Welfare, Health and Equality

Survey for 2007-2010

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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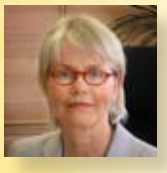
Minister of Social Affairs and Health
Liisa Hyssälä
State Secretary ***Terttu Savolainen***

Minister of Health and Social Services
Paula Risikko
State Secretary ***Ilkka Oksala***

Permanent Secretary ***Kari Välimäki***

Minister of Equality Affairs ***StefanWallin***

Head of Development
Klaus Halla
Advisory Staff assists in carrying out the Permanent Secretary's responsibilities.



Director of International Affairs ***Liisa Ollila***
International Affairs Unit harmonises the international affairs work of the administrative sector.

Director of Information and Communication
Eeva Larjomaa
The **Information and Communication** is responsible for the information of the ministry, interest group work and publications.

Ministerial Councillor for Health / Medical Affairs
Jouko Söder
The Preparedness Unit (Social and Medical Preparedness and Response) is responsible for harmonising preparedness matters.

DIRECTORS-GENERAL

Jaana Koski
Administrative Department is responsible for the ministry's general administration and personnel policy.
Ombudsman for Equality Pirkko Mäkinen oversees compliance with the Equality Act.

Tarmo Pukkila
Insurance Department directs and guides insurance policy and develops legislation on social and other insurance.
Pharmaceuticals Pricing Board operates in association with the Ministry to enforce the pricing of wholesale medicines and the special reimbursement of particular medicinal products.

Aino-Inkeri Hansson
Welfare and Health Promotion Department is concerned with the promotion of social welfare and disease prevention, supporting social inclusion, safeguarding the welfare of children and young people, income support and housing support, dealing with drug and alcohol matters, environmental healthcare, and questions concerning the social welfare and healthcare state subsidies and their planning.

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

Päivi Sillanaukee
The **Social and Health Services Department** is responsible for the functionality of the social welfare and healthcare service system and its tasks related to human resources, services for different population groups, family policy support, pharmaceutical treatment, social welfare and healthcare information management, veterans' disability legislation, and legislation concerning the status and rights of patients.

Mikko Hurmalainen
Department for Occupational Safety and Health develops and prepares legislation, policy and coordinates research on occupational safety and health and takes care of international cooperation in the area of occupational safety and health. The Department deals with the performance guidance of the district administration, which monitors occupational safety and health.

Raimo Ikonen
The **Finance and Planning Department** coordinates planning and follow-up, collates framework and budget assessments, coordinates research and development activities and is responsible for the implementation of the government's equality policy.

The possibility for a healthy and secure life for all.

The Ministry of Social Affairs and Health has two ministers, the Minister of Social Affairs and Health and the Minister of Health and Social Services. In addition the Minister of Culture Stefan Wallin is responsible for equality issues. The ministers guide the preparation of policy. They are assisted by state secretaries, special advisers and the organisation of the entire ministry (see inside cover) under the leadership of the Permanent Secretary.

The Minister of Social Afffairs and Health
Liisa Hyssälä

"A social protection for everyone that provides incentives and is just. The opportunities offered by social protection act as a springboard to society and working life."

State Secretary
Terttu Savolainen

Minister of Health and Social Services
Paula Risikko

"Services can be made functional and effective only through collaboration, an efficient distribution of work and by looking after the welfare of the employees."

State Secretary
Ilkka Oksala

Equality Minister
Stefan Wallin

"We are responsible for all the work to implement equality. Men and women must have the same rights and opportunities in all areas of life."

Welfare, health and equality

Introduction

The responsibility of the Ministry of Social Affairs and Health is to lead Finnish social affairs and health, equality and occupational safety policy. The Ministry implements its part of the government programme: prepares legislation and supervises reform measures. It is supported in this work by the expertise of agencies and institutes of the entire administrative sector.

Universal social protection and extensive welfare services constitute an essential part of the Finnish welfare society. Everyone living in Finland is entitled to social protection and to social and health services. The system is comprehensive, and over the course of each year nearly every resident makes use of at least some benefit or service that is the responsibility of the Ministry of Social Affairs and Health.

The Ministry of Social Affairs and Health has a long experience of planning and directing social protection. We reinforce people's working and functional capacity, support continuation in working life and ensure operational social and health services. We want to reduce poverty, prevent social exclusion and guarantee reasonable income security for people. We have increasingly emphasised the strengthening of policy that prevents problems and risks.

The importance of social and health policy as a basis of the integration of society is widely recognised. Finns are fairly content with their welfare state. The social insurance system has been reformed but this reform process must continue. Social and health services and income security have to develop in tempo with general changes in society. Our challenges are population ageing, the development of the economy and employment, the sustainability of social protection funding, safe-guarding the availability of social and health services and regional development. The global economy, European Union and international commitments are increasingly reflected in national activity.

This publication gives a concise overview of the extent of the Ministry of Social Affairs and Health's activity, its areas of focus and how we operate in Finland.

"An effective and economic public sector is the best guarantee of a fair and equal society."

Permanent Secretary
Kari Välimäki

The Finnish MODEL

The Ministry of Social Affairs and Health increases welfare

The development and economic growth of a welfare state requires a workforce that enjoys wellbeing and working capacity, as well as the participation in employment of as many people as possible.

The Ministry of Social Affairs and Health's goal is that everyone has the same possibilities to a healthy and socially secure life. The Ministry promotes equality between men and women. The administrative sector promotes the population's good health and functional capacity, a healthy working and living environment, ensures sufficient social and health services and reasonable income at different stages of life.

Ministry of Social Affairs and Health's long-term guidelines, *Social and health policy strategies 2015* lay out the building of Finnish welfare.

Strategic choices to bolster work

The issues under the Ministry of Social Affairs and Health's remit are outlines by four strategic lines, according to overall subject. These are:

- promoting health and functional capacity
- making work more attractive
- reducing poverty and social exclusion
- providing efficient services and reasonable income security.

The strengthening of equality and the welfare of families with children is also an essential part of this activity.

The Ministry's goals are classified with the help of these overall subjects. They also provide an outline of the Ministry's responsibility for carrying out the objectives of the existing government programme.

The Ministry's core tasks are the preparation and implementation of legislation, steering the administrative sector, and international activities. The Ministry is answerable as a headquarters of government for activity and financial planning and follow-up and reporting. In practice, this work is distributed among different schemes, projects and extensive programmes.

The most wide-ranging development programmes of recent years have been the National Project to Secure the Future of Healthcare, the National Development Project for Social Services, the National Alcohol Programme, the Health 2015 public health programme, government equality programme and

the programme to increase the attractiveness of working life – the Veto programme. New programmes underway are the national social welfare and healthcare development programme (KASTE), the health promotion policy programme, the work of the social security reform committee, the reform of the service system (the PARAS project), the depression prevention project (MASTO), the equal pay programme and other extensive reform programmes.

Work carried out together with the administrative sector

Ministry of Social Affairs and Health and its administrative sector have common goals. Institutes, for their part, carry out the Ministry's social development aims and participate in the projects of the government programme. The Ministry makes target agreements with the agencies and institutes, which set out objectives for four-year terms. The target agreements are assessed and their goals examined each year.

Improvements to the availability and quality of social and health services and to working life are made by several comprehensive programmes. In recent years, the Ministry's administrative sector has emphasised gender mainstreaming, productivity and cost effectiveness in its activities. When productivity improves, society's resources are safeguarded for effective use in coming years, when the population ages and the workforce becomes depleted.

Ministry of Social Affairs and Health and the organisation of its administrative sector are being reformed. The reforms will last from 2008 – 2009. The reorganisation of activities affects several agencies and institutes. The aim is to increase the efficiency of operations and respond to the changes in the operational environment better than before.

The main features of Finnish social protection

The Finnish social protection system is by nature universal. We all have the common and equal rights to social protection and to social and health services. All residents have the possibility to receive pensions, sickness and parental benefits and unemployment benefits. In addition, every employee is entitled to earnings-related benefits, such as occupational pensions and occupational accident benefits.

