Reports of the Ministry of Social Affairs and Health 2008:39

National Strategy Report on Social Protection

AND SOCIAL INCLUSION 2008-2011

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

ISSN 1236-2115
ISBN 978-952-00-2674-5 (PDF)

Helsinki 2008

DOCUMENTATION PAGE

Publisher Ministry of Social Affairs and Health, Finland	**Date** 15 September 2008
Authors Under direction of Director-General Raimo Ikonen, the report has been edited by Ralf Ekebom, Tiina Granlund, Mervi Kattelus, Arto Koho and Carin Lindqvist-Virtanen	**Type of publication** **Commissioned by** Ministry of Social Affairs and Health **Date of appointing the organ**
Title of publication National Strategy Report on Social Protection and Social Inclusion 2008–2010	

Summary

The European Union Member States prepare national reports for the promotion of social inclusion in 2008–2010. The national strategy reports are a part of the EU open method of coordination. They are compiled in accordance with the guidelines the Social Protection Committee issued in February 2008. The report should be submitted by 15 September 2008. A similar report has been drawn up in 2006 and a concise version in 2001 and 2003.

In addition to the key messages and the situation assessment described in the introduction, the report has three separate sections. These sections present the strategy report on social inclusion, the pension strategy report and the report on strategies for health care and long-term care. The report ends with a relatively extensive set of appendices with information on social development indicators agreed within the EU as well as some of the tables and figures of the report.

The structures and contents of the reports have been harmonised. The objective is thus to make it easier to monitor and assess the social and health policy measures adopted by the Member States. The intensity and contents of activities remains the responsibility of the Member States. The harmonised reporting supports cooperation and mutual understanding between the Member States. The social protection systems vary greatly in details. The organisation and financing of social security benefits and services fall under Member State competence. Cooperation between the Member States aims at reinforcing coordination and promoting the EU social dimension. Social policy objectives are a part of the Lisbon Strategy and contribute to the realisation of the Lisbon goals.

The report has been compiled at the Ministry of Social Affairs and Health, and experts in other administrative sectors have taken part in the process. The report has been discussed in the EU Sub-Committees under the Committee for EU Affairs. A consultation process with non-governmental social welfare and health organisations and Association of Finnish Local and Regional Authorities and the representatives of the largest municipalities was arranged during the compilation of the report. The national pension report has been drawn up in a cooperation group with representatives from insurance institutions and social partners.

The report highlights as good national practices the following: (1) cross-sectoral welfare policy programme on children and youth in the City of Turku (social inclusion project), (2) Kaiku services by the Treasury (project on pensions), and (3) coordination measures carried out in the City of Tampere for health promotion.

The key messages of the report can be summarised as:

- The general overview of the social situation is positive.
- Low income and problem prevention pose challenges to the strengthening of social inclusion.
- The growth pressure of pension expenditure is under control – small pensions pose a challenge.
- Diminishing health differences is the most important health policy challenge.

Key words

health policy, pensions policy, poverty, public health, social exclusion, social protection

Other information

Internet: www.stm.fi/english

Title and number of series Reports of the Ministry of Social Affairs and Health 2008:39		**ISSN** 1236-2115	**ISBN** 978-952-00-2674-5 (PDF)
Number of pages 140	**Language** Finnish	**Price**	**Publicity** Public
Distributor/Orders		**Financier** Ministry of Social Affairs and Health	

Contents

Key messages of the report

General overview positive

1. Finland considers its current social situation as relatively good. Social security benefits, social and health services and other public services covering the entire population have contributed to the fact that poverty and social exclusion are relatively uncommon and gender equality rather well realised.
2. Employment has developed positively in recent times. The employment rate of men, especially aged men, could be higher and structural unemployment is still a difficult problem. That of immigrants has improved but remains low.
3. Finland ranks rather highly when comparing living conditions in EU Member States. The poverty rate is low in our country and the child poverty rate the lowest among the comparison countries.

Low income and problem prevention pose challenges to the strengthening of social inclusion

4. Low income is more common among those who are outside the labour force. Jobless households are in the weakest position considered from the viewpoint of risk or threat development. The relative low income level trebled during 1993-2006 in the group of households where only some household members of working age are active in the labour market. On the other hand, there is no substantial problem of in-work poverty in Finland. Low incomes are most common among single person households and single-parent families, the majority of the latter being women. The number of households receiving income support has begun to decrease.
5. The number of homeless is decreasing and the objective is to halve the number of long-term homeless by the year 2011. The number of households living in cramped apartments is still rather high in Finland.
6. Early school dropout rates have remained low. The risk of social exclusion seems to have increased recently, especially among substance abusers and some groups of children and young people. Increased demand for child welfare has raised concerns, as has the sufficiency of personnel resources e.g. in child and youth services and mental health services as well as in services for the aged.

Pressure on expenditure on pensions under control – small pensions a challenge

7. Despite the ageing of the population, the pressure on pension expenditure is reasonable and seems fairly well under control also in the long term. Finland has prepared for demographic change by renewing pension systems and increasing the prefunding of employment pensions. Safeguarding the positive developments in employment is a prerequisite here.
8. The Finnish pension system is characterised by equal treatment of men and women. Maintaining the high employment rate of women, decreasing the pay gap and safeguarding a good coverage and a sufficient level of pensions pose challenges.

9. The risk of poverty among ageing women relying solely on the national pension is still a challenge, despite adjustments and increases of national pensions during the last years.

Diminishing health differences - the key health policy challenge

10. The health and standard of living of Finns have improved. While public health has improved, due to healthy lifestyles, living conditions and employment have improved as well. The consumption of alcohol among young people has decreased recently. However, the total consumption of alcohol has increased and the adverse effects of alcohol use, especially on the welfare of children and families, remain serious.
11. The well-being of Finns has developed positively on average but the health differences between population groups have increased.
12. In addition, regional differences in services pose challenges to health policy. Primary health care and social work, emergency care, mental health services and care for substance abusers are being developed in particular, in the implementation of the service structure reform.

Structure of the report

Part 1 describes the social situation. The end of part 1 describes how Prime Minister Matti Vanhanen's second cabinet has responded to the challenges of improving well-being, health and social inclusion.

Parts 2-4 of the report discuss these challenges in greater detail, and measures whose implementation has already been decided upon are described.

The report contains an appendix with development indicators jointly agreed in the EU and some tables and charts of the report as well.

