from 7 to 15 per cent. The Government has made it a target to improve mental health services for children and young people. One aim is that children and young people should not have to wait unreasonably long for care. Cooperation between care units should be improved, to ensure that care is still functional when a child or young person is transferred from one institution or unit to another.

An additional central government grant of FIM 25 million is allocated to subsidies for social welfare and health care services in the 2001 budget in order to improve mental health services for children and young people. The intention is that financing for mental health work among children and young people should be increased by a total of FIM 100 million, with the municipalities contributing FIM 75 million. In order to help with the allocation of this added funding and to secure mental health services for children and young people, changes are proposed in the acts on national health, specialized hospital care and mental health making it possible to issue decrees concerning maximum waiting times before admission into care, and service content and provision generally.

Once a doctor has made a referral into special medical care for a child or young person due to mental problems, the need for care must be defined within three weeks of the referral being received by the hospital. The municipality must provide the necessary care within three months. The municipality must also ensure that enough support services are available in non-institutional care for children and young people with mental problems, to help them to cope at home.

Child allowance to be extended to 17-year-olds?

The Ministry of Social Affairs and Health has appointed a working group to study ways of developing the child allowance system and to assess the need for changes. The working group was also to study the coordination of child allowance and financial aid for students and how to develop the child allowance system as a support system for families with children. It was to evaluate how well the present system functions as tax-exempt family policy support extended to all children, and assess how well the child allowance system works in special circumstances, such as adoption or multiple births. The working group was to complete its work by the end of 2000.

At present, child allowance ends when a child turns 17, but the parents' duty to maintain a child does not usually end until the child turns 18. According to consumer surveys, however, children's consumption needs are at their greatest at about this age. According to Statistics Finland, 93 per cent of 17-year-olds were students at the end of 1998. Most 17-year-olds were totally dependent on their parents, because the financial aid system for students only applies to a small percentage of this age group. During the academic year 1999-2000, about 26,000 17-year-olds received financial aid for students. 20,000 of them lived with their parents. The average monthly financial aid for students was FIM 240. There were about 5,500 17-year-olds living on their own, and these received an average student benefit of FIM 725 a month.

The present student benefit is lower than the child allowance for all 17-year-olds living with their parents. For people living on their own, the financial aid for students is usually more than the child allowance for one child.

Family structures change — do we need new legislation?

The number of families with children has been decreasing in recent years. At the end of 1999, there were 619,600 families with children. At the same time, changes are taking place in family structures. The number of cohabiting couples with children is growing all the time and now accounts for about 15 per cent of all families with children. The number of single-parent families is also growing, and accounted for 19 per cent of families with children at the end of 1999. In addition, the number of reconstituted families has been growing somewhat in recent years. At the end of 1999, there were about 47,000 reconstituted families, i.e. about 8 per cent of families with children. Altogether 97,000 children live in reconstituted families.

As family structures change, the question has arisen of how family ties should be considered in granting benefits and setting client fees. In September 2000, a study on the life of reconstituted families was published with the aim of clarifying what the legislative standpoint on these families ought to be. A particular aim was to find out how well the 'shared fridge theory' applied in social welfare law corresponds to the reality of reconstituted families' lives and whether it is felt to be fair.

According to the family legislation, only the parents of a child are responsible for its maintenance. Thus a stepfather or stepmother is not under any obligation to contribute to a child's maintenance. In the social welfare legislation, however, the size of service fees and the need for social benefits and their amounts are determined based on the situation in the household where the recipient actually lives.

The fees and benefits of a reconstituted family are determined based on the total income of the husband and wife. For instance, the daycare fee of the child of a woman living in a reconstituted family is based on the income of both the mother and the man she is living with. He is not obliged to contribute to the fees, however, as he is not the child's father and is therefore not obliged to provide for it.

According to the study, reconstituted families where the man and woman were married or had children together financed their everyday expenses much in the same way as traditional families. In these reconstituted families, the expenses of the partners' children from previous marriages were also financed in much the same way as those of their joint children. In the case of these families, the present social welfare legislation is thus justified. Meanwhile, another group of reconstituted families is more problematic. The study showed that household finances were much more loosely connected in reconstituted families where the man and woman were living together but did not have any joint children. This means about one in three reconstituted families (17,000 families).

Financing family policy expenditure

Maternity, paternity and parenthood allowances are financed out of health insurance, mainly through contributions

from the insured and from employers. The government contribution to health insurance has been changed in recent years. As of 1998, central government has been making 'guarantee payments' to secure the liquidity of the health insurance fund, and since 1999 some of the revenue from value added tax has also been used in this way. Furthermore, as of 1999, central government has funded the minimum daily maternity, paternity and parenthood allowance expenditure. Child allowance is financed entirely by central government.

The municipalities receive a central government grant to finance their social welfare and health care expenditure. In 1999, the grant covered about one fifth of the expenditure on these statutory services. Many municipalities pay a municipal supplement for home care allowance and private care allowance, for which they do not receive any central government grant. Their contribution to financing these services is therefore higher than for other municipal social welfare expenditure. Client fees for daycare cover 15 per cent of costs, and the percentage has stayed the same in recent years.

Financing expenditure on families with children in 1999 (preliminary data)

	Expenditure (FIM million)	Financing contribution (%)				
		Central government	Municipalities	Employers	The insured	Clients
Maternity, paternity and parenthood allowance	2 776	16	0	49	35	0
Child home care allowance[1)]	2 120	20	80	0	0	0
Child allowance	8 300	100	0	0	0	0
Daycare [2)]	8 250	20	65	0	0	15
Private child care allowance[1)]	240	40	60	0	0	0
Institutional care for children and young people[2)]	800	21	76	0	0	3

[1)] incl. municipalities' own support

[2)] incl. client fees

2.6. Unemployment

	1998	1999*	2000**	2001**
Expenditure on main category (FIM million)	21 900	20 800	20 650	21 000
- of which, cash benefits (FIM million)	19 900	18 950	18 900	19 300
% of social protection expenditure	11,7	11,0	10,7	10,4
% of GDP	3,2	2,9	2,6	2,5
Unemployment rate, %	11,4	10,2	9,6	8,6
Recipients of earnings-related allowance at year end	161 650	153 680	149 100	140 300
Recipients of basic allowance at year end	18 570	17 510	16 400	15 000
Recipients of labour market support at year end	185 470	172 520	165 700	157 000
No. of people in labour market training at year end	41 300	38 100	37 000	35 000
Recipients of unemployment pension at year end	49 400	52 240	54 600	57 100

* preliminary data
** estimate

Employment rate rising

Unemployment has been falling consistently since 1994, but is still rather high. In November 2000, there were 224,000 unemployed and the unemployment rate was 8.7 per cent, 0.7 percentage points less than in November 1999. Youth unemployment has fallen particularly sharply and now consists mainly of short-term unemployment connected with the shift from training to work. Despite this, youth unemployment is still quite high, at 19.1 per cent.

In 1999, the demand for labour grew very rapidly. In November 2000, the employment rate had gone up to 66.8 per cent, 1.3 percentage points higher than a year before. During 2000, the employment situation of those aged 55-59 also improved. It is forecast that the employment rate will go up to 68 per cent in 2001. Most new jobs have been created in the private sector. The demand for labour focuses primarily on well-educated young people with good IT skills.

Recurrent unemployment has increased. In 1999, there were an average of 1.4 started periods of unemployment per unemployed person, while there was no recurrent unemployment at all during the deepest recession year in 1994. Recurrent unemployment is also a sign of the growing frequency of short-term work contracts. These are particularly typical in female-dominated occupations.

Problems: elderly unemployed and recurrent unemployment

The average duration of periods of unemployment has decreased during the last few years. People find work more rapidly than before on the open labour market, but there is still a ‘hard core’ of long-term unemployment, a largish group consisting mainly of elderly unemployed for whom it is increasingly difficult to find work. The average duration of periods of unemployment among the over-50s is far longer for men than women.

Periods of unemployment ending in 1999 had lasted for an average of 11 weeks in the age group 20-24 and 14 weeks in the age group 25-29. The periods of unemployment for older people were much longer: 31 weeks for the age group 51-54, 46 weeks for the age group 55-59 and 130 weeks for the over-60s.

Employment among people over 50 has been slow to improve. The average duration of periods of unemployment is long, especially among the elderly unemployed. People who have recently become unemployed usually find work quickly, while the position of those difficult to find work for has become increasingly weak compared with other jobseekers. There continues to be a high, or even increasing, proportion of people who have difficulty finding work and people whose earnings-related unemployment allowance ends, leaving them dependent on labour market support.

A low level of basic education is the main obstacle to employment among middle-aged and elderly people. Over 40 per cent of the over-40s have only a basic education, with the corresponding figure for the over-60s being 60 per cent. In addition to a lack of formal education, elderly people are also disadvantaged by the labour market's tendency to selectiveness. Age undermines people's chances of finding work regardless of their training, professional or vocational category, employment sector or tendency to take sick leave.

The trend in the relationship between unemployment and available vacancies shows that the structural features of unemployment are becoming more pronounced. The demand for labour largely concentrates on highly skilled young people just entering the labour market or people who have been unemployed for a short time. Elderly unemployed with a low level of training or outdated vocational skills are in danger of becoming excluded from the labour market. In order to prevent this, action is needed which focuses on qualification problems, specifically, as this will also help prevent labour shortages and the spread of structural unemployment.

The ageing of the population has a tendency to slow down geographical and vocational mobility. Young people are more willing to move than older jobseekers. In municipalities subject to net outmigration, the population structure therefore ages rapidly. This causes more need for welfare services while simultaneously undermining municipalities' ability to provide such services, due to their populations.

Unemployment expenditure up in 2001

The falling unemployment rate has reduced social expenditure on unemployment. In 2000, the figure is expected at FIM 20.7 billion, slightly less than in 1999. Expenditure is likely to increase somewhat in 2001, because spending on unemployment pensions will grow faster than the expenditure on daily unemployment allowance falls.

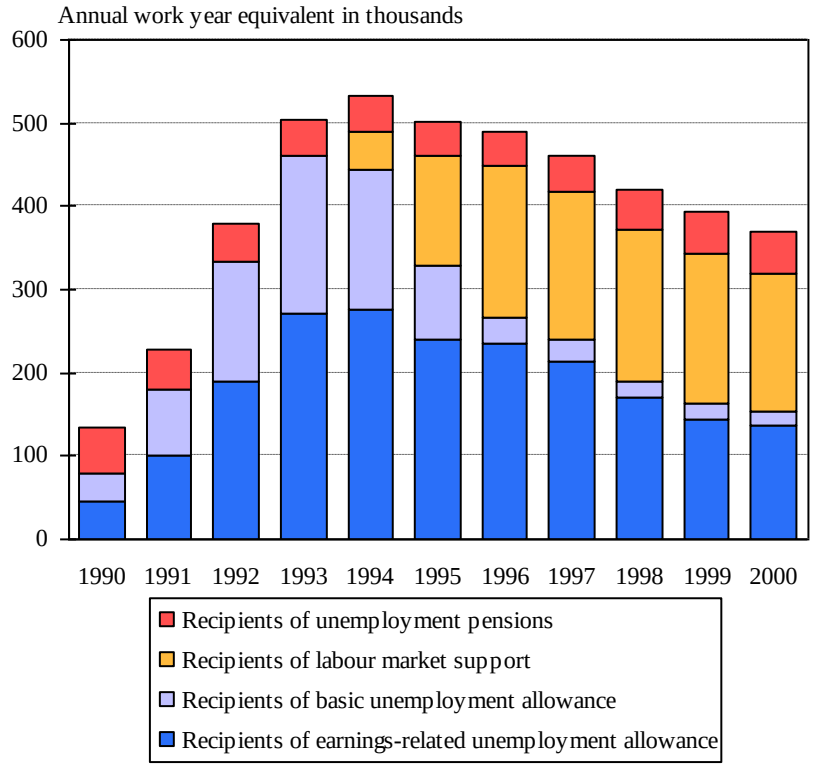
In 1999, FIM 8.4 billion was paid out in earnings-related unemployment allowance and the estimated total for 2000 is FIM 8.2 billion. Total expenditure on basic unemployment allowance was FIM 500 million, which is FIM 16 million less than in 1999. Labour market support expenditure also fell by about FIM 200 million, coming to FIM 5.1 billion in 2000. Meanwhile, unemployment pension expenditure went up by about FIM 360 million in 2000, reaching FIM 3.7 billion. It is likely to continue to rise rapidly in 2001.

The number of recipients of unemployment allowance should continue to fall. There were 334,800 recipients of earnings-related unemployment allowance in 1999, or 35,000 less than in 1998. The number of recipients of basic unemployment allowance went down to 45,700. The number of recipients of labour market support has not fallen as rapidly. In 1999, there were 311,800 unemployed recipients of labour market support, which was 10,800 less than the previous year. The continued high level of long-term unemployment and youth unemployment is slowing down the fall in the number of recipients of labour market support. An increasing number of people formerly on earnings-related unemployment allowance now rely on labour market support.

In 1999, periods on earnings-related unemployment allowance averaged around 115 days and the average period on basic unemployment allowance was 96 days. This marked a fall of 3-5 days for both allowances. Meanwhile, the average period of labour market support was 148 days, two days more than in 1998. In 2000, earnings-related unemployment allowance will be paid for slightly longer periods on average than in 1999, as the number of long-term unemployed over 50 and people on the ‘avenue’ to unemployment pensions receiving earnings-related unemployment allowance will go up.

The number of recipients of unemployment pensions continued to grow. In 1999, there were 52,240 recipients of unemployment pensions, 2,850 more than the previous year. The number of recipients will continue to grow. In mid-2000, there were 49,500 unemployed between 55 and 59, many of whom are entitled to ‘additional days’ and then to unemployment pension. In this age group, the number of unemployed began to fall in 1998. Long-term unemployed over the age of 60 are entitled to unemployment pension until they become eligible for old age pension (Figure 35).

Figure 35. Recipients of basic and earnings-related unemployment allowance, labour market support and unemployment pension 1990-2000, annual work year equivalent

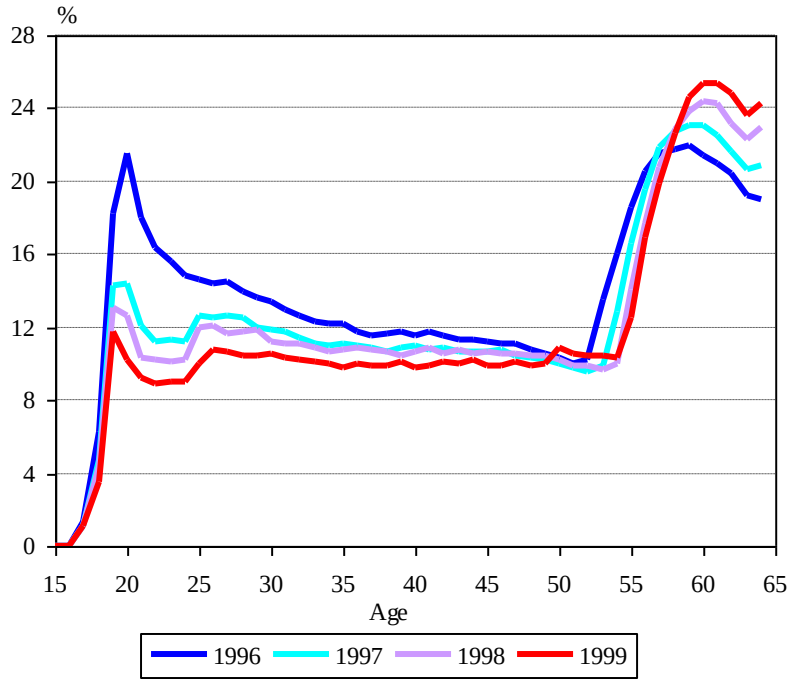


Changes in benefits to encourage later retirement

The average retirement age has increased by one year: in 1999, it was about 59. The official retirement age is 65 for the majority of employees. Extensive unemployment and the tendency to take early retirement increase benefit expenditure and undermine the financial base for social security.