The central aspects of the Finnish social protection system are risk prevention, social and health services and income security. People's incomes are safeguarded at different stages in life by a comprehensive service system and social income transfers. The municipalities are responsible for the arrangement of social and health services.

Under the arrangement of Finnish social insurance private insurance companies take care of most social insurance, though the system is statutory. Social expenditure is mainly funded by employers, the insured, the state and municipalities.

The system supports social integration, justice and equality. The income transfer system has efficiently evened out income distribution and the poverty level in Finland is one of the lowest of the EU. All children below school age are entitled to municipal day care, and this has given the mothers of small children the opportunity to take part widely in working life.

The aim of health and welfare promotion is to reduce various risks and problems, and to bolster people's wellbeing. People are encouraged to look after their health and they are urged to reduce their intake of tobacco and alcohol. Environmental healthcare, basic healthcare, occupational safety, occupational healthcare, as well as the work of maternity care and child health clinics support the prevention of problems and risks. The aim is to intervene actively in poverty and social exclusion well in advance.

Equality and safety in working life

In Finland, work to promote equality has lengthy traditions. Equality between men and women is a fundamental right, stated in our Constitution. The purpose of the Equality Act is to prevent gender-based discrimination and to promote equality.

The Finnish government is committed to the promotion of equality through its equality programme. The aim of the programme is to build the same opportunities for women and men, particularly in working life and to ease the reconciliation of work and family life. The intention is to increase the numbers of women in economic and political decision-making and to promote equality in regional development and in international cooperation. Ending violence against women and labour market segregation remain current objectives.

As with other EU countries, Finland is committed to equality mainstreaming. The aim of this is to develop equality-promoting administrative and working practices as a part of the core activities of the ministry and the authorities. The equality barometer, conducted every three years, monitors equality policy. The central aims of occupational

Ministry of Social Affairs and Health is responsible for:

- social and health policy
- welfare and health promotion
- environmental healthcare
- social and health services
- social insurance (pensions, sickness and unemployment insurance)
- the development of private insurance
- occupational safety and health
- promoting equality
- the harmonisation of the administrative sector's research and development activity
- international cooperation

safety and health are to maintain the working and functional capacity of employees and to prevent occupational diseases. With occupational safety and health, employees' mental wellbeing at work and their continuance in work are especially supported, and is a precondition for dealing with work. The aim is to have a workplace management and safety culture that promotes secure working environments.

The administration of occupational safety and health supports the opportunities for employers to take care of safety and wellbeing at work. Among other things, it ascertains the financial impacts of working conditions and develops good working environments promoting financial incentives and guidance. The forward momentum for these includes the founding of a broad-based Work Welfare at Forum.

Social expenditure as a proportion of GDP has grown steadily in recent years in almost all EU countries. Finnish expenditure is at an EU average.

The operational environment of the European Union and international organisations

Ministry of Social Affairs and Health has extensive cooperation with international, multilateral and bilateral intergovernmental organisations, non-governmental organisations and interest groups. The European Union has legislative powers that in part are binding on member states, including directly. Finland has belonged to Economic and Monetary Union (EMU) and to the sphere of renewed stability and growth agreements since their inception. EMU has stabilised the economy and reduced Finland's previously fairly high and unstable interest rate. Demographic change, labour market structural change and globalisation bring about pressures that require a strong economy that can provide for growing social expenditures.

One of the EU's most important aims is to promote the mobility of people, goods, services and capital. The Ministry of Social Affairs and Health is involved in the Union's policy so that the functionality of national systems can be reconciled with freedom of movement. The internal market and social and health policy are in tighter interaction increasingly often in the policy sector.

With the Lisbon agreement the European Community and Union were combined into one juristic entity. The agreement simplifies the Union's legislative work, as ordinary legislative procedure becomes the rule. The authority of the Union in social policy remains principally as before. The coordination of social protection is changing over to qualified majority decision-making and in agreements there is a new legal basis for a services directive concerning financial benefits. The Union's authority in health matters is growing.

The EU's growth strategy for 2000-2010 (the Lisbon strategy) has been an important instrument in economic, employment and social policy. The social dimension is being strengthened in EU decision-making and activity. Using the open method of coordination, member states set common objectives and agree on follow-up indicators and reporting, and convey information on best practices.

People's health is the mainstay of the economy and employment. In the EU, health is understood in broad terms. Health policy embraces many other areas in addition to traditional public health – health promotion, disease prevention – such as health services, products affecting health and environmental health. The EU health strategy for 2008-2013, adopted in 2007, steers EU health policy. Increasingly, health policy cuts across other policy sectors and is affected through other policies.

Equality policy and legislation have a firm foundation and basis of norms from the UN and the EU. The central principles of international statutes are equal pay and gender mainstreaming.

Finland takes an active part in preparing EU legislation and directives on occupational safety and health. The aim is to ensure the effective and even enforcement of community legislation concerning wellbeing at work and occupational safety and health.

Finland also takes an active part in the health policy sector activities of the UN, the World Health Organisation, the International Labour Organisation, the Council of Europe, the Nordic Council of Ministers and other regional intergovernmental organisations.

Finnish population's health and social welfare in statistics

The population is nowadays healthier and more functionally capacitive then ever before. Despite this, health differences between population groups have not narrowed. Traditional diseases and accidental deaths have diminished, but in their place have come lifestyle diseases, such as diabetes, asthma, allergies and intoxicant problems and mental health disorders. A strong correlation has been established between educational level and health.

Life expectancy is being continually prolonged and people's functional capacity is becoming better. Working conditions have improved and people are retiring later than even a few years ago.

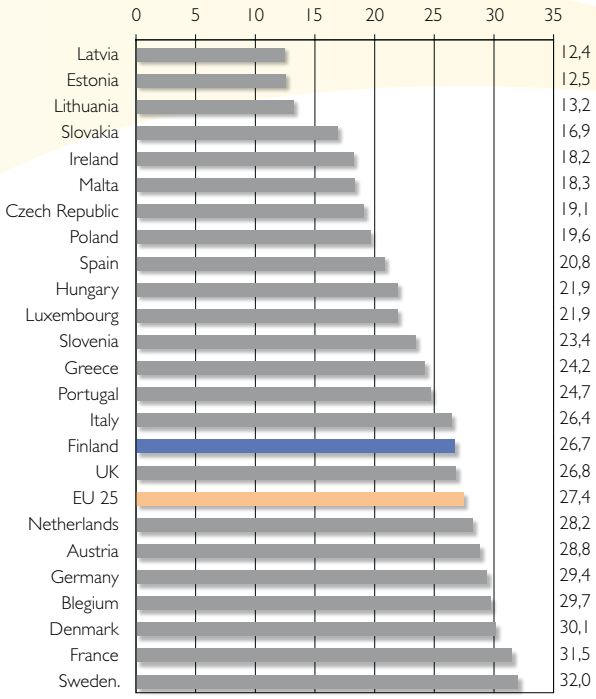
The need for social assistance has become less and equality has improved. Economic growth has clearly increased employment. The unemployment rate has dropped to nearly six percent. People over the age of 55 remain in working life for longer. Unemployment is mainly structural and there are vast regional differences in employment. All too many people are socially excluded by long-term unemployment.

Obesity is becoming a critical public health problem. Rising alcohol use is increasing alcohol and

health-related harm. There are problems concerning child welfare and there are large numbers of people on disability pensions. In particular, depression has become more widespread as a cause of work incapacity. This all increases the risks of social exclu-sion and health gaps between population groups.