Good practices

A description of national good practices has been introduced at the end of the report. In the report the following projects have been assessed as good practices:

a. **Social inclusion: cross-sectoral welfare policy programme on children and youth in the City of Turku**

b. **Sustainable pension policy: Kaiku services (State Treasury)**

c. **Public health care: coordination measures carried out in the City of Tampere for health promotion.**

Part 1 Introduction

1 General overview

1.1 Objectives set in the Government Programme

In international comparisons the competitiveness of the Finnish economy is rated among the best. Finland, like the other Nordic countries, seems to have been able to combine good economic competitiveness with an extensive public sector. However, Finland does not do that well in international comparisons on well-being and the quality of life, even though it has recovered rather well from the recession of the 1990s. The economy has grown, employment rates have improved and the purchasing power of private households has increased. Nevertheless, the recession may still be detected in high rates of structural and long-term unemployment. The majority of the population has been able to enjoy the economic growth that has resulted in increased earned income and consumer demand, and reduced taxation. Living conditions have improved and problems relating to subsistence have been alleviated. However, the entire population has not benefited from improved earned income and employment. Alongside strong economic growth, economic, regional and social inequality has increased. The real level of income transfers has been left behind the average wage level, which has decreased the mitigating effect of income transfers. In addition, decreased tax progression and the dual tax system for capital income and labour income have contributed to this.

The implementation of the Government Programme has been assessed in the Government Strategy Document. Four areas of welfare policy received a special focus in the Strategy Report for Prime Minister Matti Vanhanen's first cabinet (2003-2007). These four areas were strengthening basic services, improving access to health and medical care, lowering the risk of exclusion and preparing for an ageing population. The development in the state of well-being was assessed to be rather positive. The health status of the population and life expectancies have improved, the birth rate and total fertility rate have risen and e.g. drug abuse and suicides committed by young males have decreased.

In October 2003, the Council of State made a decision in principle on securing the future of social services. This decision was implemented by the Development Project for Social Services carried out in 2003–2007. The Ministry of Social Affairs and Health was responsible for the practical implementation of the project. In the state budgets for 2003-2007, improving the quality and availability of social services was supported by increasing the calculative amount of the central government transfers to local government by a total of EUR 110 million. At the same time, municipalities' own development projects in the social services sector were supported by government grants amounting to approximately EUR 82 million. The implementation of the project was supported by a EUR 6 million special appropriation.

A final assessment of the project has been carried out[1]. According to the assessment, the national measures under the Development Project have been important in laying the foundation for change, but they have not been implemented in practice and, in particular, no support for the implementation has been provided. In the future, attention should be paid to integrating the new

[1] Mikko Wenneberg., Olli Oosi, Kaisa Alavuotunki, Sirpa Juutinen and Henrik Pekkala: Final Assessment of the Development Project for Social Services. Report 2. Helsinki 2008. Reports of the Ministry of Social Affairs and Health 2008:7)

methods into the existing municipal structures and resources. In future programmes, the Ministry of Social Affairs and Health should choose those key development projects that will be realised as extensive programmatic entities. E.g. in regard to services for substance abusers, development work should focus on the creation of extensive sub-regional and regional entities. According to the recommendations of the final assessment, the Ministry should develop its management of social services. Furthermore, the Ministry should emphasise the development of staff skills and well-being at work in future development projects.

The welfare policy programme of the Government[2]

Prime Minister Matti Vanhanen's second cabinet began its period in office in April 2007. In its programme, the Government has committed itself to promoting societal development where (i) a balance between man and nature, (ii) responsibility and freedom, (iii) caring and rewarding, and (iv) education and competence are realised. The coordination and balancing of economic, social and ecological considerations in all decision-making within the public sector will be improved. The Government wants further to promote a decentralised approach. While the globalisation of the economy represents an opportunity for Finland, the development of the division of labour within the global economy will also pose challenges. The Government is especially concerned about climate change, trans-boundary environmental problems, increasing poverty and changes in the ageing demographic structure of the population. These changes have a dimension spanning several generations. By reacting to these challenges, Finland can shoulder its share of the burden of responsibility for finding solutions to global problems.

Finland’s key macro-economic measures are divided into three areas: (1) to ensure a sustainable pension system (2) to curb public spending and (3) to secure welfare services and increase public sector productivity.

The focal points (10) of the Government Programme's welfare policy are:

- A rewarding and just social protection system,
- Comprehensive and effective social and health services,
- Social and health care services innovation project,
- Well-being of families,
- Sustainable pension policy,
- Sustainable subtance abuse policy,
- Other social and health policy: social security of those living on grants, the farmers' holiday and stand-in scheme, and their well-being at work, the capabilities of non-governmental organisations,
- Developing working life,
- Employment policy, and
- Improving gender equality.

[2] www.valtioneuvosto.fi or www.government.fi

Economic outlook and the national reform programme for growth and jobs for 2005-2008[3]

According to the most recent Economic Bulletin[4], the strong economic upswing is levelling off and economic growth is slowing down. Employment will continue to strengthen while cost and price pressure has mounted considerably, e.g. due to a weakening international economy. This year's growth rate remains at the estimated level, but next year it is likely to range around per cent.

The Finnish economy remained in excellent condition in 2007: GDP was up by 4.4 per cent, the employment rate notched up to 69.9 per cent and unemployment dropped back to 6.9 per cent. By the beginning of 2008 the employment rate had been improving and the unemployment rate had lowered below 6 per cent (in April 2008 the cyclically adjusted unemployment rate was 5.8%). There has been a marked improvement in the financial position not only of businesses, but general government as well. On the other hand, households continued to accumulate debt and uncertainties in the international economy have increased. Since the growth in total output has slowed down and will be less than 3 per cent in 2008, the cyclical outlook has become considerably weaker. It is projected that annual growth in export volumes will decelerate but remain at an average of 3.5 per cent during 2008-2012.

In 2007, household consumption increased by 3.7 per cent, only marginally less than the year before. With the new wage settlements, earning rises will be around 3.3 per cent. However, the growth of purchasing power has been eroded by rising prices. The increase in purchasing power fell short of consumption and the savings rate remained negative. Household indebtedness has increased. Assets and debts are not evenly distributed: some households have significant debts; others have considerable financial and other assets. The most heavily indebted households represent a risk group whose consumption can be expected to slow in the future as rising interest rates reduce the amount of money available after debt servicing costs.

The ratio of public consumption expenditure to GDP is over 20 per cent. The volume of public consumption spending in Finland has increased by an average of 1.5 per cent per annum. Growing demand for nursing and care services, in particular, will drive up local government consumption in the next few years. Demand for basic services – education, social welfare and health care – is being further fuelled by the overall rise in income levels. It is estimated that staff numbers in municipal services will rise in the future.