At the beginning of 1997, the lower age limit of the 'avenue' to unemployment pensions was moved up by two years, from 53 to 55. The higher age limit and the favourable economic trend appear to have boosted the employment of older age groups (Figure 36).

Figure 36. Percentage of recipients of unemployment allowance and unemployment pensions per age group from 1996 to 1999



During the next ten years, the percentage of employees over 50 in the workforce will rise by 5 percentage points. Elderly people's participation in working life has been falling until recently and in this, Finland is like other European countries. Early retirement systems have a crucial impact on the labour market position of the elderly. The unemployment pension, in particular, has been used as a tool of personnel policy. The probability of becoming unemployed has followed the changes in the age limit for unemployment pension. Unemployment pension almost doubles the unemployment rate for the elderly. Steps to improve elderly people's working capacity and help them stay on at work are needed in parallel with pension policy action. Unemployment among the elderly cannot be completely prevented, so measures to improve their chances of returning to work are also needed.

The following steps have already been taken to improve the labour market position of elderly employees and discourage people from taking early retirement:

- The level of unemployment pension has been lowered somewhat, by up to 4 per cent. In some special cases it has, however, been made easier to get an unemployment pension.
- The financing of unemployment and disability pensions has been changed, and the employer's responsibility for costs increased.
- The age limit for an individual early retirement pension has been raised from 58 to 60.
- The age limit for a part-time pension was lowered from 58 to 56 by fixed-term legislation, which will remain in force until the end of 2002. The aim is to

reduce the number of people taking early full-time retirement.
- Fixed-term legislation providing that the pension of unemployed persons over 55 does not deteriorate if they accept temporary work with low pay was made permanent.
- The labour administration has stepped up the use of training and rehabilitation measures.
- The labour market organizations and the employment pension institutions have agreed that the rights of employed people to early rehabilitation examinations paid for by the employment pension system will be extended. The arrangement will start with 58 and 59-year-olds and will then be gradually extended, with the aim of including all employees in 2002, if resources permit.
- An action programme to promote coping at work has been launched. Workplace health promotion (WPH) has been encouraged and working conditions improved through programmes such as the extensive National Workplace Development Programme.
- The National Program for Ageing Workers continues.

The total tax rate in Finland is among the highest in the EU. The most problematic aspect of this from an employment perspective is the high tax wedge (income tax and employer and employee social security contributions as a percentage of the labour costs of the average employee) in low income brackets. It is estimated that in 2000, income tax and social security contributions will make up a total of 47.9 per cent of labour costs. During the term of the present Government, the aim is to reduce taxes and tax-type payments on earned income and indirect labour costs by about FIM 10-11 billion. The Government has decided on tax reliefs to a sum of about FIM 6 billion in 2001. In the last incomes policy settlement, the Government promised to lower income tax by about FIM 4 billion in 2002.

In 1999, a working group appointed by the Ministry of Social Affairs and Health studied ways of lowering and scaling employer contributions in a way which would improve the employment potential of employees in low wage brackets and those in danger of labour market exclusion. The working group found that the employment effects of lowering small contributions would be minor. The greatest impact on employment would be achieved through mutually supportive measures, focusing on labour demand, supply and incentives. Reductions in employer contributions, together with an earned income deduction in municipal taxation and active labour and social policy measures, could combine to improve employment in the low income brackets.

Active social policy and rehabilitation

Active measures have successfully reduced long-term unemployment, and cover about 30 per cent of unemployed jobseekers. This represents an increase, but is still well below the level of labour policy measures in Denmark and

Sweden and the leading countries in the European Union. Finnish labour policy should continue to strive to raise the quantity and quality of active measures.

Individually tailored measures are needed in order to activate the special groups which are most difficult to find work for. Reducing structural unemployment requires a high standard of employment services and cooperation between various administrative sectors.

Long-term unemployment has contributed to increasing the level of social exclusion. Action to support the long-term unemployed and excluded has been hampered by lack of cooperation between the labour administration and municipal social services. Although good results have been obtained from such cooperation on a regional basis, it has not become established on a nationwide scale.

It is considered a particularly unfortunate shortcoming that there are no special services available for long-term unemployed for whom work cannot be found with the labour administration's present means. Since the income of this target group usually consists of labour market support and housing allowance, the municipal social services are not usually able to provide services at a sufficiently early stage.

Support at this early stage can prevent imminent exclusion and prevent the occurrence of serious problems. In practice, however, the responsibilities of the social services are limited to solving the worst problems through measures involving child welfare or care for intoxicant abusers. Intervention in problems takes place too late.

Social employment projects implemented with fixed-term financing have produced good practical results. However, it is only very rarely possible to incorporate the good practices discovered through these experiments into permanent operations. A particular problem here is that it is not possible to extend experimental schemes to all municipalities, so the chances of a long-term unemployed person getting special social services in support of employment vary from one municipality to the next.

In summer 2000, the Government made a decision in principle on the measures needed to prevent exclusion and improve the position of the long-term unemployed. This active social policy package includes increasing the efficiency of employment services, improving cooperation between the labour authorities and municipal social services, and the creation of a new scheme for the long-term unemployed called 'rehabilitating work experience'.

The reform of active social policy is intended to create legislative grounds for cooperation between the labour authorities and the municipalities in order to combat long-term unemployment and exclusion. Another aim is to secure permanent funding for the new 'rehabilitating work experience' scheme.

The proposal includes the addition of more detailed definitions to the law on the rights of an unemployed jobseeker under the Employment Services Act.

The aim is to make jobseeker interviews and jobseeking plans more efficient'.

People who have been unemployed for a long time despite action by the labour authorities will be offered a new 'action package' to be agreed on when their 'activation plan' is drawn up. The intention is to require employment offices and municipalities to work together to draw up this activation plan with the long-term unemployed when they have received labour market support or social assistance due to unemployment for a period specified in a new act on rehabilitating work experience. The activation plan will be drawn up after a shorter period of unemployment for people under 25 than for those over 25.

The activation plan can comprise employment measures provided by the labour authorities under legislation currently in force, or social services, health care, training or rehabilitation services which are the responsibility of the municipality. Rehabilitating employment can also be included in the activation plan as a new service.

Rehabilitating employment will be an activation measure offered to the long-term unemployed when there are no labour authority measures available which directly promote employment. Rehabilitating employment will be used to help set up various social employment projects in the municipalities with support from sources such as the European Social Fund, making them part of standard practice.

Rehabilitating employment will not take place within a normal employment relationship, so separate legislation will be needed on the benefits and reimbursements paid for it and the content, duration, insurance and occupational safety of the scheme itself. Long-term unemployed under the age of 25 can be required to engage in rehabilitating employment, whereas participation will be voluntary for people over 25.

Measures promoting employment offered by the labour authorities will take priority over rehabilitating employment and other social services. A provision is therefore included in the Act on Social Assistance stating that a person applying for social assistance due to unemployment must always primarily report to an employment office as an unemployed jobseeker.

Sanction periods most common among recipients of basic allowance

National Research and Development Centre for Welfare and Health (Stakes) has conducted a survey of sanction periods in unemployment security. At the moment, there are about 40,000 sanction periods in unemployment security. The most common reason for such a period is that the applicant has quit his job without a valid reason. Refusal of training or labour policy measures has become more common, with one in five sanction periods in 1999 arising from this. Sanction periods occur more in areas with a high employment rate than in areas with high unemployment. Men are more likely to repeatedly refuse offers of work than

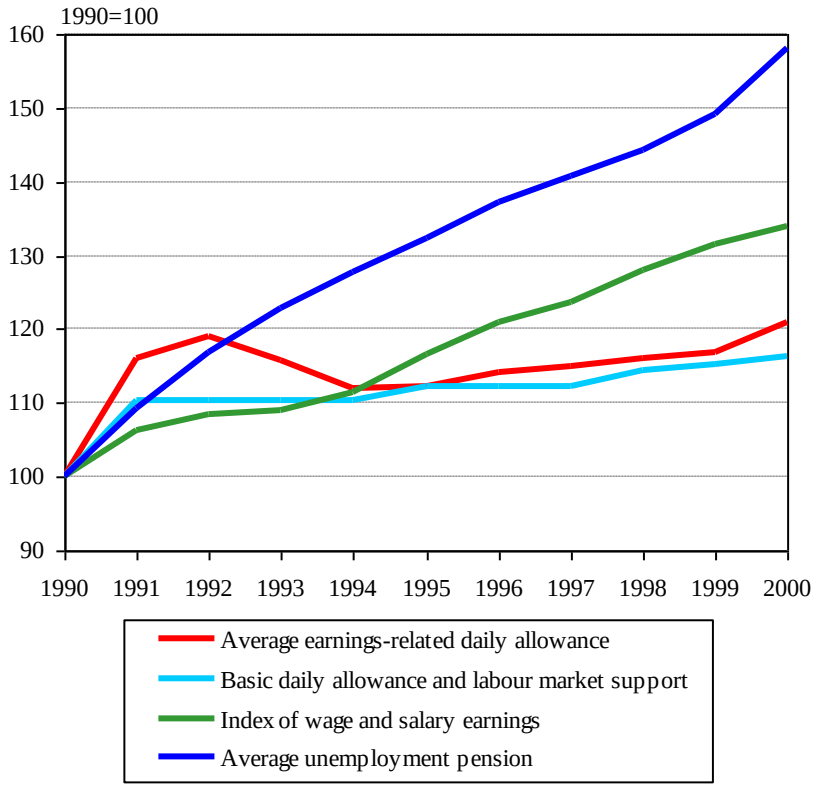
women. Sanction periods generally affect jobseekers with a low educational level. In 1999, 44 per cent of those subject to sanction periods had only a basic education. Many of those subject to sanction periods had been unemployed for over two years.

Sanction periods are more common among applicants for basic security and recipients of social assistance. In autumn 1998, more than half of those subject to sanction periods had received social assistance during the year.

Daily unemployment allowance rising more slowly than the wage level

The level of unemployment security has increased very little since the beginning of the 1990s. The basic daily allowance for labour market support and unemployment security has been increased only very slightly in certain years and the average daily allowance remains on the same level as in the early 1990s. The average level of earnings-related unemployment security has also increased very little due to cost cutting and structural changes in unemployment. According to the current collective agreement, the unemployment insurance compensation level will be raised in 2002. The average unemployment pension rises at the same rate as the general pension level (Figure 37).

Figure 37. Average unemployment benefits 1990-2000 at current prices



Financing of unemployment expenditure

Basic unemployment security is financed entirely by the central government. Earnings-related unemployment allowance is financed by a combination of employer and employee contributions and by central government. An unemployment insurance payment for wage-earners was introduced in 1993. The relative contribution of employers, employees and central government to the earnings-related unemployment allowance has varied slightly from year to year. Unemployment pensions are made up of national pension and employment pension. Employers finance about four fifths of employment pensions while the remaining fifth comes from employees. National pensions are financed by central government and by employers' insurance contributions.

Contributions to unemployment expenditure in 1999 (preliminary data)

	Expenditure (FIM million)	Financing contribution (%)			
		Central government	Munici-palities	Employers	Employees
Basic daily allowance/labour market support	5 830	100	0	0	0
Earnings-related daily allowance	8 390	37	0	39	24
National pensions	300	47	0	50	2
Employment pensions	3 050	0	0	78	22

2.7. Housing subsidies

	1998	1999	2000*	2001**
Expenditure on general housing allowance (FIM million)	2 615	2 870	2 700	2 510
Recipients of general housing allowance on December 31 (no. of households)	205 600	207 000	170 000	164 000
- of which, families with children	82 000	80 000	76 000	76 000
Expenditure on pensioners' housing allowance (FIM million)	1 215	1 287	1 360	1 450
Recipients of pensioners' housing allowance on December 31	159 000	161 000	162 000	164 000
Expenditure on student housing supplement (FIM million)	615	603	880	1 240
Recipients of student housing supplement on December 31	93 825	92 200	143 500	147 000

* preliminary data
** estimate

Housing costs rising faster than other costs

During the 1990s, public support for the housing market was reduced and prices were deregulated and allowed to follow the market. Rent control ended on May 1, 1995 in all tenancies for privately-financed housing. Rents in government-subsidized housing are still controlled. Rent levels rose throughout the 1990s, from 1996 to 1999 at a much faster pace than before (over 4 per cent annually). From April 1999 to March 2000, rents in new tenancies rose by almost 5 per cent. The fastest rise was in the Helsinki metropolitan area and other growth centres. Rents in the Helsinki area are over 48 per cent higher than in other parts of the country and the differential is growing steadily.

Rents for government-subsidized flats have been raised and tenancies have become much more difficult to obtain. Only one in four applicants obtained a rented flat and only one in five in the Helsinki metropolitan area. In 1999, more than 210,000 families were on the waiting-list for a government-subsidized flat; two in five of these families were in the Helsinki metropolitan area. At the end of 1999, there were over 43,000 applicants on the waiting-list in the Helsinki metropolitan area. While the demand for housing and rents in the Helsinki metropolitan area are rising constantly, other areas have a problem with unlet rented accommodation and housing developments whose maintenance involves the municipality in considerable costs. The shortage of housing in growth centres poses an obstacle to workforce mobility and employment in general, since housing of a reasonable size and price cannot be found where work is available.

After a drop in prices in the early 1990s, the price of owner-occupied accommodation has been rising rapidly since 1995. In the Helsinki area, prices have increased by over 10 per cent

annually. The nominal prices of flats in old buildings have already passed the peak at the end of the 1980s. In 1999, prices rose by 18 per cent, or even more in some areas. Elsewhere in Finland, the price trend has been rather more moderate so far, but it is accelerating in growth centres such as Tampere and Oulu. A flat in the Helsinki area costs FIM 12,500 per sq.m. on average. The price differential between the Helsinki area and the rest of Finland has widened with rising price levels, and at the moment the price per sq.m. in the Helsinki area is twice that elsewhere in Finland.

At the same time, the cost of owner-occupied accommodation has been increased by rising interest rates. The nominal interest rate on new housing loans was at its highest in 1993, at about 13 per cent, but in 1999 it had fallen below 5 per cent. In 2000, the interest rate increased by about 2 percentage points. Due to rising housing prices, households have been obliged to take out large mortgages. Thus the volume of household mortgages has risen considerably over the past few years, reaching FIM 147 billion. This is clearly in excess of the 1991 level. In addition to higher interest rates, housing costs are boosted by higher real estate tax and more expensive heating.

Housing construction was at a much lower level in the 1990s than during the preceding decades. Compared with the 50,000 housing units a year constructed previously, annual production is now under 30,000 units. The lowest output was in 1996, when only just over 20,000 units were built. The supply of housing is responding slowly to the growing demand, but new building is hampered by a shortage of suitable plots and high prices, among other things. Building costs have now risen above the limit for government-subsidized housing and thus all the rented housing planned cannot be built. Producers are focusing increasingly on valuable owner-occupied housing in growth centres.

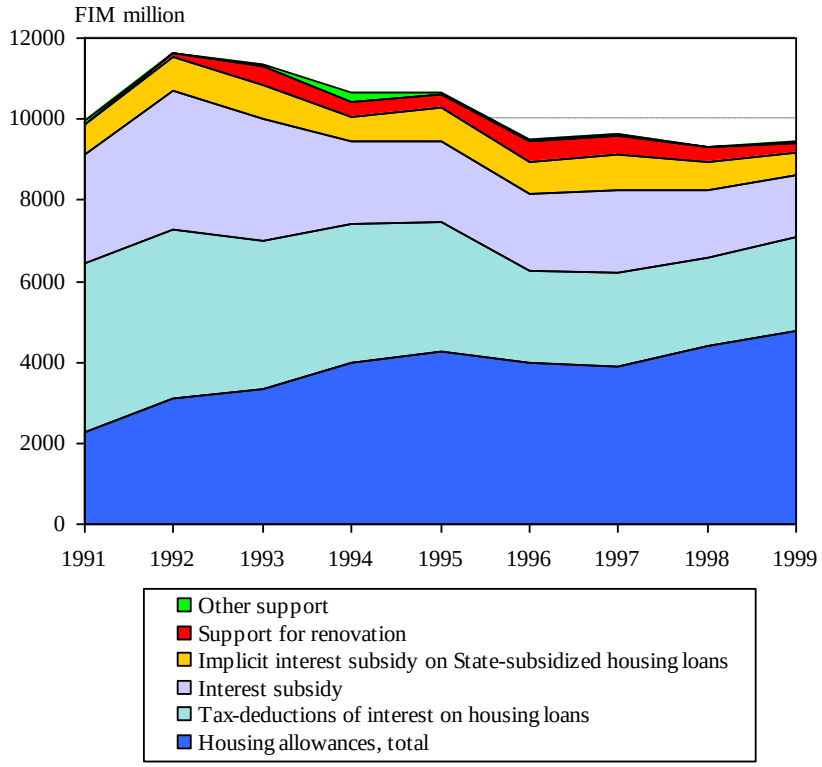
Housing costs rose throughout the 1990s, especially in rented accommodation. Meanwhile, the earnings of people in low-income brackets have been rising at a much slower rate. After a long period of improvement, homelessness has begun to increase again in recent years. It is estimated that there are already over 10,000 homeless, most of them men, but numbers of homeless women and young people are also increasing.