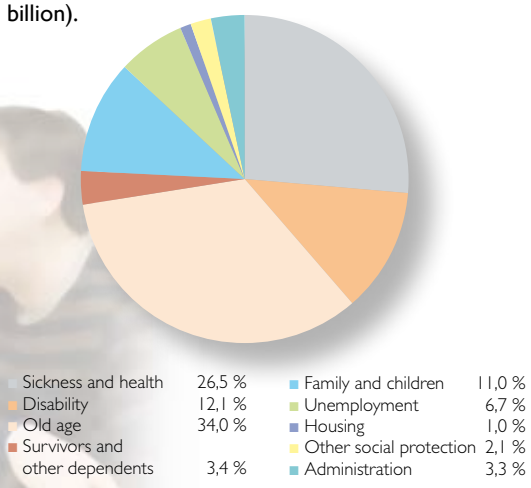
Social protection expenditure for 2008 is estimated at €47 billion, of which a third is financed via the state budget. Social protection expenditure is 25% of GDP. Social spending is for the most part comprised of pensions, municipal social and health services, unemployment protection and sickness insurance.

Figure 1. Social protection expenditure in relation to GDP in EU countries in 2005.



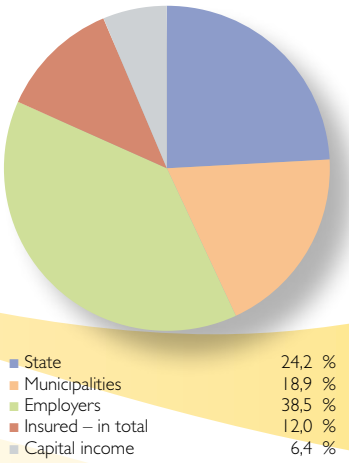
Source: Eurostat

Figure 2. Social protection expenditure by target group, 2008 (percentage of overall expenditure, €47.0 billion).



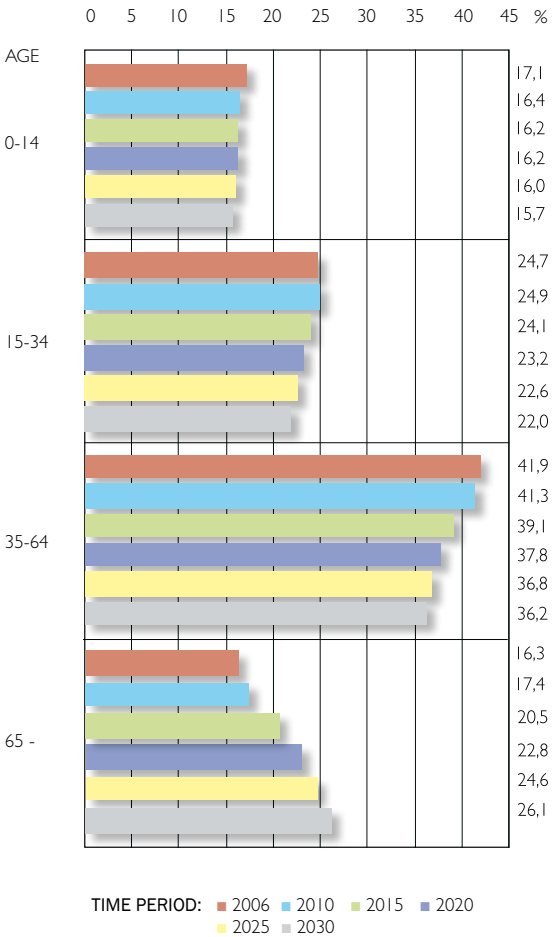
Source: STM

Kuvio 3.
Total funding of social protection in 2008.



Source: STM

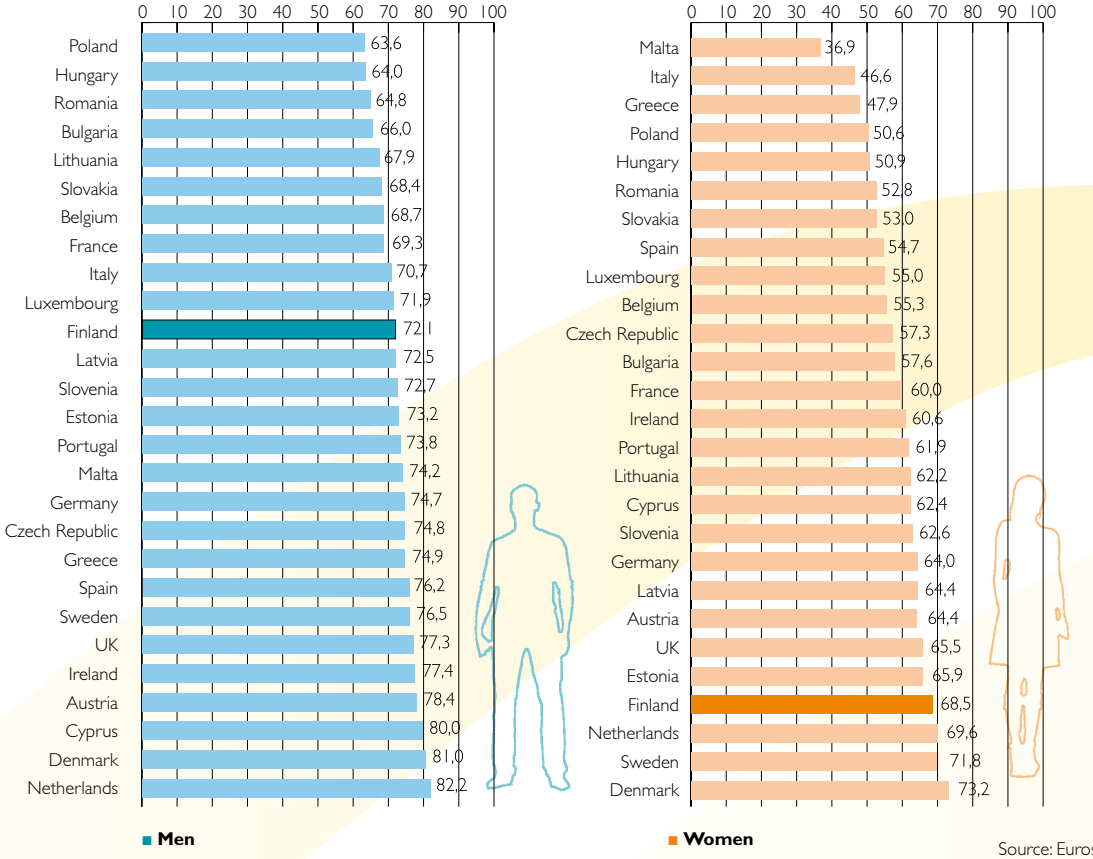
Figure 4.
Demographic development, proportions of age groups, %



Source: Statistics Finland

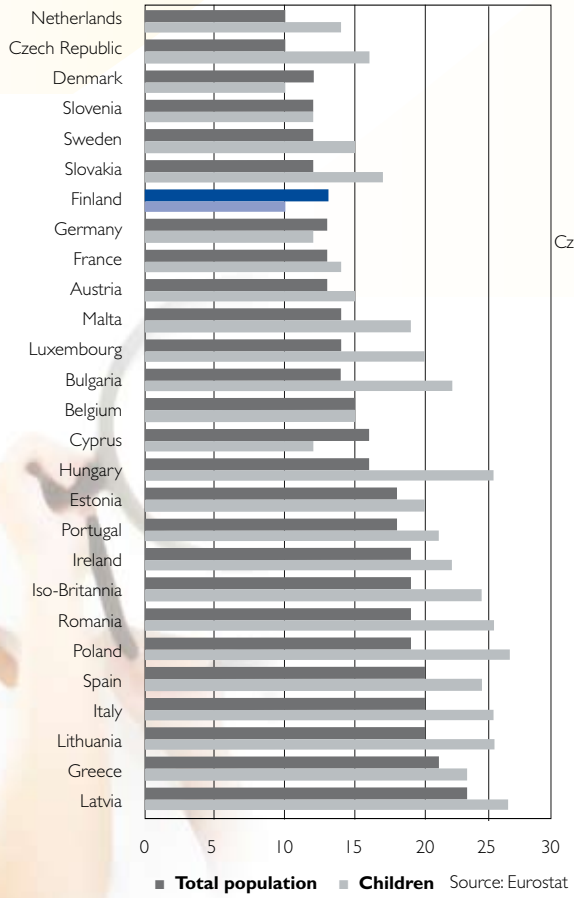
Figure 5. Unemployment rate in EU countries in 2007

Overall fertility depicts births. The rate has increased slightly in recent years and is above the EU average.