It has been stated in the Economic Survey that the unemployment rate will remain close to 6 per cent and that unemployment will be increasingly structural in nature. Challenging objectives have been set for improving employment during the Government period that lasts until the spring of 2011. The objective is to increase the number of employed by approximately 80,000 to 100,000 and raise the employment rate to about 72 per cent. In addition, an objective set out in the Government Programme is to bring unemployment down below 5 per cent on a permanent basis.

Commitments to reduce greenhouse gas emissions and increase the use of renewable energy sources, aimed at curbing climate change, may weaken the growth potential of the economy and

---

[3] Economic Survey - Economic outlook and fiscal policy for 2008-2012, Spring 2008. Ministry of finance Publications 16b/2008; The Lisbon Strategy from Growth and Jobs – The Finnish National Reform Programme 2005-2008, Annual Progress Report. Ministry of Finance, Economic and economic policy surveys 3b/2007

[4] Economic Bulletin 2/2008.Ministry of Finance Economics Department 18 June 2008

competitiveness. As for Finland, the attainment of country-specific targets for renewable energies may prove especially challenging, considering the currently high level of utilisation of renewable energies. Factors related to climate change also add to the uncertainty in overall economic developments in the long term. The European Commission has estimated that measures to curb climate change will slow down GDP growth in the Community by 0.2 percentage points by 2020.

As set out in the Government Programme, the implementation of the national reform programme on growth and jobs is being continued. The main economic policy priorities of the government's economic policy strategy are productivity, labour force issues and employment policy, since the most significant factor that will hamper economic growth in the next few years is insufficient labour supply. The Government's core economic policy strategy is to achieve economic growth at a much faster rate than that presented in economic forecasts for Finland. The number of jobs may increase if the international economy continues to develop positively and wage trends help to increase employment. Securing higher productivity in the whole of the economy and in public sector service provision is essential to safeguarding sustainable public finances. The Government Programme includes reforms aiming at increased productivity in public administration at all levels.

The most important long-term challenge is the ageing of the population, which is faster in Finland than in the EU on average. For the most part, the baby boomers still remain in the labour force, which may ease making provisions for the changing population age structure. A continued favourable economic development also provides a good opportunity to implement structural reforms that will bolster up the carrying capacity of the economy.

Finland has prepared and continues to prepare for the demographic change

- By raising the employment rate,
- By reducing general government debt,
- By reforming the earnings-related pension system, increasing the prefunding of employment pensions and increasing the return on investment from pension funds;
- By launching a productivity programme in the public sector and restructuring municipalities and services;
- By fostering conditions in working life through helping to reconcile work and family life and by improving the working capacity of those in working life; and
- By pursuing policies that promote knowledge and competitiveness.

In addition to policies aiming at raising the employment rate, one goal is to increase productivity in organising public services. Resources can be reallocated from one priority area to another according to demographic change, changes in regional structure and according to the new priorities in service needs.

In its most recent national report[5] the OECD has estimated the development of Finland's economy as well as the state of the Finnish welfare system, and the prerequisites under which it can be further developed. Some of the key messages for the year 2008 concern welfare policy. According to the report, Finland's recent economic performance has been good although large wage increases may pose risks to competitiveness. Sustaining the welfare system will require a higher employment rate, a better tax mix and more cost-effective public spending. Medium-term fiscal policy challenges should be addressed through further pension reform and tighter fiscal

[5] OECD, Economic Surveys, Finland 2008, Volume 2008/6, p. 9-15.

policy in the short term. According to the report, the dual income tax system (lower tax rate on capital income, heavier tax rate on labour income) has represented a positive response to globalisation, although it has some drawbacks. The tax burden on labour is too high, whereas the tax burden on capital income is too low. It is estimated in the report that greater competition in the delivery of social services would spur productivity growth and facilitate economic diversification. Employment should be raised, particularly among older workers, those with disabilities, and young people. A higher employment rate would also require changes to tertiary education so as to speed up the transition from secondary school to tertiary education and to shorten study times.

1.2 Assessment of the Social Situation

a) The situation in the light of national statistics

It may be estimated that the current social situation in Finland is relatively good. Comprehensive social security benefits and social and health services that encompass the whole population have contributed to poverty and social exclusion being relatively rare in Finland and gender equality relatively well realised. The main features of the social situation in Finland are described in this chapter, based on the indicators annexed to this report and two recent publications[6].

Well-being and living conditions

The well-being of Finns has developed positively in general but the differences between population groups have increased. The health of the population and the standard of living have improved. Absolute poverty, unemployment and the consumption of alcohol among young people have decreased. The process of growing regional inequality seems to have come to a halt. Various indicators show that the well-being of Finns has reached and even surpassed the level preceding the recession in the 1990s. However, on the other hand, Finland has become a more unequal society than before. Unemployment and exclusion from the labour market remain at a high level. Socio-economic differences in health have increased. Income differences and relative poverty have returned to the level of the 1970s.

Relative poverty and changes in income distribution

The majority of Finns have been able to enjoy increased prosperity. However, increased wealth has not been distributed evenly. The income and wealth of those on a high income have increased faster than those of others. The real income and purchasing power of those on a low income have increased considerably more slowly than those of people on a middle or high income. Income differences increased in the late 1990s but in the early 2000s this increase stabilised. The differences seem to have stabilised at the level of the 1970s.

[6] Pasi Moisio, Sakari Karvonen, Jussi Simpura and Matti Heikkilä (eds.), Suomalaisten hyvinvointi 2008 (Welfare in Finland 2008), Vammala 2008; Statistical Yearbook on Social Welfare and Health Care, Social Protection 2007