Less overall support for housing

Housing and housing construction are supported through direct housing allowance systems, interest support, grants and tax relief. The direct housing allowance systems consist of general housing allowance, student housing supplement and pensioners' housing allowance. The forms of interest support are the ASP scheme (government subsidy for first home purchase), government-subsidized housing loans and the interest support system. Direct housing grants focus on certain special groups and on renovation work. The main form of tax relief is the tax-deductibility of interest on housing loans.

At its peak in 1992, total expenditure on housing subsidies came to nearly FIM 11.6 billion. The figure has fallen since then and will be about FIM 9.5 billion in 2001. Expenditure on all forms of support has fallen (Figure 38). Tax relief has been considerably reduced due to a change in the tax-deductibility of mortgage interest in 1993 and falling in interest rates; the same has happened to interest subsidy. Support for housing construction has fallen slightly, in line with the economic cycle, and so has support for renovations. The criteria for receiving housing allowance have been altered and re-focused several times.

Figure 38. Total expenditure on housing subsidies, 1991-1999
FIM million at current prices



Source: Ministry of the Environment

Housing subsidies really needed

In 1999, the total expenditure on housing subsidies was FIM 9.4 billion. 72 per cent of this was made up of means-tested forms of support, while 28 per cent was general allowances. The biggest individual form of support among the general allowances was that provided through the tax-deductibility of interest on housing loans, which accounted for 23 per cent of total expenditure on housing subsidies. The means-tested forms of support are housing allowances, the implicit interest subsidy on government-subsidized housing loans, support for renovation (excluding housing corporations), the implicit interest subsidy on government-subsidized rented housing, and interest subsidy for rental housing production.

The direct forms of housing subsidies for households are subject to means testing. Housing allowance is granted in relation to household income, assets, occupation density and housing costs. The purpose of the allowance is to enable even those on low incomes to attain a reasonable standard of housing. The allowance enables housing costs to be kept at a reasonable proportion of the household's gross monthly income. Due to the strict means testing, even a very low level of income leads to a reduction in housing allowance.

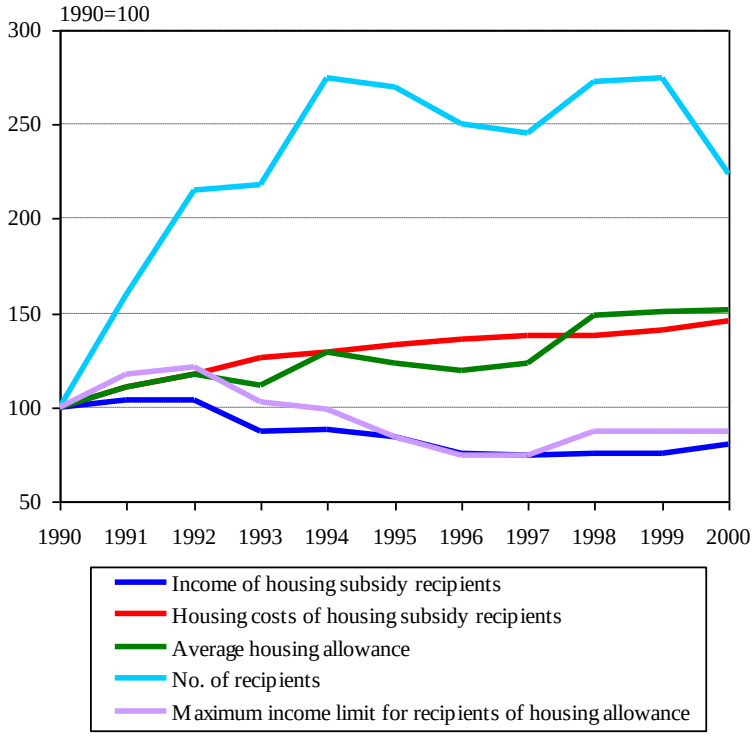
Housing costs are considered either as real costs or according to the size of the household, the maximum size of housing and maximum costs per square metre for the specific region. A basic deductible is deducted from the reasonable housing costs; the size of the deductible depends on the size of the housing, its location and the income of the household. Housing allowance is the equivalent of 80 per cent of reasonable housing costs, less deductible. The recipients of housing allowance thus always have to pay some of their housing costs themselves.

General housing allowance is meant for households on a very low income. The rise in unemployment also caused a considerable rise in the need for housing allowance. Because it became necessary to cut housing allowance expenditure through a tightening of means testing at a time when income levels were falling and rents rising, the remaining recipients of housing allowance were, to a large extent, households subsisting mainly on some form of income security. Some 53 per cent of the recipients of general housing allowance are unemployed.

General housing allowance was originally a form of support for families with children. Nowadays, only 45 per cent of recipients are families with children. About half of these are single-parent families. In October 1999, 199,000 households received housing allowance averaging FIM 1,112 a month. In 1998, both the number of recipients and the average allowance rose slightly, due to an increase in the levels of housing allowance. This trend continued in 1999. The number of recipients fell in 2000, as student couples were transferred to the student housing supplement system. The housing allowance was last raised in 1998, when recipients of social assistance were made partly responsible for their own housing costs.

Unemployment, and especially long-term unemployment, caused recipients of housing allowance to triple in the early 1990s (Figure 39). In order to reduce housing allowance expenditure, the income limits for receiving the allowance have been lowered in several years. At the same time, the housing costs of recipients of housing allowance have gone up. The average housing allowance has been raised in order to cover the increasingly high housing costs of recipients with lower incomes. Households with even lower incomes than before are forced to spend an increasing proportion on housing costs.

Figure 39. Trends in housing subsidies 1990-2000



There are separate housing allowance systems for pensioners and students which differ in detail from general housing allowance. The pensioners' housing allowance system is directly tied to pensions and its key aim is to ensure that pensioners can continue to live in the familiar environment of their own homes rather than having to move into an institution. Thus, the conditions for type of dwelling are much less strict for pensioners' housing allowance than they are for general housing allowance. The key aspect for further development of this allowance system is its relationship with services for the elderly. Last year, there were 162,000 recipients of pensioners' housing allowance, receiving an average of FIM 690 a month.

Student housing supplement is available to students who live alone in rented accommodation and student couples without children. The student housing supplement is part of the system of financial aid for students, the target being for the level of supplement paid to students to reflect the rent levels of student housing. At the end of 1999, there were 92,200 recipients of student housing supplement receiving an average of FIM 730 a month. Student housing supplement will be developed as a part of the system of financial aid for students. All students other than families with children and those living in owner-occupied dwellings were transferred from coverage by the general housing allowance to the student housing supplement as of May 1, 2000. The student housing supplement was raised at that time, but is still not payable during the summer months.

The housing allowance system has had to respond to rapid economic change. There has been fairly violent fluctuation in the supply and demand for housing.

Although the higher employment rate has not been directly reflected in the need for housing allowance, it will improve the situation in the long term if the supply of housing remains adequate. As the employment situation and the housing market stabilize, housing allowance can be more easily tailored as part of social policy to take into account the different housing markets for various population groups and regions.

Financing of housing subsidies

General housing allowance, pensioners' housing allowance and student housing supplement are funded entirely by the central government.

2.8. Social assistance

	1998	1999	2000**	2001**
Social assistance expenditure (FIM million) (net)	2 558	2 380	2 380	2 380
% of social protection expenditure	1,4	1,2	1,1	1,1
% of GDP	0,4	0,3	0,3	0,3
Households receiving social assistance during the year	313 400	292 000	273 000	270 000
Individuals receiving social assistance during the year	534 930	492 690	460 000	455 000

* preliminary data
** estimate

Slow fall in recipients of social assistance

The number of households receiving social assistance nearly doubled in the first half of the 1990s. Numbers were highest in 1996, when about 350,000 households received social assistance. These households comprised a total of 610,000 people. In 1997, the number of households receiving social assistance began to fall slightly. By 1999, recipients of social assistance had fallen below 300,000 households. At the same time, the number of individual recipients had fallen below 500,000. Compared with 1990, however, the number of recipients is still quite high.

The number of recipients of social assistance fell further in 1999. The number of households receiving social assistance fell in all regions between 1997 and 1999. These figures include both actual social assistance and preventive social assistance. The numbers fell fastest in Central Ostrobothnia (30%) and Uusimaa (20%).

The improved employment rate has not been directly reflected as a fall in social assistance, even if over half of the recipients of social assistance are unemployed. The rising demand for labour did not primarily affect people receiving social assistance.

The average duration of periods of receipt of social assistance grew during the 1990s. There was also a rise in long-term recipients and one-person households. In 1990, about 12 per cent of social assistance recipients received social assistance for almost the entire year. In 1997, the corresponding figure had gone up to almost 25 per cent. Since then, the number of long-term recipients has begun to fall. In 1999, long-term recipients accounted for 23 per cent, or about 67,000 households.

A total of 22,700 households applied for social assistance at least once a year between 1989 and 1998. The main reason for long-term social assistance is economic problems arising from long-term unemployment. Most of the households in question applied for social assistance to supplement other benefits or earned income.

Monitoring the effects of the new Act on Social Assistance

The recent fall in the number of recipients of social assistance and in social assistance expenditure is partly due to changes in social assistance and certain other benefits. A new Act on Social Assistance and its supplementary Decree entered into force on March 1, 1998. It includes responsibility for 7 per cent of housing costs in the costs to be covered by the basic amount of social assistance. The basic amount for children under the age of ten was reduced by three percentage points, and that for families with several children by 5-10 percentage points from the second child onwards. The reform of social assistance was part of a more extensive package which also included improvements to housing allowances. In 2001, the basic amount of social assistance will be FIM 2,152 a month for a one-person household.

In approving the new legislation on social assistance, Parliament stipulated that the effects of the reform will need to be monitored. A study of the effects of the changes in 24 municipalities is under way at the National Research and Development Centre for Welfare and Health (Stakes). According to the study, social assistance expenditure has fallen. Part of this change is due to a fall in unemployment. From January 1998 to February 1999, the average social assistance fell from FIM 1,623 to FIM 1,453 a month. About one in four of all recipients in January, May and November received social assistance during all three months.

Under the Decree on Social Assistance, municipalities are free to consider the housing costs included in the basic amount of social assistance. However, the monitoring study seems to indicate that municipalities are applying the 7 per cent provision for housing costs in a relatively straightforward manner. It seems that the maximum rent used by the municipalities for their social assistance calculations is usually slightly higher than for general housing allowance. In the Helsinki metropolitan area, the housing costs of people living alone would certainly seem to exceed the maximum amounts that can be used to calculate social assistance.

Increase in preventive social assistance

According to the principles of a Nordic welfare state, public support systems should function in a way which pre-empts the need to seek help from unofficial sources. One of the crucial weaknesses of the present social assistance system is that it cannot take the assistance recipient’s actual situation and subsequent support needs into account flexibly enough. An amendment to the Act on Social Assistance will enter into force at the beginning of April 2001 aimed at stepping up the use of preventive social assistance in order to encourage recipients’ own initiative and prevent exclusion. The municipalities will be instructed to grant preventive social assistance more intensively than hitherto.

Preventive social assistance can be deployed to help people in need of support to cope with foreseeable financial problems, for instance, for measures to activate the recipient, to prevent the loss of accommodation and to alleviate the effects of overindebtedness or a sudden deterioration in the person's financial situation. It can be used to prevent people from being driven into a situation where they would have to rely on long-term social assistance. In the long term, this will also generate savings.

It is estimated that about FIM 80 million will be spent on preventive social assistance in 2001, compared with FIM 20 million the previous year. Together with active social policy measures, expansion of the preventive social assistance system is an important element in action to prevent exclusion in 2001.

The financing of social assistance

The municipalities meet all their all social assistance expenditure, but receive a government grant to finance their social welfare and health care services. In 1999, the grant covered about 24 per cent of the costs of municipal social welfare and health care services. This percentage has been decreasing since 1993.

3. Social Services and Health Care

Net per capita municipal expenditure on social welfare and health care services averaged about FIM 10,100 in 1998. In urban municipalities the figure was FIM 10,400, in densely populated municipalities FIM 9,500, and in rural municipalities FIM 9,900.

In 14 municipalities, per capita expenditure was over FIM 12,000. Another 14 municipalities managed with less than FIM 8,000 per capita; in two of these the figure was under FIM 7,000. The highest per capita figure was 1.9 times the lowest. The differences between the municipalities were considerable, even after differences in service needs had been taken into account.

3.1 Implementation of Target and Action Plan begun

The Target and Action Plan for Social Welfare and Health Care for 2000-2003 approved by the Government in October 1999 contains a great number of recommendations to the various authorities and official bodies of central and regional government, and for the municipalities. NGOs and other third sector parties will also contribute to implementing many of the recommendations.

The plan emphasizes the importance of consistent monitoring and evaluation of implementation. Responsibility for promoting and monitoring implementation lies primarily with a steering group appointed by the Ministry of Social Affairs and Health, together with seven separate groups for preparation and monitoring. The group will issue an annual publication on implementation of the plan. This will also include information on financial resources connected with the next year's national budget. The Government will report to Parliament on progress with the plan every two years in its review of social welfare and health care services, and annual progress within the plan will be reported in the Ministry of Social Affairs and Health's annual review of its administrative sector.

In the first year of the Target and Action Plan for Social Welfare and Health Care, various actions were planned and cooperation started. Implementation of most of the recommendations is scheduled for later in the programme period. The plan has formed the starting point for the negotiations between the Ministry of Social Affairs and Health and its institutions regarding annual targets for the institutions. The areas of emphasis in the plan were taken into account in deciding the items that the Provincial State Offices should focus on when making their evaluations of basic services. Areas evaluated in 2000 will include school health care, alcohol use among minors, special services for children and young people, and psychiatric care for minors.

In 2000, the Ministry of Social Affairs and Health supported projects involved in implementation of the Target and

Action Plan with a grant of one million Finnish marks. Support focused primarily on preparing national standards for social welfare and health care services and on further education. A number of projects mentioned in the recommended measures in the plan were also supported with other grants from the Ministry of Social Affairs and Health.

3.2 Service provision

The provision of municipal social welfare and health care services consists largely of services provided by the individual municipalities and joint municipal boards. Service procurement from companies and the third sector is limited to various service components and individual actions, or to fairly limited packages.

According to a study commissioned by the Slot Machine Association, the cost of social welfare and health care service provision was FIM 65.5 billion in 1997. Out of this sum, municipalities and joint municipal boards contributed FIM 51.9 billion, or 79.1 per cent. NGOs contributed 11.3 per cent, companies 9.4 per cent and central government 0.2 per cent. NGOs are more important for social welfare services than health care, while companies play a bigger part in the production of health care services.

At the end of 2000, the Mehiläinen Group and Tohtoritalo concluded a preliminary agreement concerning a merger between their operations, aimed at creating a nationwide private-sector health care enterprise. At the end of 2000, the Pirkanmaa hospital district and Wittgensteiner Kliniken signed a contract on the foundation of an endoprosthetics clinic, called COXA, in Tampere. The clinic is to start operating at the beginning of 2002. In addition to the parties already mentioned, the hospital's shareholders will include certain Finnish cities and some hospital districts.