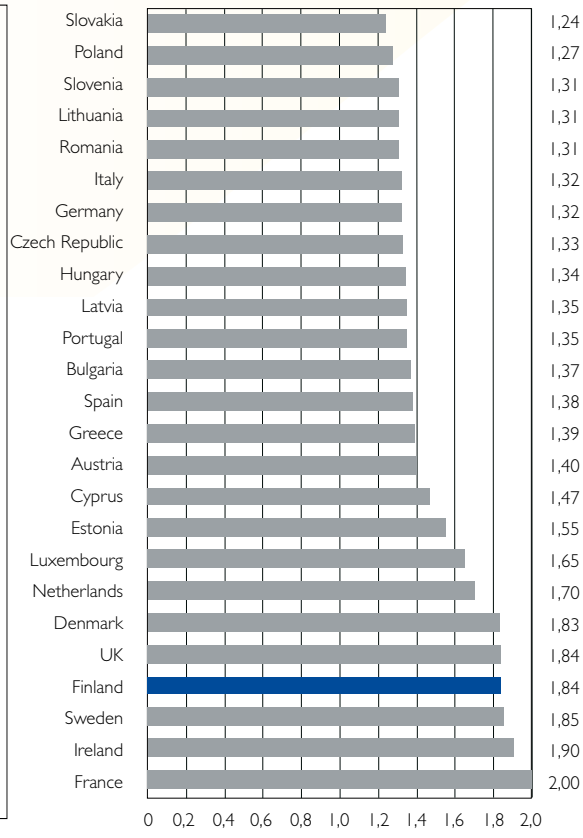
Source: Eurostat

Figure 6. Poverty rate in EU countries in 2006.



Source: Eurostat

Figure7. Overall fertility rate in EU countries in 2005.



Source: Eurostat

Welfare

YESTERDAY, TODAY AND TOMORROW

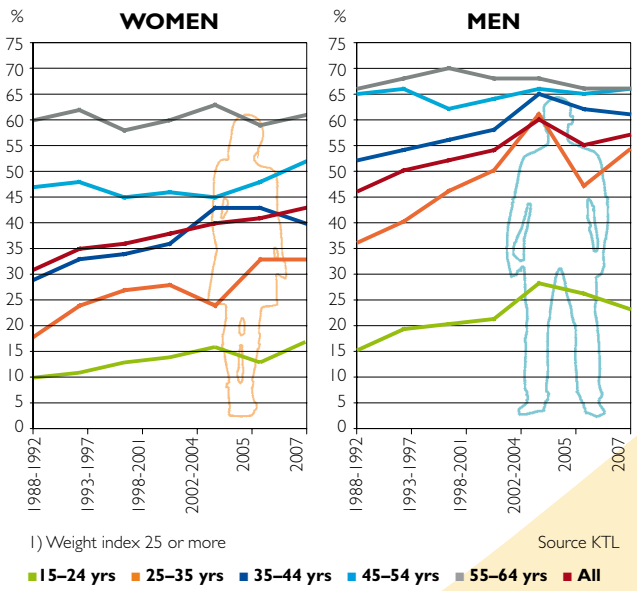
For health and functional capacity

The aim is to narrow health gaps between population groups, reduce deaths among young men from accidents and violence, and cut the harm to public health caused by alcohol. The goal is also to improve the working and functional capacity of people of working age, increase the functional capacity of people over 75 years of age, improve the possibilities of older people to live and manage in their own homes and the opportunities of people with disabilities to take part in working life.

The lifespan of the population has increased and people have more functionally capacitive years of life. The difference in life expectancy between men and women is now seven years. Internationally, the gap is large. The functional capacity and state of health of people in Finland has for the most part developed in a positive direction in all age groups. But health differences between different socio-economic groups in the population have remained as before or have even increased. Obesity, smoking, the growth in alcohol consumption and too little exercise undermine the population's welfare.

Alcohol policy has undergone extensive changes in recent years: in 2004 the limits on personal use imports of alcohol were abolished and the tax on alcohol was lowered. The same year gross consumption of alcohol rose to about 11 litres per capita. In 2007 alcohol consumption continued to increase, as did the related harm and, most dramatically, deaths due to alcohol. At the start of 2008 the tax on alcohol was raised. Drug abuse and its related harm in Finland have stabilised in the 2000s. The suicide rate has been traditionally high, though in the long term it has undergone a clear decline.

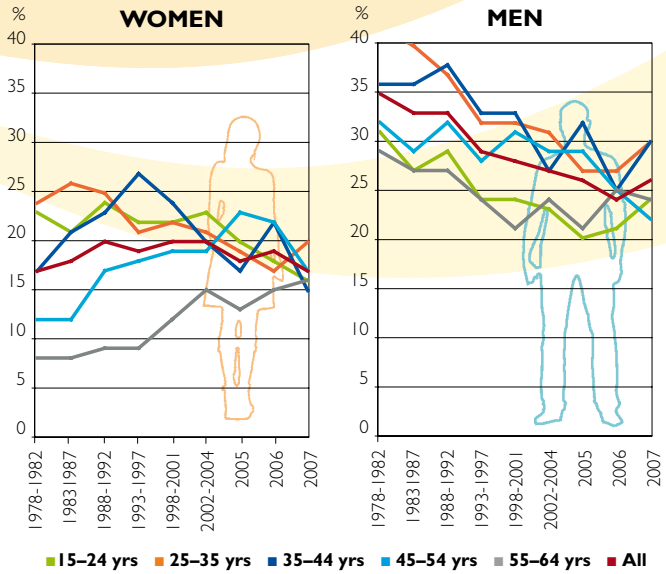
Figure 8. Obesity rate 1) according to age group 1988-2007.



1) Weight index 25 or more

Source KTL

Figure 9. Smoking rate by age group 1978-2007

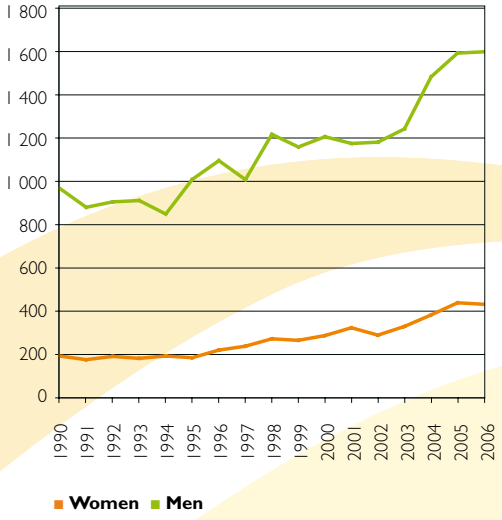


Source KTL

Obesity is a national health problem that is being tackled.

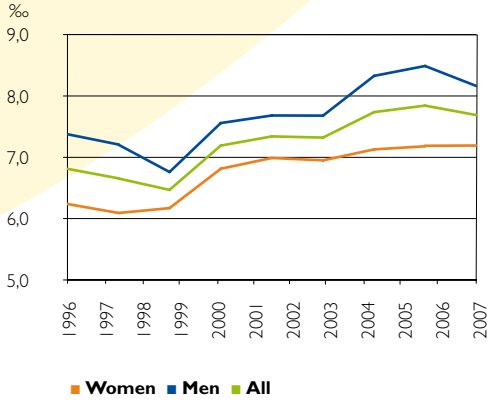
The smoking rate is low by international standards.

