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Summary
By virtue of the decisions by the Social Protection Committee, the Council, and the European Council, the European Union Member States compile national reports on strategies for social protection and social inclusion for years 2006–2008. For the first time, the national strategies and activities regarding prevention of poverty and exclusion, the pension system, health care, and long-term medical care are reviewed in one report. The completion of the national reports is a prelude to the compilation of a joint report by the Commission and the Member States for the Spring European Council in 2007.
The structures and contents of the national strategies of different Member States has been harmonised with the help of recommendations for the facilitation of mutual learning and comparison. In a meeting in March 2006, the Social Protection Committee agreed on the timetable, common goals and guidelines for the national reports on strategies for 2006–2008. Regarding the promotion of social protection and social inclusion, the streamlined strategies, the focus on the presentation of main objectives, and the extent to which the objectives are realised were highlighted. Reviewing the different spheres of social protection in a combined manner is aimed at improving the coordination and visibility of operations. Social protection objectives should be considered in the national policy coordination in connection with the Lisbon process.
The report has been compiled under the direction of the Ministry of Social Affairs and Health. The contents have been produced by different ministries, the social partners, the Association of Finnish Local and Regional Authorities, the Evangelical Lutheran Church, representatives of NGOs, Statistics Finland, and National Research and Development Centre for Welfare and Health (Stakes). Several experts have commented on the report, and the contents have been approved by the section for the preparation of social issues in the EU and by the Ministry executive. A separate consultation event was arranged for NGOs with regard to poverty and social exclusion.
The strategy is based on the existing policy definitions under the Open Method of Coordination for social protection and social inclusion, the effective Government Programme, and strategic development programmes of different actors. The Finnish policies on social protection and social inclusion are based on the principles of the Nordic Welfare State, which include universal services and adequate social security. Extensive social and health policies prevent inequalities. Different spheres of social policies aim at preventing risks of social exclusion and improving the health and functional capacity of the population. Promoting employment is still a significant challenge. The strategy describes the recent core decisions and measures that aim at achieving the set goals. The proposed reforms improve the functioning and effectiveness of welfare services and safeguard social security financing. The results will be measured by using the indicators described in the report. The report also includes examples of good practices.

Key words
Poverty, social exclusion, Social Protection Committee, health policy, pensions policy

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PART 1 General overview

1.1 Assessment of the Social Situation

The economic development of Finnish society has been fairly positive since the mid-1990s. The recession at the turn of the millennium proved to be a temporary setback, since which economic growth has been moderate. Overall, the public economy shows a surplus, and currently central government finances, which encountered deep deficit in the mid-1990s, also show a surplus. An important factor, which increases the stability and surplus of the public economy, is the earnings-related pension scheme that is partially based on funding. Finland meets the requirements of the Stability and Growth Pact. Given the economic forecasts, Finland's economic development should be favourable, although growth is expected to slow to a certain degree, along with, for example, the ageing of the population and the shift toward a service-oriented industrial structure. The greatest threats are related to the international rather than the national operating environment. The most concern is caused by the dual deficit in the US economy and the sustainability of Chinese economic growth. In Europe, structural economic rigidness and the ageing population pose problems.

Also, employment has increased steadily. Especially in 2005, the development of employment was favourable, which resulted in a labour shortage in certain industrial and service sectors. On the other hand, despite the favourable trends, employment rates are still below the levels they reached prior to the deep recession of the early 1990s. Long-term unemployment is still an important, though diminishing, challenge among some young unemployed groups and those nearer to old age. Furthermore, seeking a disability pension is still a key challenge.

Recently, adaptation to structural change arising from the globalisation of the goods, services, and capital market and European competition has become a key issue in social policy. The change in international operating environment has had a reflection on, for example, some traditional sectors of industry, such as the paper industry, where some significant layoffs have been enforced recently. The structural change has heightened the significance of redundancy protection in society and launched an extensive social debate on the principles and targets of the labour market and employment policy.

Gender equality is an important requirement for social inclusion and economic growth. Finland has a century-long tradition of equal and universal suffrage and the right to stand for election, which has furthered women's participation in political decision-making. Economic decision-making is still male-dominated.

The Finnish workforce is divided almost equally between women and men. Mothers of small children also work outside the home. In Finland, it has been possible to simultaneously instigate high employment among women and a relatively high birth rate. The children's day-care and family leave system supports either one or both parents working. However, the employment market is strongly divided into women's

and men's sectors/occupations. The gender pay gap has hardly diminished in the past decades. Women work part-time more than men, and women are also employed under fixed-term contracts more often than men. In Finland, parents do not often choose part-time work as a way of balancing childcare and work. On average, unemployment is still equally common among women and men. However, the majority of the structurally and long-term unemployed are men. Most individual recipients of social assistance are men, while most of the single parents receiving this form of support are women. The majority of those receiving the basic unemployment allowance, labour market subsidy, and earnings-related allowance are men.

The deepening of social divisions can be regarded as a key social challenge. These divisions are connected with, e.g., tensions between the rise in average affluence and the relatively low income level in some groups. Key problems include long-term unemployment, which is still a sizeable problem despite a reduction in unemployment, and the relative poverty among families with children, which has increased in the past decade. The increase in relative poverty and social exclusion is connected not only with unemployment but also with the relatively low level of fixed benefits (e.g., labour-market subsidy) and last-resort (housing benefit and social assistance) benefits. The number of people receiving social assistance, the last-resort social security benefit in Finland, has fallen steadily. Social divisions in health between socio-economic groups, assessed in terms of experienced health, have also remained unchanged for more than 25 years (1979–2004). Socio-economic differences in life expectancy have increased further in Finland. This is often associated more with lifestyle differences (consumption of fats, use of alcohol and tobacco, and lack of exercise) than with the functioning of service systems or the availability of services. Despite the wide extent of social and health services, there are considerable socio-economic differences in their availability and use.

1.2 Overall Strategic Approach

In the past 15 years, Finland has paid particular attention to constant adaptation to changing circumstances. The government has published a number of reports on the social impact of globalisation and population ageing on Finnish society and presented numerous recommendations for reforms to improve adaptability and competitiveness. The ministries reformed their strategy in 2003–2004 and are seeking extensive consensus on future challenges and the guidelines for meeting them. The Ministry of Social Affairs and Health also revised its strategy in spring 2006. In 2005, the Finnish government's foresight network was launched. The network systematically analyses future challenges and methods of forecasting. In addition, the Parliament's Committee for the Future has extensively investigated the challenges faced by Finnish society. Furthermore, a number of interest groups have studied future challenges.

At the national level, Finland has reached a fair degree of consensus that social protection will be updated on the basis of the Nordic model. At the same time, particular attention will be paid to maintaining and strengthening the mutual confidence of citizens and the government, with the aim of having systems that are economically

sustainable in the long term, extensive and high-quality services, and sufficient income transfers with adequate incentives.

The Ministry of Social Affairs and Health has formulated four strategic lines of policy for social protection in the near future. These are:

1. Promoting health and functional capacity
2. Making work more attractive
3. Reducing poverty and social exclusion
4. Providing efficient services and reasonable income security

The goal for 2015 is for Finland to be a socially and economically sustainable, efficient, and dynamic society. The social security system is based on comprehensive collective responsibility. Change in the international environment and commitments to international agreements have an increasingly clear impact on national policies. Finland is actively involved in shaping European social policy. The well-being of our society is rooted in the maintenance of working capacity and general functional capacity, adequate income protection, and independent initiative.

These goals have been specified as follows:

In 2015

- The general functional capacity and social welfare of the population will have improved.
- Health differences between population groups will have been reduced.
- People will be staying on at work for an average of 3 years longer than they do at present.
- Poverty and social exclusion will have been reduced.
- Gender equality will have improved.
- The perspective of promoting health and welfare will have become established in social policy.
- The quality, availability and effectiveness of services will have been improved.
- Income security will ensure a reasonable income for people while still providing an incentive to work.
- Social protection will have a sustainable financing base rooted in collective responsibility supplemented by individual responsibility.

Finland is starting to make preparations for the parliamentary elections in March 2007. In accordance with the Finnish model of operation, the government programme (and the comprehensive income policy settlements concluded every few years) sets forth the goals for the social and health policy to be implemented. The administrative sector's longer-term strategic goals are specified in the strategy of the Ministry of Social Affairs and Health, which was updated in early summer 2006, as described above. Therefore, it is not possible or necessary to set new political goals in the area of social protection and social inclusion in 2006; attention is being focused on bringing the policies specified in the government programme (from 2003) to a conclusion. The Finnish policies are also

governed by the EU Presidency of 7–12/2006, which will tie up the government's resources to a significant extent.

a) social cohesion, equality between men and women, and equal opportunities for all – through adequate, accessible, financially sustainable, adaptable, and efficient social protection systems and social inclusion policies;

The government is implementing the Action Plan for Gender Equality in 2004–2007. The revised equality law entered into force in summer 2005 – for example, reinforcing the obligation of equality planning in the workplace and making pay surveys compulsory. Recently, systematic attention has been paid to reducing pay differentials between men and women, reconciling work and family life, and sharing the costs of parental leave. The structures of the public economy and power are analysed from the gender standpoint.

In social and health policy, sizeable investments have been made in innovations improving social adaptability. An extensive pension reform was implemented in 2005. In addition, further public funding has been allocated to social and health services for 2003–2007. The service system has been directed from inpatient to outpatient services, while efforts have been made to improve the availability and efficiency of services for the elderly as well as health services. In spring 2006, the government prepared a reform of the municipal and service structure to further boost the production of education, social, and health services and to guarantee sustainable funding for these services.

The Economic Council under the Finnish government has conducted extensive study of the effects of ageing on Finnish society, the labour market, the economy, and the public economy. There is extensive knowledge about the significance of ageing for society, and it, along with its concomitant effects, is regarded as a key challenge. This challenge is to be met by, e.g., increasing the productivity of the public economy, thus allowing most of the new workforce entering the labour market to be allocated to the private sector, and by further revising the operating principles of the public economy by increasing their economic and social sustainability.

According to calculations performed by the Ministry of Social Affairs and Health concerning the sustainability of social protection, the sustainability of the financing of social protection essentially depends on three factors:

1) Employment rate: Longer working life
   Reducing the workforce requires the employment rate to be increased
   1) by reducing unemployment
   2) by making working life longer at both ends.

2) The health and functional capacity of the population
   The health, and the working and functional capacity, of citizens has a more crucial impact on the development of social protection expenditure than the increased number of the elderly as such:

1) A good working capacity and general functional capacity create a basis for increasing the employment rate and improve economic productivity. It will be possible to remain in the workforce longer than at present.
2) The elderly will not need treatment and care until reaching a more advanced age.

3) The productivity and effectiveness of social welfare and health services
The service structure, organisation of the operations, and method of production have a key impact on the development of expenditure.
The production of services can be made more effective with organisational changes.
The utilisation of medical science and health care technology also provides opportunities for increasing efficiency.
As a result, more services with higher standards are obtained and staff workloads can be reduced.

However, according to Ministry of Finance calculations based on fairly optimistic assumptions as to the development of employment and productivity, unless balancing measures are taken, public-economy financing doe not have a fully sustainable foundation in the longer term. It is estimated that the need for balancing – i.e., reducing public expenditure and/or increasing public income – is about 1½ per cent of the overall input.

Finland emphasises further that actions against poverty and social exclusion must be seen as measures complementing the social protection system that covers the entire population, not as measures replacing it. Basically, the same services and income transfers must be available to the entire population and social considerations must be taken into account in all policies. There is no reason to create separate additional professional systems or special systems for the most deprived as an alternative to the social protection system. In accordance with these basic definitions, in autumn 2005, the government approved a number of measures boosting the social and health policy system to improve the relative situation of the most deprived.

b) effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs, and greater social cohesion, and with the EU's Sustainable Development Strategy;

The Finnish policy model is based on reciprocal co-ordination of economic, employment, education, and social policy, with the aim of strengthening policy coherence and contributing to the policies. This policy model, which aims to strengthen the legitimacy of social policy and to boost its implementation, supports balanced and expansive social reform. Finland has a positive attitude toward social change. In its opinion, competitiveness, a high employment rate, extensive education systems, and the level of social inclusion are functioning and efficient with regard to their basic solutions also in an ageing and globalising environment.

Multi-sector subject entities are brought together in working groups with all relevant parties represented. This kind of established and institutionalised method is also applied in the preparation of EU matters. In Finland, the plans for a national reform in

accordance with the integrated guidelines forming the key part of the Lisbon strategy, co-operation in education (education and training 2010), and the definitions in accordance with the report in hand have been co-ordinated to be compatible and harmonious. The results of the report are fed into the plans for national reform in a working group containing representatives of all relevant ministries. The working group consults the key interest groups in connection with the preparation. The role of structural funds in the pursuit of targets in accordance with the Lisbon strategy will be specified and developed.

The reduction of poverty and social exclusion of families with children is a key political challenge. In Finland, children are subjectively entitled to day-care services and basic education. Children are entitled to subsidised day care regardless of whether their parents work or remain at home. The day-care fee policy also aims to boost employment. In accordance with the government programme, Finland has studied the extent and concentration of poverty and social exclusion among families with children. The government has carried into effect reforms that aim to improve the conditions of the most deprived.

In Finland, the number of immigrants has risen fairly rapidly in the last decade. In order to integrate immigrants and those of other ethnic groups, special programmes to support the settling of immigrants during the adaptation period have been created. An additional system, Special Assistance for Immigrants, has been created for ageing Finno-Ugric immigrants returning from the Soviet Union who meet certain criteria pertaining to returning migrants, with the purpose of ensuring their livelihood.

The reconciliation of working life and social protection (flexisecurity) requires flexibility in both institutions. Finland aims to ensure equal opportunities in the labour market for residents of the country, with individual social rights and obligations. In addition, employment and adaptation to changes in social conditions are supported with an extensive service system. Longer working lives are promoted by tightening the conditions for early retirement entitlements, by improving the incentives for ageing employees to continue in employment, and by making extensive investments in programmes that improve the quality of working life. These programmes, which aim to change attitudes and reform the quality of working life, have gained good results, especially in reducing voluntary early retirement. In connection with redundancy situations, protection against unemployment has been improved, enabling flexible job-seeking efforts during the term of notice.

The social and health policy is also connected to the national sustainable development strategy, which was published in spring 2006. This strategy is part of the EU sustainable development strategy. Moreover, it has points of convergence with global social development strategies.

c) good governance; transparency; and the involvement of stakeholders in the design, implementation, and monitoring of policy.

The Finnish operating model is based on openness and transparency. According to comparative studies, Finland is one of the least corrupt countries in the world. The preparation of legislation and strategies required by European co-operation takes place in broad-based working groups, in which are represented not only the key ministries responsible for the preparation and implementation but also the labour market parties, non-governmental organisations, research institutes, and often also the church and expert bodies in the field in question.

An established part of the implementation of the reforms and strategies is the creation of monitoring systems connected with, as an essential component, an indicator system. All key policy programmes are evaluated regularly, and the results of the evaluations are taken into account in making specifications on them and planning new programmes. The public economy, which consists of the state, municipalities, and social security treasuries, is assessed as one entity, as required by the Stability and Growth Pact. The annual state budget is tied to the so-called procedure on the decision on spending limits, providing long-term continuity and predictability in decision-making.

The municipal and service structure reform has been prepared by a broad-based working group. The working group agreed on a proposal to be put forth as a new draft law, according to which the service structures will be reinforced by acquiring services that require a more extensive population base than an individual municipality, and by increasing co-operation between local authorities. The objective is to guarantee high-standard services that are available to citizens throughout the country. The implementation plan drawn up by the local authority and approved by the council plays a key role in the reform of municipal and service structures. As its foundation, the local authority must prepare a population and service needs analysis extending to 2015 and 2025, and a plan to balance the finances.

As part of the implementation plan, the local authority shall present to the Ministry of the Interior by 1 June 2007 the measures it will adopt in order to establish local government or co-operation areas and how it will utilise other means in the outline law in order to safeguard services. Furthermore, the local authority shall include in the implementation plan to be presented to the Ministry of the Interior by 1 September 2007 an account of the extent of the service network and a plan concerning the organisation of the key functions of the local authority as well as on the sufficiency and development of human resources. The Basic Services Programme dealing with the tasks of local authorities and their financing will be established as part of the statutory negotiated procedure for the national government and local authorities. Economic instruments in accordance with the Basic Services Programme will be developed such that they are more efficient than at present.

Decision-making and implementation will be supported with a systematic research and development policy, which will be the responsibility of research and development units under the ministries as well as other research and development institutes. The

ministries, including the Ministry of Social Affairs and Health, have recently carried out an assessment of the needs for a structural reform as required for an efficient and effective research and development policy. On the basis of these needs, a high-level working group under the Science and Technology Policy Council will make proposals concerning the reform of the research and development system in autumn 2006. A working group of the Ministry of Social Affairs and Health will be working simultaneously, with the task of making proposals on increasing the efficiency of the research system. In order to assess social changes, Finland has an extensive information management and statistics system, which includes the key subject entities with regard to the social and health policy. Information management is based on co-operation between various actors, which makes it possible to combine databases of individual authorities and actors. For example, patient databases, statistics on the social and health service system, and various micro-simulation models have been updated recently. The income information used in studies on income differences is gathered mainly from administrative registers, which improves the reliability of the results, as well as political usability.

1.3 Overarching Messages

The Finnish social protection system adapts itself to changing conditions with frequent reforms. In Finland, there is extensive consensus that the reforms shall be based on the Nordic model, which is characterised by an extensive scope, relatively high levels of benefits, and high-standard social welfare and health care systems. Particular attention is paid to the reconciliation of income transfers and services. In developing the social protection system, the targets of economic, employment, and education policies are taken into account so that different elements support each other in the move toward an information society and sustainable development. Although, according to numerous comparative studies, the institutional structure of the Finnish model is fairly competitive, Finland is also aware that future challenges require the government to have a proactive and open attitude to, e.g., the challenges posed by ageing and globalisation and the preparedness to create and utilise social innovations.

The targets of the reforms are: adapting to globalisation and the demand for competitiveness; increasing the employment rate; utilising the (semi)market; developing partnerships among non-governmental organisations, social and health care companies, and the public sector; reinforcing the client's position; and making provisions for ageing. Social protection is examined increasingly from the point of view of life phases, with particular attention being paid to childhood, the duration of studies, premature incapacity for work, and early retirement and the quality of services for the elderly. The system is being reformed at the national level, taking the European framework into account systematically. One essential part of the European framework is the Lisbon strategy, including integrated guidelines, co-operation in social protection, and sustainable development, as well as co-ordination of the internal market, competition legislation, and social protection systems.

A key future challenge is to safeguard long-term sustainability of the public economy in a way that makes it possible to maintain an extensive social protection system and to reduce social divisions.

Efforts are being made to promote the sustainability of the public economy by reforming financing and incentive structures and increasing public-sector productivity. In light of the completed evaluations, it seems clear that the sustainability of the public sector requires a further increase in the employment rate and some structural reforms in the incentive structures affecting organisations. At the same time, it should be emphasised that the reforms that have already been implemented have increased the sustainability of the pension system considerably. A productivity increase requires an open attitude toward new ways of organising social welfare, health care, and education services while the responsibility for providing the services remains with the local authorities.

In its proposal for the outline law on the municipal and service structure reform, the government specified that the population of a municipality or a municipal partnership that is responsible for primary health care and the closely related tasks of social services must be around 20,000, or higher. In establishing a municipality or municipal partnership, deviation from the population or other requirements may be made on account of archipelago conditions, long distances, or safeguarding of language rights.

The system of central government grants to local government will be harmonised and clarified. The reform includes a decision to reinforce the basic tax revenue of local authorities by transferring tax deductions to burden the state and to remove the obstacles in the unification of local government areas and co-operation between them, related to the financing system of municipalities. The objective is to merge sector-specific central government grants. In the system of central government transfers to local government, the different circumstances and needs for services at local authority level are taken into account. The balancing system of government grats, based on tax revenues, must be neutral with regard to the relationship between the local authority and the government. The reform will not change the distribution of costs between the state and municipalities.

In order to safeguard services requiring a wide population base, the country is divided into federations of municipalities as listed in the Act on Specialised Medical Care, in accordance with the proposal for the outline law. The federation of municipalities shall be responsible for at least specialised medical care and the service system for the mentally handicapped to the extent specified by the municipality. The municipality may also assign other tasks to the federation of municipalities. In connection with the outline law, it will be investigated how the financing solutions of the federation of municipalities could be implemented while avoiding unexpected random variations for the municipalities, caused by expensive treatments. The total cost development will also be specified more conclusively in advance. Some of the procedures and treatments related to specialist medical care will be concentrated on the national level in certain health care districts.

The deepening of social divisions poses a serious social challenge, which requires extensive social attention. Improvement in the employment situation and reduction in long-term unemployment are the most important individual limiting conditions affecting the achievement of the target here. At the same time, systematic attention has been paid to the operating principles of the benefits and service system, the incentives created by the system for organisations and individuals, and the possibilities provided by it to guarantee a sufficient welfare and income level. It is still important to improve the possibilities of co-ordinating social security benefits and earned income. The political focus will be emphatically transferred from the production of new social innovations to spreading and rooting innovations that have already been established. The structural funds and other development appropriations play an important role in these measures and their implementation.

Systematic attention shall continue to be paid to strengthening the institutional structure of the social protection system so that it supports the possibilities of individuals and households to adapt to changing circumstances when life situations so require. In addition, there is reason to pay particular attention to the reconciliation of technological and social innovations in the reform of the institutional structure of Finnish society. Furthermore, there is still reason to develop the utilisation of research and development policy in support of decision-making and the implementation, spreading, and rooting of social innovations by reforming the goals and structures of the research and development policy.