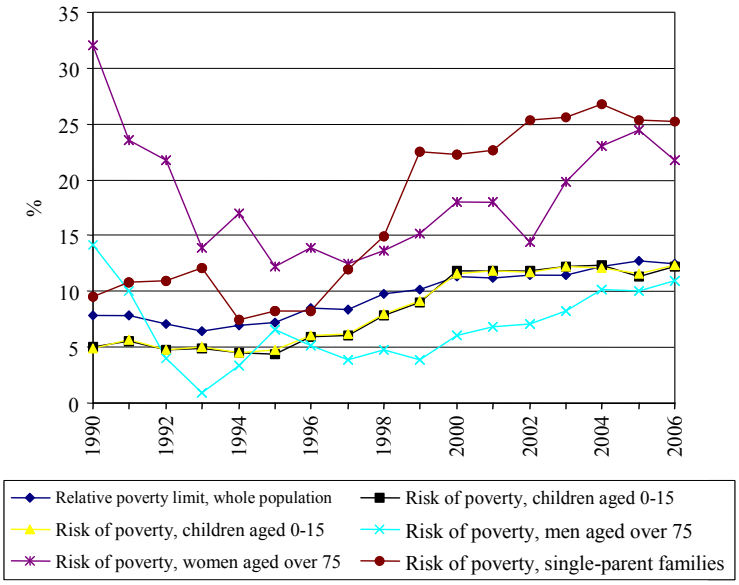
A low income is more common among those who are outside the labour force. According to the most recent data of Statistics Finland[7], the risk of a low income has trebled since 1993 in those households where only some household members of working age are active in the labour market. The relative low income level rose from 5 per cent to 12.5 per cent during 1993-2006. Thus, the number of those on a low income increased from 320,000 to 650,000. However, the income limit for low income measured in monetary terms rose from approximately EUR 750/ month (in the early 1990s) to approximately EUR 1,000/ month during the above-mentioned period.

The population group with the lowest income is young single households. The low income level of members of single-parent families has trebled within ten years. Every fourth member of single-parent families has a low income whereas every tenth member of two-parent families with children has a low income. In households with retired household members, the level of income varies according to previous activities and careers.

Only the quintile with the highest income has been able to increase its share of income. Increased income differences are also revealed by the Gini coefficient that has risen from approximately 21 per cent in 1993 to 27 per cent in 2006. However, Finland remains among the European countries with income differences lower than average.

The increase of relative poverty in Finland can be explained by increased income differences. According to the EU, those whose income does not exceed 60 per cent of the median income of the whole population are at risk of relative poverty. Using this criterion, the number of those at a relative risk of poverty has increased even though the income of those on a low income has also increased.

Figure 1. Relative risk of poverty in 1990-2006; whole population, children, those aged over 75 and single-parent families[8]



[7] Income Distribution Statistics 2006. Income and Consumption 2008. Statistics Finland; Työvoimaan kuulumattomien pienituloisuus yhä yleisempää (Low incomes for those outside the labour force more and more commonplace), Statistics Finland Press Release 2 May 2008. The threshold for being considered to be on a low income is 60% of the median available equivalent income.

[8] Source: The indicators annexed to the report. NB. Since estimates for some variables are based on a small sample, caution is required when interpreting the figures.

Employment and unemployment

The development of employment has been positive in the recent years and the number of employed has increased by 127,000 during 2005-2007. Finland has already exceeded the employment rate targets for women and older workers set by the Lisbon strategy. However, a challenge to economic growth presents itself in the fact that the working age population will decrease in the 2010s, when more labour force exits than enters the labour market. Thus, as for economic growth, it is essential that the productivity of labour be continuously increased as Finland is unable to compete by means of low labour costs. Labour force resources may be found in all age groups and better utilisation of these resources remains an important objective in the future. The positive development of employment is the primary factor in safeguarding the sustainability of the pension system.

In 2007, the average employment rate (for 15-64–year–olds) in Finland was 69.9 per cent, representing an increase of one per cent from the year before and the average number of people holding a job increased by 48,000 from the year before. The employment rate of women was 68.5 per cent and that of men 71.3 per cent. A total of 16.0 per cent of wage and salary earners worked in an employment relationship for a fixed term. Nearly two out of three of those in fixed-term employment were women. There has been an upward trend in the number of new vacancies registered with the Employment Offices during recent years; in 2007 the monthly average of new vacancies was 44,900.

According to Statistics Finland, the number of the unemployed averaged 183,000 people in 2007. The unemployment rate remains at a rather a high level, 6.9 per cent, even though it decreased by 0.8 percentage points in comparison to the year before. However, it is noteworthy that for the 55–64 age group, the employment rate has increased by almost 20 percentage points during the last ten years, mainly due to extended careers and the ageing of the active labour force.

Approximately 40 per cent of unemployed jobseekers are persons with a basic-level education only. The numbers of unemployed men and women were nearly equal, while the unemployment rate was 6.5 per cent for men and 7.2 per cent for women. Examined by age group, in the young and middle-aged groups the number of unemployed men was higher than women. Correspondingly, more women than men are unemployed in the older age classes.

The number of those who had been unemployed for an uninterrupted period exceeding one year was an average of 52,000 people in 2007. The number of long-term unemployed decreased by 12,800 from the year before. Long-term unemployment particularly affects the ageing. In 2007, 72 per cent of those who had been long-term unemployed without interruption were aged over 50 and the share of those aged over 50 of the long-term unemployed has increased by 10 percentage points in two years. In 2007, long-term unemployment fell in all age groups, excluding those aged 60–64.

Education and skills

In 2005, nearly two thirds of those aged 15 or over have a secondary-level qualification from a general upper secondary school, a vocational education institute or an institute of higher education. The share of those with a secondary-level qualification has increased by 1-2 per cent each year. However, almost 10 per cent of young people still have basic level education only. Using knowledge-based indicators, the results of the Finnish compulsory education are excellent.

However, the results concerning children's well-being at school are not as good. In addition to knowledge-based educational targets, schools must lend more support than before to the development of general well-being, emotional life, social skills as well as ethical and aesthetic skills.

The health status of the population

During recent decades, the difference in life expectancies between Finns and citizens of other countries in Western Europe has decreased. The life expectancy of a boy born today is 76 years and that of a girl 83 years. In both cases, the EU average is exceeded. As for healthy life expectancy, the relative position of Finns is improving. One of the most important problems of Finnish public health, in international comparison as well, lies in socio-economic health inequalities, which have continued to widen.

Various indicators show that the health of the Finnish population has improved but socio-economic health inequalities have generally remained or even widened.[9] Long-term illnesses are about 50 per cent more common among the lowest educational and other socio-economic groups than in the highest groups. These differences have slightly decreased among the working aged but increased among those aged 65 or over. Differences in functional capacity and self-reported working ability have also remained quite stable over the last two decades. Information on trends in mental health by population group is scarce, but severe mental disorders continue to be more common in the lower socio-economic groups. Healthy life expectancy varies according to education even more strongly than life expectancy. A separate action plan for decreasing health differences has been prepared for 2008-2011[10].The main objectives of the programme are (1) to affect poverty, education, employment, working conditions and housing conditions through socio-political measures, (2) to promote a healthy lifestyle in general and among those in a weaker social position in particular and (3) to improve the availability and utilisation of social and health services.