Figure 10. Deaths due to alcohol 1990-2006.



Source: Statistics Finland

Figure 11. Changeover of 35–54-year-olds to disability pension 1996-2007.



Source: Finnish Centre for Pensions

The health and working capacity of people of working age have improved. Mortality from coronary heart disease and cancer has dropped appreciably. Smoking among men has declined steadily, but 2007 saw an upturn in smoking among younger age groups. Smoking among women is practically unaltered.

The disparities between groups of different educational level have remained large, and among women has even grown. Obesity in the population, especially among young people and young adults, has become widespread. The functional capacity of older people has improved in recent years. The proportion of older people living at home has remained unchanged. Mental health problems, particularly depression, have become more widespread and have become the major cause of working incapacity.

2007 saw the start of the Health Promotion Policy Programme. This is one of the government's three policy programmes. The emphases are the reducing of health differences between population groups and cooperation between administrative sectors to promote health. Health promotion activity models are being developed in unison with the municipalities. The older population is being encouraged to take more exercise and be non-smoking, to drink moderately and eat healthily.

The harm caused by intoxicants has diminished with long-term and extensive action programmes. These have been carried out according to partnership criteria, in which the actors have been the municipalities, non-governmental organisations, churches and the central and regional state organisations. One of the focal points of a separate narcotics policy programme has been to ensure that drug users receive sufficient and appropriate treatment.

The importance of fighting infectious diseases has been accentuated in recent years in particular due to the threat of pandemics. Preparation is made for tackling diseases through extensive international collaboration.

Reform of services under a broad development project

People's wellbeing has to be assured by working social and health services and reasonable income security. This is why improvements are being made to the availability and quality of social and health services. The structures of service system are being reformed and regional cooperation reinforced. The reform is being steered by the National Social and Healthcare Development Programme for 2008-2011. Under the programme the desired changes are carried out in cooperation with interest groups and protagonists in the field, particularly the municipalities. The aim is to safeguard sufficient personnel levels and the availability of social and health services in Finnish and Swedish. The goal is also to assure the sustainable financing of services and social insurance.

According to the public services quality barometer, the public are satisfied with public day care. The rating of health care is slightly lower. In international studies, Finnish satisfaction with healthcare services has remained good by comparison with other EU countries.

Deaths due to alcohol have increased dramatically

About 252,000 people worked in municipal social and healthcare in 2007 – 45& in social care and 55% in healthcare.

Access to treatment safeguarded – timeframes for receiving non-emergency treatment

The National Healthcare Project was implemented from 2003-2007. Its aim was to secure access to treatment, emphasise preventive treatment, increase work sharing in specialised medical care, enhance cooperation among hospital districts and the need to organise basic healthcare as a larger entity.

The project prepared the reform of access to non-emergency treatment, which came into force in 2005. Standard criteria of non-urgent treatment were drawn up to safeguard treatment access. Timeframes have made the work of municipalities and hospital districts clearer and services have improved.

Queues over six months for treatment shortened appreciably but have not been wholly eliminated. In autumn 2002 there were about 66,000 people queuing for six months for treatment. In December 2007 the number was under 10,000. The situation worsened in the autumn of 2007 with the threat of industrial action by healthcare personnel. Access to oral healthcare is hampered by a worsening lack of dentists. There are notable regional disparities in the availability of treatment

Health centre's operational problems have been ascertained and solutions proposed. The strengthening of regional cooperation is given special emphasis. The aim is also to make more effective use of laboratory and imaging service arrangements and information technology as a greater entity. The introduction of new technology has been promoted by several healthcare and social sector development projects.

In spring 2005 the government began an extensive project for the reform of the municipal and service structure (known as the PARAS project), and in February 2007 the skeleton law for the reform came into force. The PARAS reform will strengthen the demographic base of the social and healthcare system with the implementation of municipal unions and with the creation of cooperation regions for social and healthcare. In the case of specialised services, municipal social and healthcare combinations of broad demographic bases are being formed, to which each municipality must belong. The Ministry of Social Affairs and Health stresses the integrity of the chain of care and treatment from the perspective of users and the close unity of social and health services. The measures taken under the National Social and Health Care Development Programme (KASTE) support the preparatory work carried out by the municipalities and municipal combinations.

In future, the legislative basis of healthcare services will form a new healthcare act, which will combine the public health act and the law on specialised medical care. The entry into force of this act, as with the changes to social care statutes concerning the PARAS project, will be set as the preparations proceed.

There are at present more *doctors* than ever before, and each doctor treats fewer patients than earlier. In 2007 there were about 17,200 doctors, and 4,400 dentists. It has not been possible to fill all doctors' positions, which has caused problems in small localities in particular. There is a shortage of dentists. By international standards there is nevertheless an abundance of doctors.

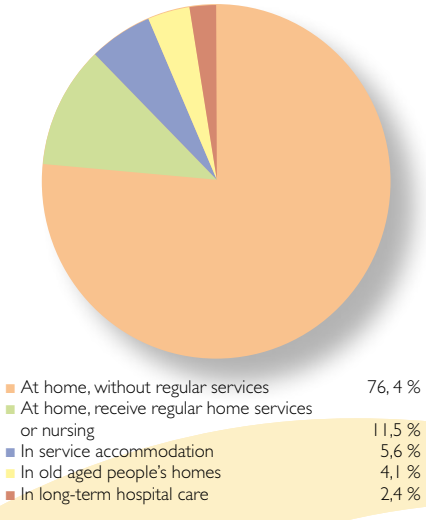
The development of the national data system of electronic patient and client records is currently under construction. The use of electronic medical prescriptions was adopted in 2008. In social care too a common national client data system is being prepared. These will make activitiess more efficient and control client queues.

Social services becoming functional

The National Development Project for the Social Sector was carried out from 2003-2007. The further development of social care is contained in the National Social and Healthcare Development Programme (KASTE 2008-2011). The main aims of the programme are to increase the participation of inhabitants and to reduce social exclusion, improve the welfare and health of the population and diminish health differences. It also aims to improve the quality, availability and effectiveness of services and reduce regional disparities.

More opportunities will be made for older people and people with disabilities to live in domestic conditions. Service or supported accommodation will be more frequently offered. Home living will be made easier with the help of home services, home nursing and family care. These principles are contained in the Quality Guidelines on Services for Older People, issued in February 2008 by the Ministry of Social Affairs and Health and the Association of Local and Regional Authorities. The participation in society of people with severe disabilities is facilitated by increasing transportation, interpretation and personal assistant services.

Figure12. Housing and services for people over 75 in 2006.



Source: Stakes

The share of the gross expenditure of municipalities spent on social and healthcare activity has grown annually. It stands on average at 50%. The municipalities receive a state subsidy for social and healthcare from the national budget, which covers almost a third of expenses. The subsidy has been increased appreciably in recent years. The numbers of people and households on social assistance continued to decrease in 2007. They nevertheless remain high, as just fewer than 7% of the population received social assistance at this time.

Overall reform of social security underway

In summer 2007 the government launched a broad project to reform social security, under the SATA committee. This broad-based committee will prepare reform proposals by the end of 2009. Urgent reform proposals will be presented to Parliament in autumn 2008. The aim of the reform of social security is to increase its incentives, improve the position of all on low incomes and reform the administration of the benefit system.

Sickness insurance reimbursements for visits to private medical practitioners, as well as examinations and treatment have risen slightly in recent years. Reimbursements for private dental treatment have grown, as since December 2002 everyone is entitled to them.

Sickness insurance financing was reformed at the beginning of 2006. Sickness insurance is divided into sickess benefits and earnings security. Earnings security is funded by employees and employers, and sickness benefits will be funded by insurance payments and state.