PART 2 Poverty and social exclusion

2.1 Poverty and Social Exclusion: Challenges, Priorities, and Areas of Operation

2.1.1 Introduction

Good social protection is the cornerstone of society. Through regulation and redistribution of resources, the government seeks to ensure that families, workplaces, local communities, and the third sector can help carry their share of responsibility for the well-being of all. Functioning social protection is part of sustainable development in society. It increases social stability and cushions the impacts of social changes.

The purpose of social protection is to promote the health and functional capacity of the population, to ensure healthy working and living environments, and to secure adequate income and services. As the well-being and equality of the population improve, each individual can live in dignity and security, developing and applying his or her own skills and talents in the different stages of his or her life.

In Finland, action against poverty and social exclusion is based on the development of extensive social security benefits and services to meet the challenges created by social risks. Measures assigned for risk groups with regard to poverty and social exclusion boost the operation of the universal system. The measures launched by the government to combat poverty and social exclusion are based on the 2003 government programme. The strategic targets of the programme were presented in the national action plan against poverty and social exclusion for 2003–2005. The strategic outlines of the government programme are supplemented and specified by different administrative sectors' own strategies and sector-specific targets.

The implementation of measures launched during the current term of government and the monitoring of results continue in the main part in 2006 and 2007. The outlines of measures against poverty and social exclusion will be re-examined when the new government takes office after the parliamentary elections of 2007. Therefore, the targets and concrete measures of the Finnish policies against poverty and social exclusion will not be specified until preparation of the programme of the next government in 2007.

2.1.2 Key political objectives for preventing poverty and social exclusion

The key objectives for combating social exclusion and poverty in Finland in 2006–2008 are:

1. Guaranteeing work opportunities for as many as possible
   Development of the welfare state and economic growth both require a labour force that is well and able to work, as well as participation in working life by as many people as possible. The attraction of working life can be reinforced by emphasising well-being at work, by increasing equality in the workplace, by developing incentives to participate in the labour market, and by reconciling work and family life in a better way. A social insurance system that is financially sustainable, provides incentives to work and guarantees a reasonable income, reinforces the significance of work as a stabiliser in the financing foundation for social protection.

2. Prevention of social problems and social risks
   The most effective way to reduce poverty and social exclusion is to adopt a preventive approach as the primary operating model. Particular attention will be paid to early intervention in the problems of children, young people, and families with children. In the prevention of health problems, the promotion of mental health and the management of substance abuse have a clear connection with reducing the risk of social exclusion.

3. Safeguarding the continuity of the existence of measures that prevent and correct social exclusions and poverty
   Selective social policy is not the basic principle or approach in Finland, but efforts are made to maintain and develop a universal service and income security system extending to the entire population. The permanence of the basic objectives of the welfare policy and long-term activities are the greatest factors in preventing the realisation of social risks and the threat of social exclusion. The best way to achieve permanent results in the work against poverty and social exclusions is to carry out determined development of social structures that safeguard people's welfare. Short-term programmes and projects have a limited impact.

4. Ensuring the supply of skilled labour in services safeguarding the welfare of residents
   The key issues of a functioning service system are client-orientation, high-quality and versatile services, sufficiency of services needed by the increasing elderly population, and a sufficient and skilled workforce. The availability of services and the regional equality of citizens can be safeguarded via a functional steering model and sufficient regional co-operation, utilising information and communication technology. (compare the reform of the municipal and service structure).

2.1.3 An assessment of the status of poverty and social exclusion

The level of relative poverty in Finland is still among the lowest in the EU, although it increased slightly in 2001–2004. The fixed poverty level measures the change in the number of persons below a certain income level over time (Indicator 1.15). Measured by this indicator, the share of poor people has decreased. High structural unemployment is a problem. The number of the homeless and long-term unemployed has fallen from the peak figures of the recession in the 1990s, and the need for social assistance has also decreased. Due to the fact that unemployment and income problems have become a long-term issue, it is increasingly difficult to break the cycle of social exclusion. The gap between the demands of working life and the skills and functional capacity of the socially excluded has grown. The most important projects with regard to the reduction of social exclusion have been the extensive programmes, measures implemented to facilitate entry to the labour market, support of return to working life, reduction in homelessness, early intervention in the problems of children and young people, support of immigrant integration, implementation of alcohol and drugs programmes, and prevention of crime.

Multiple disadvantages and social exclusion

The cycle of social exclusion is often launched by either long-term unemployment or, in the case of young people especially, difficulties in entering the labour market. There may be various lacks in skills, or health or social problems in the background. A loose connection with the labour market results in income problems and a lack of work-related social networks. The risk of social exclusion is often impaired by mental health problems or substance abuse, which may label the individual. Financial deprivation may also give rise to a feeling of social inferiority, resulting in isolation and estrangement from everyday life. Finally, the accumulating disadvantages lead the individual through a cycle of social exclusion, in which a number of adverse factors reinforce one another, resulting in increasingly wretched circumstances.

The connection between factors linked with social exclusion varies in different groups. For example, it has been established that the significance of long-term unemployment as a factor that aggravates social exclusion and isolates one from social networks is greater for men than for women. The risks of social exclusion change over time. Those suffering from learning difficulties find it increasingly hard to become employed in the normal labour market, which may increase the risk of social exclusion for this group. Ever-increasing demands of work raise the risk of social exclusion for those suffering from mental health problems or substance dependency. Decreased time with the family may result in disturbed behaviour among children and young people, and in a threat of social exclusion.

The risks of social exclusion seem to have increased recently, especially among children and young people, as well as among substance abusers. The number of children and young people subject to child protection measures has risen alarmingly. Growing substance abuse is evident in the increase of alcohol-related deaths and illnesses. (see

Appendix: Part 2.) The administrative sectors are encouraged to carry out close co-operation in order to manage the multiple problems of the socially excluded. Motivation of the socially excluded to improve their own situation is the prerequisite for successful activation measures. The fact that the available resources are not always sufficient sets limits for provision of individual support. However, the savings in social costs achieved in the long term with the prevention of social exclusion is noteworthy in addition to the alleviation of human distress.

Financial difficulties (poverty)

In Finland, the level of relative poverty, which refers to the proportion of the population with a low income, is still low compared with equivalent figures for most other EU countries. However, the level of poverty has risen since the mid-1990s. Measured by the fixed poverty level, the share of poor people has decreased. The fixed poverty level does not account for general increase in income. The real income of those with a low income has also risen, but it has clearly lagged behind the general income trend. The number of people with a low income has increased further, but considerably more slowly than in the late 1990s.

Low income is most common among single people and single parents. In the past few years, low income levels have also increased among young families with children. Growing unemployment and employment problems have been of special concern to the generations who entered the labour market after the recession; an increasing number of parents of today's families with children may be found in this group of people. Nevertheless, low income among young families with children is clearly more uncommon than among single people and single parents.

Households whose reference person is a student, unemployed, or on a full state pension are at the greatest risk of poverty. According to age, those aged 16 to 24 are at the greatest risk of poverty. The level of poverty among people under 18 years of age is often called the child poverty level. In 2003, for the first time, it was higher than the level of poverty among the entire population.

The number of people with a low income in the long term continued to increase in 2004. As financial difficulties become prolonged, the risk of social exclusion increases. As a rule, prolonged poverty is connected to remaining permanently outside the labour market. Social assistance systems that are meant to be temporary cannot efficiently prevent the risk of social exclusion resulting from long-term low income.

In the long term, the available income for households has shown the greatest increase in the Åland Islands, Uusimaa, and Eastern Uusimaa. The development in 1995–2004 was worst in households in the provinces in Northern and Eastern Finland, which also have the highest level of low income. There are probably many factors behind the differences in income trends between the provinces; in addition to changes in income, the trend may have been affected by changes taking place in income structures and the structure of income-earning households due to for example, migration. The various provinces also showed increasing disparities in household income. In 2004, the greatest income

differences were among the households in Uusimaa and the Åland Islands. Long-term low income was clearly most common in North Karelia, while it remained at its lowest level in the Åland Islands throughout the study period (1998–2004).

In 2003, 51 per cent of Finnish households had debts and 28 per cent had a mortgage. The number of large loans has grown rapidly. However, a decrease in the interest rate and longer loan periods have diminished the figure for debt servicing expenses as a proportion of income; the median in 2003 was 7% of income, but those with a mortgage have considerably higher debt servicing expenses. Over-indebtedness has fallen since the late 1990s. One fifth of indebted households in the two lowest income deciles regarded themselves as over-indebted. Of single parents, 16% considered themselves to be over-indebted. The financial risks of families with large mortgages or consumer debt will grow if loan interest rates rise.

The number of insolvent people in the credit reference agencies has remained at around 300,000 thus far in the 2000s. These are mainly people from whom unpaid debts are being recovered by means of legal proceedings and enforcement orders. According to preliminary information, the debt counselling offices of local authorities had about 17,000 new clients in 2005; this figure remained more or less stable in 2002–2005.

Economic and employment trends

A favourable economic trend usually means better employment and a decrease in the number of people receiving income security benefits paid in cash. This also creates more possibilities for developing the welfare services. At the same time, it is easier to safeguard a reasonable level of income security benefits, including pensions, when the number of people receiving them is lower. Social protection expenditure is financed mainly through taxes and social insurance contributions. A good employment trend guarantees favourable development of tax revenues, also with a lower scale of taxation.

A favourable trend for employment and working conditions is a basic requirement in adapting to the challenges brought by an ageing population. A core target has been to raise the rate of employment among older workers, which has seen clear improvement. The baby-boom generation has remained actively involved in working life longer than the previous generations. However, the number of older unemployed job-seekers has not fallen. Employment rates among older generations have been lower in Finland than in the other Nordic countries, but in the past few years the differences have started to diminish rapidly.

Almost 44% of unemployed job-seekers over 50 years of age are long-term unemployed. Among the unemployed over 50 years of age, the rate of re-employment in the open labour market has been low, even during an economic upswing.

The rate of unemployment among young people has fallen continuously since 1993, while the average duration of the period of unemployment has shortened. In 2005, the reduction in unemployment among young people was considerable. The greatest problems of youth unemployment include the difficulty of obtaining the first job; the

often short duration of employment; and, in some cases, the lack of education and/or motivation for education. Moreover, there is a group of young people whose employment opportunities are hampered by various factors, such as learning difficulties, substance abuse, and other social problems.

As a third group, in addition to older and young people, refugees can easily become excluded from working life. Quick placement in the labour market is of primary importance in their integration into Finnish society.

The favourable trend in unemployment is overshadowed by the persistence of structural unemployment. This problem is emphasised as groups of people of working age diminish in size. Necessary resources remain unused to an unreasonable extent. Unemployment has fallen, but the hard core of unemployment still exists. Simultaneously, problems related to recruitment by companies seem to have become even worse.

The most problematic group of structurally unemployed are those who have been constantly, long-term unemployed. In practice, only a small proportion of them are placed in the open labour market without special measures. In 2005, the trend of long-term unemployment turned into a slight decline. Prolonged unemployment is still a great problem, although labour market measures have been strongly focused on the hard-to-place unemployed. The majority of the long-term unemployed end up in a placement arising from labour policy measures or a transfer outside the labour force. The number in long-term unemployment seems to have settled at about 70,000. In relative terms, unemployment is still most common in many municipalities in North and East Finland, but in quantitative terms, most of the unemployed live in growth centres.

The improvement in the employment situation in 2005 did not significantly ease the problem of structural unemployment; the year saw an average of 162,000 structurally unemployable people, which is almost 6,000 fewer than the year before. Most of the structurally unemployable, an estimated 100,000, are under 55 years of age and could still be involved in working life in respect of their age. The dismantling of structural unemployment is hindered by the insufficient number of jobs suitable for the structurally unemployable even in the next decade.

Measures to improve the labour market situation of the structurally unemployable include activities of the employment service offices, reforms of employment subsidies, and developing social enterprises. However, these are not enough to reduce structural unemployment. The demand for workers in the open labour market should be focused on this group of job-seekers more vigorously than at present. For this reason, reforms that increase the demand for labour and lower companies' employment threshold play a strategic role in the combating of structural unemployment.

Recent years' developments indicate that employment has become selective: some of the unemployed find work more easily than before, but the average duration of unemployment is getting longer. Still in the late 1980s, an unemployed person found a new job relatively easily. More than 40 per cent of the unemployed found employment

in the open labour market within one year. When the recession was at its deepest, only 20 per cent of the unemployed found a job within one year. Since the end of the recession, the situation has barely improved. It has been typical of the development of the Finnish labour market that the occupational structure and competence requirements of the growth industries and industries in recession have been very different. The workforce of the growth industries has been recruited from new generations or from those already in employment, and only to a minor extent from among the unemployed. This partly explains the fact that vacancies and the unemployed do not meet.

Finland's position in the international division of labour will continue to be based on high levels of expertise, research, and product development. However, we will also need measures to promote the creation of jobs in industries with lower educational requirements as well.

Health factors

The health of the population is better than ever before. The life expectancy is higher, and the number of disability-free years has increased. The positive trend is overshadowed by excess weight gain and clearly increased consumption of alcohol among citizens. Both of these result in considerable, multiple, and expensive problems for the individuals, their families, the public health, and the entire society. Further threats include poorer development in the health of certain population groups (i.e., inequality in health).

The number of new disability pensions has remained more or less unchanged in the past few years. However, the number of new disability pensions granted annually is still greater than that of new old-age pensions. One third of disability pensions are granted in consequence of mental health problems, and another third due to diseases of the musculoskeletal system. Depression has become an increasingly common reason for drawing a disability pension. On the other hand, studies indicate that the number with mental health problems has not increased as such. This trend is partly attributable to the development of working life, which nowadays is so demanding that those with mental health problems feel earlier that their situation is too difficult for coping in working life.

Health differences between population groups are still great. Tobacco and alcohol account for half of these differences. In Finland, the most expensive disease groups in respect of treatment are cardiovascular diseases, mental health problems, respiratory diseases, and diseases of the musculoskeletal system. Half of the health care expenses are allocated for the treatment of these diseases. Many of our current national diseases can be prevented. The impact of health care on the health of the population accounts for only 10–15 per cent. The individual's health-related lifestyle and environment together have the greatest impact.

The further development of public health in a favourable direction requires constant efforts. It is of primary importance to make people aware of the impact their choices and lifestyle have on their health. The foundation for a healthy adulthood and good functional capacity in old age is laid in one's early years. The prevention of diseases and

an efficient health education save costs if they can be used for avoiding the need to address problems at a later date.

The most urgent task with respect to the development of public health is to reverse the growing trend of alcohol consumption and to prevent excessive weight gain. Obesity is most commonplace among the least educated; especially in the case of women, obesity has a clear relationship with the level of education.

Long-term heavy drinking is a serious health risk. A strong state of drunkenness significantly increases the risk of accidents and the likelihood of violent crime. About 60–70 per cent of violent crime is carried out under the influence of alcohol. The number of episodes of hospital care due to the harmful effects of alcohol increased rapidly in the early 1990s, with subsequent stabilisation at just under 35,000 episodes of hospital care per year. However, in 2004 the number of these treatments increased significantly, particularly rapidly among men. The adverse effects of intoxicants with respect to social exclusion focus on risk groups, especially on deprived young adults and middle-aged men. Women's alcohol-related episodes of hospital care have risen steadily year by year. At the same time, the number of alcohol-related deaths has risen, with an alcohol-related disease or alcohol poisoning being the cause of death to an increasing extent. Alcohol has been the second most common cause of death among men for some time. In 2002, it also became the second most common cause of death among women of working age.

The health differences between population groups can also be affected by general social policy. Social decisions have health impacts, but so far they have not been taken into account to a sufficient extent. It is especially important to take into consideration the impact of the decisions on special groups, such as children, people with disabilities and mental disorders, and the long-term unemployed, and to guarantee equal treatment opportunities. The occupational health care system facilitates the availability of health services for employed people. Other population groups do not have this form of service at their disposal.

The housing market

In housing, the difference in the average price per square metre, in percentage terms, between the Helsinki region and the rest of the country has increased considerably since 1995. In the third quarter of 2004, the average price of houses and apartments per square metre in the Helsinki region was just more than double that in the rest of the country. In 2002, the general rent level was about 37% higher in the Helsinki region than elsewhere in the country. The difference diminished somewhat in 2004, due to the slowing down of rent increases in the Helsinki region.

The availability of houses and apartments has improved. The number of people applying for state-subsidised housing has gradually fallen in this decade, primarily due to the fact that the financing terms of owner occupation have become more favourable than before as a result of lower interest rates and longer loan periods. This trend has increased further in 2004–2006. For this reason, the availability of larger state-

subsidised rented apartments has also increased throughout the country. Correspondingly, the number of empty rented houses and flats has grown, especially in areas with population loss. The changing market situation is characterised by the fact that the refusal of offered rented accommodation has increased also in growth areas.

Poverty and small incomes result in inadequate housing and increased homelessness. Therefore, a sufficient income for households in different life situations is an essential part of preventive social work. Housing allowance is the most important form of financial support that safeguard reasonable housing. Homelessness concerns men especially. The Government Programme on Housing and the metropolitan programme on homelessness have produced good results, and homelessness has decreased somewhat especially in the Helsinki Metropolitan Area.

Level of education

The population's level of education has risen rapidly in the past few decades. At the end of 2004, 38 per cent had an upper secondary qualification and one fourth of those aged 15 or over had a higher education qualification. About 40 per cent of men and 36 per cent of women had an upper secondary education, while 23 per cent of men and 27 per cent of women had a higher educational qualification. Women under 45 had a degree-level qualification more often than men. Finland has a regionally extensive and free school system, including higher education.

Young people have received considerably more education than members of older generations. Those aged 25–29 are the most highly educated. Some 86% of people in this age group have a post-comprehensive-school educational qualification. Especially in the younger age groups, differences in education between the sexes are clear – women are more highly educated than men.

There are significant regional differences in the education level of the population. Uusimaa has the highest number of people over the age of 15 with a qualification: 67 per cent of people have a post-comprehensive-school educational qualification. Central Ostrobothnia (58%) and the Åland Islands (57%) have the fewest people with a qualification.

According to Statistics Finland, in 2004, 95% of school-leavers were placed in general upper secondary education, vocational training, or voluntary additional basic education immediately in the year they left school. The situation has remained almost unchanged from the previous year, but it has improved somewhat in the longer term. The proportion starting in vocational training and in general upper secondary education has remained fairly stable, whereas the number of people taking up voluntary additional basic education has been declining: 3% transferred to this type of education.

Some 5% of school-leavers remained outside the statistics on education in 2004. This figure is about one percentage point lower than in the previous year. Regionally, the immediate placement of school-leavers in further studies varies. In 2004, the greatest numbers remaining outside upper secondary education were in Päijät-Häme and Uusimaa – just under 10% of the population. The education level of ageing employees

is poorer than with the other age groups, and therefore their insufficient professional qualifications will make it more difficult for them to re-enter the labour market if they become unemployed.

2.2 The Strategic Targets to Be Followed in Different Policy Sectors

Strategic targets

- The need for income security is reduced.
- The minimum social security benefits are sufficient, and the earnings-related benefits are adequate.
- The insurance cover is extensive.
- Poverty among families with children is reduced, and chains of social exclusion across generations are prevented.
- Client fees in health care are set at a reasonable level, and the transparency of the fees is increased.

2.2.1 Income security

All citizens are guaranteed an resonable income with social insurance security against loss of earnings or large expenses due to sickness, incapacity for work, unemployment, accident, old age, the death of a spouse, or the birth of a child. Adequate minimum security is guaranteed for all citizens. Earnings-related benefits guarantee a reasonable consumption level for those previously employed. The minimum security benefits safeguard a sufficient income when the person has no earned income.

Most of the income security consists of earnings-related benefits. For this reason, the level of benefits primarily follows the trend of the general income level. Long-term unemployment or other long-term absence from work means that the person will be dependent on minimum benefits or last-resort income security – i.e., social assistance. Also, retired women in the oldest age group often have to depend on the national pension only, or on a combination of the national pension and a small employment pension.

The minimum and last-resort benefits will be retained at a level that safeguards existence at a reasonable quality of life. The threat of long-term poverty is combated with sufficient minimum protection. The client fees of health care and social welfare services are defined so that their level will not prevent appropriate use of the services.

Focal areas of action

- The Government budget proposal for 2007 incorporated new measures to improve the well-being of families and the status of persons with the lowest income levels. For example, the survivors' pension received by a child is no longer considered income in terms of the general housing allowance. The child maintenance allowance is raised with approximately EUR 6 per month per child. The special childcare allowance and child disability allowance are raised with EUR 15. The sibling supplement of the child home care allowance is raised with EUR 10. Over EUR 0.5

million is proposed for the improvement of the availability of private child care providers. Also, interpreter services for severely disabled persons are increased. The maximum amounts for pensioners' housing allowance are raised. The housing allowance is raised with a maximum of EUR 4.5–11 per month depending on the municipality category. The special care allowance for pensioners is raised with a maximum of EUR 15 per month. The entitlement of entrepreneurs' family members to the unemployment benefit will enter into force in 1 October 2007.

2.2.2 Development of the service system

Strategic targets

- Health differences between population groups will be reduced.
- The availability and quality of services will improve.
- The harmful effects of alcohol on public health will diminish.
- The elderly will be helped to live and cope at home longer.
- The disabled will have a better opportunity to participate in society.

Reinforcing the structures of welfare policy and developing procedures that stretch across sector boundaries form the basis for combating social exclusion. The prevention of problems will be established as a normal part of service system operations. It will be possible to use the available resources for necessary services in a more appropriate way when preventable illnesses, accidents, and social problems are identified, prevented, and dealt with at an early stage.