Service provision in the social welfare and health care sector is becoming more international in character. Espoo is acquiring children's daycare services from the ISS corporation outside Finland. The Swedish nursing enterprise Carema Vård och Omsorg has a subsidiary called Carema Oy, which owns two Finnish nursing enterprises in the Helsinki metropolitan area.

Removing obstacles to competition

Competition between providers of social welfare and health care services and the removal of obstacles to competition have been discussed in a number of contexts. Several obstacles to competition arising either from the circumstances or for other reasons have been observed in the sector. Finland's scattered population and municipal structure also tend to undermine the potential for competition. In order to create private service provision, the municipalities will have to work together across municipal borders. What is needed are joint projects, contracts of suitable duration and coordinated tendering. It should also be considered, however, that the municipalities are in a weak negotiating position in procuring services from major service providers. There is a need

for more flexible cooperation between municipalities. Municipalities are also finding it difficult to compare the differences between various service providers' costs due to disparities between cost estimates and variation in the way price lists are presented by providers such as hospitals.

There are other competition-related problems, too, in the provision of social welfare and health care services. The corporate sector feels that the Government grants given to municipalities to fund investments give municipal service providers an unfair advantage. Representatives of the private sector also feel that the practice of returning value added tax to the municipalities distorts the competition. They likewise complain that current indemnification practices for traffic and accident insurance give insurance companies a clear financial incentive to have their patients treated solely at municipal health care units and to avoid private-sector hospitals, clinics, laboratories and diagnostic units.

Four out of five doctors working in the private sector have a post in the municipal sector, too. In such situations, municipal employers fund employment pension benefits on the scale required of them, while the private sector gets away with less costs. The fact that a doctor operates in two competing units as both procurer and provider prevents real competition.

Third sector organizations receive considerable financial support from the Slot Machine Association. In 2000, FIM 1,390 million of the Slot Machine Association's income was channelled into support for voluntary non-profit organizations and foundations which promote health and social welfare. In April 2000, the Slot Machine Association and the Federation of Finnish Enterprises approved common principles for ensuring that the Slot Machine Association's support payments do not distort the market for social welfare and health care services. According to these principles, support will not be granted for the provision of services of a type which is already provided by municipalities, companies or other organizations. Support cannot, furthermore, be used for operations or projects which will be submitted to tendering. If new entrepreneurial operations begin to emerge in a sector, supported service provision will be stepped down correspondingly.

At the beginning of 2000, the Ministry of Trade and Industry initiated an entrepreneurship programme included in the Government programme. The aim of the two-year programme is to increase the founding of new companies and also the growth rate of companies and improvements in competitiveness. There is a project plan for over one hundred actions, prepared in cooperation across administrative boundaries. The plan puts great emphasis on opening public service provision to competition. A plan for increasing municipal procurement of outside nursing services is also in preparation.

HUS begins working

At the beginning of 2000, the new Helsinki and Uusimaa Hospital District (HUS) came into existence. The new hospital district replaced the former separate hospital districts of Helsinki and Uusimaa. This solution was justified by the need to eliminate overlap in health services in the metropolitan area of Helsinki and to promote greater efficiency. In the first phase the change has meant reorganizing specialized medical care within the City of Helsinki. It has also increased the responsibilities of primary health care, to which resources have been transferred from specialized medical care.

National standards for care on the way

National standards for care emerged as a topical subject in 2000. National Research and Development Centre for Welfare and Health (Stakes) has started preparing national standards for mental health services and care for the elderly. The aim is that the standards for mental health services should be ready in 2001. The first phase, covering standards for care of the elderly, was under way in the early months of 2001. The second phase will consist of more intensive study and supplementation of the standards resulting from the first phase.

The 'Current care' project of the Finnish Medical Society Duodecim and consultants' associations has continued to prepare national care recommendations suited to Finnish conditions. The concise and readable care recommendations are useful both for doctors in practice and as a foundation on which to build regional care programmes. So far, over 20 recommendations have been completed.

Information technology offers new potential and calls for new cooperation models

The *Makropilotti* IT project being implemented in seven municipalities in Satakunta has progressed from the planning stage to practical tests and experiments. Gradual implementation of the programme has started in cooperation with information technology companies.

Good practices discovered through the project will be extended from the original pilot municipalities to other places in Satakunta and, gradually, to other provinces as well. A plan for introducing and establishing seamless social welfare and health care services and an electronic information system has therefore been prepared by the project's national steering group.

The project also strives to improve the client's status and influence over services, and assembles user-friendly access to information and services in an electronic network. Kela has also started testing a social security card with an electronic identification code.

Experiences from different projects show that only a few municipalities have the expertise needed to arrange the tendering and ordering of complex technological solutions and similar acquisitions. Creation of new regional and sub-regional cooperation models

and structures is needed in order to obtain sufficient know-how concerning the regulations on, and cost and quality of, acquisition and purchases. Guidelines and rules for use at the regional, sub-regional and municipal level are also needed concerning cooperation with companies, NGOs and other service producers.

FIM 20 million in the 2001 State budget is earmarked for improving the social welfare and health care system with the aid of information technology and for setting up the infrastructure needed. The earmarked funds will be used to develop an intermunicipal consultation system for social welfare services and local and regional service models to help the disabled and the elderly to live independently, as well as for the *Makropilotti* project.

3.3. Different funding models for health care services

More efficient use of the resources available will be a crucial issue in coming years. Changes in the financing of services will also be necessary. In health care services, especially, the client obviously cannot know enough about the subject to make independent decisions. The crucial position of doctors in determining how services are used should also be taken into account in financing solutions. The financing solutions adopted should not give service providers economic or other incentives to favour inefficiency.

Health care service financing systems could be grouped as follows:

A. Mandatory	B. Voluntary
1. From tax revenues	1. Insurance chosen by individuals/households
2. Health insurance	2. Insurance taken out by employers
3. Client fees	3. Funding public-sector operations through private-sector funds
4. Medical savings accounts	4. Foreign funds
	5. Grants, etc. from abroad (in developing countries).

This classification only concerns financing arrangements. In practice, services can be provided at institutions managed by the public authorities, the third sector or the private sector.

Public financing percentages converging

From 1970 to 1998, the percentage of public financing (tax revenue and statutory social insurance) of health care expenditure had gone up in those OECD countries where it was low 30 years ago (table 4). The change was greatest in the USA, where public financing stood at 44.7 per cent in 1998. While total health care expenditure in the USA accounted for 13.6 per cent of GDP in 1998, health care expenditure with public-sector financing accounted for 6.1 per cent, or more than the figure for Finland (5.3 per cent).

Meanwhile, the percentage of public-sector financing for health care expenditure had generally gone down a few percentage points by 1998 in the countries where it had been high. Within the OECD as a whole, there has been some convergence of public financing percentages.

Table 4. Public financing as a percentage of total health care expenditure

	Public financing as a percentage of total health care expenditure		Public financing as a percentage of GDP	
	1970	1998	1970	1998
EU				
Unweighted average	74,2	76,3	3,8	6,1
Weighted average	75,9	75,3	·	6,6
Finland	73,8	76,3	4,2	5,3
USA	36,4	44,7	2,6	6,1
OECD				
Unweighted average	69,4	74,4	·	6,2
Weighted average	56,0	59,6	·	6,1

In countries with tax-funded health care, the central government has delegated financial responsibility and decision-making concerning services to the regional and local levels. Money collected through taxes is usually not earmarked for specific uses. The funds accruing are used to finance services for the entire population. The tax-funded model appears to ensure equal access to care and control of the total costs of health care more effectively than other models.

Models based on social insurance are usually less progressive than tax-funded solutions. Both employers and employees pay obligatory insurance contributions, and this has an impact on labour costs. In France, for instance, social insurance contributions accounted for as much as 55 per cent of wage costs before the government proposed a partial and gradual transfer to tax funding. The present government has followed the same policy. In Germany, the emphasis is now on limiting further growth in insurance contributions and increasing competition between contributory sickness funds: it is felt that high obligatory health insurance contributions undermine business competitiveness on a global market.

Client fee policy highlighted in Finland

Citizens are often required to pay client fees for use of health services. Client fees have not featured in the health care system reforms of other countries; Finland is very different in this respect, and some of the client fees charged here are the highest in Europe. In Finland, the percentage of total health care expenditure covered by client fees from households went up in the 1990s. In 1998, the figure (19.8%) was higher than in the United States (17.7%).

The OECD countries have not shown any interest in client fees. The importance of such fees as a way of regulating costs or controlling demand is considered to be negligible. There are a number of reasons for this. Firstly, client fees have no impact on total health care expenditure and can only influence the use of services to a limited extent, because clients only become significant service users after they become clients of the health care system. At that stage, however, the doctor's opinion becomes the decisive factor in the choice of further examination and treatment. Such choices can thus mainly be influenced by influencing doctors.

Secondly, client fees are a question of legitimacy: when citizens pay considerable obligatory taxes or contributions, the additional use of client fees undermines the credibility of the service system. Furthermore, the administrative costs are high in proportion to the revenue client fees generate. Finally, higher client fees make it more difficult for those in the most exposed position to use services, something which is unacceptable for reasons of equality.

Medical savings account model being tested

A medical savings account model is being tried out in Singapore and a couple of cities in China. Experimentation with this model have also been discussed in the United States.

In this model, the client has a personal medical savings account for payment of any medical expenses. When a person falls ill, he uses the money in this account to pay his medical expenses. If there is money left in the account, the person is entitled, at least in part, to decide on how it is used. Differences between the different account models include how money is deposited in the account in the first place. In the United States, it has been suggested that the government should provide the funds to be deposited, while in China and Singapore, employers and employees have to fund the deposits together. One of the justifications for the model is that it makes the client more discerning and cost-conscious regarding his care.

Experiments with the medical savings account model started in China in December 1994 in two cities with 2.5 million inhabitants. The model consists of a personal medical savings account, a deductible and funding from society. The model is obligatory for public sector employees and State-owned companies with more than one hundred employees. The families of the employees are not included in the model. Employees pay one per cent of their salary and employers 10 per cent of wage costs towards the funding. The revenue thus received is divided, with 45 per cent being channelled into joint public use in the form of a risk fund, while 55 per cent is put into personal medical savings accounts. When a person falls ill, he uses the funds in his own account first. The funds left unused during one year are transferred to the next. The heirs inherit the funds left in the account when the person dies. If the person has used up his account,

he has to spend up to 5 per cent of his annual salary on medical expenses. If this is still not enough, more funds are taken from the risk fund, though the sick person still has to pay part.

During the trial period, the grounds on which service providers such as hospitals are compensated for their work and services has been changed; there has been a shift from fee-for-service criteria to prospective payment forms.

In the Singapore Medisave model, each employee and self-employed person is expected to pay part of their earnings into their account. Hospital care and some of out-patient care are paid for from the account. Any remaining costs have to be met out of the person's own money. When the Medisave account reaches a certain level, some of the money can be withdrawn and used for other acceptable purposes. In the case of death, the funds in the account are the property of the deceased account holder.

In the United States, the Republican party proposed the medical savings account model in 1995. According to the proposal, Medicare would pay a certain annual sum (e.g. USD 5,100 in 1996) to people covered by the Medicare scheme, to be spent on insurance from an insurance company, primarily against major medical expenses with a high deductible. The remainder was to be deposited in a personal medical savings account. If, within a year, the funds in the account had not been needed for medical care expenses, the account holder would be entitled to keep some of the money. It was estimated that healthy people would be likely to opt for the account model, as they would probably be left with money in the account at year end. A trial has been planned with 750,000 people. They should be employed by small companies or self-employed, and the account would be tax-exempt.

The data from different experiments with the medical savings account model are, as yet, considered insufficient to allow any conclusions to be drawn. It has been claimed that the model will cut down on unnecessary use of services. The disadvantage is thought to be that the model could easily lead to client selectivity, and that only the healthy and well-off would be able to afford to maintain the model. The account model is not enough in itself to control costs, and will need to be supplemented by strict controls over the actions of suppliers.

Insurance cover generates unnecessary use of services

In voluntary insurance provision, the insurance company selects clients according to their probable risk of becoming ill and the probable costs involved, and also according to their financial situation. Being covered by insurance tends to encourage the client to use services more than really necessary. Awareness of a client's insurance cover or lack of it also influences the decisions of doctors and service providers generally.

Long-term care insurance spreading slowly

Interest in long-term care insurance for the elderly is growing as the population ages. This type of insurance for elderly people can pay for care in sheltered housing or old people's homes, or for home care, when an elderly person is unable to cope alone. The insurance can also reimburse for home improvement which helps old people to live in their own homes for longer. Insurance indemnification and the way in which insurance is coordinated with public services varies from one country to the next. Possible forms of indemnification include reimbursement of costs, payment of pension, or acquisition of aids or services. Long-term care insurance for the elderly indemnifies when the need for help is shown to be long-term or permanent. The insurance is not meant for acute or transient situations. In practice, the insurance premiums are not tax-deductible in Europe.

In Germany, long-term care insurance has been obligatory since 1995. The insurance covers care only, and not, for instance, the cost of staying in an old people's home or home help services. People must be able to pay for their accommodation themselves, even in an old people's home. Old people are not expected to sell their homes during their lifetime to pay for accommodation, but after their death, selling their home is one way of paying outstanding bills. Children are required to pay their parents' living costs by, for instance, selling hereditament while an old person is still alive, or after his/her death.

In Germany, there are eight million people with private insurance whose high incomes enable them to bypass the obligatory insurance system and choose private insurance cover instead. The basic part of long-term care insurance for the elderly has been standardized, and is the same for people with private insurance as it is in the obligatory system. Insurance premiums for voluntary insurance are tax-deductible up to DM 3,800. In addition, people born after 1958 may deduct an extra DM 360. This ceiling on tax deductions is the same for health insurance, pensions, unemployment insurance and long-term care insurance for the elderly. In practice, someone taking out long-term care insurance for the elderly thus does not benefit from the tax deduction right.

In the UK, long-term care insurance was first introduced in 1991. By the end of 1998, only 30,000 policies had been sold. The people choosing this type of insurance are those who can afford to pay GBP 10,000-12,000 in premiums each year and whose assets total about GBP 250,000. The premiums are not tax-deductible.

In Europe, long-term care insurance is most widespread in France, though even there not common. About 300,000 of the total 550,000 long-term care insurance policies in France are low group insurance policies taken out by trade unions. The remaining 250,000 are more substantial. Nevertheless, they cover a very small proportion of the elderly, only 3 per cent. The premiums are not tax-deductible.

A working group at the Ministry of Social Affairs and Health has studied the potential for introducing long-term care insurance in Finland. The starting point was that the insurance should be a funding system for care for the elderly which would supplement the statutory municipal service provision and other public services. The working group will conclude its work in spring 2001.

Interest in public-private partnership

Public-private partnership is a concept used to describe an operating model where a service or project which is in the interests of the public sector is arranged in cooperation between the public and private sector. Public-private partnerships are based on extensive, long-term agreements between the two parties. Under these agreements, the public authorities order services and help with investment funding in some cases, while the private partner funds, plans, constructs and provides services as ordered by the public authorities against an agreed remuneration. In the extensive model, a package comprising several services is bought from the private sector — for instance, the planning, financing, construction and maintenance of a building project — while reserving for the authorities their appointed duties. In the extensive model, the private partner organizes service procurement, from tendering to service quality monitoring.

This subject is increasing the focus of public and political debate in Finland. In 1999, the Cologne European Council exhorted the Commission and the Member States together with the European Investment Bank, to evaluate solutions such as public-private partnerships.

In Finland, public-private partnerships have not been used so far in health care services, but many other countries have experience of such models, though mainly in solutions related to infrastructure, e.g. construction and services related to railways, motorways, bridges and water-treatment plants. The model has also been used in health care services in individual countries, e.g. the UK, Japan and Australia.

European Investment Bank funds health care investments

The European Investment Bank (EIB) is the financial institution of the European Union. The Bank is a non-profit institution. Its brief is to promote balanced economic development of the Union by obtaining long-term funding on favourable terms for good investment objects. The bank has an excellent credit rating (AAA). Major loans of over EUR 25 million are granted by the bank to individual applicants. It grants loans for small and medium-sized projects in the form of framework loans to an intermediary, which then grants credit to individual applicants. In Finland, Municipality Finance plc serves as the intermediary for EIB loans. By the end of 1999, nearly FIM 12 billion in EIB loans had been granted to Finland.