The Ministry of Social Affairs and Health defined the most important aims of the current decade for national *pharmaceutical policy*. The starting point is to safeguard the good regional availability of medicines and to sustain pharmaceutical safety. In order for pharmacotherapy to develop, the attention must be given to the functional requirements of pharmaceutical research. The rational prescription and use of pharmaceuticals is being furthered by long-term activities. In 2003 the medicine exchange option was introduced, making it possible to choose a less expensive generic versions of medicines in place of those prescribed by physicians. The approach has worked well and has meant annual savings of about €90 million. It is important that the costs of medicines are kept under control in coming years too. The administration of pharmaceutical matters will be studied in 2008.

Accident and traffic accident insurance was transferred to the full expenses reimbursement system. This means in practice that accident and motor insurance recipients' medical expenses are calculated directly from the relevant insurance institution. They are passed to the accident and motor insurance company's social insurance institution without an intermediary payment being made. The change aims to ensure swift accessing of treatment and returning to work. Statutory accident insurance was transferred with the occupational pension system to the use of standardized indexes.

Wellbeing in working life

The goal is to ensure that working conditions are safe and that people enjoy wellbeing at work. We want to make occupational safety and health and the opportunities for rehabilitation functional. Over the last ten years extensive measures have been carried out in Finland to encourage people to remain in employment. The broad-based Veto programme to bolster work and working life attraction was implemented form 2003-2007. Its work is being continued in work welfare forums. The aim is that by 2010 people will remain in working life for two to three years longer than they did in 2002, that sickness absenteeism will have declined by 15%, that people enter working life earlier, that the frequency of occupational accidents and incidence of occupational diseases have decreased by 40% and that their severity has diminished.

Finland's provision for population ageing received prominent recognition when the German-based Bertelsmann Foundation presented its international award for merit to Finland. Foundation made the award particularly for the National Ageing Programme and the Veto, Tykes and Nosto programmes. In its citation the Foundation drew attention to Finland's ability to adapt to changing circumstances and lauded the early detection of the problem of ageing in

Patients requiring emergency care are treated immediately.

Immediate phone contact with a health centre must be available in working hours, or during the health centre's announced opening hours.

Health centres must assess the care requirement of patients within three days of patients' contacting them. The assessment can be made over the phone and it can be performed by a healthcare professional other than a physician.

The timeframes for hospital treatment are three weeks for a treatment assessment. If a physician states that a patient requires hospital treatment, the treatment must begin within six months.

working life and the broad cooperation with which the challenge was taken up.

Physical working conditions have generally improved. On the other hand, the drop in occupational accidents appears to have stopped: in the last few years accidents have occurred more in proportion to working time. The number of occupational deaths has also increased. There are more uncertain factors, threats and demands linked to working life. In particular the psychosocial strain of work remains challenging. Nevertheless, work pressure has decreased and the opportunities for training and development have grown.

Table 1. Development of working conditions 1996–2007.

	1996	2001	2005	2006*	2007*
Occupational accidents (per million work hours)	30	30	32	33	34
Occupational deaths	47	44	51	46	46
Deaths on journeys to and from work	24	42	31	20	16
Compensated occupational diseases	6 400	5 100	4 350	4 800	5 000

Source: Occupational accident and disease statistics

Pension reform at the implementation stage phase

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

The reform of the *occupational pension system,* introduced in the beginning of 2005, was crucial to the sustainability of the financing of the pensions system. One's entire working life is assessed concerning future pension payments in such a way that longer lifetime does not automatically increase pension expenses.

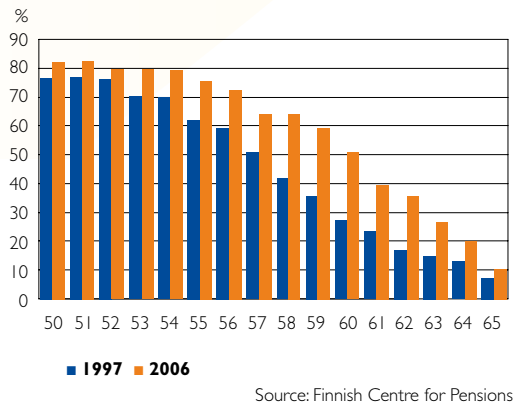
Pension reform encourages older people to remain in employment. People can retire at 63 but can remain in work until they are 68. The earnings-related pension is calculated throughout one's working life. Pension reform contains many incentives to remain in work and supports the sustainable funding of pensions. Municipal and state pensions were reformed on the same principles as the private sector.

Older people take part in working life more than before. People are retiring later. This has been influenced by the 2005 pension reform, the general economic situation and many measures for the development of work and working life and maintaining working capacity. Attitudes have been successfully changed so that longer careers, remaining in work and older employees are appreciated more than before.

Older people are employed better than earlier, because the amount of earning related pension payments no longer depends on the age of employees, nor does the last employer worked for have to pay as much disability pension as earlier.

The *earnings related pension payment* quotient of wages has remained the same over the past two years, at 21.4%. The employee's contribution will increase in the near future but not as much as was anticipated before the pension reform. Finland's partly funded earnings related pension system safe-guards pensions in the long term better than the systems of many other countries. The proportion of GDP for earnings related pensions has increased evenly and in 2005 this was already 66%, while at the end of the 1990s it remained under the 50% level.

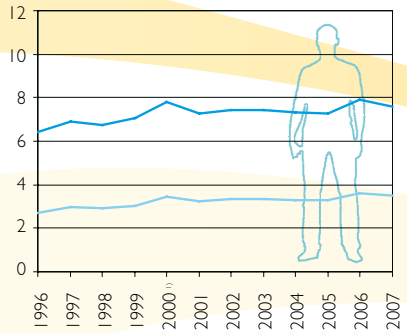
Figure 13. Employment rate of 50–64 -year-olds in 1997 and 2006



Source: Finnish Centre for Pensions

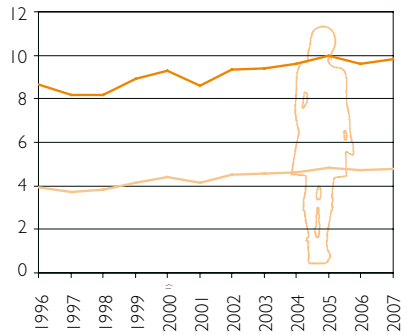
The amount of sickness absenteeism among women grew, while among men it dropped. The main reasons for absenteeism were musculoskeletal diseases and mental health disturbances. Part-time sickness benefit became possible at the start of 2007. This prevents the prolonged sickness absences and continual work incapacity. It helps in people's rehabilitation and returning to work. Depression is the cause of some 4,000 people taking work disability pensions each year. For this reason in 2007 the several-year MASTO project on depression prevention was started.

Figure 14. Sick days in relation to days worked and per employee (17–75-year-olds) 1996–2007.



■ **Sick days per employee, men**

■ **Percentage of sick days out of workdays, men**



■ **Sick days per employee, women**

■ **Percentage of sick days out of workdays, women**

Source: Statistics Finland

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

The reconciliation of work and family life is easier. The part-time care leave reimbursement used to be paid to parents with a child under the age of three, but is now paid during pre-school and the first two grades of primary school. *Parental leave benefits* have improved and the reimbursement for annual leave expenses to be paid to employers has been increased. Fathers in particular are encouraged to make more use of family leave than they have earlier, among other things by the two-year, tripartite campaign, which will continue throughout 2008.

Reducing poverty and tackling social exclusion

The Ministry of Social Affairs and Health wants to ensure that poverty is reduced and that care is taken of social exclusion. Work is being done so that long-term unemployment and structural unemployment, the need for long-term social assistance and poverty among families with children declines. The aim is to increase preventive health services for children and young people, as well as intoxicant treatment, mental health and child welfare services. The Ministry wants to ensure that sufficient drug treatment services are provided, that cooperation by administrative sectors in combating social exclusion is intensified and that homelessness is reduced. There is a strong third sector whose work supports the public sector. Its most important source of funds is the Slot Machine Association.

The point of departure for preventing social exclusion is the notion that work is the best form of social protection. People are not socially excluded when they have work, reasonable earnings security and sufficient minimum benefits.