The objective is to have the entire social policy support health and welfare, with their foundation laid already in childhood and youth. It is equally important to improve the functional capacity of working-age people, to seek new operating models to support the ability of older people to cope independently, and to decrease health differences between population groups. The significance of a healthy environment for public health is emphasised.

Reducing health and welfare differences so that the health and welfare of the disadvantaged will improve contributes toward social cohesion. The management of many risks of social exclusion requires good reconciliation of services and income transfers. Safeguarding regional equality of the population requires a functioning operating model and co-operation between regions, with the help of extensive utilisation of new information and communication technology.

It is particularly important to increase the assessment of social and health impacts in all sectors of social policy. There must be intervention in the structures of social exclusion in working and family life. The objective is to reduce the high-risk abuse of alcohol and other drugs among adults and to prevent and reduce the negative effects of substance use. Maternity clinics, day-care centres, schools, and workplaces play a key role in this preventive work. Developing supported housing and preventing the segregation of residential districts are among the common challenges in the management of social

exclusion. The right to accommodation is supported with measures taken by those involved in social services and health care.

Mental health problems are prevented with measures targeting entire population and identified risk groups. Solutions for mental health risks in the workplace are sought in a more efficient way. The need for institutional care can be reduced with a functioning combination of outpatient care, housing services and day activities.

A functioning service system and its quality are safeguarded with client orientation, good and versatile services, sufficient services for the elderly, and a sufficient number of skilled employees. The personnel and skills structure is developed to meet the clients' needs and fit the tasks of the employees. The number of employees is dimensioned to correspond with the clients' and patients' functional capacity and requirements.

Focal areas of action

- In the 2006 budget, the appropriation for the administrative sector of the Ministry of Social Affairs and Health is about EUR 11 billion. This figure is 12 per cent greater than the previous year's budgeted amount. The budget of the Ministry of Social Affairs and Health emphasises the functionality and availability of social welfare and health care services, the clarification of financing systems, and safeguarding of sufficient income for all. A total of EUR 4,021 million is proposed as state subsidies for the operating expenses of the social and health care of municipalities, an increase of 9.5 per cent on the 2005 level.
- The national public health care project, the Health 2015 public health programme, and the social sector development project will continue according to plan (see previous implementation report). In health promotion, actions will focus on reducing the risks of national diseases, preventing accidents, and creating health-promoting conditions. A sufficient number of employees in social welfare and health care, as well as their expertise, is ensured within the programmes. The purpose of the social sector development project is to address the most urgent near-future development needs and to ensure long-term development of the social sector. The objective is to foresee the increasing demands of the changing operating environment in order to prevent and solve social problems. For this purpose, preparation for the Welfare 2015 programme has been launched.
- The broad-based preparation for the Welfare 2015 programme seeks especially methods for boosting early intervention and prevention and for improving people's welfare, social safety, and livelihood. It also seeks models to improve the support of policies that prevent problems and promote social responsibility in relation to community-building, housing policy, and the demands of working life. The programme seeks solutions for balancing individual coping and the support of the community, and it

examines the position and role of different actors in the social sector in the organisation of social services.

- In 2003–2006, a total of EUR 153 million in state subsidies was distributed in accordance with the social sector development project, national public health care project, and alcohol programme. With the subsidies, almost 900 projects have been launched since 2003 with the aim of developing social welfare and health services and reducing alcohol use and the negative effects of alcohol. Almost all of the Finnish municipalities are now involved in this development work. Some EUR 40 million will still be distributed in the last application round in 2007. In addition, EUR 75 million was reserved in the Government budget proposal for 2007 to municipalities for the implementation of the National Health Care Project and the Development Project for Social Services. EUR 17 million out of the EUR 25 million reserved for the Development Project for Social Services has been allocated to the improvement of various services.

2.2.3 Employment and the labour market policy

Strategic targets

- There will be a reduction in long-term and structural unemployment.
- The degree of labour-market participation will increase in different age groups.
- Working life is to be extended by at least two or three years by 2015.
- The work incentives of social protection will increase.
- Productivity of work will be increased.
- The organisation and meaningfulness of work will be improved.
- The availability of skilled labour will be ensured, and preparations will be made for the decrease in the labour force arising from changes in the age structure.

The attractiveness of working life will be reinforced by improving job satisfaction, by increasing equality in the workplace, and through a better work–family balance. A social insurance system that is financially sustainable, provides incentive to work, and guarantees a reasonable income emphasises the significance of work as a stabiliser in the financing foundation for social protection. Unemployment security will be developed and modernised as part of social insurance. It will provide more incentives: working must always be the primary choice, and it must also be rewarding. There is reason to simplify and clarify the unemployment security system, and it shall be understandable and transparent to the citizens.

The significance of unemployment security is vital for raising the employment rate. Its primary purpose is short-term protection that supports active job-seeking and promotes the flexibility of the labour market. Development of skills, maintenance of working capacity, and rehabilitation play a primary role in respect of unemployment security and early retirement. The labour market prospects of an unemployed person diminish rapidly if unemployment is prolonged. Active labour market policy and training shorten the duration of unemployment and make it easier to enter the free labour market.

Good working conditions improve productivity and create an important competitive factor. A meaningful job where the person's physical and psychological health and safety are guaranteed is a key factor in life quality and welfare. Well-being at work contributes to the degree of employment. A good minimum level of working conditions is safeguarded via legislation. This prevents absences due to sickness and incapacity for work. The target is still to reduce accidents at work and occupational diseases. The attractiveness of work and the opportunities for obtaining work will be improved so that working would be the primary alternative.

The objective of the government programme is that all young people will be offered a training, work practice, or workshop place after three months' unemployment. More efficient labour market services and different measures for 'social guarantee for young people' will focus largely on young unemployed people already in the early stages of unemployment. The purpose of the means of employment management is to support young people's training, application for training, and employment.

Focal areas of action

- Employment and employment policy reforms to reduce structural unemployment, included in the government programme and employment programme, have been launched. Their efficient implementation is essential in order to achievement of a good end result.

- The key project in the employment programme is the restructuring of the employment services. As part of the restructuring, some 40 labour force service centres will be established during the term of government to provide services for the structurally unemployable. At the service centres, the labour administration, the department of social services and health care of the municipalities, and the Social Insurance Institution of Finland (Kela), together with other service providers, will provide multi-professional services for job-seekers. In the future development of the service centres, it is essential to safeguard job and activation places for the clients of the service centres and to implement reforms of labour market support. To achieve this, the service centres must play a strong role in the so-called interval labour market, where the employee's income is composed of the flexible combination of the employee's work contribution and various forms of assistance. The development of a separate interval labour market is deemed necessary because there are no workplaces available that would be suitable for the unemployed who have taken part in activation.

- At the beginning of 2006, a labour market reform prepared in the employment programme came into force. With the reform, the use of labour market support as an active form of assistance in the improvement of job-seeking skills will be increased. The objective of the reform is to have a combination of benefits and active programmes that is more efficient, incentivised, and balanced than at present. The reform consists of three policies that support each other:

1) change in the financing of labour market support and social assistance between the state and local authorities,
2) a new active period and social guarantee for the long-term unemployed, and
3) an increase in the requitedness of labour market support. The extra finances accrued by the local authorities will be fully compensated for from the state resources.

- The implementation of social guarantee for young people, launched in early 2005, will be continued. After a continuous maximum period of unemployment of three months, young unemployed job-seekers under the age of 25 will be offered an active alternative that will further their position (training in job-seeking, preparative or occupational labour market training, trial work placements, on-the-job training, preparatory training for working life, start-up grants, or wage-subsidised work).

2.2.4 Housing policy

Strategic targets

- In growth centres, reasonably priced homes' supply and demand become more balanced.
- The social balance of residential areas is retained, and the structure of residents becomes more versatile.
- The implementation of the social housing policy is managed with public funding.
- Housing that takes into account the needs of the ageing population and the disabled is developed.
- Homelessness is reduced.

The objective of public housing policy is the promotion of reasonably priced housing in a housing market that is becoming regionally differentiated, as well as the reinforcement of socially functional towns, residential areas, and housing communities. A new kind of innovative co-operation is required both within the state and municipal sector and among public, private, and non-profit actors in order to safeguard basic housing rights.

The needs of different resident groups can be taken into account by offering different kinds of housing management and financing alternatives; by developing a clear, safe, and diverse environment; and by ensuring a sufficient population base to finance the services. The authorities can direct the development of the quantity of housing with subsidised housing, refurbishment, and tenant selection. Social segregation and inequality of residential areas must be prevented with available means.

In order to make the service offering more versatile, closer co-operation of the public, private, and third sector will be utilised. The management of the high investment and running expenses of housing projects aimed at special groups requires studing, planning, and building of new, more efficient, and high-standard forms of housing, with

a better price/quality ratio than at present. The state authorities must also make new investments in order to make the housing costs of special groups more reasonable.

The ageing population and an increase in special needs also constitute a challenge for the housing policy. There are not enough accessible, reasonably priced homes that would safeguard independent, decent living, and this results in increased pressure on supported and service accommodation organised by the social services.

For a long time, local authority housing has been developed by law so that actions will be focused especially on the improvement of housing conditions for the homeless and those living in poor conditions. Local authorities shall develop the housing conditions in their areas so that reasonable accommodation can be arranged for residents of the municipality who have become homeless and are unable to arrange accommodation on their own initiative without undue difficulties. Independent housing of special groups shall be promoted by developing housing support services.

Focal areas of action

- Towns, municipalities, non-profit lessors, service providers in the housing industry, and organisations develop new housing production and financing models in order to improve housing conditions for different population groups. The state will increase its contribution to the financing of special housing and housing benefits, and it will safeguard reasonable housing for the most deprived citizens in collaboration with the local authorities. In 2007 the government will allocate EUR 45 million for development of housing conditions for groups in need of special support.

2.2.5 Education and youth policy

Strategic targets

- Preventive elements of the approach to student welfare will be strengthened.
- Student transfers from comprehensive school to vocational education will become faster and more efficient.
- Dropping out of the education system is reduced.
- Young people's growth and independence is supported, and their active citizenship is promoted.
- Practices for young people's social empowerment are developed, and their growth and living conditions are improved.

In education legislation, there are separate provisions for pupil and student welfare. These provisions were reformed with an act that came into force in 2003. In the new provisions, pupil and student welfare is specified in more detail than before. In addition to learning-related targets, the law addresses taking care of the holistic welfare of children and young people, the safety of the school community, and the obligation for co-operation between administrations. It is specified that the task of the school is not

only to promote learning and learning skills but also to look after the welfare of children and young people and to provide them with guidance in their life choices.

In addition to the above reforms, more efficient methods than before are needed to improve welfare at school and prevent social exclusion. The Ministry of Education has launched an action entity with a focus on basic education and development of the transitional stage in secondary education. The objective of the long-term action entity promoting welfare at school is to develop the school into a community that promotes the welfare of children and young people and to increase early intervention and preventive actions.

Dropping out of school is a factor that increases the risk of social exclusion. It is most frequent in the early stage of one's studies. The most common reasons to drop out of vocational education are unsuccessful training choices or learning and studying difficulties. The dropout rates for vocational education have fallen evenly over the three years when statistics on dropouts have been kept. In 2004, some 9.6% of students in basic vocational education gave up their studies completely. About one per cent of students changed education sector.

The development of youth policy as co-operation between different administrative sectors will improve the reconciliation and implementation of decisions having an impact on the growth and living condition of young people. A comprehensive youth policy offers a functional tool for combating social exclusion and poverty among young people needing social empowerment. The objective is that young people are taken into account in decision-making, as their own group, and that inequality of young people both within their generation and in relation to other generations is prevented.

Focal areas of action

- Measures aimed at reducing dropping out of education have been implemented on a wide scale. These measures have included educational guidance and various support and guidance services for students, especially in the early stage of studies, and development projects related to the reduction of dropout rates in vocational schools.
- Training providing guidance and preparation for vocational education will be launched on a trial basis in 2006. The objective of training is to lower the threshold for transferring from comprehensive education to vocational education and to reduce the dropout rates in vocational training.
- The on-the-job learning worth 20 credits that is included in vocational training will increase the link with working life during studies and the students' learning motivation, and it will therefore contribute to reducing dropout rates.
- An extensive entity of national measures will be launched for the support of well-being at school. EUR 8 million has been allocated for the purpose in the Government budget proposal for 2007.

- The new Youth Act took effect on 1 March 2006. The act includes a target on the social empowerment of young people, with measures aimed at young people to improve their life skills and prevent social exclusion. The Ministry of Education is preparing a development programme for a national youth policy in co-operation with other ministries with a joint interest; key actors in youth work and policy are also being heard in the preparation.

2.3 Risk Groups Requiring Special Measures

- **The long-term unemployed**

The employment of the long-term unemployed is related to the close co-operation of training, the development of labour market skills, and rehabilitation. Furthermore, flexible determination of what health problems hinder the employment of the ageing long-term unemployed and their rehabilitation for working life, and the improvement of the employment conditions of the disabled, will help these groups to become integrated into working life. Not all of the long-term unemployed will be employed in the open labour market, at least not permanently. Nevertheless, social participation of the unemployed is safeguarded. The position of the long-term unemployed is facilitated by developing and trying so-called social employment and interval labour market models. Taxation, income transfers, and services are reconciled in order to reduce structural unemployment so that as many as possible find employment.

The long-term unemployed can be grouped according to their likelihood of finding employment in the open labour market and the degree of support they need in order to find employment.

1) People with a stable working capacity who would be able to hold a regular paid job, but with the person's reduced productivity taken into account at work. These people need preparatory training for working life and a wage-subsidised job.

2) People whose rehabilitation and restoration of working capacity is likely. The purpose and target of rehabilitation is to directly prepare the client to take up a normal job or be subject to primary measures by the labour administration.

3) People who are sometimes able to work, maybe even to perform to an excellent standard, but are incapable of holding a regular job in the open labour market. This group includes those undergoing mental health and substance abuse rehabilitation. The latter of the two groups have the opportunity to receive sickness allowance, but the situation of a person recovering from substance abuse is difficult. The process for those in mental health rehabilitation to gain a trial work placement is slow, and negative attitudes also prevent companies from taking on these persons on a trial work basis. The long-term unemployed with a substance abuse problem do

not receive enough obligations from the local authorities to be involved in addiction rehabilitation procedures, and an alcoholic is not able to raise the necessary funds for treatment.

4) People who are not at all able to take part in work activities. In respect of life management, it is important for these people to have somewhere to go and to be part of the community. Their lives, perhaps like those of some others, may involve substance abuse, a loss within the family or circle of friends, and untreated traumas and guilt.

Co-operation between the social services and employment administration is the most efficient way to tackle the causes of long-term unemployment and to remove obstacles to integration into working life.

- **Families with children and young people under the threat of social exclusion**

In order to take care of the welfare of children, young people, and families with children, their life situation must be examined as a whole. All psychosocial and health aspects of welfare must be taken into account. Preventive work supports the ability to successfully transfer from one life situation to another.

Young people's ability to look after their health, social welfare, and other life management is supported in collaboration with the various participants in the young person's growth environment, such as the school, the home, social and health care services, sports and youth departments of the local authority, organisations, and the media. The objective is to promote a healthy, substance-free lifestyle in order to prevent social exclusion and to promote the active participation of young people in the activities of society as well as training.

Early social exclusion is tackled actively and is cut short as early as possible. A successful comprehensive school stage, a place in vocational training, and completion of studies are safeguarded.

- **The homeless**

Key measures to prevent homelessness include safeguarding the supply of reasonably priced accommodation, a functioning service system, and a sufficient housing allowance and income.

The objective of the government programme was to eradicate homelessness, by, for example, implementing the action plan for reduction of homelessness by the state, as well as the cities Helsinki, Espoo, and Vantaa (2002–2005). The target was to build and acquire one thousand new homes each year during the programme period of 2002–2005 and to safeguard the necessary support and housing services. It can be stated that, since the programme was launched, further homes have been both built and acquired, and there is a plan to acquire a total of more than 3,000 homes mainly for the use of the

social services. Therefore, there is a further need for about 1,000 homes in order to achieve the target of four thousand homes.

A supply of reasonably priced rented accommodation for young people who are becoming independent, students, those with a small income, and others in a special group in need of accommodation reduces the risk of homelessness. In addition, an acquisition system for reasonably priced rented accommodation for the homeless and those clients of social services with nowhere to live was launched in Finland in the late 1980s. The system has been built with the support of government resources, and it is linked with the support and housing services of the social welfare and health care authorities and the third sector. There are currently some 50,000–60,000 of these kinds of service and support homes provided by the social services in the service system. The housing stock of the social services continues to grow rapidly.

In order to eradicate homelessness, several forms of work have been created for improving the situation of not only the homeless but also others in the most difficult circumstances. These forms of support include housing advice (prevention of evictions), financial and debt counselling (management of rent and other debts), substance abuse and mental health clinics (management of dependence and disturbing situations), building of individual paths (transition from institutional care into everyday life), management of crisis situations and conciliation work (crisis centres for men, mother-and-child homes, and shelters). This work is being carried out by local authorities, social organisations and foundations, and (increasingly) service companies. In addition to the above, the largest towns have organised special services for the homeless, such as emergency shelters, day centres, support accommodation, support homes, and small flats meant for independent living.

Finland's Slot Machine Association (RAY) has played a key role in the implementation of the reduction programme of homelessness; it has allocated a total of some EUR 37 million for non-profit foundations and organisations for the implementation of the action plan in 2002–2005. In the long term, the reduction and gradual eradication of homelessness requires several simultaneous actions that support each other. The number of homeless people has started to fall (see appended table).

- **People with a chronic illness and the disabled**

The position of people with a chronic illness and the disabled is discussed in Part 4.

- **Substance abusers**

The strong rise in alcohol consumption, along with the reduction in alcohol tax, has increased the adverse effects of intoxicants and the need for related services. In accordance with the government's decision in principle, the target of the alcohol policy is to significantly reduce the adverse effects of alcohol use on the welfare of children and families and to reverse the trend in the total consumption of alcoholic drinks.

The prevention of alcohol and drug experimentation and drug use, especially among children and young people, will be made more effective. One target is that a maximum of 15 per cent of 16–18-year-olds would smoke and that the level of alcohol and drug abuse among young people would be no higher than it was in the early 1990s. The retail monopoly of alcoholic drinks will be retained so that it will be possible to monitor the availability of alcohol.

- **The over-indebted**

The situation of people with serious income problems is improved with social crediting (see previous plans and good practices). Development and expansion of debt counselling promote sustainable and fast solutions to debt problems. The number of people with debt problems can be reduced, and debt can be prevented, through efficient financial guidance.

- **People guilty of a penal offence**

In developing the implementation of penalties, reduction in re-offending is adopted as the key target of operations. The legislation on the implementation of prison sentences will be reformed so that an individual plan is drawn up for each prisoner for the duration of the penalty, supporting successful release. The rehabilitation into society of convicted people and their chances of a crime-free future are supported.

The identification of violent behaviour and early intervention in its causes will be boosted. The prevention of domestic violence and of the circle of violent behaviour passing from one generation to the next poses a particular challenge.

- **Immigrants under a threat of social exclusion**

The general objective of social policy is to efficiently prevent the aggravation of cultural conflicts and to promote the inclusion of all ethnic groups. The target is a balanced society where welfare is not bound to cultural background. Participation in the labour market and non-discrimination at work and in education are important in respect of the inclusion of all ethnic groups and the integration of immigrants. The most important condition for integration is learning either Finnish or Swedish. Independent life management of immigrants is supported with measures by various administrative sectors. The availability of services in immigrants' own language and interpreter services are improved under the policy. Good integration enables employees with an immigrant background to be included in the production of services where the special characteristics of immigrants and their adaptation to the dominant culture are taken into account.

Key measures aimed at risk groups

- The investigation of rehabilitation possibilities for the long-term unemployed, as well as their pension requirements, is carried on (in the ELMA project); see the implementation report for 2005. Furthermore, an additional one million euros for the health check-ups of the long-term

unemployed has been taken into account as a basis for state subsidies already in the 2006 budget.

- The interval labour market improves the employment situation of the structurally unemployed. Hiring out of labour to companies is adopted by the labour force service centres as one of the means of lowering the employment threshold. This model of hiring out staff is a service of general interest.

- Employer's low-wage support was adopted at the beginning of 2006. The support boosts the employment of older low-wage employees. The law on temporary low-wage support will be applied from January 2006 until December 2010. A company listed in the employer register can on its own initiative deduct the amount of the low-wage support from the tax to be paid on salaries and wages or from the recovered withholding tax.

- The establishment of workshop activity for young people and the development of its contents, as well as the building of the multi-professional network, are carried on. The minimum standards for the workshop activities for young people will be specified during 2006.

- The implementation of the national alcohol programme will be continued in accordance with the government's decision in principle. The new Narcotics Act will be carried into effect. The purpose of the act is to prevent illegal import into Finland, export from Finland, manufacture, distribution, and use of narcotics. Furthermore, preparation of a law on intensifying the monitoring of substances injurious to health and used for intoxication purpose has been launched.

- On the basis of proposals by the working group on after-care for ex-prisoners, joint recommendations by the Ministry of Justice, the Ministry of Social Affairs and Health, and the Association of Finnish Local and Regional Authorities on the development of follow-up care for ex-prisoners were prepared. The implementation of the recommendations will take place simultaneously with the carrying into effect of the new Prison Act and the implementation of the restructuring of the prison administration. The implementation of the recommendations will be monitored separately. The Government proposes an extra appropriation of EUR 3.5 million for prison administration.