Well-being of children and young people

A lively debate on the well-being of children and young people has been ongoing in Finland. An important reason for this has been the continuously increasing demand for child welfare services, children's and adolescents' psychiatric treatment and special needs teaching. Whilst the well-being and health of children and young people have improved, the burden on services related to disturbances has increased rapidly. The need for specialised children's and adolescents' psychiatric care and the number of outpatient clinic visits has increased. The number of children taken into care has grown. Child welfare covers children and young people that, based on a decision by the municipal social welfare board, are provided with non-residential care services, that have been taken into care or that are provided with support after the end of foster care. In 2006, the number of children and young people placed in a foster home was approximately 15,600. The number of children taken into custody was approximately 9,500 in 2006 and that

[9] Hannele Palosuo et al. (eds.), Health inequalities in Finland. Trends in socio-economic health differences 1980–2005. (Publications of the Ministry of Social Affairs and Health 2007:23

[10] Kansallinen terveyserojen kaventamisen toimintaohjelma 2008-2011. Sosiaali- ja terveysministeriön julkaisuja 2008:16 (National Development Plan for Social and Health Care Services. Kaste Programme 2008–2011. Ministry of Social Affairs and health publication 2008:16).

number has been rising. The well-being of children and young people has been emphasised in two policy programmes included in the Government Programme of Prime Minister Vanhanen's second cabinet.

The number of children transferred to full-time special needs teaching in comprehensive school has also increased, totalling approximately 46,100 children in the autumn of 2007. This number has grown during recent years. More and more often, special-needs education is attached to regular education. On average, approximately 50 per cent of pupils transferred to special-needs teaching have been integrated into regular education groups and 50 per cent have been given special-needs teaching in special groups and special schools.

A follow-up report on the living conditions of young Finns has been published annually since 2001. In the 2008 yearbook the polarisation of the living conditions was the main theme [11]. The majority of young people are doing well or excellently but some seem to be accumulating social problems. This theme is assessed in research articles and statistical reviews in the yearbook. A special issue discussed in statistical reviews is the estimate of the number of young people at risk of social exclusion or being "sidelined". These estimates vary considerably, which reflects the difficulties in defining the phenomenon.

Housing and wealth accumulated in property

Two out of three Finns live in owner-occupied properties. This percentage has not changed significantly during the last 20 years. The wealth accumulated in properties has been increased through second apartments, holiday apartments and apartments bought for investment purposes. In addition, apartments are bigger, better equipped and more expensive. However, in 2005 approximately one million Finns still lived in households where there was more than one person per room. Cramped housing conditions have ameliorated slowly. In 2007, there were approximately 7,600 homeless households in Finland, of which 7,300 comprised single persons and 300 families. More than half of these lived in the Greater Helsinki Area. The number of homeless people has been decreasing during recent years.

Alcohol, drugs and crime

In 2006, the total consumption of alcoholic beverages amounted to 10.3 litres of pure alcohol per capita. Documented consumption grew in comparison to the year before, whereas undocumented consumption declined due to a marked decrease in passenger imports of alcoholic beverages. The long-term trend in alcohol consumption has been upward. Among other things, this has been due to the changes that took place in the availability and prices of alcohol in 2004. The growth in alcohol consumption has increased the demand for services for substance abusers and the number of alcohol-related periods of hospital care. In 2006, A-clinics had approximately 44,400 clients. Detoxification and rehabilitation centres had approximately 11,200 clients. Drug experimentation and use increased in the 1990s throughout the country. After the turn of the decade, the development has been more positive. The development of figures indicating drug abuse and experimentation has stabilised and the increase has slowed down. In 2006, some 13 per cent of Finns aged 15−69 reported having experimented with cannabis at some time or other.

---

[11] Minna Autio, Kirsi Eräranta and Sami Myllyniemi (eds.), Polarisoituva nuoruus? (Polarising youth?), Helsinki 2008 (Advisory Council of Youth Affairs publication 38, Finnish Youth Research Society publication 84)

Immigration and refugees

The number of immigrants moving to Finland has increased considerably since the 1990s. The reception of refugees has become more commonplace in line with the decision in principle concerning a government programme on migration adopted in 1997. The programme was reformed in 2006 to respond to the new situation, the development of migration and new objectives. At the beginning of 2006 there were approximately 110,000 foreign nationals living permanently in Finland. Approximately 27,000 people had entered the country as refugees. Moreover, immigrants have entered Finland due to contemporary reasons, to work or to study – a larger group of such immigrants may also use services directed at immigrants. As far as the country of origin is known, immigrants originating from 171 countries have entered Finland. Most of these have arrived with their families. The employment rate of immigrants has remained at approximately 45 per cent and their unemployment rate respectively at approximately 28 per cent. In addition, children and young people coming from immigrant families should be considered as a separate group when implementing measures combating social exclusion. To promote inclusion and integration it is important that a non-discriminative environment and education be safeguarded.

b) The situation compared to the Member States of the European Union

In this chapter, the situation in Finland is assessed in comparison to the situation in other EU Member States, based on the statistical summary of the Joint Report 2008[12].

According to the statistical summary of the Joint Report, the following can be stated when comparing the social situation in Finland and its development to those in other Member States:

- The development of employment has been positive recently. That of men and especially older men could be better. Women's employment is high, including in the age groups of older women workers.
- The poverty rate is low in our country, and the child poverty rate is the lowest in comparison to other Member States. Based on a comparison between EU Member States, the poverty risk to which ageing people and pensioners are subject poses a challenge. However, the situation of jobless households is the weakest of all, whereas there is no significant in-work poverty problem in Finland. Income transfers are eradicating poverty efficiently.
- Early drop out from school is not widespread.
- The pressure on expenditure on pensions is reasonable and rather well under control, including over the long term (the reference period of the report is 2004-2050).
- The healthy life expectancy of Finns is one of the lowest among the EU Member States. This indicator is problematic. However, it is undisputable that the number of those who leave working life before statutory retirement age due to disability is rather large. The development of the health status of such persons is also more unstable.
- The availability of health services is good, as is the development of public expenditure on health care. The response to expenditure on health care has been good, the level of expenditure is reasonable and the results good. Special attention must be paid to the development of the health status of those in the lowest income groups and weakest economic position.

[12] Commission proposal for a draft chapter on the monitoring of the OMC on social protection and social inclusion – 2008 exercise, European Commission 25 May 2008. A Joint Report on the social situation is under preparation.