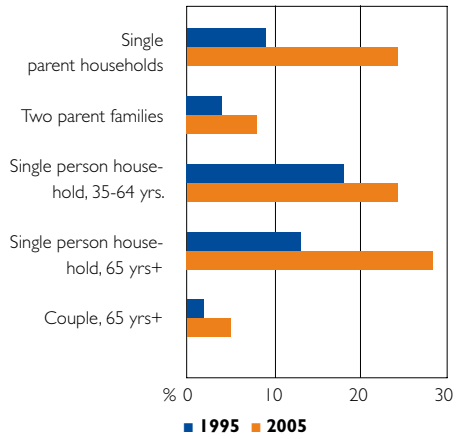
The numbers of the population on small incomes and perpetually on small incomes have increased in recent years. This is in part due to the general rise in the income level, a consequence of which is that the low income limit fixed to middle incomes has increased. The increase in incomes in the lowest income deciles has been slower than on average for households. The numbers of long-term unemployed fell, but structural unemployment remains high. The majority of long-term unemployed are people over 50. Young people were rarely unemployed for long.

The poverty level of families with children[1] fell in 2007 following a rise over several years, and was lower than for the whole population. The small income levels of single parents remained an important problem. Relative poverty in Finland is less compared to many EU countries. Full-time work is the surest guarantee that a household does not fall into the lowest income groups. Adjustments were made in recent years to the national pension and other minimum benefits, as well as the abolition of the own liability from income support for housing costs, have improved the economic situation of people on low incomes.

[1] Whose disposable income is 60% of the mean disposable income of the whole population as a calculation per consumption unit.

Long-term unemployment remains a challenge.

Figure 15. Proportion of the population on low incomes according to different types of household in 1995 and 2005.



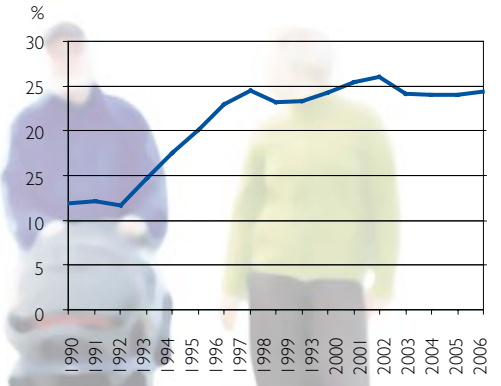
The low income limit is 60% of household's disposable mean income for each year.

Source: Statistics Finland, income distribution statistics.

There is an increasing demand for *intoxicant treatment services*. The numbers of clients have not, however, grown in recent years. The numbers of people using mental health services has increased slightly but the numbers of mental health patients in institutional care have dropped.

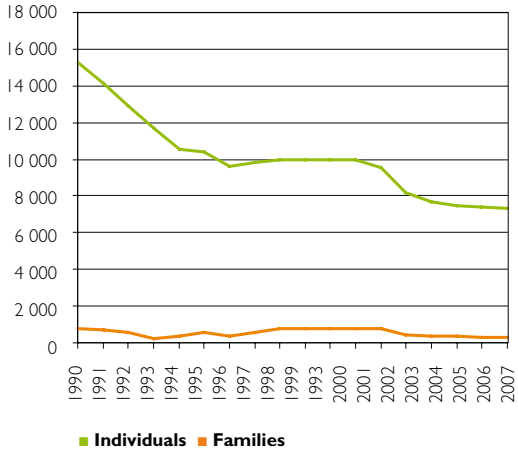
The numbers of people on *social assistance* and using it over a long term have declined. The need for long-term support is nevertheless a significant challenge. The improvement in the unemployment rate has meant a drop in the numbers of recipients of unemployment benefit. There is clearly less homelessness than earlier.

Figure 16. People on social assistance for 10 – 12 months in relation to total social assistance recipients from 1990 – 2006.



Source: Stakes

Figure 17. Numbers of homeless people 1990–2007.



Source: State Housing Fund

Relief for homelessness in the greater Helsinki area has been sought particularly by the *Homelessness Programme*. The government's aim is to halve homelessness by 2011. Early intervention in the problems of children and young people, support to immigrants to assimilate and the implementation of the national alcohol and drug programmes and crime prevention are used to prevent social exclusion.

From the start of 2008 the position of all indigent people when, in line with, the new government programme, the level of minimum benefits was adjusted.

The third sector is a central player in activity against poverty and social exclusion. Non-governmental organisations have an important responsibility in preventive activity and as producers of services for special groups. Funding in 2008 by the Slot Machine Association for NGO activity ran to €312 million.

The EU's open method of coordination has intensified national cooperation in measures against poverty and social exclusion. There are numerous activities in progress funded by the Union to support the employment of the people who are most difficult to employ. 2010 will be theme year for European poverty and social exclusion.

Support for the welfare of families with children

Support is given to parenthood and family cohesiveness to assist the daily situation of families with children. Expenses derived from raising children are levelled out so that families are not forced into unequal positions in relation to one another. Children are given the opportunity to grow and develop in safe environments and the harmonisation of work and family life is made easier.

The government programme contains several adjustments to the levels of family policy benefits. In 2008 the child supplement for single parents was adjusted by €10 a month and from the start of 2009 the supplement will be adjusted for families with three or more children. The minimum levels of maternity, paternity and parental benefits and sickness benefits will be increased from the start of 2009. The post of Ombudsman for Children was started in autumn 2005 to promote the interests of children. Intervention in children's problems is made as early as possible.

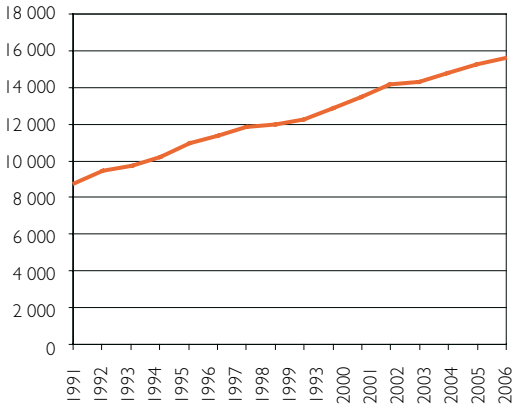
The most important forms of *family policy support* are the child allowances and day care. Child poverty is low in Finland compared to other EU countries. Since 1995 the number of families living below the poverty line has doubled, but in 2005 their numbers began to fall. Families with many children and single parents are in the most difficult position, and in 2005 24% of them lived below the poverty line.

Work and family life cannot always be reconciled. This issue has received much attention, as have efforts to deal with the drabacks. The costs incurred by employers for *family leave* entitlements were evened out among employers. This is being done so that costs to be paid do not pile up on women's employers.

Fathers have made use of family leave entitlements increasingly since the beginning of the 1990s. In 1990 42% of fathers used paternity leave, while in 2007 the figure was 71%. From the start of 2010 paternity leave will be extended by two weeks. The family leave system is being developed further so that both parents have the opportunity to spend more time with their small children.

About 20% of children live in single parent families. The majority of Finnish children fare well, but the constantly growing numbers of children in need of child welfare is worrying.

Figure 18. Children placed outside the home, 1991-2006. This concerns children who have been placed temporarily for reasons of child welfare.



Source: STAKES

There remains an abundance of children and parents who need special support. The numbers of children taken into care and placed outside the home continued to grow. The numbers of children and young people in non-institutional child welfare care have decreased. The reasons why children are taken into care include parents' long-term unemployment, mental health problems as well as increased alcohol and drug abuse by parents or children.

There are larger numbers of children under school age in *day care*. The proportion of children aged 3-5 years looked after outside the home has risen to 70%. The figure for 1-2-year-olds is 38%, as the majority of infants of this age are looked after at home with home care support. Nearly all 6-year-olds take part in preschool. There has been an emphasis on morning and afternoon activities for school children in recent years. In addition the parents of first and second grade primary school learners, whose weekly working hours are at most 30 hours, receive a small compensation for shortening their working time.