- In order to help the over-indebted, many legislative measures have been taken to prevent difficult debt problems: In order to develop financial and debt counselling, proposals have been made, the conciliation procedure has been facilitated, the legislation on securities has been reformed, provisions concerning interest on delayed payments have been revised, and the act on debt collection has been reformed. In April 2006, the Finnish government approved the government bill on changing the act on the restructuring of debts. This means that debtors' obligation to pay their debts with additional income they receive during the payment programme will be alleviated. The reforms of the Enforcement Act are

under further preparation. It was proposed in connection with the latest partial reform of the Enforcement Act that receivables the closing date of which has expired would fall under the statute of limitations for good. The government bill is scheduled to be submitted in 2006.

- The Ministry of the Environment co-ordinates the work for the reduction of homelessness on the national scale and in the Helsinki region by promoting especially the supply of small rented flats, by directing investment grants for special groups to projects for the homeless, and by supporting the development of new operating models for the housing of the most deprived special groups in accordance with the government's housing policy programme. Finland's Slot Machine Association is allocating investment, operation, and project grants for support accommodation and acquisition of rented accommodation for the homeless in 2006–2007 within the competition regulations. The cities in the Helsinki region have drawn up a regional development plan for the social services concerning housing services for the homeless for 2005–2007. In accordance with the plan, a development co-operation network was launched in the region with project funding from the Ministry of Social Affairs and Health. In addition to the towns, the key actors in the network include the Centre of Expertise in Social Affairs of the Helsinki Region and organisations and companies providing housing and support services for the homeless. The Ministry of the Environment, the Ministry of Social Affairs and Health, and Finland's Slot Machine Association participate in the network as government representatives. The cities of the Helsinki region, in co-operation with the National Research and Development Centre for Welfare and Health (Stakes), will draw up quality recommendations for the standard of emergency shelters, hostels, and night shelters and the housing services in the Helsinki region during 2006. The Ministry of Social Affairs and Health is responsible for the development measures of its own administrative sector in order to safeguard housing and services for homeless people in need of housing services.

- The EU structural funds provide support for local and national projects, especially in order to combat exclusion from working life.

2.4 Good Governance

Preparation of the plan

The plan has been prepared in co-operation with various ministries, organisations representing the poor and socially excluded, labour market organisations, research institutes, local government representatives, and social work representatives of the Evangelical Lutheran Church of Finland. The streamlining of the processes of the open co-ordination method of social protection has made the co-operation and co-ordination

between public administrations closer. The plan has been dealt with by the EU subcommittee preparing material on social affairs and by the management group of the Ministry of Social Affairs and Health. A separate hearing has been arranged for the participants in the work against poverty and social exclusion.

Policy co-ordination

Broad-based preparation concerning key issues has a long tradition in Finland. Co-operation between the national government, local authorities, and labour market organisations has been close in the introduction of economic, employment, and social policy solutions. The labour market parties are prepared to carry their share of the responsibility when aiming for a high rate of employment and stable economic growth. In their collective agreements, these parties aim for solutions to improve employment and facilitate long careers and well-being at work, while combating the threat of social exclusion. The role of non-governmental organisations has strengthened, especially in addressing issues of social welfare and health policy.

The preparation of measures having an impact on the prevention of poverty and social exclusion progresses in co-operation in different sectors. The purpose of drawing up a national strategy report in Finland is to bring together the work carried out in different quarters. The method of open co-ordination does not provide the only co-operation forum in action against poverty and social exclusion. Successful co-operation requires mutual confidence on the part of all of the parties involved.

Mobilisation and participation of actors

The basis for having an influence on the decision-making affecting poverty is a functioning, democratic system; a solid judicial system; and good governance that listens to the citizen. Most of the decisions that have a direct impact on the position of poor population groups are made on the local level. Municipal democracy and initiative support local influence in Finland. The administration shall act close to the citizens and be aware of the situation of various population groups. In Finland, the Administrative Procedure Act regulates the principles of good governance. It is important to guarantee that it is as easy as possible for a citizen to appeal to an administrative authority. The implementation of citizens' rights is monitored by special authorities, such as social ombudsmen appointed by the local authorities.

Non-governmental organisations (NGOs) are part of the civil society, which is a key factor in functioning democratic societies. Non-governmental organisations build social cohesion and foster values. They accumulate social capital and have an influence on the direction of social development. Active citizenship and participation are also built with participation in organisations and by learning. Their operation prevents the development and deepening of problems and supports people's coping in everyday life. Organisations often reach out to people who would otherwise be left alone and without support with their many problems.

The services provided by NGOs and the partnerships of government and organisations have long traditions in Finland. These operations are important in respect of the prevention of poverty and social exclusion and in providing learning opportunities for socially excluded people. Organisations have had an important task of meeting special needs in areas such as child welfare, services for substances abusers and the disabled, care of the elderly, and rehabilitation. In areas where organisations provide support and services, there are often not many other actors, and specialist expertise has developed within the organisations.

It is emphasised in the strategy for the activities of non-governmental organisations by the Ministry of Social Affairs and Health that the service provision of the organisations has added value with respect to other service providers. Added value is brought by the reliability of operations, which is based on the strong, committed, and sustainable value base of the organisations. The organisations operate in the long term. They contribute to the building of the connection of national policies against poverty and social exclusion with the local level in co-operation with local authorities, and they create forums for expressing the needs of poor and socially excluded people.

The pastoral and social work of the Evangelical Lutheran Church of Finland has some 800,000 client contacts each year. The operations prevent poverty and social exclusion via concrete measures, with the basic task of alleviating and removing distress and suffering. Solutions to overwhelming debt problems and looking after the rights of the unemployed are examples of the church's operations. In situations of over-indebtedness, good results have been gained with voluntary conciliation procedures, by improving networking with various quarters that would be of help, and by supporting peer activities. In order to improve the rights of the unemployed, the church has made efforts to have an impact on their situation, in terms of, e.g., the conditions of unemployment security, and has aimed to alleviate the psychological burden of unemployment by emphasising the value of people. In addition to other problems, mental health issues have gained increasing power as a factor that heightens the risk of social exclusion.

Examples of co-operation between various actors include the sub-projects in the social sector development project, the alcohol programme, and the programme for reducing homelessness. Currently, 153 partners are involved in the implementation of the alcohol programme, including NGOs, municipalities, churches, and representatives of the labour market and industry and commerce. There have been 16 non-governmental organisations and institutes involved in the implementation of the homelessness programme, among them building contractors and owners; service providers for the mental health, substance abuse and prison services; and organisations representing homeless men and women, prostitutes, and ex-prisoners.

Mainstreaming

In respect of the policy aiming for the prevention of social exclusion and poverty, it is of primary importance for the targets and measures to be in line with the national reform programme of the Lisbon process. Broad-based preparation of the national reform

programme guarantees that prevention of poverty and social exclusion is addressed in the economic and employment policy.

Policy monitoring and assessment

The results of actions against poverty and social exclusion are to be assessed separately in an event to be organised in the autumn, by which time the updated statistics on changes in poverty and social exclusion will be completed. In the assessment of practised policies, efforts are made to use the available qualitative descriptions on the development of Finnish welfare as well. The development of poverty and social exclusion is assessed in connection with the follow-up of the government programme and in the annual reviews of various administrative sectors. The statistics authorities regularly publish information about changes that have taken place in the citizens' living conditions, welfare, and poverty situation. In addition, organisations regularly publish reports on the development of people's welfare. Research institutes play a significant role in the provision of background information on the phenomena related to poverty and social exclusion. All available topical information is used in the preparation of political decision-making and in the annual assessment of the development of poverty and social exclusion.

Appendix 2.1: Good Practices

THE LABOUR FORCE SERVICE CENTRE MODEL

Good Practice Examples: Suggested Form

Name of Policy/Project	Member State
The labour force service centre model	Finland

End Purpose of the Initiative

Reducing structural unemployment and raising the level of employment. The use of all employment reserves should be safeguarded in the predicted labour market situation, where the age groups entering the labour market are not sufficient to replace the age groups leaving the labour market. This is part of the reform of the service structure of the public labour force service, where the services will be differentiated by concentrating specific services and resources for the structurally unemployed in the labour force service centres.

Main Results

A study on the effectiveness of the operations of the labour force service centres will be carried out in 2006–2008.

The results of the follow-up study of the joint service experiment (in 2002–2003), which preceded the building of the network of labour force service centres, indicate that the clients of the joint service centres participated in the labour administration's employment and training measures somewhat more often than the recipients of labour market support in general. According to the study, about one in five of those whose clientship had ended by the end of 2003 had become employed. The researchers regard this figure as high, considering the client structure. According to client satisfaction surveys, clients had a favourable attitude toward the joint service. The clients felt that they were heard and the employees were interested in their affairs, there was enough time to deal with everything, and the employees of the service centres provided clear information and instructions.

According to statistics, in 2005 the labour force service centres had a total of 20,000 unemployed job-seekers as clients. The average number of unemployed clients per month was about 10,000. The clients of the service centres are placed mainly in wage-subsidised work (e.g., organisations), preparatory training for working life, vocational work trial placements, and preparatory labour market training.

Targeted Beneficiaries		Policy Focus	
The general population	☐	Social exclusion	☒
Children	☐	Health care	☐
Single-parent families	☐	Long-term care	☐
The unemployed	☒	Governance	☐
Older people	☐		
Young people	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants/refugees	☐	National	☒

Ethnic minorities	☐	Regional	☐
The homeless	☐		
Those with a specific illness/disease	☐	**Implementing Body**	
Other (please specify):	☐	Labour market service centre operations are based on multi-occupational co-operation between the authorities in local and regional administration (employment offices, the local authority, and the Social Insurance Institution of Finland) where clients are offered support in life management and versatile rehabilitative and activating measures. The labour force service centres are not independent offices but fixed network organisations based on a co-operation agreement, whereby the services of three different authorities are provided under one roof.	

Context / Background on the Initiative

The implementation is nationwide. The basis has not been to provide an even provision of services from the regional policy point of view. The Ministry of Labour has granted financing for the establishment of labour force service centre if there are many clients in the area who have been unemployed for at least two years and the operating model presented meets the funding criteria. In 2006, some 77% of the unemployed job-seekers who have drawn labour market support as passive support for at least 500 days live in the areas of the labour force service centres.

The labour force service centres were preceded by a two-year joint service experiment and projects funded on the national level and by the EU. The positive results of the experiment had an impact on the establishment of the labour force service centre network. Establishment and development of the network was adopted as part of the government programme and the related inter-administrative employment programme.

The national policies and local needs and conditions are the basis for the operating model. The establishment of labour force service centres is based on voluntary commitment and agreement on the operating model at the local and regional level. The municipalities and the Labour Administration together pay for the expenses related to the operation of the labour force service centres. The state budget has allocated EUR 16 million per year for the Labour Administration for the administrative

costs of the labour force service centres. The municipalities and the Social Insurance Institution of Finland have not received further resources from the state. The Social Insurance Institution of Finland is responsible for its own expenses.

In 2006, with the network complete, there are 38 labour force service centres in operation. In the catchment areas of the employment offices, there are 66 service centres; i.e., more than 40% of the employment offices are involved in the operation, and 162 municipalities are also involved. Labour force service centres are located throughout the country.

Details of the Initiative

1. Specific objectives

The national targets of the labour force service centre operations are: 1) reducing structural unemployment; 2) reducing the social assistance expenses and the labour market support paid on the basis of unemployment; 3) increasing the degree of activation and the active measures under the labour market support; and 4) increasing the clients' working capacity and functioning, and their active life and participation.

2. How did the initiative address these objectives?

The targets have been set by a national steering group, represented by the Ministry of Labour, the Ministry of Social Affairs and Health, the Association of Finnish Local and Regional Authorities, and the Social Insurance Institution of Finland.

3. What is/was the time scale for implementing the initiative?

Building of the network and development of the operating models in 2004−2006, after which the operations will continue as part of the normal services.

Monitoring and Evaluation

How is/was the project monitored/evaluated?

Statistical follow-up specific to each labour force service centre of the Ministry of Labour. Also, follow-up information on the development of social assistance on the municipal level.

Two studies will be carried out. In one, the effectiveness of the operations is investigated, and, in the other, a multi-occupational service will be developed with process analysis, for example.

Outcomes	
1.	**To what extent have the objectives been met?**
	It is typical for the labour force service centres to combine services of different administrative sectors into service entities, which means that the client's participation in support measures will last longer than average. In many cases, individual targets are made up of many intermediate targets. The service entities can be built to start with a health survey, medical and occupational rehabilitation, and activating measures by the social services. After that, it will be possible to either offer active measures in the labour market, such as preparatory training for working life or wage-subsidised work, or perhaps direct the client to training. Reaching of the targets is promoted with a multi-occupational service. In larger labour force service centres, the multi-occupational service is built on versatile expertise. In the service centres, expert services are offered by, e.g., public-health nurses, doctors, rehabilitation psychologists, social workers, social welfare supervisors, debt counsellors, social workers for intoxicant abusers, youth workers, rehabilitative work activity advisors, training consultants, vocational psychologists, career advisors, individual advisors, employment advisors, and employment co-ordinators. The smaller service centres can offer only the services of the labour administration and social services, and clients are directed to basic services, if necessary. Efforts have been made to dimension the resources of the service centres so that the objectives will be achieved. The service centres employ a total of some 600 full-time officials, of which the Labour Administration has about 320 employees.
2.	**What obstacles/risks were faced in implementing the initiative?**
	The results of the joint service experiment indicated that application of a multi-professional approach to work, the client structure, and administrative operations under various authorities are challenging. The operation of the labour force service centres includes development challenges due to the arrangement of multi-sector operations and a large number of clients, as well as to the building of 'paths' for the clients' employment. The special issues related to the cross-sector management of operations are one of the areas for development. It is important that the service is focused on the correct client group – those whose working capacity and labour market preparedness must be assessed on a broad spectrum and who also need social welfare and health care services in addition to employment services. Employment requires that the clients also receive other services, among them social welfare and health care services. The operations also require participation by different co-operation partners and the development of outsourcing operations. The key issue is the demand for labour, so co-operation with business life is another area for development.

3.	**How were these obstacles and risks addressed?**
	The handling of matters at national steering group level. Training events and work meetings have been arranged. A study focusing on the problems of multi-professional activities from the point of view of process analysis contributes to the elimination of the above operational risks. Local steering groups handle and outline, for example, direction of the client to the services.
4.	**Were there any unexpected benefits or weaknesses?**
	The clients are directed to the service centres mainly from the employment offices and the social services of the local authority on the basis of an estimation of service needs. Clients whose employment cannot be promoted solely through the expertise and services of the labour administration are directed from the employment offices to the service centre, as the services of social welfare and health services in particular will be necessary in addition to employment services in order to assess the client's working capacity and labour market preparedness. The number of potential clients is greater than what the labour force service centres can receive. It is necessary to outline the order of receiving clients and which client groups take priority in the provision of services. The operations have indicated that the time frame for the need for multi-professional services has been longer than has been estimated. Furthermore, implementation of the plans has been hindered by the fact that clients have to queue for some services – e.g., health care services – or that the necessary service has not been available. An assessment of the positive reception of the multi-professional service has been completed; the clients are satisfied with the 'one stop' service and the support they have received.

SOCIAL GUARANTEE FOR YOUNG PEOPLE

Good Practice Examples: Suggested Form

Name of Policy/Project	Member State
Social guarantee for young people	Finland

End Purpose of the Initiative

The objective of the so-called social guarantee for young people, included in the government's employment programme, is to develop young people's vocational expertise and preparedness for working life, promoting young people's placement in education and the labour market, preventing prolonged unemployment of young people, and ensuring early intervention to address the threat of social exclusion among young people. Young people's training, their seeking of education, and their employment are supported by means of employment management, public services, and cross-sector service co-operation. The reduction of youth unemployment is the main common objective.

Main Results

The youth unemployment rate has fallen: according to statistics from the Ministry of Labour, in 2005 there were, on average, some 13% fewer young unemployed persons per month than in 2004. According to Statistics Finland, the youth unemployment rate at the end of 2005 was 19.9% and in the equivalent period in 2004 it was 20.9%.

Unemployment periods among young people have become shorter; the number of job-seeking plans of young people utilising the public employment service has increased; resources have been allocated for youth employment services, service co-operation, and activation measures; services have become faster; and operating models have been made more efficient in the sectors of employment authorities, education authorities, and the municipal youth and social services.

Targeted Beneficiaries

The general population	☐
Children	☒
Single-parent families	☐
The unemployed	☒
Older people	☐
Young people	☒
People with disabilities	☐
Immigrants/refugees	☐
Ethnic minorities	☐
The homeless	☐
Those with a specific illness/disease	☐
Other (please specify):	☐

Policy Focus

Social exclusion	☐
Health care	☐
Long-term care	☐
Governance	☐

Geographical Scope

National	☒
Regional	☐

Implementing Body

The main responsibility lies with the public employment

	services (employment offices, follow-up, and support), the labour market departments of the Employment and Economic Development Centres, and the Ministry of Labour.

Context / Background on the Initiative

Part of the employment policy programme of the government programme (cross-sector employment programme).

The employment authorities carry the main responsibility for implementation of the social guarantee for young people. The education authorities carry the main responsibility for implementation of the educational guarantee and the development of guidance counselling. The youth department of the Ministry of Education and the organisers of the youth workshops carry the main responsibility for the establishment of youth workshop activities as a key activation alternative for unemployed young people. Finally, the various administrative sectors bear joint responsibility for making the service co-operation more efficient in support of young people's transfer to training and the labour market.

Details of the Initiative

1. Specific objectives

The social guarantee for young people within the area of responsibility of labour administration applies mainly to young people as defined in the Act on the Public Employment Service – i.e., unemployed job-seekers under 25 years of age. The social guarantee includes the boosting of the employment service process for unemployed young people and a guarantee that, after continuous unemployment of at least three months, all young unemployed job-seekers under 25 years of age will be offered an active alternative advancing their situation.

Early intervention in order to prevent prolonged unemployment: in the service for the young unemployed, the service need is assessed immediately at the beginning of the client relationship; an individual job-seeking plan is drawn up before three months of unemployment have elapsed; and the young person is directed to other services, if necessary. The monitoring of the service process and its results is an integral part of the implementation (with the objective of the young person's placement in work, active programmes, or training).

The social guarantee for young people as part of the public employment service also includes the development of operating models through the organisation of services and by allocating resources to services for young people as well as by developing service co-operation – for example, counselling on further education for young people, with the involvement of other actors.

2.	**How did the initiative address these objectives?**
	The employment programme, which is part of the government programme, included the following objective: Young people's transition to education and the labour market will be accelerated. In respect of the public employment services, young people's job-seeking, employment, and guidance services have been made more efficient, as has the cross-sector service co-operation. The objective of the employment service for young unemployed job-seekers is that a training, work practice, or workshop place will be offered to unemployed people under 25 years of age after three months of unemployment if the person concerned is not offered a job in the open labour market within this time. Unemployed young people without any vocational qualifications should be directed to appropriate training in order to gain vocational qualifications.
3.	**What is/was the time scale for implementing the initiative?**
	The social guarantee for young people will be implemented as a project starting from the beginning of 2005 and continuing to the end of the current government's period of office (spring 2007). In future, the principles of the intensified service model for young people will be included in the normal activities of the public employment service and service co-operation.
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	The statistics of the Ministry of Labour A questionnaire on implementation for the Employment and Economic Development Centres An evaluation study to be launched in 2006
Outcomes	
1.	**To what extent have the objectives been met?**
	(In the employment authority's area of responsibility) In 2005, average youth unemployment measured per month fell at the national level by just under 13%. On average, there were a total of 30,530 unemployed young people per month. The trend was favourable in the

catchment area of all employment and economic development centres. In 2005, the reduction of youth unemployment was significant compared with the decrease in unemployment in 2004 when youth unemployment fell by one per cent from the previous year. The unemployment of people under 25 years of age was at the 2005 level in the early part of the 1990s.

An individual job-seeking plan must be drawn up for all young people under 25 years of age not later than after continuous unemployment of three months. The number of individual job-seeking plans for young people has increased clearly since 2004. An individual job-seeking plan had been drawn up within three months for 28% of the young people whose period of unemployment had started in 2005. There are great regional variations. The number of job-seeking plans should be increased, and the matter is influenced by management by results and performance; i.e., it has been specified as a target for payments by results in 2006.

The employment offices have developed and reorganised services for young people. In 2005, counsellors for young people and young people's teams were appointed in the employment offices. Co-operation in the organisation of services for young people within the employment offices has been developed. Youths requiring multi-professional services have been directed to the labour force service centres, some of which have established teams dedicated to young people.

On the basis of reports by the employment departments, efforts have been made to determinedly and systematically strengthen the service co-operation of educational establishments and employment offices throughout the country on both regional and local level. The extent of the co-operation varies by area, which is partly justifiable on account of areas' different co-operation needs and requirements. In areas where co-operation has traditionally been strong, the implementation of social guarantee for young people has meant the strengthening of existing forms of work. In other areas, active building of the foundation for network co-operation has started partly from a new foundation, and partners and co-operation models that are feasible given the resources have been sought. According to estimates provided by the employment departments, this work has progressed and concrete actions have been implemented in accordance with the main policies for the social guarantee for young people.

According to an estimate by the Employment and Economic Development Centres, the reduction in youth unemployment is due to an increase in the demand for manpower and the implementation of the social guarantee for young people. Some of the effects of the development outlines included for the social guarantee for young people will be visible only in the longer term.

In 2005, the duration of unemployment among young people shortened to a certain degree and the number of young people within the social guarantee system fell.

2.	**What obstacles/risks were faced in implementing the initiative?**
	In the reform, no further appropriations were allocated for human resources, so the efficiency of the implementation depends on the possibility of reallocating existing resources.
3.	**How were these obstacles and risks addressed?**
	According to the instructions of the Ministry of Labour for the implementation of the social guarantee for young people, regional and local levels of administration were advised to reallocate resources to services for young people and to develop operating models for the services and service co-operation.
4.	**Were there any unexpected benefits or weaknesses?**
	The use of active alternatives in the employment services for young people did not increase, despite the further resources received for this purpose. Young people were employed without support measures as a result of good economic and employment trends.