In June 1997, the Bank’s Board of Governors decided to extend the bank’s mandate to health care investments,

though only in the case of EU Member States.

Other EU funding

The Ministry of Social Affairs and Health has been granted an annual sum of FIM 20 million, to be used for part-funding regional and local EU Structural Fund projects. Social welfare and health care projects have focused on groups such as people with disabilities, the long-term unemployed and young people threatened by exclusion. In geographical terms, the projects have focused on Northern Karelia, Kainuu and Lapland. Regional Development Fund projects have also involved the use of information technology in social welfare and health care services.

Disadvantages of financing from several sources

Decisions involving health care legislation and financing have been made on several separate occasions over the years. The result is separate independent financing channels for services. Health care services are financing from the State budget through several different allocations and also through sickness insurance. A considerable part of the Slot Machine Association's profit is also distributed to health care. New sources of financing include the EU Structural Funds and the European Investment Bank.

The variety of sources of financing has caused problems in service management and coordination on both the nationwide and the local level. Each financing body also adheres to a perspective of its own.

This situation has led to overlap and even under-use of facilities, to conflicts between municipalities and Kela over who should pay for services, to discontinuity in client care, and to difficulties with controlling the amount of financing and the structures involved. The present financing practices create undesirable incentives for arranging services based on each service provider's own preferences, create unnecessary distortion of competition and make it possible to shift costs to another body for payment without taking any account of the consequences for the public economy as a whole. The ultimate result has been inefficiency and unnecessary additional expenses for the economy generally.

3.4 Provider payment mechanisms changed — comparisons difficult

The methods used to pay providers changed in the 1990s. The payment mechanism types for hospitals can be grouped as follows:

A. Retrospective payment
B. Prospective payment
   1. Advance agreement on either the price of services or the amount of services.
   2. Advance agreement on the total budget for the entire period.
C. Combinations of the above systems and bonus payment for specific acts or behaviour.

Under payment system A, the service procurer pays the hospital for its services according to the real costs, which are paid as they occur. In Finland, the hospitals were funded according to this model until December 31, 1992. Since then, prospective remuneration forms have been used, i.e. advance agreement on prices or the amount of services. Prices are set in detail, often using DRG pricing. Since the cost to the buyer is the product of the price and the amount, this type of payment system only goes halfway towards effective cost management. In Finland, as in other countries, there is therefore interest in defining an advance overall budget for future hospital services (model B.2). There are several ways of doing this, for instance based on the previous year's budget. In practice, the tendency has been to shift to a capitation-based budget (section 3.5). This means that the hospital undertakes to provide the services agreed for the population specified by the buyer. The hospital is paid according to the number of people included in the target group.

The basis for the reform of hospitals' payment systems is that they should not create incentives for service providers to operate inefficiently, i.e. to keep patients in hospital needlessly or to perform unnecessary procedures.

There are several different payment types in use in different parts of Finland. This makes it more difficult for the municipalities to compare the prices of different hospitals.

3.5 Grounds for doctors' reimbursement

Reimbursement for doctors' services has features similar to the payment mechanisms for hospital services. Doctors are key decision-makers. The incentive effects of their reimbursement are therefore of considerable importance. Doctor's reimbursement could be divided into the following categories:

A. Fee-for-service
B. (Monthly) salary
C. Capitation
D. Per case payment
E. Combinations of the above and a bonus payment for specific acts or behaviour

A fee-for-service payment is common where doctors work as self-employed entrepreneurs. A monthly salary is usually paid when a doctor is employed by an organization.

Capitation means that the doctor undertakes to provide medical care for a certain number of people, and is paid a set annual fee for each person on the list, irrespective of the amount of services actually provided. In per case payment, the doctor is paid a set fee for each patient he treats. Reimbursement systems for doctors vary a lot in EU countries, and furthermore there are differences in how doctors in primary health care and specialists are reimbursed.

Each reimbursement system has features which are thought to be good or bad (Table 5). A monthly salary is considered to promote passivity. The

fee-for-service system is also being gradually abandoned. Meanwhile, capitation is becoming more common, as are various combinations of the different systems.

In 1998, the OECD recommended to Finland that the way municipal doctors are paid should be changed to comprise a combination of a monthly salary, a capitation factor and a fee-for-service system. Maintaining a significant salary component would allow the authorities to control care costs directly, while the introduction of fees-for-service would give doctors an incentive to expand the care provision inside hospitals and health centres. Capitation payments could supplement these sources of remuneration, as they would encourage doctors to establish lasting contacts with their patients.

Table 5. Strengths and weaknesses of the doctors' remuneration system

System	Strengths	Weaknesses
Fee-for-service	Doctor's earnings based on amount of work. Examinations and procedures can be itemized. Clients/patients have freedom of choice.	Cost control difficult and expensive. Incentive to unnecessary examinations and treatments. No incentive to delegate work.
Monthly salary	Administratively simple. No need to define and price individual cases or procedures. Costs known in advance. May promote regional policy aims.	Patients' wishes may go unheeded. No incentive to focus on problems of individual patients (if numerous). No incentive to strive for productivity and high standards of care. Tendency to refer patients elsewhere for further treatment. Difficult to itemize work done by doctors.
Capitation	Administratively simple. No need to define and price individual cases or procedures. Costs known in advance. May promote regional policy. Incentive to add clients to the list (if clients have the right to change doctors). Freedom of choice for clients (if they have the right to change doctors). Long-term doctor/patient relationships.	Incentive to choose low-risk clients and avoid high-risk clients. No incentive to focus on problems of individual patients (if there are many patients). Tendency to refer patients elsewhere for further treatment. Difficult to itemize work done by doctor.

Source: 'Carte blanche or good care?' Doctors' remuneration systems. Ministry of Social Affairs and Health, Reports 1999:4. (In Finnish)

3.6 Social welfare and health care staff: crucial issues

About 218,000 are employed in municipal social welfare and health care services in Finland. They are under considerable pressure due to cost cutting caused by the recession and the subsequent low level of recruitment. New operating models, quality criteria and the introduction of information technology constantly face employees with new qualification demands, though most of them are fast approaching retirement age. The aim set for personnel development in the Target and Action Plan for Social Welfare and Health Care is to improve personnel competence, ensure adequate personnel numbers and help staff cope at and stay on at work, while also expanding use of personnel accounting.

The Target and Action Plan draws attention to the fact that social welfare and health care employees need further training. According to the plan, the Ministry of Social Affairs and Health will make an allocation for additional training in the social welfare and health care sector for 2000-2003, specifically mental health work in primary health care, care for drug addicts, management training, child welfare, and care for dementia sufferers. In 2000, the Ministry allocated funding to projects such as the start of the drug abuse treatment further training programme organized by the A-clinic Foundation and further training in various levels of treatment for opioid addicts.

A study has been made of ways of supporting the municipalities in implementing permanent further training programmes for entire work communities. A proposal for social-sector centres of expertise was completed by the end of 2000. The aim is to reinforce the connection between practical social welfare work, training and research, and high-level expertise on the regional and local level.

A special committee was appointed by the Ministry of Social Affairs and Health in April 2000 to assess the adequacy of personnel levels in the social welfare and health care sector in the future. The committee is to draw up a forecast of workforce needs in the sector and, based on that, to produce an estimate of the training volumes needed in 2001-2010 and propose a workforce needs monitoring system. The forecast will cover the main occupational categories in social welfare and health care services. The committee's mandate will end in spring 2001.

Efforts to increase the proportion of permanent employment relationships in the social welfare and health care sector include revised instructions for using municipal employment subsidies. According to the new practice, a municipality receives employment subsidy for 10 months when it gives an unemployed jobseeker a permanent job.

A programme of research and action called Well-Being at Work has been drawn up in cooperation between the Ministry of Labour and the Ministry of Social Affairs and Health. In 2000, FIM 10 million had been earmarked for the programme in the State budget. Some of the funds have been spent on municipal personnel projects. The municipalities have also received

support for their own personnel projects from the National Workplace Development Programme, to which a total of FIM 36 million was allocated in 2000.

It was agreed in the income policy negotiations in November 2000 that job-alternation leave would continue according to the present model.

The Institute of Occupational Health launched an action programme in 2000 to improve working conditions, working capacity and well-being at work in the social welfare and health care sector. The programme involves training and information in addition to research projects and studies.

3.7 Experiments and development

Together with the Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health carried out a health care development project in 1997 which studied the functioning of municipal health services and possible problems related to client status, and made proposals concerning the measures needed. Based on this study, an implementation programme was then drawn up, and the Terveydenhuolto 2000-luvulle ('Health Care into the 21st Century') project was started.

Five cooperation areas were set up for implementation of the project. Regional cooperation groups are in charge of implementing the regional action programmes and of reporting to the national preparation and management groups. Implementation of measures has been integrated into hospital districts' and health centres' own development activities. All the cooperation areas have projects designed to promote the drafting of welfare programmes for individual municipalities, to improve the availability and functioning of primary health care, to eliminate overlap in specialized medical care, to construct regional information networks in health care and to introduce quality control systems. The project will continue up to the end of 2001.

The aim of the Verkostoituvat erityispalvelut ('Networking of specialized social services') project is to secure specialized social welfare services for all citizens who need them, regardless of where they live. In the second stage of the project, which started in 2000, 12 regional management groups are working in sub-regional units on organizing inter-municipal cooperation. The aim is to initiate agreement procedures which will lead to regional and provincial social welfare agreements. The production of specialized services demands specialist knowledge, which can be produced by the social welfare centres of excellence currently being planned.

A Dental Care Development Project, designed to find ways of allocating dental care services based on care needs rather than age, was started at ten different health centres in different parts of Finland in February 1998 (Hämeenlinna, Jyväskylä, Kokkola, Mikkeli, Posio, Seinäjoki, Sipoo, Vaasa, Vantaa, Uusikaupunki). In these

municipalities, studies have been made of local people's dental care needs, the time-use of dental care personnel, the dental care models used, and any management problems. The internal division of labour between personnel has also been made more efficient in all these municipalities, and the number of routine examinations of healthy people has been cut while also admitting adults with dental problems into care. The final report, including proposals for action, was scheduled for completion at the beginning of 2001.

The municipalities have been looking for new ways of arranging for both primary health care and specialized medical care. The most notable examples include an agreement between the municipality of Karjaa and Samfundet Folkhälsan concerning the provision of health care and certain social welfare services, and the Pirkanmaa model for specialized medical care agreements.

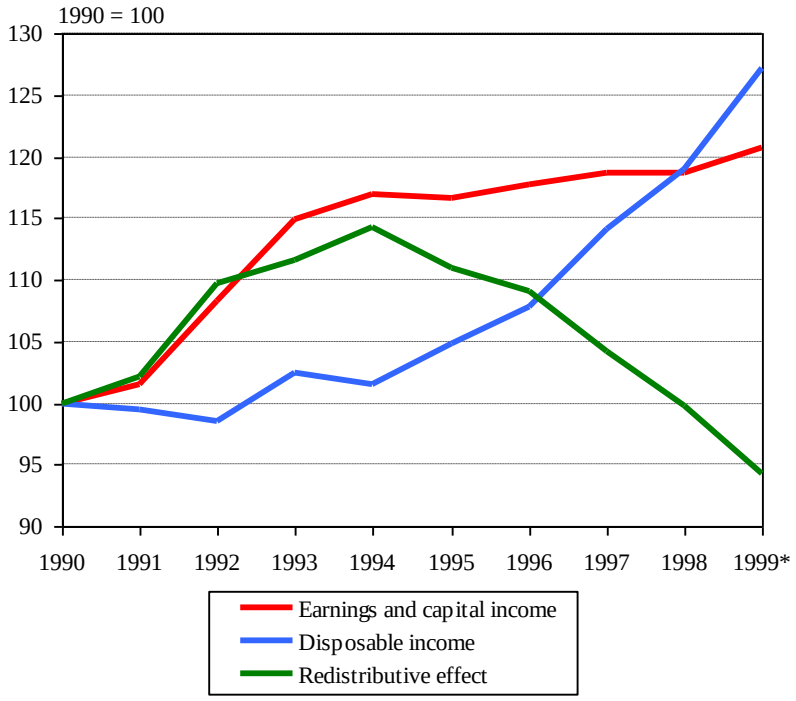
The Makropilotti project in Satakunta has progressed from the planning stage to practical tests and experiments. The project is dealt with above in the section on service provision (3.2). This gives details of the funding made possible by the 'future action package', and ways in which it can be used to introduce new technologies in the social welfare and health care sector.

4. Income distribution

Rapid increase in income differentials

Income differentials between households have grown rapidly since the mid-1990s. The income of the top tenth has increased especially fast. The equalizing effect of income transfers and taxation has weakened since the mid-90s. Where income transfers are concerned, this is partly due to the improvement in the employment situation (Figure 40).

Figure 40. Trends in income differentials and redistributive effect of income transfers, 1990-1999

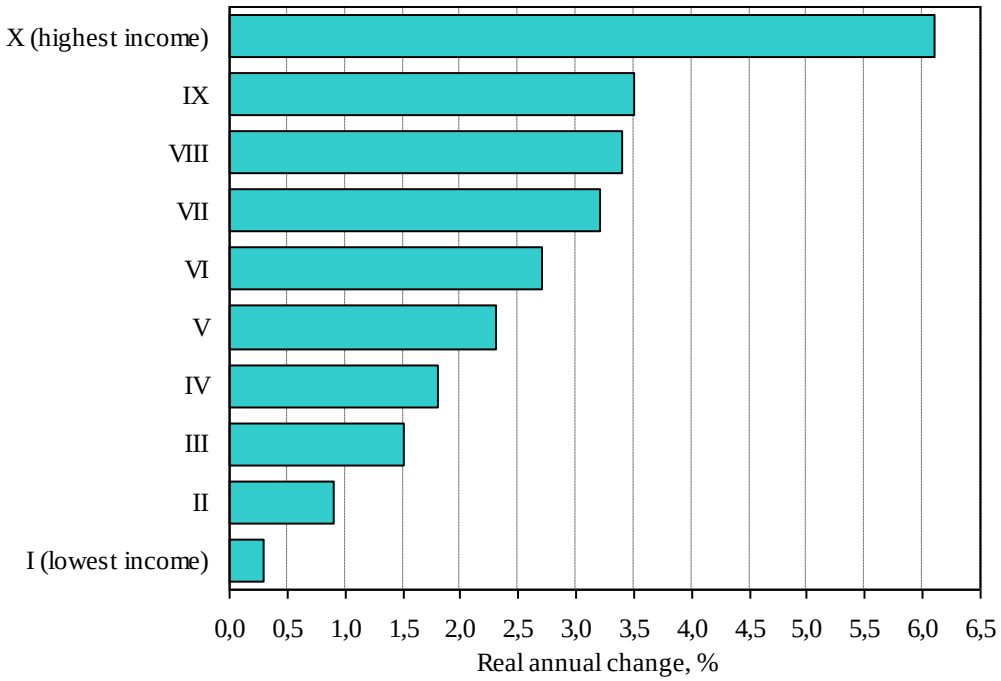


Income differentials: Gini coefficient, the higher the figure, the greater the income differentials, 1990=100. Income/OECD consumer unit. Redistributive effect (Kakwani): effective reduction of income differentials by income transfers received and paid, 1990=100.

Uneven income trend

The brisk economic growth during the last few years has not been reflected in the income of all households equally. The income trend has been most favourable in the upper income brackets, with about 6 per cent annual growth in the real disposable income of the top tenth (decile) between 1994 and 1998. In the two lowest deciles, real income growth remained below an average of one per cent per annum in the same period. According to advance information on 1999, the top decile boosted its income even further that year (Figure 41).

Figure 41. Real change in the disposable income of the income deciles from 1994 to 1998, average % per annum



Source: Statistics Finland, income distribution statistics 1998

Capital income increases income differentials

The growing income differentials in 1994-1998 was largely due to an increase in capital income and the fact that such income focused mainly on high-income households. The changes in other types of income were less conspicuous. Income transfers (excluding employment pensions) were slightly less effective in alleviating income differences. Income transfers also accounted for a lower percentage of income than during the recession. This was partly offset by the fact that they focused more than before on low-income households.