1.3 Strategic Guidelines[13]

A rewarding and just social protection system

The Government has initiated a reform of the social protection system that will be implemented in stages and the first proposals of which will be presented to Parliament during the 2008 autumn session, if not earlier[14]. The reform will be prepared by a Government-appointed committee in which the labour market organisations are also represented. The goal of the social protection reform is to offer more incentives for work, to alleviate poverty and to provide an adequate level of social protection in all life situations.

In order to improve the functioning of the labour market, taxation, basic security (including housing allowance), and unemployment benefits will be reviewed in conjunction with the social protection reform. The position of the recipients will be improved by simplifying and streamlining the protection system. This reform will be implemented in such a way that social protection can be funded on a sustainable basis in the long term as well. Taxes on benefits and client charges will also be reviewed in connection with the social protection reform. Based on the Government Programme, the management of housing allowances has been relocated from the Ministry of Environment to the Ministry of Social Affairs and Health as of 1 January 2008.

Comprehensive and effective social and health services

According to the Government Programme, responsibility for the provision of these services will continue to rest with municipalities, and funding must primarily be based on central government transfers and the taxes raised by the municipalities. In order to guarantee the availability and quality of the services, the funding base also needs to be reassessed with regard to client charges. A just payment ceiling system will be introduced in social and health care services in order to alleviate the position of those using the services frequently or needing a lot of medication. At the same time, the system will be reformed in such a way that patient or client charges do not induce people to select inappropriate forms of treatment.

The Government's goal is to ensure the funding and availability of social and health services. To lower the barriers between primary and specialist health care and improve cooperation, the Primary Health Care Act and the Act on Specialized Medical Care will be combined into a comprehensive Health Care Act. In order to restructure the services, special measures will be taken to develop primary health care, social work, emergency care, and mental health and substance abuse services. Particular consideration will be given to the identification of mental

---

[13] The strategic guidelines have been presented according to the grouping in the Government Programme (cf. www.valtioneuvosto.fi, www.government.fi; the social politic and health politic targets of the programme are not summarised here, the focal points are combinations of the ten mentioned above; in addition, housing policy and education policy have been included as emphasised in the Government Programme). The strategic outlines of the Government Programme correspond to those of the Ministry of Social Affairs and Health (Strategies for social protection 2015. Ministry of Social Affairs and Health publication 2006:15). The strategic outlines of the Ministry are (1) promoting health and functional capacity, (2) making work more attractive, (3) reducing poverty and social exclusion and (4) providing an efficient service and reasonable income security.

[14] Cf. www.stm.fi/sosiaaliturvauudistus; Kohti mahdollisuuksien sosiaaliturvaa, Sosiaaliturvan kokonaisuudistus – SATA. (Towards the Social Security of Opportunities. -The reform of the social protection system SATA. Brochures of the Ministry of Social Affairs and Health 2008:3)

health problems in children, young people, the working-age population and older people, and access to services and staff skills and competence in mental health care. The Government has also launched a policy programme to promote good health. The Government will continue to pursue the National Alcohol Programme during the period 2008-2011.

The recommended quality criteria for the services will be revised to increase the level of commitment. Steps will be taken to improve the evaluation of the quality and effectiveness of services and related supervision and guidance. The system of guaranteed access to health care will be reviewed, and necessary changes to time limits and procedures will be made. Furthermore, the development of electronic information systems will be continued.

The Government will ensure that organisations continue to be able to operate as non-profit charitable actors. Non-governmental organisations offer activities designed to support well-being and prevent social exclusion. The operating environment of non-governmental organisations will be improved by rendering donations made to such organisations exempt from tax.

Legislation on social firms will be reviewed to make it easier for mental health rehabilitees, people on cash rehabilitation benefit and those who have temporarily relinquished their disability pensions to find work with social companies.

A social and health care services innovation project will be carried out aimed e.g. at improving the citizens' initiative, civic engagement and capacity for action, developing the division of duties, the effectiveness of activities and services, improving cost-efficiency and expanding the diversity of services. This project will also seek to increase transparency in decision-making and systems, evaluate the performance of a multi-channel funding system and improve efficiency in guidance. Additionally, the adoption of new technology and commercialisation and exports of technological innovations in the social and health care sector will be encouraged. Good practices will be developed in order to secure services for older people in remote areas.

Promoting the equality of citizens

The equality of citizens will be secured by upholding the rights of service users. A just payment ceiling system will be introduced in social and health care services in order to alleviate the position of those using the services frequently or needing a lot of medication. At the same time, the system will be reformed in such a way that patient or client charges do not induce people to select inappropriate forms of treatment. Access to social and health services will be guaranteed in Finnish and Swedish and, where possible, they will be provided in Sámi as well.

To guarantee equality for people with disabilities, legislation will be reformed and a special disability policy programme will be prepared outlining the key measures to be taken in this field over the next few years. The system of personal assistants for people with disabilities will be developed in stages. Funding for disability services and the methods of organising and providing the services will be developed.

The Government is committed to promoting equality in all decision-making and its goal is to reduce differences in pay between men and women during its term of office. The Government Action Plan for Gender Equality was adopted in July 2008. The equal pay programme is being realised and women's careers and promotion to managerial positions will be advanced. The gender perspective is being mainstreamed across all law drafting, budget procedures and other

major projects. It will also play a part in social and health care services and in efforts to reduce health inequalities. A report on gender equality will be issued to Parliament at the beginning of 2010.

Sustainable pension policy

The statutory pension system will be based on the national and earnings-related pension schemes. Issues related to earnings-related pensions will be prepared in consultation with the major labour market organisations. A model securing the livelihood of those living on the lowest pensions will be prepared. On 10 March 2008, the Ministry of Social Affairs and Health set up a Pension Forum to monitor and assess the implementation of the pension reforms enacted in 2005 and 2007 in Finland and to monitor and assess the implementation of the pensions policy in particular, from the perspective of forecasting on population ageing. According to the Government Programme, competition in the field of earnings-related insurance will be promoted based on the report prepared on the earnings-related pension scheme. The possibilities of transferring insurance portfolios and the related solvency margins between all employee pension institutions will be investigated.

Insurance and financial supervision duties will be assumed by a single agency that will begin operating at the beginning of 2009. Responsibility for the preparation of insurance legislation will continue to rest with the Ministry of Social Affairs and Health.

Employment policy and developing working life

Amendments to the Employment Contracts Act and the Act on the Supervision of Occupational Safety aim at reducing the number of unjustified fixed-term contracts. Furthermore, the aim is to oblige employers to consider their justification for fixed-term contracts more closely than before and ensure that the employee is informed of said justifications more effectively. Violating the obligation to assemble information concerning the key conditions of the employment relationship has became subject to a penalty. In addition, the means of supervision available to the occupational safety and health authorities were improved.