NATIONAL REPORTS ON STRATEGIES
Good Practice Examples: Suggested Form

Name of Policy/Project	Member State
Social credit	Finland

End Purpose of the Initiative

Social credit refers to the granting of loans pertaining to the social welfare system. The aim of social loans is to prevent financial exclusion and indebtedness and to help improve people's ability to manage their situation. Social loans may be granted for justifiable reasons to a person who, due to being on a low income and having few assets, has no other means of applying for a loan with reasonable terms through other channels and who, nevertheless, is able to make loan payments.

Social credit was developed as a pilot project (1999–2001). In the pilot project, more specific information about the need for social credit, target groups, its social and financial significance, and the relation of social lending to the credit market and social security was obtained. Furthermore, the organisation and funding of social credit were examined. On the basis of the results of the pilot project, a government proposal on the law on social credit was put forward. The pilot project was accompanied by a public policy evaluation throughout the development process, and a public policy evaluation was also carried out from the end of the pilot project on the repayment of social loans. The Social Credit Act came into force on 1 January 2002. The law ensures that, as the local authorities introduce social credit, the basis of the system is the same throughout the country. In connection with the law entering into force, state funding for the social welfare and health care services of the local authorities was increased for the operating expenses caused by the arrangement of social credit. According to the law, the local authorities may arrange social lending to the extent they decide. When organising the lending, the local authorities must specify more specific bases for granting the loan, taking into account what the law prescribes on the matter. The local authority is responsible for the credit capital and losses. The local authority may charge the borrower interest on the loan that may not be higher than the base rate of interest, but no other charges.

Main Results

Social loans have helped in achieving sound financial management for the borrower, broken debt cycles, given the opportunity to purchase household goods at a reasonable cost, promoted rehabilitation and employment, safeguarded accommodation, helped in managing social crises, and in other ways had an impact on the independent life management of the borrower. The financial knowledge and expertise of the borrower has been strengthened by providing financial advice and guidance in connection with the granting of the loan and during repayment, if necessary.

The lending model created during the pilot project on social credit functions well and is utilised by all of the local authorities that have introduced social lending. Regardless of their small income and lack of means, the borrowers have managed to repay their loans and, accordingly, the credit losses of the local authorities have remained low.

Targeted Beneficiaries		Policy Focus	
The general population	☐	Social exclusion	☒
Children	☐	Health care	☐
Single-parent families	☒	Long-term care	☐
The unemployed	☒	Governance	☐
Older people	☐		
Young people	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants/refugees	☐	National	☒
Ethnic minorities	☐	Regional	☐
The homeless	☒		
Those with a specific illness/disease	☐	**Implementing Body**	
Other (please specify):	☐	Local authorities	

Context / Background on the Initiative

Social credit is part of the strategy for addressing poverty and social exclusion. It was developed during the recession of the early 1990s for people with a small income or lack of means in order to solve their problems that had arisen due to over-indebtedness and unemployment. Short-term work and irregular employment relationships still have an impact on the financial coping of this citizen group, and making purchases by means of high-interest partial payments or on consumer credit will easily result in over-indebtedness. Applying reasonable terms and conditions, social credit, in its impact, will focus increasingly on the prevention of financial problems in the long term.

Details of the Initiative

1. Specific objectives

Reducing over-indebtedness

Guaranteeing a level of income and consumption

Improving availability of loans

2. How did the initiative address these objectives?

3.	What is/was the time scale for implementing the initiative?
	1999–2001 forward
Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	The Ministry of Social Affairs and Health Constant follow-up with municipal statistics and follow-up studies
Outcomes	
1.	**To what extent have the objectives been met?**
	As the introduction of social credit is based on the discretion of the local authorities, its implementation throughout the country faces slow progress, although new local authorities enter the system each year. Social credit is not a new task for the local authorities *per se*, but it is one of the methods of adult social work applied in rehabilitating the indebted and often also those recipients of social assistance who are long-term unemployed. As a method of early intervention in the debt problems of young people, social credit has also contributed to the possibility for young people to enter training and to find accommodation and employment.
2.	**What obstacles/risks were faced in implementing the initiative?**
	-
3.	**How were these obstacles and risks addressed?**
	-
4.	**Were there any unexpected benefits or weaknesses?**

NATIONAL REPORTS ON STRATEGIES
Good Practice Examples: Suggested Form

Name of Policy/Project	Member State
The Advisory Board on Romani Affairs	Finland

End Purpose of the Initiative

The Advisory Board on Romani Affairs, which was established in 1956, acts according to the provisions pertaining to public law and the advisory tasks and initiative stipulated for the advisory board in the statutory order. Since its establishment, the advisory board has operated in connection with the Ministry of Social Affairs and Health.

Main Results

The tasks of the advisory board have not included the implementation of national or international projects. Instead, the board has aimed to have an impact in relation to the fact that the policies and other programmes under different administrations also take the Roma population into account. Correspondingly, its tasks include providing information about the programmes, project funding, etc. Regional advisory boards on Romani affairs, and EU, state-subsidised, and other projects, at the local level have implemented, e.g., projects promoting the vocational training and employment of Roma, and those supporting the participation of Roma people in pre-primary education. In addition to these governmental *ad hoc* activities, the local Roma population has been able to participate and become active in responding to issues that concern them. This can be seen in, for example, the increase in the establishment of local Romani organisations.

Targeted Beneficiaries

The general population	☐
Children	☐
Single-parent families	☐
The unemployed	☐
Older people	☐
Young people	☐
People with disabilities	☐
Immigrants/refugees	☐
Ethnic minorities	☒
The homeless	☐
Those with a specific illness/disease	☐
Other (please specify):	☒

Policy Focus

Social exclusion	☒
Health care	☐
Long-term care	☐
Governance	☐

Geographical Scope

National	☒
Regional	☐

Implementing Body

Ministry of Social Affairs and Health

Context / Background on the Initiative

The living conditions and equality of the Roma population have been steadily developing in Finland in the past few years. This is evident not only in the development of legislation but also in the reinforcement and resourcing of the institutions in which the Romani themselves participate. For example, the establishment of regional advisory boards on Romani affairs, operating within the provinces, by government decree in 2004 and the appropriations granted by Parliament in the state budget in 2006 have created new buoyancy in the regional and local promotion of Romani affairs.

Individual achievements of the advisory board include the special dwelling act in the 1970s, which enabled favourable-interest-rate financing with a special appropriation by the state to purchase housing for Roma. This had a significant impact on the ending of the acute housing problem among the Roma population at the time. The advisory board and related boards have also played a role in the development of legislation concerning minority and human rights in Finland in the 1990s–2000s.

Details of the Initiative

1. Specific objectives

Improving the social position of Roma, including housing and health conditions, educational and employment opportunities as well as reinforcing their culture.

2. How did the initiative address these objectives?

3. What is/was the time scale for implementing the initiative?

1956–present; continuous activity within permanent administrative structures

Monitoring and Evaluation	
	How is/was the project monitored/evaluated?
	Special studies on social situation and living conditions of Roma (education, child care, employment, housing)
Outcomes	
1.	**To what extent have the objectives been met?**
	Moderately well
2.	**What obstacles/risks were faced in implementing the initiative?**
	Attitudes towards the Roma. General lack of cultural competence in Romani affairs, immigration of new ethnic groups – the Roma no more the only special minority.
3.	**How were these obstacles and risks addressed?**
	Expansion of the regional advisory boards on Romani affairs.
4.	**Were there any unexpected benefits or weaknesses?**

PART 3 Finland's national pension strategy report

Finland forwarded its latest national pension strategy report to the Social Protection Committee in summer 2005. The synthesis report on adequate and sustainable pensions (SEC(2006)304)), drawn up on the basis of the European Commission's national reports, was completed in spring 2006. For this reason, the reporting on pensions in this shared report on social protection and participation focuses on the updating of information presented in the earlier pension strategy report in as far as the amendments have been significant.

As stated in the 2005 report, Finland's national pension policy decisions are, in broad outline, in harmony with the EU's common objectives, which are based on the three principles for pension policy adopted at the Gothenburg European Council in 2001. These are adequacy of pensions; financial sustainability of pension systems; and adjustment of pension systems in response to the changing needs of the economy, society, and individuals. The challenges of the Finnish pension system are mainly due to the change in the age structure and the accelerated growth of pension expenditures that results therefrom. Achievement of longer working careers and a higher employment rate is crucial to ensuring both the adequacy and the sustainable financing of pensions.

3.1 Updating of the Finnish National Pension Strategy Report

3.1.1 Sufficiency of pensions – fulfilment of social objectives

In Finland, the statutory pension provision consists of an earnings-related pension scheme and a national pension scheme. The purpose of the earnings-related pension scheme is to ensure to a reasonable degree that the level of consumption achieved during employment is retained after retirement. The statutory earnings-related pension covers all wage- and salary-earners and self-employed persons. It is supplemented by the residence-based national pension, which is intended to guarantee a minimum income for all pensioners. The national pension is proportional to the earnings-related pension. People who receive no earnings-related pension at all or a very small earnings-related pension receive the full amount of national pension. The pension scheme is supplemented by pensioners' housing allowance and pensioners' care allowance for supporting living at home and independent coping. Furthermore, special tax treatment of pensions supports pensioners with a small income. Public social and health care services also supplement the fulfilment of social objectives. Statutory pension provision can be augmented by a supplementary pension provision arranged by the employer or acquired by individuals themselves according to their personal needs.

The earnings-related pension is adjusted annually according to an earnings-related pension index[1]. The national pension is adjusted yearly for the national pension index, which follows changes in consumer prices. Therefore, for national pension recipients the level of the pension provision has risen at a slower pace than that for the recipients of earnings-related pensions, which has been compensated for with separate increases in the level of the pension in order to maintain the relative level of national pensions.

An increase in the level of the national pension will be implemented on 1 September 2006. The increase will be five euros per month. This increase will also be made to, e.g., the additional amount of the spouse's pension, special assistance for immigrants, and the national pension contribution to the pension assistance for the long-term unemployed. The increases will be implemented as part of the measures proposed to support the most deprived. In 2006, the full amount of the national pension is EUR 432.44–510.80 per month, depending on the place of residence and family relationship.

The increase affects some 660,000 national pension recipients. The net pension amount will also be increased for recipients of an earnings-related pension who do not receive a national pension but are entitled to a pension income tax deduction2. As a result of the increase in the level of pensions and the subsequent increase in the pension income deduction in municipal taxation, it is estimated that the net income of more than 900,000 pension recipients will increase in 2006. The previous level increase in the national pension, about seven euros per month, was carried out on 1 March 2005.

The national pension will also be affected by a reform under preparation, which will remove the municipality categories from national pensions and some other income benefits at the beginning of 2008. In practice, the change will mean that the benefits for those in municipality category II will increase in early 2008.

An extensive pension reform entered into force in Finland in 2005, under which, for example, the retirement age was made more flexible, so that it is possible to retire between the ages of 63 and 68. It is calculated that the possible rise in the retirement age also has a positive impact on pension amounts (see replacement rates summary table, Table 1).

Despite the equality of the Finnish pension system, it is a challenge to ensure sufficient pensions for women. In particular, women in older age groups may be at a risk of poverty if they receive no earnings-related pension and have to rely solely on the national pension, due to divorce or the death of the breadwinner. However, women's employment rate in Finland is high on the international scale, and increasing numbers of

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[1] With respect of earnings-related pensions, a wage-coefficient is used in the review of income during the working life, with the weighting of the index for the level of income being 80 per cent and the weighting of the consumer price index 20 per cent. All current earnings-related pensions are reviewed with an index with the weighting of the index for the level of income being 20 per cent and the weighting of the price index 80 per cent.

[2] The pension income deduction reduces the taxation of people with a small pension income. The deduction ensures that a person who receives only the national pension does not have to pay tax on his/her pension. The amount of pension income deduction is technically tied to the level of national pension.

women in the younger age groups are covered by an earnings-related pension scheme, which reduces women's risk of poverty.

People who have retired young on a disability pension may also be at a risk of poverty.

3.1.2 Sustainability of the funding of pension systems – a healthy foundation for funding

To ensure sustainable funding for pensions, the objective is to increase the retirement age by two to three years in the long term. The pension reform launched in 2005 (see section 3.2 on the results of the pension reform) will adjust the pension expenditure to take into consideration the increase in average life expectancy in the future, which will ease the pressure to increase contributions. However, according to calculations, the pressure to increase contributions will ease off around 2030, when the contribution should settle at about 27 per cent. The private-sector pension plan investment reform, which came into force in early 2006, further aims to reduce the pressure to increase contributions.

In addition to extensive reforms presented in the previous reports, the legislation on the operation of authorised pension insurance companies is under reform. The reform plans concern, e.g., the investment operations and the rules regarding coverage and solvency within the earnings-related pension scheme. The rules on the monitoring of operations and administration of employee pension institutions are also under reform.

The objective of the reform under preparation is to reform the pre-funding principles and solvency mechanism of the pension institutions so that it will be possible to increase the pension institutions' investment in shares to an average level of about 35 per cent of their overall investments within the next five years. The returns on investments from earnings-related pension assets have a crucial significance in the curbing of pressure to increase earnings-related pension premiums in the Finnish system, which is based on defined benefits and is partially pre-funding. Ultimately, efforts are made to have an impact on the level of employee pension contributions by increasing the pension institutions' possibilities of seeking higher returns on their assets. It is estimated that, along with the increase in investments in shares, the level of returns will rise and the pressures to increase premiums can be eased in the long term by one to two percentage points (see Figure 1).

As the reform plan for the increase of returns on investments requires further risk-taking, the reform also includes the need to make the supervision and control of pension institutions more effective. The reform of the rules on the supervision of the operations of employee pension institutions also aims to increase openness in their operations and therefore also to promote competition. The target is to increase the institutions' obligation to inform about their financial activities and to provide related data to the supervisory authorities in more detail than at present. At the same time, the intention is to intensify the supervisory authorities' access to information and the obligation to provide sufficient public reports about the operations of the authorised pension insurance institutions.

The target of the reform affecting the administration of employee pension institutions is to improve the transparency of the operations of authorised pension insurance companies and the equality of their administration. In the regulation of the companies' operations and administration, efforts are made to use corporate governance recommendations confirmed for exchange-listed companies, where applicable. As the reserves of the employee pension institutions are particularly large by Finnish standards, and their operations partly pertain to public administration, it is also important to ensure the efficiency and transparency of the supervision of the companies' operations.

The government bill on the reforms will probably be presented to Parliament in summer 2006. The reforms are scheduled to become effective on 1 January 2007.

3.1.3 The reform of pension schemes to meet the changing needs of the economy, society, and individuals

In the statutory earnings-related pension scheme in Finland, principally all salaries, wages, and entrepreneurial income increase a person's future pension. One's pension also accrues during unpaid periods considered equivalent to working life, such as periods of child care. Employers are obliged to arrange for statutory earnings-related pension provision for all persons in their employ, regardless of the duration of employment. Short-term or otherwise irregular employment is also covered by earnings-related pension provision. The same principles apply to municipal and state pensions as to the earnings-related pensions in the private sector.

As regards the development of pensions provision for grant recipients, the investigation work referred to in the previous report has progressed, and the pension provision for grant recipients will be prescribed in connection with the pension reform. Currently, grant recipients are not principally covered by statutory earnings-related pension insurance. The new regulations are scheduled to become effective in 2007.

For example, the reform plans concerning the operation and supervision of employee pension institutions aiming at openness and transparency of pension schemes are reported in item 3.1.2 above.

3.2 Attention to Special Issues

In its synthesis report on sufficient and sustainable pension provision, published in spring 2006, the European Commission has already raised, e.g., the link between flexibility in the age of retirement and longer working lives as a common subject shared by the EU member states.

In Finland, a significant private-sector earnings-related-pension reform took effect at the beginning of 2005, which was reported on extensively in the 2005 pension strategy report. With the reform, for example, retiring on an old-age pension was made flexible between the ages of 63 and 68 (instead of the previous 65); an incentive accrual of 4.5 per cent will spur people to carry on working. In the long term, calculations indicate, the new scheme should postpone the age of retirement by two to three years, adapt the

pension scheme to the average increase in life expectancy, and level out the pressures to raise earnings-related pension premiums.

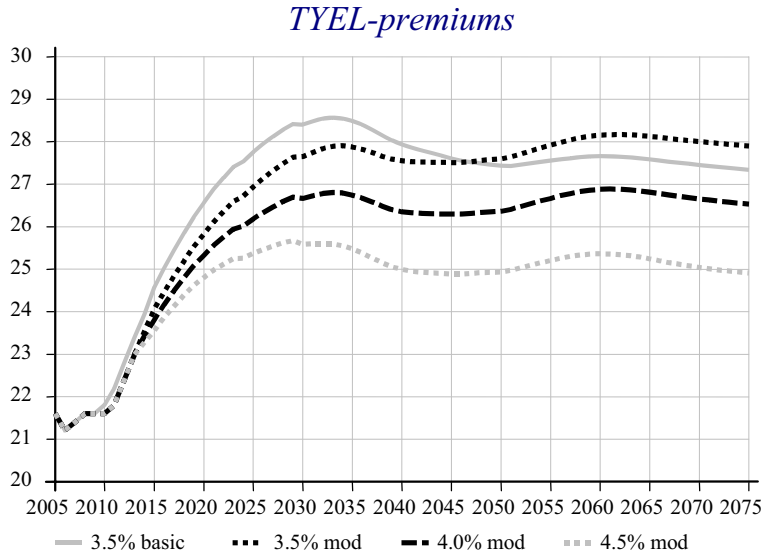
In respect of Finland, the follow-up report on the reform programmes in accordance with the Lisbon strategy highlights the considerable positive development in the employment of older workers. In the commission's opinion, this is a result of, e.g., the recent pension reforms. This positive trend seems to be continuing. According to the latest statistics, it would seem that the option of retiring on an old-age pension at the age of 63 has been used more moderately than was earlier predicted (see Table 2): about one in four took the option of retiring at the age of 63–64 provided by the pension reform. This trend has been supported by the good employment situation of older workers (see Figure 1). The employment trend in 2005 was favourable in general, too. The average employment rate was 68.0 per cent (an increase of 0.8 percentage points). Examined by age group, the number of people in employment increased most in the age group of 60-to-64-year-olds, by 4.3 percentage points, to 33.2 per cent. The good employment trend of older workers has been influenced by the changes in legislation governing employment pensions and similar factors, as well as by particularly good economic developments.

Appendix

Table 1. Replacement rates summary table, 2.6.2005 (source: Finnish Centre for Pensions)

	Base case: 100% of average earnings (and 10 years after retirement; relative to projected average earnings)					2/3 of average earnings		Concave earning profile		Rising earnings, from 80% to 120% of average		Rising earnings, from 100% to 200% of average		Broken career (30 years of seniority at retirement)		*Working career of 38 years, between 25 and 63*		*Working career of 42 years, between 25 and 67*	
	2005	In 10 years	2010	2030	2050	2005	2050	2005	2050	2005	2050	2005	2050	2005	2050*	2005	2050	2005	2050
Gross replacement rate, 1st pillar	56.6	48.7	60.3	57.3	53.9	64.8	53.9	56.6	51.8	54.5	46.1	53.4	42.3	45.8	42.3 (44.7)	51.2	46.8	64.2	60.8
Gross replacement rate, 2nd pillar	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total gross replacement rate	56.6	48.7	60.3	57.3	53,9	64.8	53.9	56.6	51.8	54.5	46.1	53.4	42.3	45.8	42.3 (44.7)	51.2	46.8	64.2	60.8
Total net replacement rate	62.6	55.1	66.2	65.7	63.6	74.1	67.0	63.5	60.7	60.7	56.1	61.5	53.2	54.6	54.3 (56.1)	58.5	56.2	66.5	69.5
Of which means-tested benefits, in percentage points of total net replacement rate	-	-	-	-	-	4.9	-	-	-	-	-	-	-	0.6	-	-	-	-	-
Note: '2005' refers to pension in 2005 with reference to work income in 2004 except where the MS needs to refer to a different moment or a previous year.																			

Figure 1. The trend in TyEL premiums with different expected income* (source: Finnish Centre for Pensions)



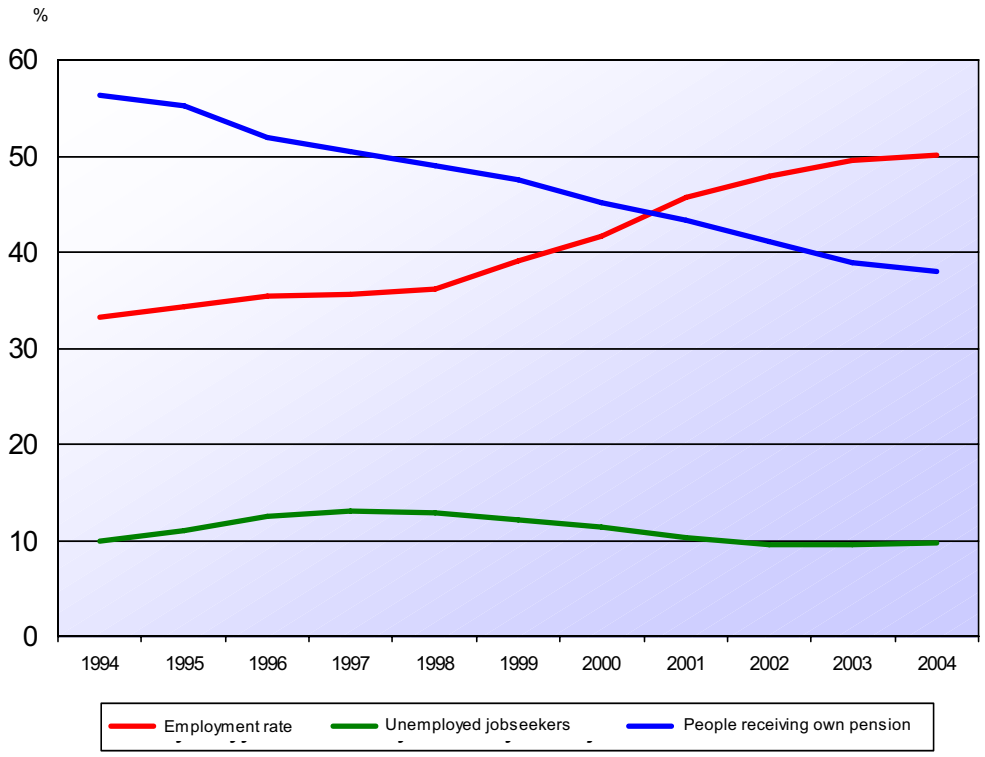
* *basic: current rules*
mod: rules in accordance with the reform

Table 2.