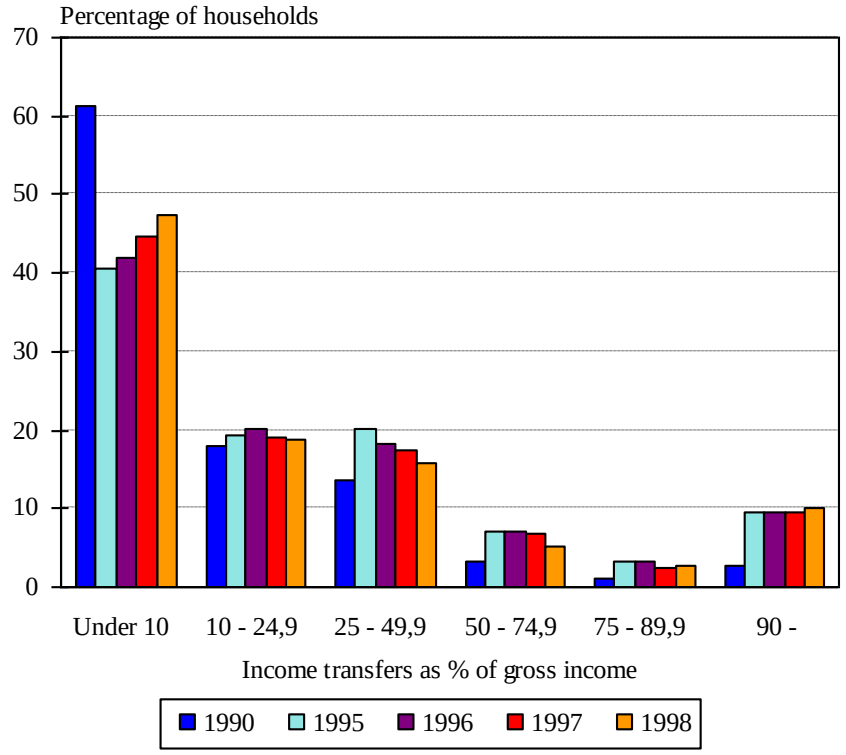
Dependence on income transfers still great

Household dependence on income transfers grew in the first half of the 1990s. More and more households comprising people of working age have come to rely largely on various income transfers. As the employment situation improved, this dependency decreased somewhat in the second half of the 1990s. Nevertheless, the number of households comprising people of working age relying almost totally on income transfers appears to have remained higher than before (Figure 42). Most of those relying almost totally on income transfers consist of single people or single-parent families, usually either unemployed or pensioners.

Income trends in different age groups

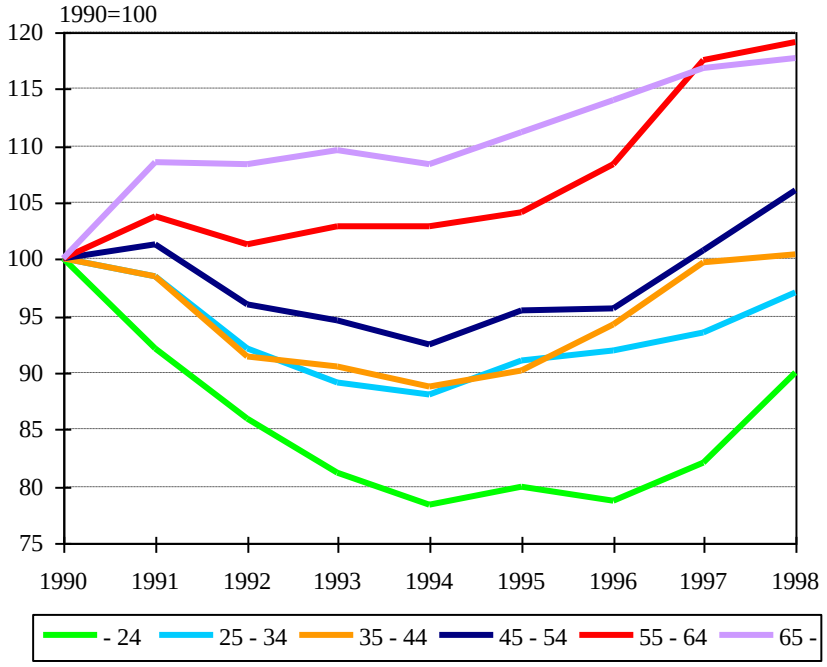
The steep economic fluctuations have been reflected in different ways in the income trends of different age groups. In the early years of the 1990s, the economic position of young people, in particular, weakened. Older age groups were less affected by the recession than people of working age. Subsequently, the income trends of different age groups have been more even. At the end of the 1990s, the incomes of elderly households increased less than those of people of working age (Figure 43). In this sense, the trend is similar to that of the 'boom years' at the end of the 1980s; the income growth of the older age groups was weaker than that of other age groups at that time, too.

Figure 42. Income transfers as a percentage of gross income in households where the reference person is aged 25-54



Income transfers received as % of gross cash income. Income transfers also include transfers between households. The reference person is generally the member of the household with the highest income.

Figure 43. Trends in average real incomes of households by age group, 1990-1998



Real disposable income, 1990=100. The figure examines only changes in income, with the index illustrating each age group's average income set at 100 in 1990. Thus, differentials in income levels between the various age groups do not come out.

Comparison of pensioners' income trends difficult

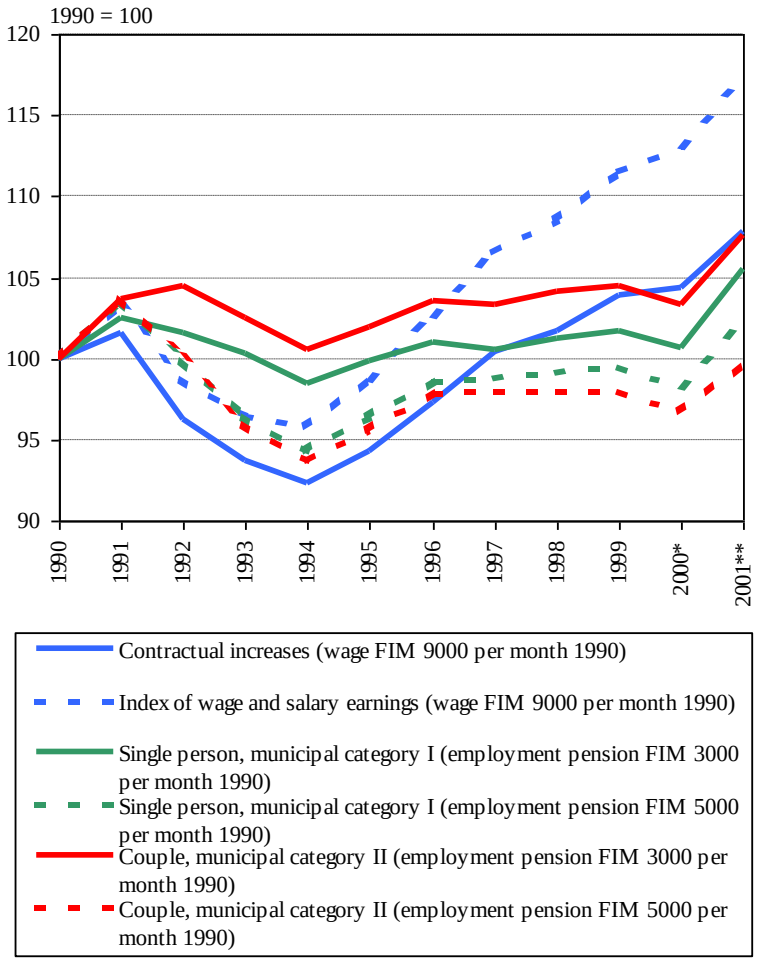
In figure 43, the incomes of elderly households are increased by the fact that new age groups with better employment pensions are retiring. The change in income thus does not describe the average income trend of the households that were in the group at the beginning of the period.

Figure 44 shows that the real change in the net income of old age pensioners in certain example cases between 1990 and 2001 was modest. On certain income levels real income even fell slightly during the 1990s. In the early 1990s the income trend was undermined by heavier taxation[4]. This applied particularly to pensioners with above-average incomes. In the second half of the 1990s, income trends were undermined by changes in the pension systems. People receiving higher employment pensions (over FIM 5000 per month) will be affected in 1996-2001 by the gradual phasing out of the basic amount of the national pension. Thus the lower taxation in the late 1990s will not be reflected as a corresponding increase in net income. The income trend of the retired spouse receiving a lower employment pension (FIM 3000 per month) is improved by the rise in spouses' national pensions in autumn 1991[5].

4 Taxes include also the national pension and health insurance contributions of the insured.

5 In evaluating annual changes in real income it should be noted that pension index adjustments are based on past development of prices and wages. In calculating the real change in income, the price change during the year in question has been taken into account.

Figure 44. Trends in the real net incomes of pensioners and wage-earners in certain example cases, 1990-2001



Pensioners who retired in 1990. Includes only standard tax deductions.

Calculations of pensioner income trends have been compared from time to time with wage-earners' income changes. There are certain problems involved in such comparisons. The income trend of old age pensioners is generally fairly steady, especially if the pensioner's main income is the pension itself. Wage-earners' incomes, meanwhile, are subject to fluctuation. Income trends can be undermined by unemployment or other career interruptions. The calculations, however, tend to assume that the wage-earner's employment continues uninterruptedly and that income rises according to the index of wage and salary earnings. The index also includes changes caused by structural factors. The income trend of wage-earners changes during their career, and that of a wage-earner nearing pensionable age and employed in the same position may be better described by the contractual wage index than by the index of wage and salary earnings.

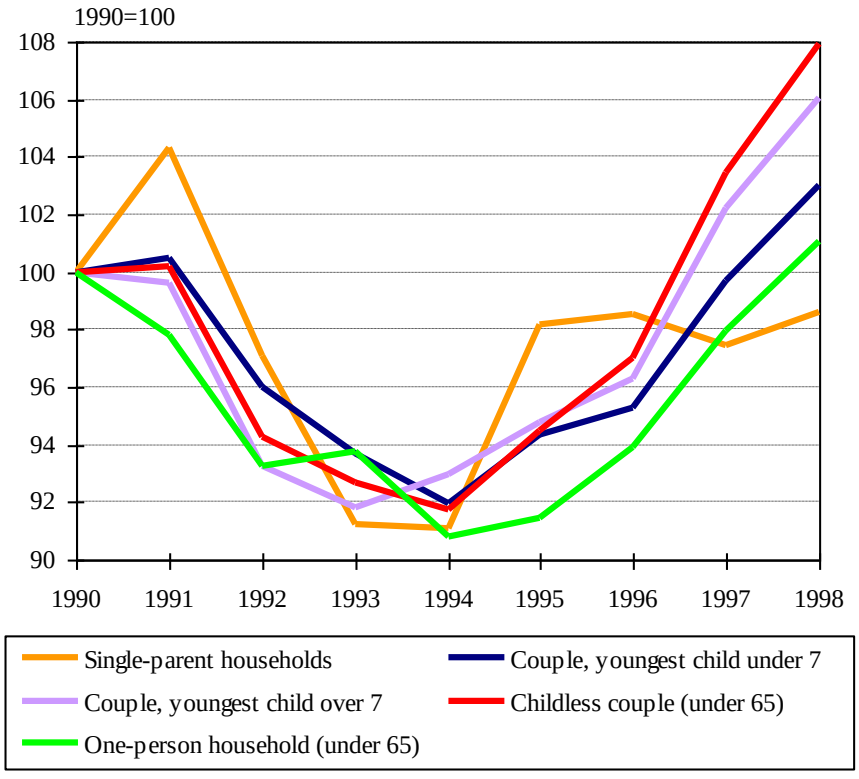
In addition to the income trend of pensioners, figure 44 demonstrates the net income trend of a wage-earner with an average income. Earnings have been raised annually either by the index of

wage and salary earnings or the change in contractual wages. The choice of index has a fairly large impact on the resulting impression of the income trend.

Modest income trend for single parents

During the recession in the early 1990s, the average real incomes of the working age population fell in all family types. Incomes did not begin to regain the pre-recession level until after the mid-1990s. Unlike the incomes of other groups, the incomes of single parents have not grown much in recent years (Figure 45). Based on preliminary information for 1999, the incomes of single parents have finally begun to improve, however. The income differentials between different family types have increased slightly since the mid-1990s. However, the income differentials between family types still accounted for a smaller proportion of the overall fluctuation in 1998 than in 1990.

Figure 45. Trends in real incomes of households of working age in different household types, 1990-1998



Real disposable income, 1900=100.
NB: Random variation in the sample data may result in overestimation of annual income changes, especially in categories with rather small sample sizes (e.g. single parents).

Increase in relative poverty

In an income distribution comparison, relative poverty is often defined as a situation in which a household's disposable income is less than half of the median for all households. Such comparison endeavours to take account of differences in household size and family type. In 1998, almost 200,000 people, or some 4 per cent of the population, belonged to households whose income was below the relative poverty line according to this definition[6]. In the mid-1990s, relative poverty began to increase noticeably.

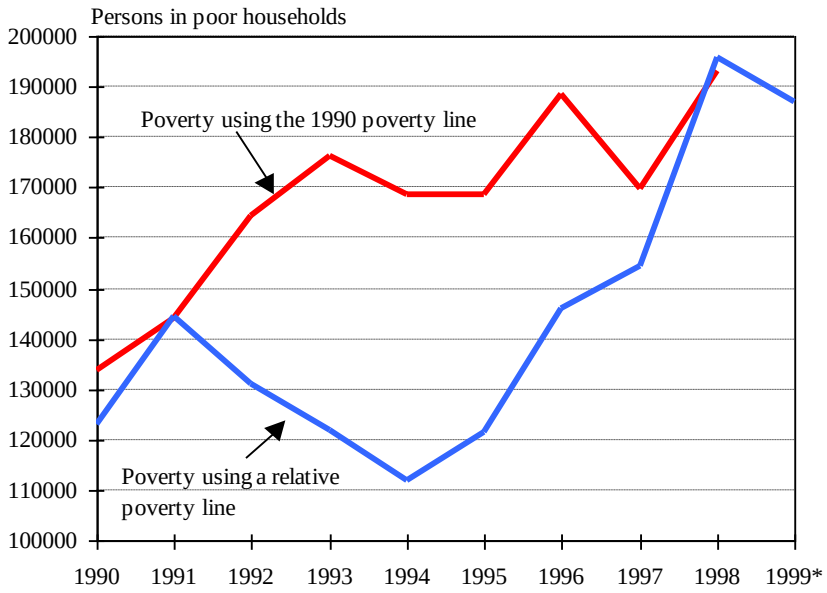
The increased incomes of economically active households and the improved employment situation boosted the average income of households and also raised the relative poverty line. At the same time, a number of benefits that are important to people with low incomes underwent actual cuts, or at least the index increases attached to the benefits were abandoned.

A different picture emerges of development in the 1990s if the 1990 poverty line is used. Based on a fixed poverty line, the poverty rate rose appreciably during the recession. The rise seemed to level off in the mid-1990s and it was hoped that the better employment situation would help further. In 1998, however, the poverty rate based on a fixed poverty line took an upward turn again (Figure 46). A possible explanation for this would be the cuts made in social assistance in 1998. Based on model calculations, these changes would appear to explain some of the growth in the poverty rate. The cuts in social assistance caused an increase in the poverty rate mainly in the case of single parents, young families with children and 30 to 64-year-olds living alone.

At the end of the 1990s, relative poverty appears to have fallen slightly, even though the good income trend for households has raised the poverty line. On this basis, poverty as defined by a fixed poverty line has fallen more noticeably.

6 Estimates of how widespread poverty depend greatly on the income limits or other definitions used. The concept of poverty also changes if household consumption data or households own assessment of financial problem are used instead of income data.

Figure 46. Poverty using a fixed and a relative poverty line, 1990-1999



Income definition: Disposable income/OECD consumption units

The figures based on a relative and a fixed 1990 poverty line are different for 1990 itself, as an adjustment was made to the 1990-1993 figures due to a revised definition of 'income'.