Within the human resources policy of the public sector, the Government will promote the creation of permanent employment relationships. In order to secure the availability of labour in the public sector, a programme will be launched to retain employees in the sector and attract new ones. To improve productivity in public administration, special consideration will be given to management and supervisory skills and the utilisation of modern communications technology.

The Act on Job Alternation leave was extended by two years. A permanent job alternation act will be passed when final agreement is reached on the funding of the scheme. At the same time, steps will be taken to determine whether the alternation system can be extended to entrepreneurs. In collaboration with the labour market organisations, the Government will enhance the operation of the collective bargaining system. Another objective is to promote local bargaining, which will make it necessary to guarantee equal bargaining positions for all parties and personnel categories in the workplace.

The Government will promote versatile arrangements of working hours to advance employment, facilitate work and make it easier to reconcile work with family life, while giving due

consideration to the needs of the employers and employees. The establishment of "working hours bank" will be promoted by removing the related legal obstacles. Moreover, the occupational health care system will be developed as part of developing workplaces on a broad front. Special attention will be paid to age management and mental health at work.

Housing policy

The objective of the Government's housing policy is to reconcile the needs and wishes of the people, the needs of society, and the requirements imposed by sustainable development. The Government is seeking to promote the efforts of all citizens to arrange housing suitable for their needs. To stabilise the housing market, the supply of land and dwellings will be promoted through joint action by the Government, municipalities and other actors in the field in order to respond to demand.

The goal is to increase the production of moderately priced housing in order to secure the availability of labour and the competitiveness of business and industry, particularly in growth centres.

To address the special issues affecting the Greater Helsinki Area, a metropolitan policy will be launched to identify solutions to the problems associated with land use, housing and traffic, promote business and internationalisation and prevent social exclusion. Multiculturalism and bilingualism will be promoted. The letter-of-intent procedure between the central government and the Greater Helsinki Area and cooperation based on partnerships with individual administrative sectors will be reinforced and extended.

Education policy

The education system will be developed overall to meet global challenges and respond to changes in occupational and demographic structures. The Government will reform its foresight procedures. Apprenticeship training will be strengthened as a form of provision. Measures will also be taken to reduce the dropout rate. Each comprehensive school leaver will be provided with a training place and access to adequate guidance counselling and support. In basic education, the goal is to reduce group sizes, to strengthen remedial and special needs teaching, guidance counselling and student welfare, and to invest in extracurricular club activities. The task of the upper secondary school as a general educational channel preparing students for further studies will be enhanced. The attractiveness and appreciation of vocational education and its worklife orientation will be increased, and the related intakes raised. The structural development of higher education institutions will be continued, with the goal of increasing world-class expertise and creating higher education entities that are regionally stronger and more effective in terms of knowledge. A comprehensive reform of professionally oriented adult education will be implemented in order to clarify decentralised administration, funding, benefits and education and training provision.

Monitoring of the targets set out in the Government Programme and the indicators used

A more detailed monitoring system has been included in the Government Programme. To ensure the effective implementation of the objectives defined in the Programme, the Government has prepared a strategy document in which the indicators used in the monitoring of the Programme are included.[15]. Most indicators describe the development of themes essential to the Government policy. Some indicators are process indicators describing the progress of policy measures, while some are statistical indicators that can be used for the constant monitoring of the Government Programme. With the help of indicators, information on social development trends is gathered. Certain themes are monitored and assessed so that new or more efficient means can be introduced to affect these trends.

The Government's Strategy Document encompasses e.g. the following themes (indicators included): policy programmes, projects under the Government's special monitoring, developing sectoral research, legislative plan, the plan on reports to be submitted to Parliament and the plan on the decisions in principle by the Council of State.

In promoting well-being and reducing poverty, the main areas for action and monitoring are the social security reform, the restructuring of municipalities and services, the policy programme for health promotion, the policy programme for the well-being of children, youth and families, the policy programme for employment, entrepreneurship and working life, the gender equality programme and the service innovation project in social welfare and health care.

The Government's Strategic Document lays the foundation for each ministry's action plan. The action plans of ministries and other documents required in steering are based on the Strategy Document. Its indicators are used for sector-specific monitoring.

[15] cf. Hallituksen strategia-asiakirja 2007. Valtioneuvoston kanslian julkaisuja 18/2007, www.valtioneuvosto.fi; Government Strategy Document 2007. Prime Minister's Office Publications 4/2008, www.government.fi

Part 2 Strategy Report on Social Inclusion

2.1 Key objectives and focal areas of action of the strategy

Key objectives for strengthening social protection and social inclusion in 2008-2010 have been grouped in accordance with the previous national report.[16]. The key objectives 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 healthy 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, increasing equality in the workplace, developing incentives to participate in the labour market, and 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, will reinforce the significance of work for consolidating the financing of 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 control of substance abuse have a clear connection to reducing the risk of social exclusion.
3. **Safeguarding the continuity of measures that prevent and correct social exclusion and poverty.** Selective social policy is not the basic principle or approach in Finland, but efforts are being made to maintain and develop a universal service and income security system covering the entire population. The permanence of the basic objectives of the welfare policy and long-term activities are the major factors in preventing the realisation of social risks and avoiding the threat of social exclusion. The best way to achieve permanent results in combating poverty and social exclusion is through the determined development of social structures that safeguard people's welfare. Short-term programmes and projects have a limited impact.
4. **Improving the functioning of the service system.** The key issues of a functioning service system are client-orientation, high-quality and versatile services, the sufficiency of services needed by the increasing elderly population, and a sufficient and skilled workforce. Availability of services and regional equality of citizens can be safeguarded via a functional steering model and sufficient regional co-operation, utilising information and communication technology.

2.2 Strategic challenges

Challenges on increased work opportunities

Finland's employment policy priorities, as set out in the national reform plan, are to raise the employment rate and improve the functioning of the labour market. The measures aimed at achieving these goals are grouped into three main areas: extending working lives; improving the

[16] They are based on the targets set for the prevention of social exclusion in the Ministry's strategy; Strategies for Social Protection 2015. Ministry of Social Affairs and Health, Publications 2006:16

incentives of tax and benefit systems and wage formation; and improving the balance between labour demand and supply.