Retiring on an old-age pension at the age of 63-64 in 2005			
People with an employment pension insurance 31 Dec. 2004*	Number 160,000	Not retired 45,000	Retired 115,000
	Number	Working	Not working, not retired
Possibility of retiring during 2005	45 000	34 000	11 000
Number of people retired at the age of 63-64	16 000	12 000	4 000
Estimated number of people retiring on an old-age pension in 2005 enabled by the reform (aged 63-64)	11 000	7 000	4 000

*People with an unemployment pension insurance born in 1940-42 with an option of using flexible retirement in 2005 in respect of their age.
Source: Finnish Centre for Pensions

Figure 2. Percentage of people in employment, percentage of unemployed jobseekers excl. persons laid off) and percentage of people receiving own pension excl. people on a part-time pension) of the population aged 55 to 64 in 1994-2004



Sources: Statistics Finland, the Ministry for Labour, the Finnish Centre for Pensions)

PART 4 National plan on public health service and long-term care

4.1 Summary

The target of the Finnish health care policy is to prolong people's healthy and active life, to safeguard as high a quality of life as possible for everyone, and to reduce both health inequalities between population groups and the premature mortality. This requires health considerations to be taken into account in all decision-making in society – health must be part of the social policy.

The public health service is based on preventive health care and well-functioning health services available to the entire population. The target is to maintain and improve psychological, physical, and social capacity – the foundation for health must be created at a sufficiently early stage. The health policy focuses on a functioning primary health care and occupational health service, correct division of tasks between primary health care and specialised care, an appropriate ratio of outpatient and inpatient care, and improvement of environmental health.

The social welfare and health services are based on services that are organised by the local authorities and tax-funded, and which are available for everyone's use, regardless of social or financial position. Private social welfare and health services complement the municipal services and provide an alternative to them. Private service providers include private companies and the third sector. Purchaser–provider models can be introduced in services that have a functioning market and in which the packaging of services is possible, sensible, and in the interests of the clients.

Long-term care is part of the primary health care and social welfare system. The target of Finland's policy on ageing is to maintain the functional capacity of older people for as long as possible. The services are dimensioned according to the individual's functional capacity. Outpatient services are provided for people with only slightly reduced functional capacity, and long-term care is given to people whose functional capacity is impaired in the long term or permanently. This safeguards the right of the elderly to live independently at home in their familiar living and social surroundings for as long as possible while ensuring provision of necessary services and allocating resources in an appropriate way.

The policy on ageing has at present six main lines: improving health and functional capacity, supporting living and coping at home, improving the quality of services, reinforcing and clarifying clients' rights, safeguarding a reasonable income, and ensuring sufficient funding for services and income security. These lines of policy are implemented via various projects for promoting independent initiative of the elderly and postponing the need for institutional care. The social welfare and health care sector, together with the housing authorities, support independent living and accessible environments.. The funding of the services shall support elderly people receiving the treatment corresponding to their functional capacity. Another

target is to ensure high-standard services in close co-operation with the local authorities, organisations in the third sector, volunteer workers, and companies in the field.

The target of the disability policy is to safeguard the necessary services for all residents of the municipality, regardless of their financial or social status. The foci of operations include removal of obstacles to the participation of the people with disabilities, services for the disabled, and their rehabilitation. The objective is that the primary services meet the needs of disabled people as far as possible. Their equality is ensured with specialist services, such as personal help and individual housing solutions.

The need for social welfare and health care services is on the increase. However, it is not growing in fixed proportion to the increase of the ageing population, because the health and functional capacity of the population have constantly improved and the elderly are healthy and coping independently to a higher age than before. Today, the average age of people entering home-care services is 76, and that of people transferring to institutional care is 82. According to estimates, the need for care will see its strongest increase after 2010, with an increasing number of very elderly people. Demographic factors explain most of the increased need for long-term care. A particular challenge lies in the development of safe and high-quality home care and service housing for older people suffering from dementia.

The state is responsible for the steering of policy and the systematic development of the steering system. The transparency and manageability of state steering are being improved. These means are necessary for safeguarding the equal availability and quality of welfare services and social income transfers throughout the country. At the same time, co-operation among the state, local authorities, and the private and third sector is supported. Income transfers and services form one entity.

The funding for Finnish health care services consists of a combination of funding by the local authorities and the state, client fees, and the private health care sector supported by sickness insurance. The Slot Machine Association provides significant funding for for the NGOs in the disabled and the elderly service sector in addition to youth work. In 2005, local authorities funded about 57 per cent of the costs of social welfare and health care services. State subsidies covered some 33 per cent of the costs, with the remaining 10 per cent covered by client fees.

The funding of social welfare and health care services is developed on the basis of tax funding so that the payment system supports the pursuit of social policy targets set for social welfare and health care. The public sector's funding channels are developed so that they do not result in an inappropriate supply of, or demand for, services. Furthermore, they must not enable inappropriate transfer of the responsibility for care and costs to another funding channel.

The government prepared the municipal and service structure reform in 2005–2006. The target of the project is to provide a sufficient structural and financial basis for services under the responsibility of local authorities in order to safeguard their organisation and provision in the future. The quality, impact, efficiency, and technological development of services are taken into account at the same time. A framework law on the implementation of the municipal

and service structure reform will be submitted in autumn 2006. Tasks in social welfare and health care will be pulled together in regional cooperation structures.

The decisions to be taken in the organisation and funding of social welfare and health care services are part of the mandate of member states. However, it is possible to learn from others in the development of these systems. An EU-level debate would be expected to provide added value especially in the cost containment on the macro level. This is related to, on the one hand, the opportunities for health promotion to be implemented on different levels and sectors of social policy and, on the other hand, for example, the challenges to curb the increase in the cost of pharmaceuticals.

4.2 Health Care

4.2.1 Description of the health care system

The Finnish health care system applies to all residents of the country. Municipalities are obliged to arrange health services for their residents. At the beginning of 2006, there were 416 municipalities in mainland Finland. The province of Åland is responsible for organising the health care services in the Åland Islands.

The law contains general, but not detailed, prescriptions concerning the arrangement of services, and in most cases the ways for organisation are left to the discretion of the local authorities. Local authorities may organise the services themselves, together with other municipalities, by purchasing services from private service providers or from overseas, or by distributing service vouchers to the service's users for purchasing the services from a private provider approved by the local authority. Service vouchers are used mainly in certain social welfare services.

Primary health care is organised in health centres that must provide a wide variety of statutory services. These include preventive services, family planning, maternity care, child health services, school and students' health services, outpatient and inpatient care, physiotherapy, care of the elderly, oral health care, occupational health care, and local patient transport services. The health centres provide health care services in co-operation with other municipal services, such as basic education and day care.

Specialist care is arranged in hospitals at either an outpatient clinic or an inpatient ward. State-run hospitals are owned by the hospital districts. There are 20 hospital districts in Finland. The population base of the hospital districts varies between 70,000 and 800,000 residents.

In addition to the municipal system, there are private health care services available. The services most commonly provided by the private sector include physiotherapy, dentist's and doctor's surgeries, and occupational health care. To a great extent, appointments with a private doctor are with specialists and amount to fewer than one in four of all doctor's appointments. The number of private hospitals is about 40, most of which have only a few beds reserved for short-stay surgery.

Some of the medicine and travel expenses and the private medical fees are reimbursed by the statutory sickness insurance. The sickness insurance system also pays earnings-related benefits in the case of a short-term illness, pregnancy, childbirth, or childcare. All residents of Finland are personally insured, including children.

Public authorities fund the municipal health services mainly with tax revenue. The state participates in the funding by paying the local authorities a general, not earmarked, state subsidy, which is, on average, 33 per cent (2005) of the costs. The state subsidy paid to the municipality depends primarily on the age structure of the municipality and the number of disability pensions. State subsidies cover about a quarter of the true operating expenses of municipal social welfare and health care. In 2004, the percentage of funding for households in the operating expenses for social welfare and health care was 7.7%.

The funding for sickness insurance was reformed at the beginning of 2006. The sickness insurance is divided into medical expence insurance and earned income insurance. The sickness insurance contribution of all employers is 2.06% of salaries and wages. The employee sickness insurance contribution is 2.10%, consisting of a sickness benefit fee and 0.77% of the unemployment allowance fee of 0.77%. For pensioners, the sickness benefit fee of the sickness insurance is 1.5%.

In respect of sickness insurance expenses, the management of rising medicine expenses is a key issue. The reform concerning generic substitution for medicines and the reduction in wholesale prices of medicines have curbed the increase in medicine expenses. The insured's share of payment responsibility has been increased.

In Finland, occupational health care services are an important part of the health care system. The target of occupational health care is to have a healthy and safe working environment, prevention of work-related illnesses and accidents, and employees with a good working and functional capacity. Employers must arrange preventive health care for their employees (refund category I). If desired, the employer may also arrange for medical and other health care services (refund category II). Entrepreneurs and other self-employed people can arrange their own health care on a voluntary basis. In 2004, the number of employees within the sphere of the system was about 1.8 million, which is about 86% of all wage- and salary-earners.

The Social Insurance Institution of Finland reimburses 60 per cent of the necessary and reasonable expenses arising from the arrangement of occupational health care (refund category I). In refund category II, the reimbursement is 50% of all expenses. The municipal health centre is obliged to sell occupational health care services to employers who wish to purchase these services. Employers may also arrange for occupational health care services themselves or purchase them from private service providers. Employees are not charged for the use of the services arranged by the employers on a statutory basis.

4.2.2 Availability (target j)

The target of the Finnish health care policy is to increase human health and functional life expectancy with the promotion of health, thus also reducing the need for treatment. The

significance of health promotion as part of municipal health care operations is emphasised in the legislation amendment that came into force at the beginning of 2006.

At the local level, the responsibility for organising health care services is decentralised. Legislation sets forth an extensive scope for organising municipal health care services but provides the opportunity to adapt the service offering to local circumstances and needs. From the standpoint of the patients, it is essential to receive high-standard services as close to home as possible. The target of the municipal and service structure reform is to develop the production methods and organisation of services in order to realise regional equality in the access to services. In regional structures, the organisation of services and the promotion of health, functional capacity, and social safety are taken into account.

The availability of care for the working population is boosted by free occupational health care services, which, on the other hand, has been regarded as increasing inequality of access to care on the level of the entire population (e.g. OECD).

Improving access to care

The availability of health care services in the municipal system has been improved through amended legislation, which came into force on 1 March 2005, with maximum time frames for access to non-emergency treatment. According to the new legislation, clients must be able to contact the health centre immediately during its normal opening hours either by telephone or personal visit. It is often possible to assess the patient's need for treatment by phone, and this can be done by a health care professional other than a doctor. If it is necessary to visit the health centre in order to assess the need for treatment, an appointment must be arranged within three working days of the patient contacting the health centre. Treatment at a health centre will usually begin with the first visit. If this is not possible, treatment must be provided within three months. If the health centre provides specialised medical care, access to it must be given within six months. Treatment that is considered odontologically necessary must be provided within a reasonable time – within six months, at most.

Hospital treatment requires a doctor's referral, and the need for treatment must be assessed within three weeks of the hospital receiving the referral. The assessment can be made either on the basis of the referral or by examining the patient in hospital. If the medical examination indicates that the patient requires hospital treatment, the treatment must be started within six months of the assessment.

If the health centre or hospital cannot treat the patient within the prescribed time, the patient must be given the opportunity to receive treatment elsewhere, either in another hospital district or through the private sector. No extra costs shall arise for the patient as a result of this arrangement. The patient is also entitled to refuse treatment.

Each hospital district joint municipal board is responsible for the ogranisation of specialized medical care within its area in accordance with uniform medical and dental grounds. Harmonised principles for access to non-emergency care have been prepared for the treatment and examination of about 200 diagnoses. Doctors use these guidelines when deciding on patient care. In addition to guidelines on treatment, a doctor must always take into account the

patient's individual situation and need for treatment. The doctor decides on treatment with the patient.

The reform of access to non-urgent treatment has decreased the number of patients in waiting significantly.When the project was launched in October 2002, about 66,000 people were on the waiting lists for specialised care; at the end of 2005, the number was 20,000; and in June 2006, there were some 12,000 people on the waiting lists. There have been great differences between hospital districts in the treatment of patients on the waiting lists for operations. The reform includes the development and introduction of monitoring of the management and comparison of waiting lists. Particular attention is paid to the position of mental health and chronically ill patients and to access to outpatient treatment.

Care guarantee has clearly reformed, and improved access to treatment also in primary health care. Practices have been changed and services improved. Results have been gained by centralising telephone services, developing division of tasks, and utilising technology – i.e., organising Internet guidance. The situation in health centres is now significantly better than before the care guarantee was instituted. In Finland, four out of five people now live in an area where it is possible to make immediate contact with the health centre. In January 2005, before the reform came into effect, nearly four out of five health centres reported that they had constant or occasional problems with contact.

Assessment of the need for treatment within three working days, which is required by the system, is successful in most cases. Approximately 96 per cent of the population live in an area where the need for treatment can be assessed within three working days. According to a study carried out by the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health in February 2006, constant problems in the assessment of the need for treatment no longer exist. Four per cent of the population live in an area where implementation of the specified time frame causes occasional problems. Before the law became effective, one health centre in three reported being unable to assess the need for treatment within three working days.

Immediate contact with the oral health care staff of the health centre is available almost everywhere. At the beginning of 2006, about 80 per cent of health centres reported that they are keeping to the time limits prescribed by the care guarantee, even though the demand for treatment had increased. Dental clinics are seeing an increasing number of patients who did not have regular visits before.

The Ministry of Social Affairs and Health is monitoring the implementation of the time limits for access to treatment in collaboration with the State Provincial Offices.

Patient co-payments

In Finland, most municipal health services involve a fee for the client. There are two main purposes for the fees: to fund the operations and to direct demand. The client fee system was introduced in the 1980s and, in some respects, even earlier. Since then, a number of individual changes have been made to the fees.

In 2004, the proportion of funding for households in the operating expenses of the social welfare and health care system was 7.7%. The percentage varies with the services involved. For specialised care, the share of households amounted to 4.9%, in primary health care 9.9%, in inpatient care for the elderly 18.2%, and in home care 14.5%. In the households' share of funding, the proportion consisting of medicine costs is considerable. The municipal system and the sickness insurance system use several separate payment ceilings, which reduce the cost burden on clients.

The needs for reform in relation to the payment policy and system of municipal social welfare and health care were investigated by the committee appointed by the Ministry of Social Welfare and Health, which submitted its report in September 2005. The proposals of the committee are explained in further detail in section 4.3.4, below.

4.2.3 Quality (target k)

Extensive health promotion is the basis for quality in health care. A functioning service system and its quality are safeguarded with client orientation, good and versatile services, sufficient services for the elderly, and a sufficient number of skilled employees. Quality is made an increasingly integrated part of the operation of service organisations. Municipalities use national quality recommendations for different social welfare and health care services, which can also be utilised by other service providers. The utilisation of assessments and feedback from the clients and patients is increased in the assessment of the quality of services. Citizens are given information about the availability of services. Private services must have the same standard of quality as municipal operations.

In the quality control of social welfare and health care, proactive monitoring and guidance, steering, and monitoring data for the service providers are emphasised. This way, any failings in the content and quality of services can be tackled before they become a significant problem.

Extensive health promotion

Health promotion and reduction in the prevalence of national diseases and their risk factors are influenced with different means of social policy. To an increasing extent, health is adopted as a principle that directs decision-making at different levels of social policy: in international co-operation and on the national, regional, and local level. In decision-making, effects on human health and social welfare are assessed in advance, and the gender effects of the decisions are also evaluated. People's independent initiative in the maintenance and promotion of their health and welfare is supported by making sure that the environment and conditions promote healthy options. In order to diminish health inequalities, plans are made to prepare an extensive national action plan. Health inequalities are diminished especially through an impact on groups with the highest health risks, such as those exhibiting smoking, alcohol abuse, and obesity.

Mental health problems are prevented with measures aimed at the whole population and identified risk groups. Solutions for mental health risks in the workplace are sought in a more efficient way. In support of these, a national action plan for mental health care and substance

abuse treatment will be drawn up on the basis of experiences in previous national development projects.

Reinforcing the position of service users

Patient rights are protected, for example, with the law on the rights and status of patients. All permanent residents of Finland are entitled, without discrimination, to the health care and medical treatment required by the condition of their health within the limits of the resources available for health care at any given time. Patients are entitled to high-standard health care and medical treatment. Patients are entitled to sufficient information about their health status and treatment alternatives. Patients must be treated in mutual understanding. In Finland, patients do not have an absolute right to choose the doctor at the health centre or hospital for their treatment. However, whenever possible, efforts are made to take patients' wishes into account if, for example, they want to change their doctor. Patients can usually decide whether to acquire services from a private or public service provider (where private services are available). The opportunity for clients to choose their place of treatment is intended to be increased. People requiring urgent treatment must be given medical treatment regardless of their place of residence. In addition to the above-mentioned law, patients' rights are protected by the statutory patient insurance scheme, from which a patient may receive compensation for patient injuries. The compensation is not contingent on negligence by health care personnel.

Legislation safeguarding patients' position is supplemented with regulations and recommendations on services and treatment, which ensure appropriate service, treatment, and access to treatment within a reasonable time. The objective is to ensure the opportunity of clients and their relatives to take part in the planning of treatment and treatment arrangements. With a versatile assessment of the need for services and with an individual treatment, service, and rehabilitation plan, drawn up with the client, the need for services and treatment is established, the services required by the client are adapted, and the division of tasks between the service providers is agreed. This improves the effectiveness of the services. The binding nature of the plans is emphasised. The need for services and the resources required for them in the municipality are also made visible with the treatment, service, and rehabilitation plans. People's independent initiative and self-care possibilities are reinforced by providing information about health, health services, and self-care.

Cost-effective care

The target is to ensure the quality of health services throughout the country by specifying the local authorities' obligation to provide services and by reinforcing the clients' position. The meeting of necessary care and its provision is improved with research data. Before introduction of new treatment methods, their cost-effectiveness is assessed on the national level, utilising international assessment data. Also, in the assessment of substitute medicines, the economy and treatment value of the medicine in question are taken into account.

The production of Current Care recommendations started toward the end of the 1990s as part of the national health strategy. As a result, evidence-based clinical practice guidelines have been developed for the health care system. There are a total of 70 guidelines so far, some of which have already been updated. Finland's leading medical society, Duodecim, prepares the

care guidelines. The work is funded by the Slot Machine Association with the same funds it uses for supporting public health work. The guidelines are adapted to different conditions with regional care programmes. All Current Care guidelines are freely available on the Internet.

Patient safety as part of quality assurance

Quality assurance has long been carried out on the local level, but the objective is to make it an even more integral part of the operations of service organisations. The promotion of patient safety is an essential part of quality assurance. The measures of patient safety promotion have been implemented on the local level; for example, special attention has been paid to the prevention of hospital infections. In spring 2006, the Ministry of Social Affairs and Health approved guidelines for the national patient safety policy. The national patient safety network started operation toward the end of 2005.

4.2.4 Sustainability of funding (target l)

In Finland, expenditure on health care services was 7.5% of the GNP in 2004, clearly a lower proportion than for the EU countries on average. Expenditure on health care services per resident was also among the lowest in the EU. The difference is explained in part by the low pay level of Finnish health care workers. Another factor explaining the difference is the statistical difference in the expenditure on institutional care for the elderly between Finland and many OECD countries. In Finland, expenditure on institutional care for the elderly is included in expenditure on health care services more concisely than in many other OECD countries. If these expenditures will be added to the total health expenditure, their share will remain at 8.0 per cent of the GNP.

Although the ratio of health care expenditure to the gross national product has diminished compared with the early years of the 1990s, this expenditure has grown in real terms since 1995. In the last few years, expenditure on health care services has grown in real terms at more than four per cent each year. Expenditure on medicines and dental care has increased the most. The increase in dental care expenditure is due to the expansion of dental care coverage. Since December 2002, the entire population has been entitled to publicly funded dental care.

Curbing the cost of medicines

Drug treatment is an essential part of modern health care, and its significance is increasing. Medical expenditure in outpatient care amounts to more than two billion euros on the annual level. More than a billion euros went to medicine reimbursements in 2005. In 2004, medicine reimbursements increased by as much as 11 per cent. In 2003, the increase was less than seven per cent, a result of the introduction of generic substitution. Despite the accelerated growth, price revisions of medicines and generic substitution with its price competition slowed down the development of reimbursement expenditure. Advanced drug treatment enables earlier patient discharge and home care than before. Hospital treatment periods are growing shorter.