In the second half of the 1990s, the relative poverty rate of young adults living alone and of single parents increased particularly fast (table 6). The poverty rate of young adults living alone grew partly as a result of the higher poverty rate among the students in this category. In 1998, about 70 per cent of single young people below the poverty line were students[7]. Income transfers play a major part in the livelihood of single parents. The trends in income transfers , compared with the general income trend, have a major effect on the poverty rate of single parents.

Changes in the poverty rate and employment in various population groups are also clearly linked. Single parents have not joined the labour market at the same rate as other groups since the end of the recession. Students and unemployed people still account for a high proportion of people under 30 who live alone. The proportion of employed people has increased much faster in other family types, and no corresponding changes in the poverty rate have taken place (Figure 47).

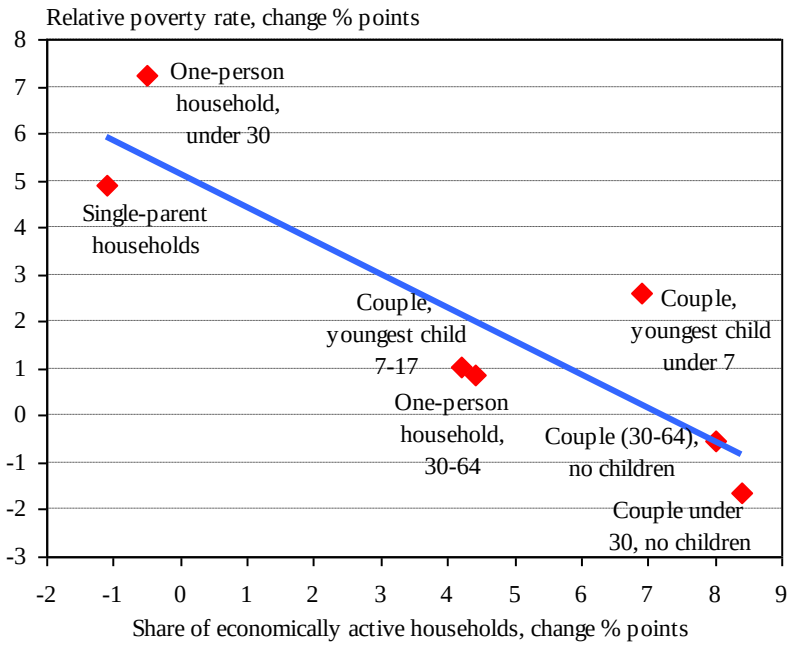
7 The low income level of students is influenced by the fact that study loans are not included in the definition of income.

Table 6. Relative poverty rate in different household types, 1994 and 1998, %
Poverty line: 50% of median income

	OECD consumption units			Eurostat consumption units		
	1994	1998	Change, % points	1994	1998	Change, % points
Single-parent households	2,8	7,7	4,9	3,4	7,0	3,6
Couple, youngest child under 7	2,3	4,9	2,6	1,5	2,4	0,9
Couple, youngest child over 7	1,3	2,3	1,0	1,1	2,3	1,1
Elderly household (over 65)	0,4	1,5	1,2	1,1	2,6	1,5
Couple under 30, no children	6,7	5,1	-1,7	7,9	6,0	-1,9
Couple (30-64), no children	1,2	0,6	-0,5	1,4	0,8	-0,6
One-person household, under 30	15,7	22,9	7,2	25,0	29,7	4,7
One-person household, 30-64	3,6	4,5	0,9	7,2	8,6	1,4
Other households	0,7	3,2	2,5	0,5	3,5	3,0
All households	**2,2**	**3,9**	**1,6**	**2,7**	**4,1**	**1,3**

Percentage of people below the poverty line in each household type.
Because of rounding, the difference between poverty rates in 1994 and 1998 may not correspond to the indicated change.
Definition of income: Disposable income of household/consumption unit
Consumption units:
Eurostat: Consumption unit scale used in the Eurostat ECHP survey
OECD: 'Old' OECD consumption unit scale used by Statistics Finland

Figure 47. Change in the share of economically active households and change in the poverty rate for certain family types from 1994 to 1998



OECD consumption units. For other definitions see table 6.

Overindebted households are one group suffering from serious financial problems that normal poverty analysis does not bring out. Like poverty, overindebtedness is very difficult to measure. Evaluations of the number of people in excessive debt, and changes in it, vary, depending on the method used. In 1998, there were about 110,000 overindebted households, measured using their own views of their indebtedness[8]. Measured in this way, the volume of indebtedness rose throughout the 1990s, and only stopped growing in 1998. The number of people with payment defaults also began to fall in 1998. The peak of new cases of payment defaults had already been reached some time before, in 1995. After a four-year falling trend, new cases of payment default began to rise again slightly at the beginning of 2000.

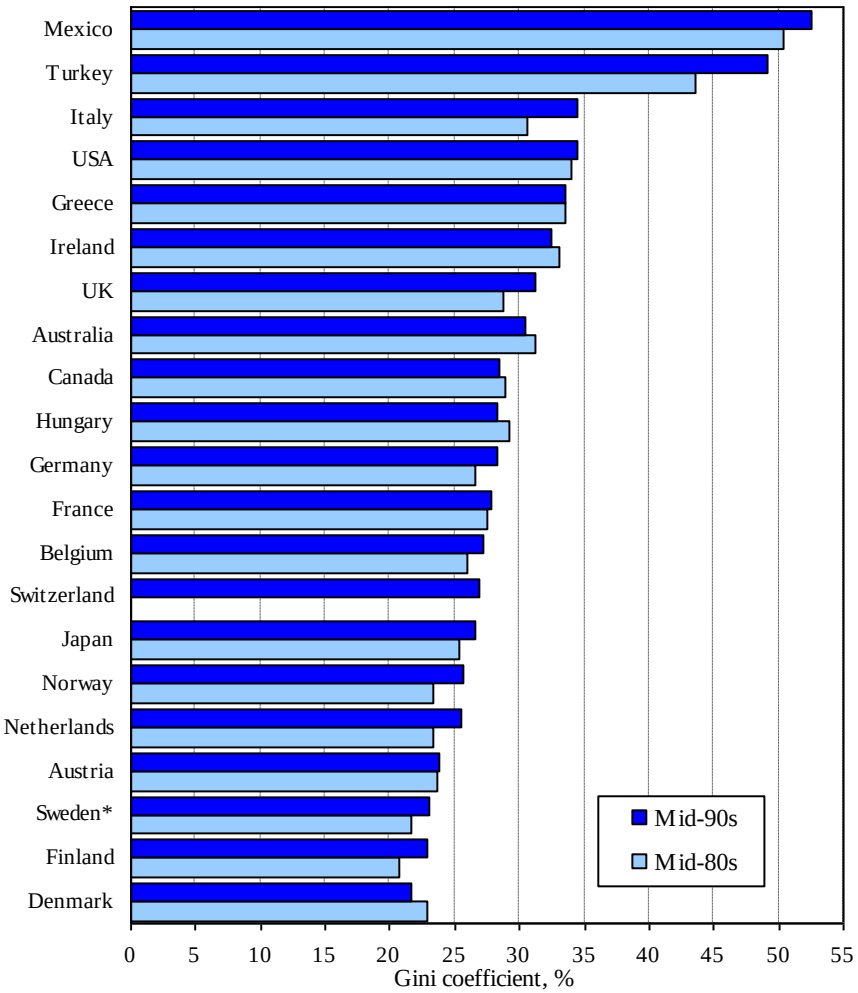
Income differentials compared with other countries

Compared with most other OECD countries, income differentials in Finland are still relatively small. The most recent international comparisons only go as far as the mid-1990s, however. The rapid growth in income differentials in Finland in the second half of the 1990s is thus not yet visible in international comparisons (Figure 48).

The smaller income differentials in Finland and the other Nordic countries are partly the result of the equalizing effect of social security benefits and taxation. Measured by earnings and capital income, income differentials are roughly in the same class as in many other OECD countries. The redistributive effect of income transfers and taxation varies, both within the Nordic countries and in other OECD countries.

8 Interviews were carried out at the beginning of 1999, but the question concerning overindebtedness applied to 1998.

Figure 48. Income differentials and trends in certain OECD countries
Disposable income



* Different definition of household (overestimates income differentials compared with e.g. Finland)
Source: OECD

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APPENDIX 1

SOCIAL PROTECTION INDICATORS

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000**	2001**
I Social protection expenditure and financing												
Social protection expenditure												
Social protection expenditure, FIM million	131 407	148 961	163 657	170 463	176 589	179 564	185 272	185 988	187 799	189 400	193 400	201 400
GDP, FIM million	523 034	499 357	486 923	492 609	522 309	564 566	585 865	635 532	689 523	721 958	787 885	841 500
Social protection expenditure/GDP	25,1	29,8	33,6	34,6	33,8	31,8	31,6	29,3	27,2	26,2	24,5	23,9
Social protection expenditure, FIM/inhabitant at 1999 prices	31 648	34 233	36 492	37 068	37 826	37 941	38 806	38 385	38 104	37 899	37 323	37 990
Social protection expenditure by target group:												
- sickness and health care	27,5	25,9	22,7	20,7	19,7	20,3	20,7	21,3	22,0	22,5	23,4	23,7
- disability	15,0	14,8	14,7	14,7	14,5	14,5	14,3	14,3	13,9	13,6	13,1	12,8
- old age	28,6	27,8	27,3	27,5	27,3	28,1	29,0	29,1	29,5	30,3	30,6	31,2
- survivors	4,0	3,9	3,9	3,9	3,8	3,8	3,8	3,9	3,9	3,9	4,0	4,0
- families and children	13,0	12,9	12,5	11,8	13,3	13,0	12,1	12,3	12,4	12,2	12,1	11,8
- unemployment	5,9	8,5	12,8	15,6	15,2	14,0	13,5	13,0	11,7	10,9	10,7	10,4
- housing	0,7	0,9	1,1	1,1	1,4	1,5	1,2	1,2	1,4	1,6	1,4	1,3
- other	1,8	2,1	2,2	2,0	2,0	2,0	2,3	2,4	2,1	2,0	1,9	1,9
- administration	3,5	3,0	2,8	2,6	2,8	2,8	3,1	2,7	3,1	2,8	2,8	2,8
- total	100	100	100	100	100	100	100	100	100	100	100	100
Contributions to the financing of social protection expenditure, %												
- Central government	25,0	28,8	29,4	30,3	30,4	29,1	28,3	26,9	25,5	24,6	24,1	23,4
- local authorities	15,6	15,3	15,2	15,1	15,9	16,7	16,2	17,3	18,2	17,5	17,6	17,6
- employers	44,1	40,9	36,7	34,7	33,0	33,7	35,3	35,5	36,6	36,7	37,2	37,9
- the insured	8,0	7,2	10,4	12,3	14,3	13,7	13,1	13,4	12,9	13,0	12,8	12,2
- property income	7,3	7,8	8,3	7,6	6,4	6,9	7,2	6,8	7,3	8,2	8,2	8,9
- total	100	100	100	100	100	100	100	100	101	100	100	100
The Ministry of Social Affairs and Health's main division expenditure in the State budget												
Ministry of Social Affairs and Health's main division expenditure, FIM million	38 961	51 775	53 858	53 814	53 541	49 027	47 983	45 124	44 998	41 930	43 491	45 093
Government grant to municipalities for operating costs of social services and health care, FIM million	19 498	21 387	21 133	20 568	18 409	17 942	15 945	13 557	12 857	12 690	13 035	13 868
Ministry of Social Affairs and Health's main division expenditure as a percentage of total government expenditure	27,7	30,8	28,9	26,6	27,0	24,7	24,1	24,1	22,1	19,8	21,8	22,8

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000**	2001**
Expenditure of municipals												
Municipal operating costs, on health care and social services, FIM million	41 099	45 632	47 486	50 010	50 358	52 746	55 448	57 712	58 870	60 655	63 000	65 500
Municipal social services and health care personnel												
Social services and health care personnel	206 700	213 650	212 700	202 700	205 700	205 100	216 050	220 400	220 450	217 700	216 000	217 000
Government debt												
Government debt, % of GDP	11	18	34	53	59	64	67	65	60	56	50	46
II SICKNESS AND HEALTH CARE												
Sickness and health care expenditure (net), FIM million	36 123	38 639	37 204	35 372	34 867	36 529	38 422	39 695	41 279	42 700	45 200	47 800
Cash benefits	7 949	8 248	7 659	6 953	6 809	7 142	7 261	7 493	7 951	8 600	8 900	9 500
- daily sickness allowance	3 063	3 341	3 172	2 683	2 620	2 523	2 373	2 384	2 509	2 700	2 900	3 000
- sick pay	4 100	4 100	3 700	3 600	3 500	3 900	4 200	4 400	4 700	5 100	5 200	5 600
Services (net)	28 174	30 391	29 545	28 419	28 058	29 387	31 161	32 202	33 328	34 000	36 250	38 300
- primary health care	11 178	12 149	11 887	9 161	9 347	9 660	10 153	9 887	10 196	10 300	10 900	11 550
- specialized health care	12 266	12 940	12 083	13 546	12 945	13 631	14 459	15 154	15 703	16 000	17 000	17 950
- sickness insurance	2 893	3 264	3 240	3 292	3 560	3 910	4 346	4 681	4 870	5 150	5 600	6 250
Life expectancy and infant mortality												
Life expectancy, years												
- men	70,9	71,3	71,7	72,1	72,8	72,8	73,0	73,4	73,5	73,7		
- women	78,9	79,3	79,4	79,5	80,2	80,2	80,5	80,5	80,8	81,0		
Infant mortality (1/1000)	5,6	5,9	5,2	4,4	4,7	3,9	4,0	3,9	4,2	3,6		
Morbidity												
Recipients of daily sickness allowance	397 900	385 100	355 100	293 300	283 200	284 400	275 000	271 800	278 100	286 900	284 600	281 400
Absences due to sickness as percentage of total working days, %	3,8	3,7	3,4	3,8	3,5	3,5	3,4	3,4	3,4	3,5		
Number of persons caught an occupational disease	9 100	8 800	8 000	7 000	6 700	5 800	5 700	5 000	4 800	5 200		
Prescriptions/inhabitant	6,1	6,3	6,0	5,9	5,7	6,0	6,3	6,4	6,6	6,8		
Bed-days and discharges of health care												
Primary health care, wards												
- discharges/1,000 inhabitants	51	42	46	48	51	52	58	57	59	60		
- bed days/1,000 inhabitants	1 676	1 538	1 544	1 525	1 542	1 571	1 620	1 575	1 592	1 568		
Specialized health care, wards												
- discharges/1,000 inhabitants	162	173	179	182	183	187	193	194	191	189		
- bed days/1,000 inhabitants	1 552	1 578	1 464	1 359	1 294	1 242	1 190	1 158	1 093	1 049		