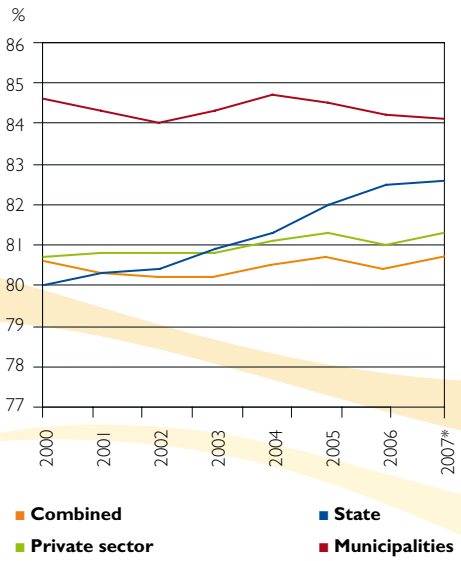
Using the equality action programme

Equality between women and men still needs to be reinforced. The government promotes the realization of equality between women and men systematically. Equality awareness is being increased in schools and the strong segregation in areas of study by women and men are being ameliorated. This will diminish segregation according to gender in the labour market. Women's equal career development is important from the viewpoints of competitive capacity and welfare. Activities are needed in the private and public sectors. The better reconciliation of work and family life supports the possibilities of equality. The aim is to get rid of gender-based wage differentials. The government is promoting this with its same wage programme. Reducing violence against women is also an important goal.

Gender mainstreaming means that the equality perspective is taken into account in all drafting and decision-making in the administrative sectors.

The government's equality programme will collate and coordinate equality policy for 2008-2011. All administrative sectors are involved in carrying out the programme. The programme presents leading projects, based on the main points of government programme's equality policy. These include increasing equality awareness in schools, reducing segregation, improving the reconciliation of work and family life, reducing gender-based wage differences, promoting women's career development, reducing violence against women and gender mainstreaming. This is a strategy according to which all measures and decisions are assessed from the perspective of their impact on men and women.

Women's earnings as a percentage of men's earnings



Source: Statistics Finland

Pay-based equality is stipulated separately by the Finnish Constitution and the Equality Act. Women's wages remain in average smaller than men's corresponding wages. The major reason for wage differentials is the lower estimation of fields and professions dominated by women compared to those of men. The government aims to promote pay equality by the broad same pay programme involving the government and social partners. In this context equality plans are also being investigated and pay surveys carried out.

The proportion of women in political decision-making has grown at both the local and national levels. This positive trend depends in the future on whether more women can be put forward as candidates. The equality act requires that there are as many women as men in municipal administrations. In 2001 45.4% of municipal administration members were women, while in 1993 the figure was 24.5%. It is noteworthy that the proportion of women in top levels of leadership in Finland is the lowest in Europe. Trends in financial decision-making are also not self-evidently positive, as the advancement of women in such things as stock market management is slow.

Looking ahead

The major challenges facing social protection in the coming period are population ageing, safe-guarding the availability of quality social and health services, international economic trends, the closer cooperation of the European Union in the area of social protection, the impacts of new technology and Finland's regional development.

A policy programme on health promotion is being carried out from 2007-2011. The Ministry is participating actively in two other government policy programmes – to strengthen the position of work and entrepreneurship, and welfare in working life, and to improve the welfare of children, young people and families. From 2008-2011 there will be an overall reform of social security. An extensive overhaul of the service system is being carried out. This involves broad legislative programmes, such as the drafting and implementation of a new healthcare act.

The National Social and Health Care Development Programme (KASTE) sets the framework for the development of the work of the service sector. Part of it includes the implementation of a social and healthcare innovation project. An impact on disability pensions caused by depression will be made by the broad depression prevention, or MASTO, project. The government equality programme to promote gender equality will also continue.

The pension forum and work welfare forum start work in 2008. The reform of social security will continue beyond the government term.

The development of the EU's internal market and the Lisbon strategy raise challenges for national social policy. Also, the debate continues on the position of the public sector, its tasks and guiding role as well as the form of collaboration between the public and private sectors.

The administrative sector is being reformed. The operations of agencies and institutes will be reorganised. The organisation of the Ministry of Social Affairs and Health will also be developed.

Looking AHEAD

Social and health policy challenges

- Globalisation
- European integration
- Demographic change
- Technological development
- The development of working life and work environment
- Employment
- Poverty and social exclusion
- The development of public health and the environment
- Development of the economy
- Regional development, urbanisation
- Changing values

Points of emphasis in activities

- Strengthening preventive courses of action concerning problems and diseases
- Improving the population's working and functional capacity
- Reducing obesity
- Reducing drug and alcohol harm

- Encouraging people to remain in work
- Reducing sickness absenteeism
- Increasing wellbeing at work
- Preventing depression
- Starting social security reform
- Follow-up measures on pension reform

- Reducing long-term unemployment
- Reducing poverty among families with children
- Safeguarding intoxicant and drug treatment

- Implementing the National Social and Health
- Care Development Programme
- Service legislation reform
- Implementing the reform of the service structure
- Sufficient personnel in social and healthcare

- Reconciling work and family life
- Safeguarding the special services for families with children
- Safeguarding children's growing environments

- Implementing the equality act
- Reducing the pay gap between women and men
- Reducing violence against women

The administrative sector of the MINISTRY OF SOCIAL AFFAIRS AND HEALTH contains much specialist expertise.

The administrative sector will be reorganised from the beginning of 2009 in order to make its work more effective and productive.

National Research and Development Centre for Welfare and Health promotes the welfare and health of the population, and social and health services. Produces research and statistics. *www.stakes.fi*
National Public Health Institute researches and monitors the state of public health and produces information on it. *www.ktl.fi*
The research and development work of these institutions is being reorganised and an entirely new organisation will start operations from 1 September 2009.

National Authority for Medico Legal Affairs authorises healthcare professionals to practice their professions and oversees their activities. In future it will also oversee the work of healthcare organisations. *www.teo.fi*
National Product Control Agency prevents harm from substances containing alcohol, tobacco and chemicals, and promotes a healthy and safe living environment. *www.sttv.fi*
The work of these institutions is being reorganised and an entirely new organisation will start operations from 1 September 2009.

National Agency for Medicines ensures that medical products on the market are effective, safe and of good quality. *www.nam.fi*
The Centre for Pharmacotherapy Development works with the National Agency, collecting and disseminating information on promoting rational medical treatment. *www.rohto.fi*
The Centre will be amalgamated with a new reserch- and development centre.

Insurance Supervisory Authority monitors and checks that insurance and pension institutions are financially sound, conduct relevant internal inspection, have sufficient risk management and sound management. *www.vakuutusvalvonta.fi*
The authority will be merged with the Financial Supervisory Authority at the start of 2009. The new agency will operate under the auspices of the Bank of Finland.

Inspection Board is a special court handling social insurance comparable to an appeals board. *www.stm.fi*
The Unemployment Security Board is a social insurance appeals board handling unemployment security matters. *www.stm.fi*

Radiation and Nuclear Safety Authority oversees nuclear power stations, nuclear materials and nuclear waste, as well as the use of radioactive substances in healthcare, industry, research and teaching. *www.stuk.fi*

Finnish Institute of Occupational Health is a multidisciplinary institution dealing in research and expertise, which promotes the working capacity, overall health and quality of life of people of working age. *www.ttl.fi*

Finland's Slot Machine Association collects resources from gaming activities for research activities by Finnish social and health organisations. *www.ray.fi*

There are numerous independent institutes and offices operating in the ministry's administrative sector. They produce research for the ministry's work – for the preparation of legislation, drawing up social and health policy lines and for the bases of decision-making. Some offices are authorisation and inspection authorities. Over 4000 people work in the administrative sector's agencies and institutes.

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