The target is to limit medicine expenditure's current annual growth of some 10 per cent to a maximum of five per cent in 2008–2011. The cost-effectiveness of drug treatments can be improved significantly. This will be achieved by promoting rational prescription and use of medicines and by increasing price competition between pharmaceutical manufacturers. The medicine reimbursement scheme is being developed toward application of appropriate practices in respect of treatment. The prices on which the medicine reimbursement is based will take the medicine's value of treatment into account in a better way than at present.

The system that supports small pharmacies, which is currently implemented with the pharmacy fee and medicine tariff, will be reformed so that it has no inflationary effect on the retail sale prices of medicines. The pharmacy system will be reformed so that medicine distribution throughout the country and information about medicines for their users, provided by pharmacies, will also be safeguarded.

In addition to increased cost-effectiveness in drug treatment and distribution of medicines, the problems related to the current two-channel funding for drug treatment will be investigated so that the responsibilities of the municipal health care system in relation to drug treatment funded by sickness insurance will be as unambiguous as possible. Appropriate drug treatment will be safeguarded for both inpatients and outpatients.

Sufficiency and expertise of personnel

The sufficiency of health care workers and their good professional skills ensure high-standard service for the clients. In the municipal health care service, the shortage of doctors has remained almost unchanged in the 2000s, and there are great regional differences. Lack of doctors concerns remote areas especially. The problem is greater in primary health care than in specialised care. However, the lack of dentists in health centres has been growing constantly. The shortfall in nursing staff (nurses, auxiliary nurses, and nursing assistants) numbers is considerably smaller. The development of the need for health care staff is regularly monitored. It is estimated that 43 per cent of those municipal social welfare and health care workers working in 2003 will retire by 2020. Efforts have been made to provide for the retirement of employees by increasing the number of study places for doctors and dentists, in basic professional education in the field of social welfare and health, and in polytechnic education.

The personal and skills structure is being developed to meet the clients' needs and in response to the tasks of the employees. The number of employees is dimensioned to correspond with the clients' and patients' functional capacity and requirements. Good and efficient service requires that the personnel have extensive general and specialist skills. The skills of the personnel in relation to geriatric care are strengthened in both health care and social welfare. It is ensured that municipalities have sufficient expertise in social welfare and health care leadership at their disposal for assessing the planning, development, decision-making, and effectiveness of operations.

Individual services required by patients, changing problems, and the utilisation of new technology require new kinds of skills and new working models and practices. The updating of employees' skills and the development of their individual tasks are supported with regular

statutory supplementary training. The employees' and work community's preparedness to work in a multicultural environment is improved, and the integration of foreign-born employees into the social welfare and health care work communities is facilitated.

4.3 Long-term Care

4.3.1 Description of the long-term care system

In Finland, there is no separate legislation on care of the elderly or long-term care, but long-term care is part of the general health care and social welfare system. Everyone who needs services or other support is entitled to social welfare and health care services. Local authorities provide long-term care in the inpatient wards of health centres and non-medical long-term care in institutions for the older persons and the disabled. The latter are covered by the social welfare services. It is important to note that, as the arrangement of health care and social welfare services is the responsibility of local authorities, in principle, there are excellent possibilities for close co-operation and integrated care.

Local authorities use various models for the co-ordination of care, depending on the method of social welfare and health care administration. Therefore, integrated care may refer to the integration of administration (shared board of social affairs and health) or functional co-operation between social welfare and health care providers. In any case, the target is to arrange seamless services for the clients and to draw up a personal service and care plan for them, created by cross-disciplinary groups. Home care, consisting of home help services, home health care, and other support services, is an important area in integrated care.

In the past few years, the provision of long-term care has diminished, and the social services have organised clearly more long-term care than the health care services have. The service providers offer a variety of outpatient services so that the elderly can live at home for as long as possible. These services include home help services, home health care, day hospitals and other day-care centres, as well as part-time care.

The main reason for the increased proportion of outpatient care for the elderly is the upturn in the percentage of service housing and family care arising from the decline in the number of older people receiving home services. In 2004, 17.8 per cent of people aged 75 and over received home services. In the priority and action programme for social welfare and health care, the government has set as the national target the provision of home services on an annual basis for 25 per cent of people aged 75 and over by 2007.

In service housing, people live in their own flats, but they have various services at their disposal, such as meals, medical treatment, and other help needed in everyday life. Outpatient and inpatient units for the elderly have also developed interval care, which supports living at home. A considerable proportion of service housing for the elderly have been built with funding from the Slot Machine Association. About half of the municipal service housing for the elderly is intensive service housing: with round-the-clock supervision. At the end of 2004, 5.6% of people aged 75 and over lived in service housing.

Informal carers may receive financial support from the local authority. The system has been in use since 1984, and it has been amended several times, the last time being at the beginning of 2006. The minimum amount of support for informal care is EUR 300 per month. If the carer is unable to be gainfully employed during a transitional stage with the nature of care being heavy, the support for informal care is at least EUR 600 per month. The support is classified as taxable income. A carer with an agreement with the local authority is covered by earnings-related pension provision for his or her work, provided that he or she is not already retired. The local authority also provides for the informal carer's accident insurance. In the care and service plan, support services for the carer are also specified, in addition to the services provided for the patient.

The person receiving support for informal care is entitled to have at least two days off in any month during which the nature of the care is extremely restraining. The local authority provides for the care during the statutory time off. The local authority may also provide recreational time off without reducing the amount of support for informal care. When the informal carer exercises his or her right to have a day off, the patient will have to pay a maximum of nine euros per day for home help services arranged via a service voucher.

In Finland, rehabilitation is organised by the social welfare and health care authorities, the social insurance system, and the labour administration. The target of rehabilitation is to improve the person's functional and working capacity and to support his or her social abilities, life management, and independent living. Rehabilitation can be organised either as a statutory or discretionary service.

Rehabilitation is understood as an extensive concept. It covers, for example, rehabilitation counselling, a review of individual rehabilitation needs and possibilities, care and rehabilitation courses improving general condition and working capacity, acquisition of technical aids and their maintenance, adjustment training, and rehabilitation guidance. In addition to medical rehabilitation, it also includes special arrangements in comprehensive schools, special vocational training, and vocational rehabilitation. The main responsibility for the rehabilitation and maintenance of functional capacity of the aged lies with the municipal social welfare and health care service. Rehabilitation is part of the care and other service provided for the elderly.

In services for the disabled, the public services have a primary role in the organisation of the services. A personal service plan is drawn up for a disabled person in order to establish the required service and support measures. It is drawn up by the municipal authorities in consultation with the disabled person and his or her carer or family members. The service plan improves the client's power of influence and exercise of the right of self-determination. The plan is revised at regular intervals, and a person in charge is appointed for co-ordinating the services and convening the relevant authorities for negotiation.

4.3.2 Availability (target j)

The extensiveness targets for home help services for the elderly have not been achieved yet, but the dimensioning of institutional care staffing has been improved. Co-operation between the administrative sectors still needs further reinforcement. Based on reviews, the Ministry of

Social Affairs and Health will prepare a development programme on the policy for ageing in 2007.

The availability and quality of services for the older people is ensured by increasing the resources available for the services as the number of elderly people grows. The focus is on services provided at home or in the neighbourhood. The target is to provide sufficient, correctly timed, and appropriate care and rehabilitation services. Sufficiently early availability of social welfare services is ensured by enforcing time limits for signing up for key services. A preventive and rehabilitating approach is systematically adopted in the services, and care practices are improved such that they are more client-oriented, activating, and multi-professional. The services are based on the older person's own resources, functional capacity, and network of family and friends. The local authorities in concert with the third-sector service providers support the input and capabilities of the relatives.

The equality of older people in their access to services is being improved by developing a more extensive and harmonised assessment of service needs. Since March 2006, all people over 80 years of age and those receiving a special care allowance from the Social Insurance Institution of Finland may have an assessment of their non-emergency service needs if they so require by the seventh working day from the day of contact. In urgent situations, the need for all services must be assessed at once, regardless of age. After the assessment of service needs has been carried out, the client must be given a written decision on the acceptance or non-acceptance for services if the client so requires. The client may appeal the decision. If the decision on the arrangement of services is positive, a care and service plan must be drawn up for the client.

The local authorities may organise home help and home nursing services as home care either separately or jointly. Efforts are made to boost the guidance of home help and home nursing services on the national level as part of the social sector development project. The main target of the project is to achieve permanent improvement in the availability, quality, and financial and functional efficiency of home help and home nursing services. Improvements are necessary in the availability, structures, content, and work methods of services. The project gives the local authorities an opportunity to take part in a guided process where they can utilise learning, mutual support, and their network in order to exchange experiences. Increasing co-operation between the social welfare and health care sectors is an important aspect of this project. Deficiencies in co-operation may have a key impact on the client's view of the municipal services. Home help and home nursing services and institutional care shall be closely linked and form a well-functioning entity.

Another target is to increase the sufficiently early and versatile preventive and rehabilitating activities in order to improve the functional capacity of the older people. This includes independent exercise, rehabilitation with an emphasis on exercise, guidance on healthy eating, and reinforcement of social networks. The activities are available in the home environment and neighbourhood of the elderly. The older people are motivated and supported in taking responsibility for maintaining their health and functional capacity. The target is to improve the functional capacity of the elderly. An accessible, functional, and safe home environment and neighbourhood enable independent activities of the elderly when their functional capacity diminishes.

The local authorities increase co-operation with the third-sector service providers and utilise their expertise in the improvement and establishment of preventive activities, rehabilitation, and citizens' activities. The resources of pensioners in good health are utilised actively in different sectors of society on a voluntary basis.

Equal treatment of disabled people, elimination of discrimination, and independent living and participation in society require an accessible society and the development of services and different forms of housing. The objective is that the primary services meet the needs of disabled people as far as possible. Special services safeguard the equality of the disabled among their own group and with the rest of the population. The challenges related to improvement of the functional capacity of the disabled are met with new operating and co-operation models and by developing rehabilitation and improving socially responsible planning. Local authorities and federations of municipalities are activated, guided, and supported in the development of more individual solutions in housing and services, to replace institutional housing. In the development of services for the disabled, the focus is on the expansion of personal aid and interpreting services. There is a need for more housing that is suitable for disabled people and for employees for the housing units, in order to enable transfers from institutional care to more individual housing solutions.

With realisation of this target, social welfare and health care experts' knowledge and understanding of disabilities are increased. The individuality of disabled people and the special needs of different groups of disabled people are taken into account. Services are provided with a sufficiently large population base. The expertise of disabled people and organisations for/of the disabled is utilised in the planning, decision-making, and development activities.

4.3.3 Quality (target k)

The objective of the law on the position and rights of social welfare clients is to promote a client-oriented approach, to support the client's right to good social welfare services and to promote the client's and social welfare employees' commitment to jointly agreed targets. This is implemented with an individual care and service plan. The client/patient and the service provider draw up a plan in which they agree on how the service, care, or rehabilitation will be implemented.

In the last few years, several quality guidelines have been published, such as quality assurance for social welfare and health care services and quality guidelines for the care of, and services for, the older people. The latter includes recommendations on the dimensioning of human resources in various care units. The implementation of the recommendations is monitored separately.

Multi-professionalism is reinforced in the care of long-term patients. Efforts will be made to further improve the seamless service chain of basic and specialised care and social welfare. With high-standard services in the outpatient and interval care of the social welfare and health care system, older people with advancing dementia can live safely in their own home. Efforts are made to provide the services in the patient's mother tongue.

4.3.4 Sustainability of funding (target l)

In the near future, Finland will see more rapid ageing of the population than most other countries. The longer life expectancy and falling birth rates result in a permanent change in the age structure of the population. The number of children, young people, and those of working age is falling, and the number of the elderly is increasing. Furthermore, it is estimated that the population will start declining near the end of the 2020s. The change in the age structure has an impact on the entire society. Above all, the change poses a significant challenge for the sustainability of the public economy because in the future the declining working-age population will be responsible for an increasing number of people outside working life. According to estimates, the change in the age structure will increase the need for health care services by an average of one per cent each year and the need for social welfare services by 2.5 per cent a year in 2005–2020.

In many respects, Finland is prepared for the change in the age structure. The country has also succeeded in the cost containment, which is evident as a small share of the health care expenses in relation to the gross national product. It must be remembered that the change in the age structure of the population also includes opportunities. Moreover, calculations of the social expenses indicate that health and working capacity factors have a greater (and more favourable) impact on these expenses and the sustainable funding of welfare services than merely an increase in the number of the elderly.

It is the intention to improve the economic efficiency of home help and care services via methods that can be accepted by the employees and clients also. These may include reasonable work arrangements and the use of technology in a client-friendly way. The assessment framework functions well as a tool for developing good practices and monitoring home help and home nursing services. Alternatives increasing the range of choices for those in need of the services will be created for the production and funding of home and care services. The funding ensures that the elderly receive services that match their individual functional capacity.

The proportion of users of these services in the funding of social welfare and health care services will be dimensioned so that services are available for everyone and people are guided to the appropriate use of the services. The needs in reforming the payment policy and system of municipal social welfare and health care were investigated by the committee appointed by the Ministry of Social Welfare and Health, which submitted its report in September 2005. In the committee's opinion, the key areas of the current payment system are functional and well justified. The committee concluded that the payment system should be changed in such a way that the service user could be charged only for the services that are subject to a charge by law. Furthermore, the cost development of the services should be taken into account in the charges. The committee proposed that the payment ceiling system in health care services should be harmonised and that charges for the care of minors should be abolished. In home services, a fee determined by the duration of care specified in the care and service plan should be adopted in stead of the visit-based charges. No decision has yet been made on the implementation of the committee’s proposals.

Appendix 4.1: Examples of good practices

Uniform criteria for access to non-emergency treatment

There have been great variations in treatment practices across the country, and decisions on access to non-emergency treatment have been made on different grounds. The aim of the legislative amendments that came into force in March 2005 is to secure access to treatment on equal grounds irrespective of the place of residence. In accordance with the amended Act on Specialised Medical Care, the federation of municipalities of the hospital district is responsible for arranging statutory specialised medical care in its area, on uniform medical and odontological grounds.

As part of the National Health Care Project, the compilation of uniform grounds for access to non-emergency care was initiated in February 2004. A management group was appointed for the project, with members from, e.g., the Ministry of Social Affairs and Health, the National Authority for Medicolegal Affairs, the National Research and Development Centre for Welfare and Health, the Association of Finnish Local and Regional Authorities, hospital districts, health centres, and various associations. The task of the management group has been to steer, guide, and co-ordinate the work of drawing up uniform criteria. Professional organisations in the health care sector, specialised medical associations, municipalities, authorities, and patients' organisations have been consulted during the process.

The actual drawing up of the criteria for treatment has been allocated to the health care districts according to specialities (the country is divided into health care districts on the basis of specialities/tertiary care). In the districts, the work has been carried out in co-operation with those possessing primary health care, nursing, and medical expertise such that the relevant organisations, the Social Insurance Institution of Finland, and the local authorities have been consulted whenever possible. The treatment criteria have been revised on the basis of this consultation process and views presented during meetings.

Treatment criteria have been drawn up for the treatment and examination of 193 diseases. The goal was to draw up the criteria for some 80% of non-emergency treatment. The work will not be completed in one go; the treatment criteria are revised and developed further based on experience. The hospital districts and health centres assess and monitor the functioning of the criteria. The criteria are published as a handbook, and they are available on the Internet. Tthe names and contact details of the members of the relevant working groups, as well as of the person in charge of the working group, are given at the end of each set of criteria.

The criteria are revised and developed continuously. The latest criteria are available at www.stm.fi and www.terveysportti.fi. The public Internet access to the criteria means that they can also be accessed by citizens.

Doctors will be using these criteria as a guide when deciding on the treatment of patients. In addition to the criteria, a doctor will always take into account the patient's individual life situation and need for treatment when making the decision on treatment. The doctor will make a decision concerning the patient's treatment in mutual understanding with the patient.

The patient is not entitled to all treatment he or she wants. Individual doctors or dentists may, with justification, diverge from the uniform criteria.

Example

NON-URGENT OPERATION ON OSTEOARTHRITIS OF THE HIP

ICD classification of diseases

M16 Coxarthrosis

Primary health care / data to be included in the referral

The patient has been clinically and radiologically diagnosed with clear primary or secondary arthritis.

The criteria for non-urgent operative treatment in specialised care (scoring: 0–100)

The justification for operative treatment is always based on an individual assessment. The basis for treatment is a limit of 50 points. A written statement of reasons must be provided for any treatment decisions deviating from this. If the point limit is exceeded, the operation still is not carried out if it can be expected that the patient will gain no benefit from it, in view of the patient's associated diseases and other factors.

• *Pain*
  0 points Painless
  10 points Mild pain, during exertion
  20 points Moderate pain; frequent use of painkillers
  30 points Severe, pain during rest or severe pain during movement
• *Walking distance*
  0 points More than 1,000 metres
  5 points 100–1,000 metres
  10 points Less than 100 metres
• *Other functional limitations* (standing up, walking up the stairs, putting shoes on, care of feet, washing, etc.)
  0 points No limitations
  5 points Slight limitations
  15 points Moderate limitations
  30 points Presents a challenge in everyday life
• *Clinical findings* (restriction of motion, different length of limbs, limping)
  0 points No findings
  5 points Slight findings
  10 points Serious findings
• *Possible progression of illness on the basis of X-ray* (protrusion of cavitas glenoidalis, risk of fracture, defect or depression in the bone)
  0 points No challenges
  10 points Moderate challenges
  20 points Clear risk

Current Care guideline: No

Working group:

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APPENDIX, INDICATORS FOR THE PART 2

1 ECONOMIC EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005

RELATIVE RISK OF LOW INCOME / POVERTY

*The income level representing the relative poverty risk is calculated on the basis of a household's disposable income (per modified OECD consumption unit (1.0 – 0.5 – 0.3)), the poverty risk limit being 60% of median income each year. Poverty risk indicators by main occupation, by gender and by type of household have been published online; see http:www.stat.fi/tk/el/hyv_031.html

1.1	**Number of low-income persons**															
	Persons in households below the poverty level															
	-- number	395 000	389 000	353 000	316 000	329 000	370 000	419 000	423 000	494 000	500 000	532 000	554 000	564 000	575 000	618 400
1.2	**Poverty risk – relative poverty level**															
	-- total, percentage of population	7,9	7,8	7,0	6,3	6,5	7,3	8,3	8,3	9,7	9,8	10,4	10,8	11,0	11,2	12,0
	-- men	6,5	6,9	6,6	6,3	6,6	7,7	8,5	8,5	9,7	9,6	10,1	10,8	11,3	11,1	11,6
	-- women	9,3	8,6	7,4	6,3	6,5	7,0	8,1	8,0	9,8	10,1	10,7	10,9	10,7	11,2	12,3
1.3	**Poverty risk among children**															
	-- % of population aged 0 to 15	5,0	5,5	4,6	4,9	4,0	4,7	5,6	5,8	8,0	8,2	10,8	10,7	11,0	11,8	12,2
1.4	**Poverty risk among young people**															
	-- % of men aged 16 to 24	9,3	13,6	16,4	13,0	13,8	17,5	20,8	19,0	17,5	19,4	18,4	21,8	21,6	20,4	22,4
	-- % of women aged 16 to 24	13,1	16,8	17,6	16,1	18,7	20,3	23,2	24,4	24,2	24,2	21,2	24,8	24,3	25,8	27,8
1.5	**Poverty risk among the middle-aged**															
	-- % of men aged 25 to 49	4,8	5,3	5,7	6,1	6,9	7,4	8,2	9,1	9,4	8,5	8,9	9,4	11,0	11,0	10,0
	-- % of women aged 25 to 49	4,5	5,3	4,4	4,3	3,9	4,8	6,2	6,1	7,3	7,8	9,1	8,4	8,9	8,4	9,0
1.6	**Poverty risk among the ageing**															
	-- % of men aged 50 to 64	8,7	7,8	6,6	6,0	6,4	7,9	7,9	5,9	8,3	8,5	8,5	8,4	8,0	7,7	9,5
	-- % of women aged 50 to 64	8,8	6,3	4,3	3,5	3,6	3,5	4,1	5,1	6,5	6,9	6,5	6,7	6,1	5,6	6,7
1.7	**Poverty risk among pensioners**															
	-- % of men aged 65+	10,4	6,6	3,5	2,2	2,8	4,3	3,6	4,2	7,4	6,8	6,3	6,6	7,1	7,4	8,1
	-- % of women aged 65+	23,5	17,6	14,6	9,3	10,1	8,9	8,9	7,6	11,2	10,9	12,2	13,1	11,2	13,3	15,7
1.8	**Poverty risk among the unemployed, percentage of total unemployed**															
	-- % of unemployed	27,1	21,6	16,9	14,3	16,9	20,7	23,2	25,6	30,9	33,4	35,6	37,2	40,7	36,0	40,1
	-- % of unemployed men	32,2	23,4	17,5	16,2	20,3	24,9	28,3	32,4	39,0	40,1	43,9	42,0	47,8	42,6	45,7
	-- % of unemployed women	18,9	18,8	16	11,6	12,6	15,8	17,9	18,6	23,4	27,0	27,8	32,7	32,8	28,3	33,6
1.9	**Poverty risk among wage-earners, percentage of total wage-earners**															
	-- % of wage-earners	1,9	1,9	1,4	1,1	1,2	1,4	2,1	1,9	2,0	2,2	2,5	2,2	2,6	2,5	2,2
	-- % of wage-earning men	1,8	1,7	1,5	1,1	1,0	1,4	2,2	1,9	2,4	2,0	2,5	2,6	2,4	2,6	2,1
	-- % of wage-earning women	2,0	2,1	1,3	1,1	1,3	1,3	1,9	2,0	1,7	2,4	2,5	1,8	2,7	2,4	2,4