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
Reimbursements of National health insurance, number of refunds												
- medicines, basic refund category	3 127	3 212	3 117	3 057	2 954	3 056	3 123	3 133	3 098	3 136	3 255	3 350
- medicines, special refund category (75%)	641	666	687	707	708	695	708	720	730	737	755	770
- medicines, special refund category (100%)	290	303	319	336	340	330	337	345	353	361	375	380
- private doctors' services	1 481	1 484	1 340	1 326	1 262	1 302	1 340	1 333	1 360	1 361	1 370	1375
- private dentists' services	167	201	215	241	253	269	288	382	666	467	470	500
- private examinations and treatments	845	845	729	685	635	634	661	675	715	718	720	730
- transportation sevices	723	722	640	485	507	521	553	558	561	564	575	580
Refunded expenditure as a % of medical expenses												
- medicines (basic refund category)	37	38	38	29	35	38	39	40	40	41	41	42
- private doctors' services	38	36	36	36	36	38	40	39	38	37	37	36
- private dentists' services	57	54	54	57	56	53	50	49	49	47	46	46
- private examinations and treatments	40	38	38	38	40	42	43	43	43	42	41	41
- transportation sevices	82	83	83	82	84	85	85	86	86	86	83	83
III DISABILITY												
Expenditure on disability, FIM million	19 691	22 090	24 033	25 030	25 582	26 124	26 440	26 554	26 157	25 700	25 400	25 800
Cash benefits	16 461	18 435	20 370	21 246	21 470	21 783	21 792	21 648	20 872	20 300	19 750	19 800
- disability pensions	11 113	11 961	12 702	13 125	13 166	13 422	13 633	13 925	13 586	13 500	13 200	13 400
- individual early retirement pensions	2 089	2 834	3 424	3 814	4 078	4 242	4 050	2 624	3 120	2 750	2 400	2 200
- military injuries indemnities	1 740	1 976	2 138	2 024	1 779	1 756	1 712	1 699	1 655	1 500	1 400	1 350
Services (net)	3 230	3 655	3 663	3 784	4 112	4 341	4 648	4 906	5 284	5 400	5 700	6 000
- institutional care for the disabled	896	966	927	944	892	801	780	789	763	750	750	750
- services for the disabled	1 021	1 207	1 250	1 306	1 566	1 765	2 164	2 454	2 672	2 800	2 900	3 000
- rehabilitation	829	956	948	1 084	1 173	1 191	1 104	1 132	1 308	1 400	1 500	1 500
Disability pensions												
Recipients of disability pensions on December 31	300 930	305 410	308 540	309 730	310 630	309 510	301 780	294 990	288 050	282 050	276 700	271 500
Services for the disabled												
Disabled persons in institutional care on December 31	4 390	4 850	4 870	3 630	4 000	3 770	3 650	3 370	3 200	3 000	2 800	2 700
Households with a disabled person receiving home help services during the year	7 920	6 780	7 090	6 120	6 210	7 000	6 950	6 615	6 290	6 580	6 600	6 600

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
IV OLD AGE												
Expenditure on old age, FIM million	37 529	41 472	44 683	46 856	48 153	50 420	53 697	54 081	55 463	57 400	59 100	62 800
Cash benefits	33 547	37 217	40 480	42 463	43 660	45 472	48 321	48 771	50 024	51 900	53 300	56 600
- old age pensions	31 790	35 199	38 339	40 138	41 425	43 240	45 169	46 617	47 892	49 600	50 900	53 900
Services (net)	3 982	4 255	4 203	4 393	4 493	4 948	5 376	5 310	5 439	5 500	5 800	6 100
- institutional care for the elderly	2 431	2 611	2 530	2 671	2 667	2 865	2 888	2 701	2 727	2 750	2 800	3 000
- open care of the elderly	1 551	1 644	1 673	1 722	1 826	2 083	2 488	2 609	2 712	2 750	2 800	3 100
Pensioners												
Recipients of old age pensions, December 31st	737 150	750 900	762 570	776 810	789 390	804 060	822 520	836 700	843 900	858 200	860 500	875 000
Recipients of part-time pensions, December 31st	430	700	1 210	2 260	4 470	5 440	6 100	6 930	10 920	18 284	24 800	32 000
Services for the elderly												
Persons in old people's homes on December 31st	26 620	25 820	25 350	24 210	23 410	22 950	22 910	22 270	21 420	21 070	21 000	21 000
Elderly households receiving home-help services	124 010	122 720	103 780	99 100	91 680	86 750	87 410	85 400	84 820	84 280	85 000	86 000
Elderly clients receiving auxiliary services during the year	200 170	113 910	128 000	109 720	93 950	97 970	99 210	103 300	105 620	103 420	104 000	105 000
V SURVIVORS												
Expenditure on survivors, FIM million	5 291	5 854	6 345	6 648	6 720	6 800	6 984	7 181	7 254	7 500	7 700	8 100
- survivors' pensions	4 994	5 534	6 003	6 337	6 438	6 528	6 754	6 941	7 014	7 200	7 450	7 800
Recipients of survivors' pensions on December 31st												
- widows' and widowers' pensions	194 780	203 720	212 430	220 040	225 050	230 830	238 380	243 450	247 550	250 300	262 300	270 800
- children's pensions	28 430	28 740	29 080	29 530	29 630	29 340	29 250	29 340	28 880	28 250	28 250	28 200
VI FAMILIES AND CHILDREN												
Expenditure on families and children, FIM million	17 118	19 268	20 445	20 086	23 441	23 307	22 448	22 808	23 297	23 150	23 300	23 800
Cash benefits	9 930	11 538	13 106	12 838	16 204	15 549	13 924	13 874	14 007	13 900	14 000	14 100
- parents' allowance	3 314	3 585	3 774	3 416	3 130	3 016	2 773	2 733	2 713	2 800	2 800	2 900
- home care allowances	2 234	2 650	3 212	3 229	3 274	3 053	2 042	2 076	2 231	2 160	2 150	2 200
- child allowance	4 094	4 791	5 549	5 539	9 101	8 768	8 398	8 384	8 353	8 300	8 200	8 150
Services (net)	7 188	7 730	7 339	7 248	7 237	7 758	8 524	8 934	9 291	9 250	9 300	9 700
- child day care	5 872	6 292	5 895	5 553	5 527	5 946	6 589	6 894	7 127	7 000	7 000	7 200
Recipients of parents' allowance during the year												
- mothers	54 910	56 320	57 660	57 070	55 210	53 340	51 570	49 870	48 430	48 960	48 500	48 000
- fathers	1 300	1 870	1 850	2 050	2 210	1 930	2 210	2 030	2 190	2 810	2 700	2 600
Families receiving home care allowance on December 31st	81 210	85 210	92 570	95 820	95 380	84 480	73 980	75 490	74 360	73 030	70 000	69 000
Children in municipal day care on December 31st	200 200	195 500	182 300	174 300	180 800	189 900	217 300	219 700	218 500	215 100	213 000	210 000

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
VII UNEMPLOYMENT												
Unemployment expenditure, FIM million	7 723	12 724	20 973	26 611	26 892	25 093	25 099	24 143	21 888	20 800	20 650	21 000
Cash benefits	6 559	11 398	19 388	25 047	25 095	25 549	23 186	22 111	19 929	18 950	18 900	19 300
- basic daily allowance	860	2 321	4 464	5 789	5 133	2 703	939	818	606	520	500	500
- earnings-related daily allowance	2 231	5 698	10 897	15 177	14 855	13 001	12 958	11 847	9 458	8 390	8 250	8 200
- labour market support	0	0	0	0	1 307	4 089	5 327	5 117	5 357	5 310	5 100	5 050
- unemployment pensions	2 644	2 481	2 329	2 313	2 373	2 432	2 397	2 683	2 986	3 350	3 700	4 200
- labour market training benefits	739	671	1 142	1 274	1 108	1 130	1 308	1 327	1 152	950	880	900
Services	1 164	1 326	1 585	1 564	1 797	1 544	1 913	2 032	1 959	1 850	1 750	1 700
- labour market training for adults	703	778	1 040	1 026	1 217	937	1 283	1 381	1 201	1 050	1 050	1 000
Unemployment rate												
Unemployment rate, %	3,1	6,8	11,7	16	16,6	15,4	14,6	12,7	11,4	10,2	9,6	8,6
Number of unemployed persons, average	82 000	169 000	292 000	405 000	408 000	382 000	363 000	314 000	285 000	261 000	250 000	235 000
Recipients of daily unemployment allowances, during the year												
Earnings-related daily unemployment allowance	171 300	339 100	489 300	596 200	544 400	468 200	468 800	418 300	369 800	334 800	318 000	305 400
Basic daily unemployment allowance	126 100	236 800	325 900	363 100	280 500	215 300	93 600	58 900	50 800	45 700	42 100	39 100
Labour market support	0	0	0	0	123 600	270 000	314 900	308 600	322 600	311 800	307 500	294 100
Unemployment pensions												
Recipients of unemployment pensions on December 31	55 490	47 780	43 720	42 790	42 960	39 150	41 410	44 860	49 390	52 240	54 600	57 100
VIII HOUSING												
Expenditure on general housing allowance, FIM million	957	1 280	1 862	1 900	2 444	2 623	2 299	2 169	2 615	2 870	2 700	2 500
Recipients of general housing allowance (on December 31, households)	110 490	146 270	192 830	182 370	227 560	213 820	191 880	184 610	205 590	207 000	170 000	164 000
IX OTHER												
Main category of other expenditure												
Expenditure on other, FIM million	2 387	3 142	3 571	3 457	3 515	3 658	4 220	4 443	3 991	3 800	3 800	3 800
Cash benefits	1 238	1 745	2 127	2 375	2 467	2 614	3 072	3 213	2 661	2 350	2 350	2 350
- social assistance (net)	1 085	1 413	1 665	2 005	2 308	2 493	2 906	3 039	2 558	2 380	2 380	2 380
Services (net)	1 149	1 397	1 444	1 082	1 048	1 044	1 148	1 230	1 330	1 450	1 450	1 450
- care for alcoholics and drug abusers	448	505	403	362	387	408	437	452	436	450	470	500

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
Social assistance												
Households receiving social assistance during the year	181 600	222 700	258 900	292 600	329 400	339 000	349 600	344 700	313 400	292 000	273 000	270 000
Average duration, months	3,9	3,9	3,9	4,3	4,8	5,1	5,4	5,6	5,4	5,4	5,3	5,2
Alcohol, tobacco, drugs												
Daily smokers, percentage on 15-64 year-olds												
- men	33	33	33	29	29	28	28	30	30	27		
- women	20	21	21	19	19	19	19	20	20	20		
Alcohol consumption, l/inhabitant												
- in official statistics	7,7	7,4	7,2	6,8	6,6	6,7	6,7	6,9	7,0	7,1		
- illicit	1,2	1,3	1,3	1,4	1,4	2,1	2,1	1,9	1,8	1,7		
- total	8,9	8,7	8,5	8,2	8,0	8,8	8,8	8,8	8,8	8,8		
Drug-related crimes	2 500	2 500	3 300	4 000	5 700	9 100	7 900	8 300	9 500	9 300		
X POPULATION AND INCOME												
Income												
Disposable income per capita, FIM at 1999 prices	66 400	66 800	65 100	61 100	59 100	63 700	63 300	66 900	69 200	71 400	72 000	
Income differentials												
(Gini coefficient, the higher the figure the greater the differential, 1990=100)	100	102	108	115	117	117	118	119	119			
Factor income (earned income + capital income)	100	98	99	102	101	104	106	110	114			
Gross income (factor income + income transfers received)	100	100	99	102	101	105	108	114	119			
Disposable income (gross income - taxes)	100	104	97	91	91	98	99	97	99			
Disposable real income, 1990=100	100	101	96	94	92	94	95	100	103			
Single parents	100	100	93	92	93	95	96	102	106			
Other families with children (youngest child under 7)	100	109	109	110	108	111	114	117	118			
Other families with children (youngest child over 7)	100	100	94	93	92	94	97	103	108			
Elderly households (over 65)	100	98	93	94	91	91	94	97	103			
Childless couples (under 65)	100	102	97	95	95	98	100	105	108			
Single persons (under 65)												
Others												
Poverty rate												
(Percentage of persons living in households whose disposable income is less than 50% of the median disposable income for all households)												
Poverty rate	2,5	2,9	2,6	2,4	2,2	2,4	2,9	3,0	3,9	3,7		

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
XI SOCIAL INSECURITY												
Suicides, accidental deaths and violent crimes												
(Average per 100,000 people; violent crimes include murders, manslaughters and assaults)												
Suicides	30,3	29,8	28,8	27,6	27,3	27,2	24,3	25,7	23,8			
Accidental dealths	56,5	55,7	53,7	50,8	50,8	51,8	50,3	53,1	55,1			
Violent crimes	3,2	3,1	3,4	3,3	3,2	2,9	3,3	2,8	2,4			
Divorce and abortions												
(Divorces per 1,000 married women; abortions per 1,000 women aged 15-49)												
Divorces	12,6	12,3	12,5	12,4	13,4	13,9	13,6	13,4	13,8	14,0		
Legal abortions	9,7	9,3	8,7	8,1	7,9	7,8	8,3	8,2	8,7	8,8		
Children and young people placed outside home and in open-care												
Placements outside home												
- total	..	8 720	9 410	9 670	10 210	10 700	11 120	11 760	12 130	12 370		
- of which taken into custody	..	6 203	6 382	6 393	6 403	6 478	6 474	6 803	7 144	6 861		
Children and young people in open-care												
- total	..	..	..	24 690	27 820	30 690	33 270	35 810	38 630	43 680		
Recipients of maintenance support												
Children receiving maintenance support	73 090	78 730	85 580	92 590	98 480	103 100	106 810	107 900	108 500	108 960	109 000	109 000

*) forecast/estimate

Sources: Ministry of Social Affairs and Health
Statistics Finland
SOTKA database
National Research and Development Centre for Welfare and Health (Stakes)
Institute of Occupational Health
Central Pension Security Institute
Social Insurance Institution

APPENDIX 2

Average pension and social insurance contributions[1]

	1992	1993	1994	1995	1996	1997	1998*	1999*	2000*	2001**
EMPLOYERS										
National pension insurance [2]	2,94	3,20	3,41	3,39	3,45	3,24	3,25	3,23	3,18	3,1
Sickness insurance [2]	1,56	1,90	1,91	2,05	2,05	1,74	1,74	1,70	1,70	1,7
Unemployment insurance [2], [3]	3,70	5,60	5,40	4,50	2,90	2,90	2,78	2,79	2,55	2,3
Employment pension insurance [4]	14,40	15,50	15,60	16,60	16,80	16,70	16,80	16,80	16,80	16,6
Municipal pension insurance	19,10	17,20	18,90	20,30	21,00	20,80	21,10	21,40	21,70	22,0
INSURED GROUPS										
Wage-earners	5,25	6,90	8,32	8,32	7,70	7,90	7,60	7,55	7,20	6,9
national pension insurance	3,05	1,80	1,55	0,55	0,00	0,00	0,00	0,00	0,00	0,0
sickness insurance [5]	2,20	1,90	1,90	1,90	1,90	1,90	1,50	1,50	1,50	1,5
unemployment insurance	0,00	0,20	1,87	1,87	1,50	1,50	1,40	1,35	1,00	0,7
employment pension insurance	0,00	3,00	3,00	4,00	4,30	4,50	4,70	4,70	4,70	4,5
Retired persons	**5,25**	**6,70**	**7,45**	**6,45**	**4,90**	**4,90**	**4,20**	**3,90**	**3,20**	**2,7**
national pension insurance	3,05	2,80	2,55	1,55	0,00	0,00	0,00	0,00	0,00	0,0
sickness insurance [5]	2,20	3,90	4,90	4,90	4,90	4,90	4,20	3,90	3,20	2,7

(1) Annual average. Employers' contributions and unemployment and employment pension insurance contributions paid by the insured as a percentage of salaries. National pension and sickness insurance contributions paid by the insured as the number of pennies out of each tax unit.

(2) The average weighted with the total payroll in the various payment categories.

(3) The progressive employers' unemployment insurance contribution introduced during 1993. The level is 3.75% of the salary if the annual total payroll is less than FIM 1 million; for larger amounts the contribution is 6% of the total. The contributions for 1994-1999 are as follows:

- In 1994, the contribution was 3% for the first FIM 1 million total payroll, otherwise 6.3%.
- In 1995, the contribution was 2% for the first FIM 5 million total payroll, otherwise 6.1%.
- In 1996-97, the contribution was 1% for the first FIM 5 million total payroll, otherwise 4%.
- In 1998, the contribution was 0.9% for the first FIM 5 million total payroll, otherwise 3.9%.
- In 1999, the contribution was 0.9% for the first FIM 5 million total payroll, otherwise 3.85%.
- In 2000, the contribution was 0.9% for the first FIM 5 million total payroll, otherwise 3.45%.
- In 2001, the contribution is 0.8% for the first FIM 5 million total payroll, otherwise 3.1%.

(4) Employment pension contribution

(5) Contribution percentage in the table up to 80,000 tax units. A surcharge was levied on amounts in excess of 80,000; the contributions were as follows in 1992-99: 1.5%/1992-93, 1.9%/1994-95, 1.45%/1996 and 0.45%/1997-98. The surcharge will no longer be in effect after the beginning of 1999.