APPENDIX, INDICATORS FOR THE PART 2

1 ECONOMIC EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
1.10 Individual poverty rate before income transfers																
Percentage of persons living in households below the poverty level, based on net factor income + pensions (%)																
-- % of the population	17,7	20,3	24,0	25,4	26,9	25,8	25,5	25,4	24,7	24,0	23,4	22,9	22,7	22,0	22,3	
Percentage of persons living in households below the poverty level, based on net factor income alone (%)																
-- % of the population	33,0	36,0	40,9	44,2	45,1	43,9	43,7	43,1	41,5	40,8	39,5	39,6	40,3	40,0	40,0	
1.11 Persistent poverty																
Percentage of persons below the 60% poverty level in at least three out of four years (%)																
-- % of the population	..	..	..	..	..	..	..	..	4,8	5,5	6,0	6,5	7,0	7,3	7,6	
1.12 Inequity of income transfers (S80/S20)																
Median income of the highest-earning 20% divided by the median income of the lowest-earning 20%																
-- highest/lowest	2,8	2,8	2,7	2,8	2,8	2,9	3,0	3,2	3,4	3,5	3,7	3,6	3,6	3,6	3,7	
1.13 Poverty gap: difference between the poverty level and the median income of those below the poverty level, as % of the poverty level																
-- total	13,5	15,1	14,6	13,4	14,0	13,1	13,3	14,3	13,6	13,7	14,2	15,0	15,2	14,3	14,4	
-- men	14,0	15,3	16,2	15,5	15,9	13,3	14,6	14,8	13,9	14,1	14,7	16,4	16,1	14,7	15,1	
-- women	13,2	15,1	12,9	11,8	11,8	12,9	12,3	13,8	13,4	12,8	13,0	13,1	13,7	13,1	13,7	
1.14 Poverty rate at various relative poverty levels																
-- 40 % of the median	1,3	1,6	1,4	1,3	1,1	1,3	1,4	1,6	1,7	1,5	1,5	1,9	2,0	1,8	2,0	
-- 50 % of the median	3,4	3,7	3,1	2,8	2,8	3,0	3,5	3,6	4,1	4,1	4,3	4,8	5,1	4,7	5,2	
-- 70 % of the median	16,0	15,6	14,0	13,6	14,3	14,8	16,5	17,0	19,2	19,0	19,3	19,7	19,8	20,3	20,4	
1.15 Poverty rate at fixed poverty level (poverty level inflation-adjusted for 1995)																
-- total, % of population	5,9	5,6	6,3	6,9	7,3	7,3	7,3	6,5	6,6	5,8	5,9	5,7	5,2	4,2	3,8	
(deflated poverty level for 2000)																
-- total, % of population	10,5	9,2	10,8	12,3	13,4	12,7	13,0	11,7	11,7	10,4	10,4	9,8	8,7	7,7	6,7	
LAST-RESORT SOCIAL WELFARE BENEFITS																
1.16 Income support																
-- persons receiving income support during the year	314 000	396 000	465 000	528 000	577 000	584 000	610 000	594 000	535 000	493 000	454000	443000	430 000	424 000	401 000	380000*
-- percentage of persons receiving income support, % of the population	6,3	7,9	9,2	10,4	11,3	11,4	11,9	11,5	10,4	9,5	8,8	8,5	8,3	8,1	7,7	7,2

APPENDIX, INDICATORS FOR THE PART 2

1 ECONOMIC EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
-- households receiving income support during the year	182 000	223 000	259 000	293 000	329 000	339 000	350 000	345 000	313 000	292 000	272 000	264 000	263 000	261 000	251 000	238000*
-- percentage of single-parent households, % of households receiving income support	..	..	27,3	31,6	32,0	30,7	31,9	31,3	29,5	28,1	27,0	27,6	28,6	28,1	26,9	
-- households receiving income support for 10 to 12 months of the year	21 000	26 000	30 000	43 000	57 000	68 000	80 000	84 000	73 000	68 000	66 000	67 000	68 000	63 000	60 000	56000*
-- percentage of households receiving income support for 10 to 12 months of the year, % of households receiving income support	11,8	12,0	11,5	14,6	17,5	20,1	23,0	24,6	23,3	23,4	24,4	25,6	26,1	24,2	24,1	23,5*

INDEBTEDNESS

1.17 Debt recovery

Persons subject to debt recovery, % of the population	..	..		8,7	8,1	9,0	8,0	7,7	7,0	5,6	5,3	5,8	5,9	5,6	5,2	5,6	4,5

2 HEALTH PROBLEMS	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
PERCEIVED STATE OF HEALTH															
2.1 Percentage of persons assessing their state of health as bad or fairly bad															
- men aged 25 to 64	9,7	9,7	8,6	8,6	8,6	8,4	8,4	8,4	8,9	8,9	9,0	8,2	7,6	10,6	7,5
- women aged 25 to 64	7,6	7,6	6,9	6,9	6,9	7,4	7,4	7,4	7,2	7,2	7,8	8,5	7,0	8,3	7,7
FUNCTIONAL CAPACITY OF PENSIONERS															
2.2 Age-adjusted percentage of persons aged 65 to 84 with problems in their ability to move (measured by climbing stairs)															
- men	..	..	..	23,4	..	20,7	..	22,1	..	18,3	..	18,8	..	19,9	..
- women	..	..	..	30,3	..	25,6	..	29,5	..	27,7	..	27,4	..	26,9	..
SOCIAL-BASED HEALTH DIFFERENCES															
2.3 Life expectancy of 35-year-olds by social group (managers = 100)															
- managers, men	100,0	..	..	..	..	100,0	..	..	..	..	100,0	..	..	..	..
- white-collar workers, men	94,5	..	..	..	..	94,9	..	..	..	..	94,7	..	..	..	..
- blue-collar workers, men	86,4	..	..	..	..	86,7	..	..	..	..	86,5	..	..	..	..
- farmers, men	92,1	..	..	..	..	93,2	..	..	..	..	92,1	..	..	..	..
- managers, women	100,0	..	..	..	..	100,0	..	..	..	..	100,0	..	..	..	..
- white-collar workers, women	97,7	..	..	..	..	98,1	..	..	..	..	98,2	..	..	..	..
- blue-collar workers, women	94,0	..	..	..	..	93,9	..	..	..	..	93,4	..	..	..	..
- farmers, women	94,9	..	..	..	..	95,9	..	..	..	..	95,0	..	..	..	..

3 EXCLUSION FROM THE LABOUR MARKET	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
UNEMPLOYMENT																
3.1 Unemployment rate, %																
-- total	3,2	6,6	11,7	16,3	16,6	15,4	14,6	12,7	11,4	10,2	9,8	9,1	9,1	9,0	8,8	8,4
-- men	3,6	8	13,6	18,1	18,1	15,7	14,3	12,3	10,9	9,8	9,1	8,6	9,1	9,2	8,7	8,2
-- women	2,7	5,1	9,6	14,4	14,8	15,1	14,9	13	12	10,7	10,6	9,7	9,1	8,9	8,9	8,9
3.2 Unemployment rate among foreigners, %																
-- total	..	..	..	..	53,0	49,0	48,0	44,0	39,0	37,0	31,0	31,1	28,4	28,6	29	28
-- men	..	..	..	..	..	..	..	..	..	..	..	25,8	24,0	24,6	..	21
-- women	..	..	..	..	..	..	..	..	..	..	..	37,7	34,0	33,7	..	31
3.3 Unemployment rate among young people (aged 15 to 24), %																
-- total	9,3	16,3	26,4	33,6	34,0	29,7	28,0	25,2	23,5	21,5	21,4	19,8	21,0	21,8	20,7	20,1
-- men	10,2	19,0	30,1	36,4	37,2	30,7	29,5	25,4	22,8	20,8	21,1	19,6	21,2	21,9	22,0	20,6
-- women	8,2	13,4	22,5	30,6	30,4	28,6	26,3	25,1	24,3	22,1	21,6	20,0	20,9	21,6	19,4	19,5
3.4 Long-term unemployment rate																
Percentage of workforce unemployed for more than a year																
-- total	..	0,7	..	5,8	..	5,5	4,6	4,5	3,9	2,9	2,7	2,2	2,1	2,1	2,0	2,0
-- men	..	1,1	..	7,3	..	6,2	4,9	4,7	4,2	3,1	2,7	2,3	2,4	2,4	2,1	2,1
-- women	..	0,7	..	4,2	..	4,7	4,4	4,4	3,6	2,7	2,6	2,0	1,8	1,8	1,8	1,8
3.5 Long-term unemployed jobseekers registered with employment office																
-- unemployed for over one year	3 029	5 298	29 239	86 018	133 561	140 224	134 898	124 558	112 612	97 981	88 968	82 693	77 661	72 426	73 040	72 366
-- unemployed for over two years	..	539	1 302	10 079	32 740	53 620	59 957	56 957	54 656	50 620	43 508	39 224	36 407	33 336	31 756	31 397
3.6 Unemployed jobseekers with disabilities																
-- number during the year	..	..	42 000	46 000	48 800	50 900	54 900	59 600	62 500	66 600	68 700	68 600	67 400	66 900	67 500	67 300
-- % of unemployed jobseekers			6,5	6,0	6,0	6,3	6,9	7,9	8,9	10,0	10,9	11,6	11,7	11,7	11,8	12,1
3.7 Distribution of regional employment rates (NUTS2 level)[**)]																
-- total	..	..	..	..	..	..	7,4	7,1	7,4	6,7	6,8	7	6,7	6,1	5,5	
-- men	..	..	..	..	..	..	7,8	7,6	7,0	6,5	6,2	6,4	6,3	5,7	5,2	
-- women	..	..	..	..	..	..	7,6	7,2	8,4	7,4	7,8	8,1	7,6	6,7	6,2	
MEASURES TO PROMOTE EMPLOYMENT																
3.8 Persons employed as a result of such measures																
Persons employed through wage-based measures, end-of-month average[*)]																
-- total	30 500	40 300	52 100	56 800	66 400	63 600	64 600	62 600	57 000	51 500	43 000	38 500	38 300	39 800	39 800	38 500
-- women, %	..	45,3	43,7	45,1	50,3	54,3	56,7	58,0	59,8	61,6	62,7	63,9	62,6	58,5	59,3	57,1

3.9 Persons participating in labour market training

End-of-month average	16 800	17 300	26 300	27 200	28 400	33 900	42 300	46 800	41 300	38 100	30 900	26 100	26 350	29 900	30 700	29 200

NON-PARTICIPATION IN WORK

3.10 Rate of non-participation during the year

According to Income distribution statistics

Total persons living in households including at least one person of working age (18 to 59) but with no one employed during the year, percentage of all persons living in households including at least one person of working age (excluding student households)

-- total	3,8	4,4	6,9	8,9	9,7	9,2	10,0	9,6	9,3	8,9	8,4	8,3	7,4	7,6	8,1
-- men	3,8	4,6	7,2	9,1	10,1	9,5	10,2	9,8	9,8	9,5	8,5	8,6	7,5	7,9	8,4
-- women	3,8	4,3	6,6	8,8	9,3	8,9	9,8	9,4	8,7	8,4	8,3	7,9	7,2	7,4	7,8
-- children (aged 0 to 17)	1,2	1,9	4,8	5,7	6,6	5,4	5,6	6,1	5,6	6,2	5,9	5,9	4,4	4,5	5,6

According to Labour force survey (in an unemployed household no household member has been employed during the survey week)

-- total	..	..	..	..	..	..	..	..	..	..	..	..	..	10,9	11,0
-- men	..	..	..	..	..	..	..	..	..	..	..	..	..	11,6	11,2
-- women	..	..	..	..	..	..	..	..	..	..	..	..	..	10,3	10,9
-- children aged 0 to 17	..	..	..	..	..	..	..	..	..	..	..	..	..	5,7	5,7

*) The number of wage-based measures in 2003 and 2004 is determined more preciously than in the previous years.

**) Variation coefficient for regional employment rates (15 - 64 years) calculated at NUTS2-level.

4 EXCLUSION FROM THE HOUSING MARKET	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
ACCOMMODATION PROBLEMS																
4.1 Households living in very inadequately equipped accommodation																
-- % of all households	9,7	9,3	8,8	8,2	7,9	7,8	7,5	7,3	7,2	7,1	7,0	6,8	6,7	6,7	5,7	
4.2 Persons living in cramped quarters																
-- % of the population	30,5	29,6	29,1	28,6	28,1	27,5	26,9	26,3	25,4	24,5	23,4	22,5	21,7	20,9	20,2	
4.3 Households in queue for ARAVA rental housing																
-- total	57 000	69 000	86 000	57 000	69 000	86 000	90 000	96 000	106 000	107 000	118 000	112 000	110 900	95 600	87 400	79 315
-- percentage of applicant households in especially urgent need of housing ..		23,9	24,4	22,7	24,4	22,6	24,5	24,5	26,7	24,5	26,7	26,2	24,2	21,7	22,1	21,5
HOMELESSNESS																
4.4 Total no. of unattached homeless persons																
-- total	15 250	14 100	12 880	11 670	10 560	10 430	9 610	9 820	9 990	9 990	10 000	10 000	9 560	8 186	7 651	7430
-- immigrants	..	..	..	..	..	..	..	..	..	..	..	330	330	243	282	232
-- outdoors, in temporary shelters or night shelters	3 610	3 370	3 030	2 560	1 760	1 710	1 720	1 720	1 770	1 750	1 790	2160	2 060	1 986	1 912	1623
-- in institutional care	3 690	3 340	3 030	2 410	2 170	2 110	2 110	2 450	2 350	2 390	2 420	2080	2 080	1 307	1 264	1277
-- temporarely with friends or relatives	7 950	7 390	6 820	6 700	6 630	6 610	5 780	5 650	5 870	5 850	5 790	5720	5 420	4 556	4 192	4244
-- women, %	..	..	..	..	..	..	18,7	25,6	19,6	18,2	17,5	17,5	17,3	19,2	19,0	19,3
-- under 25, %	..	..	..	..	..	..	15,7	22,0	19,8	18,4	17,5	16,8	16,7	19	18,6	18,4
4.5 Homeless families																
-- total	800	700	570	250	380	560	360	600	820	780	780	780	770	415	357	355
-- immigrants	..	..		..	..	..	..	..	..	..	..	130	210	79	80	50

5 EXCLUSION FROM EDUCATION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
INADEQUATE SCHOOLING																
5.1 Not completed comprehensive education																
-- dropouts, those receiving a leaving certificate and those who left without a certificate	335	363	228	..	304	253	210	197	262	322	296	292	315*	335	301	353
5.2 Young people with deficient education																
-- persons aged 18 to 24 who have only completed comprehensive education and are not in training, percentage of the age group	..	..	..	..	..	12,8	11,1	8,1	7,9	9,9	7,4**	10,3	9,9	8,2	8,7	
-- men			..	..	..	..	11,4	9,1	8,6	12,0	9,8**	13,0	12,6	10,1	10,6	
-- women			..	..	..	..	10,8	7,0	7,2	7,9	5,1**	7,7	7,3	6,5	6,9	

** adjusted time series from 2000-. Conscripts are excluded. In addition, the statistical reference period in years 1995 - 1999 is the second quarter of the year, from 2000 onwards the first quarter of the year..

6 OTHER EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
CHILDREN AND YOUNG PEOPLE THREATENED BY EXCLUSION																
6.1 Young people who have finished school but are not at work, in education, military service, non-military service or in pension *)																
persons aged 15 to 19																
-- number	..	..	..	..	..	19 000	18 000	18 000	18 000	20 000	20 000	20 000	19 000	18 000	18 000	
-- % of total aged 15 to 19	..	..	..	..	..	5,8	5,6	5,6	5,5	6,0	5,9	6,0	6,0	5,8	5,6	
-- men, % of total aged 15 to 19	..	..	..	..	..	6,5	6,2	6,1	5,9	6,3	6,2	6,3	6,3	6,0	5,9	
-- women, % of total aged 15 to 19	..	..	..	..	..	5,0	5,0	5,1	5	5,6	5,8	5,7	5,6	5,4	5,2	
persons aged 20 to 24																
-- number	..	..	..	..	..	25 000	24 000	19 000	18 000	18 000	17 000	17 000	18 000	18 000	18 000	
-- % of total aged 20 to 24	..	..	..	..	..	8,2	7,6	6,1	5,6	5,4	5,2	5,4	5,5	5,6	5,4	
-- men, % of total aged 20 to 24	..	..	..	..	..	8,8	8,1	6,3	5,7	5,4	5,4	5,5	5,9	5,9	5,8	
-- women, % of total aged 20 to 24, %	..	..	..	..	..	7,5	7,0	5,8	5,4	5,4	5,2	5,1	5,1	5,2	5,1	
6.2 Children subject to child protection																
Children and young people in open care	..	..	..	24 700	27 800	30 700	33 300	35 800	39 700	43 700	49 350	49 600	54300	56 400	59 900	59 100
Children and young people placed outside the home																
-- total	..	8 700	9 400	9 700	10 200	10 950	11 350	11 800	12000	12 300	12 850	13 500	14 150	14 350	14 800	15 050
-- children placed outside home, % of total aged 0 to 17		0,7	0,7	0,7	0,7	0,8	0,8	0,9	0,9	0,9	0,9	1,0	1,0	1,0	1,1	1,1
-- number of the above taken into custodial care	..	6 200	6 400	6 400	6 400	6 400	6 500	6 800	6 800	6 900	7 300	7 500	8 000	8 400	8 700	9 200

CRIMINALITY, SELF-DESTRUCTIVENESS, INTOXICANT PROBLEMS

6 OTHER EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
6.3 Prisoners																
-- average per day	3 441	3 467	3 511	3 421	3 275	3 248	3 197	2 974	2 809	2 743	2 855	3 135	3433	3 578	3577	
-- women, %	3,2	3,2	3,1	3,5	3,7	4,1	4,7	4,8	5,0	4,6	5,0	5,1	5,9	5,7	5,8	
6.4 Violent crime																
-- number of cases	26 274	25 067	22 845	21 767	22 844	24 884	27 320	27 586	28 293	28 750	30 408	29 974	30 611	31 667	32 668	
-- rate per 10 000 persons	52,7	50,0	45,3	43,0	44,9	48,7	53,3	53,7	54,9	55,7	58,7	57,8	58,9	60,7	62,4	
6.5 Youth crime																
-- persons aged 15 to 20 suspected of crimes investigated by police	126 200	114 130	122 188	111 726	109 817	118 500	..	102 700	102 000	103 900	113 200	110 400	107 600	107 718	110 810	
6.6 Suspects in narcotics-related crime																
-- rate per 10 000 persons	4,5	4,5	6,3	7,8	11,5	18,8	16,9	18,5	18,6	23,5	27,7	30,8	28,9	28,8	29,5	
-- total	2 267	2 240	3 200	3 952	5 835	9 593	8 641	9 526	9 594	12 123	14 332	15 992	15 010	15 009	15 448	
-- women	281	277	445	458	679	1 026	1 116	1 422	1 241	1 537	1 899	2 283	2 068	2 319	2 610	
6.7 Suicides																
number:																
-- men	1198	1189	1156	1107	1080	1080	965	1038	962	954	873	933	824	815	812	
-- women	322	304	296	291	307	309	282	284	266	253	292	271	271	260	252	
age-adjusted mortality per 100 000 persons:																
-- men	50,1	49,2	46,6	44,6	43,5	42,8	38,0	41,0	37,9	37,5	33,7	35,7	32	31	31,1	
-- women	12,1	11,3	11,1	10,8	11,3	11,5	10,3	10,3	9,7	9,2	10,6	9,5	9,5	9,1	9,1	
ALCOHOL																
6.8 Alcohol-related deaths	2500	2475	2535	2476	2467	2541	2257	2251	..	2474	2411	2454	2431	2507	2826	
-- alcohol ailment or similar as primary cause of death	1417	1341	1341	1372	1326	1483	1316	1246	1503	1428	1477	1490	1465	1560	1860	
-- deaths by accident or violence while intoxicated	1036	1074	1123	1059	1097	1020	901	967	..	1001	879	887	913	896	966	

6 OTHER EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
-- total number of deaths directly or indirectly caused by alcohol									3 581	3 593	3 578	3 566	3 648	3 754	4 271	
6.9 Persons treated in hospital for alcohol-related ailments																
Alcohol-related ailment as main or subsidiary diagnosis																
-- total	16 600	16 800	16 900	17 700	19 100	19 800	20 200	20 000	20 400	19 750	20 200	19 750	20 200	19 175	21 148	
-- women, %	17,7	17,8	17,4	18,6	19,2	19,3	20,1	20,6	21,6	22,0	21,8	22,0	21,8	23,0	23,1	
DRUGS																
6.10 Number of deaths with forensic drug-related findings	38	60	57	47	65	74	87	89	107	140	170	151	153	146*	176*	
6.11 Persons treated in hospital for drug-related ailments																
Drug-related ailment as main or subsidiary diagnosis																
-- total	4 700	4 800	4 850	5 000	5 600	5 400	5 300	5 400	5 450	5 900	6 550	5 900	6 550	6 980	7 040	
-- women, %	48,1	45,8	45,0	45,5	45,9	44,5	43,6	43,6	42,7	41,0	42,8	41,0	42,8	44,8	46,5	
6.12 Clients in open intoxicant care during the year																
-- alcohol outpatient centres ('A clinics')	38 500	37 500	35 500	34 100	35 400	35 600	38 200	39 100	39 300	40 000	39 300	41 800	42 000	42 000	43 000	42 800
-- short-term treatment centres for young people	3 000	2 700	2 600	2 600	2 700	2 700	3 100	3 700	3 800	4 300	5 600	5 600	5 200	5 400	5 300	5 900

* adjusted time series. Conscripts and prisioners excluded.

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