The Finnish national reform programme 2005-2008 of the Lisbon strategy for growth and jobs emphasises the targets set for promoting competitiveness and productivity in certain service industries, the simplification of labour subsidies, the promotion of local bargaining and the prevention of labour market bottlenecks, especially in order to improve the low employment rate of young people and eradicate high structural unemployment. The Government is seeking further improvements in employment and aims to raise the employment rate to 72 per cent by the spring of 2011. Employment services and active measures will be redirected so that employment in the open labour market will be supported more efficiently than before e.g. by means of flexicurity. As labour reserves grow scarcer the focus will be shifted to labour exchange services, vocational training realised in cooperation with enterprises and pay-subsidised work taking place in enterprises.

As for the long-term and recurrently unemployed, the gulf between the requirements set by working life and skills and capacity has grown. Structural unemployment continues to be an important problem that is becoming emphasised as working age groups diminish in size. The most important projects aimed at preventing unemployment have included comprehensive programmes comprising various measures making access to the labour market easier and subsidised employment. Unemployment has fallen, but the hard core of unemployment still exists.

Efforts in Finland to remove unemployment traps and increase the appeal and attraction of waged employment have mainly relied on tax policy as well as measures to increase the incentive effect of social security. The implementation of measures for increasing the incentive effect of the tax and benefit system as well as wage formation has progressed according to plan. Tax policy outlines affect both the demand and supply of labour force; taxation of earned income has been cut while the overall tax wedge on labour has been narrowed by making cuts in earned income taxes. In Finland, the jobless rate is high in particular among people with a low level of education. Thus, tax policy measures have also been taken to support low-productivity jobs. In order to improve the functioning of the labour market, the need to renew taxation, basic social security and unemployment security will be assessed in conjunction with the social security reform. The taxation of social benefits, and payments for public services, will be also reassessed. The social security reform will be realised in phases.

Challenges concerning the prevention of social problems

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 in alcohol-related deaths and illnesses. The branches of the administration are being encouraged to engage in close cooperation 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 on the provision of individual support. However, the savings in social costs achieved in the long term through the prevention of social exclusion are noteworthy in addition to the alleviation of human distress.

Low income is most common among single person households and single parents. In recent 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 person households and single parents.

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. The number of households receiving income support has decreased year-by-year in the 2000s, but annual spending on income support has mostly been increasing.

Over-indebtedness has fallen since the late 1990s. 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.

The health of the population is better than ever before. Life expectancy is higher, and the number of disability-free years has increased. This positive trend is overshadowed by excess weight gain and the clearly increased consumption of alcohol among citizens. Both of these result in considerable, multiple, and expensive problems for individuals, their families, public health, and the whole of society. Further threats include poorer development in the health of certain population groups (i.e. inequality in health). Health differences between population groups remain substantial. 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 health care expenses are allocated to the treatment of these diseases. Many of our current national diseases could be prevented. The direct impact of health care on the health of the population is limited, the individual’s health-related lifestyle and environment having the greatest impact.

The most urgent task with respect to the development of public health is to reverse the growing trend in 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. In context of social exclusion the adverse effects of intoxicants are focused on risk groups, especially on deprived young adults and middle-aged men, but alcohol-related episodes of hospital care among women have risen steadily year by year as well.

Health differences between population groups can also be affected by general social policy. Social decisions have health impacts, but so far these have not been taken into account to a sufficient extent. It is especially important to take consideration of the impact of these decisions on different age groups and special groups, such as 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.

Challenges concerning safeguarding the continuity of measures preventing social exclusion

When emphasising economic development and growth, it is also assumed that economic growth will benefit everybody equally. This may suggest that increased income differences are not considered a problem because those with a low income also benefit from economic growth. Indeed, the sustainability of public financing is intertwined with economic growth.

In the summer of 2007, the Government started to prepare a comprehensive social security reform. A broad-based committee (the SATA committee) has been appointed for this preparative work. The objectives set for the committee include taking care of the well-being and purchasing power of those population groups that are left outside the employed labour force and the prevention of increased social inequality. However, the main emphasis of the reform lies in reinforcing the incentives for employment. Thus, the reform aims at both the enhancement of the incentive nature of employment and the improvement of social security.

Reinforcing the structures of welfare policy and developing procedures that stretch across sector boundaries will 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 the necessary services in a more appropriate way when preventable illnesses, accidents, and social problems are identified, prevented, and dealt with at an early stage.

Poverty and low 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 safeguards reasonable housing. Tax rebates on interest repayments of personal housing loans is a significant form of support for owner-occupants. In addition, housing costs are lowered by means of interest subsidy in publicly supported housing production. With the help of housing allowance, the living conditions of even low-income households are relatively good but they do not live as spaciously as the rest of the population. The share of dwelling costs of the total income of households receiving housing allowance has remained high and even increased during recent years. As the employment rate has improved the number of households receiving housing allowance has decreased.

Homelessness concerns men in particular. 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. The Government has reacted strongly in favour of alleviating homelessness and the objective is to halve the number of long-term homeless by the year 2011.

The Government is launching an intersectoral programme (2009-2011) to make suburban residential areas more appealing, to prevent segregation and to improve the competitiveness of areas. The use and condition of property are being developed. In particular, efforts will be made to encourage local action.

Some 5-10 per cent of school-leavers have remained outside the statistics on education. Regionally, the immediate placement of school-leavers in further studies varies. The educational background of ageing employees is poorer than that of other age groups, and therefore their insufficient professional qualifications will make their re-entry into the labour market more difficult if they become unemployed. Young people have received considerably more education than those belonging to older generations: those aged 25–29 are the most highly educated. Some 86 per cent of people in this age group have a post-comprehensive-school educational qualification. Women are more highly educated than men.

Improving the functioning of the service system

The Council of State launched the PARAS project[17] in the spring of 2005. The aim of the project is to reform Finland's municipal and service structure, with the further aim of safeguarding in the future the availability of social and health services, for which the municipality is responsible. The Act on the reform of the municipal and service structure entered into force in February 2007 and the measures required by the Act will be realised by 2012. This project's success will be evaluated and the additional measures decided upon in the report to be submitted to Parliament in 2009. Before the report is drawn up, each municipality must have arrived at decisions on how the requirements set by the framework legislation will be fulfilled. Considering the evaluation and feedback of the first phase, attention has been paid to the fulfilment of the 20,000 population baseline for services, to responsibility for organising services and to the integration of social and health services in collaborative areas with a minimum population of 20,000.

The Council of State adopted a national development plan for social and health care services for 2008-2011, called the KASTE programme, on 31 January 200818. National targets for social and health policy, focal points for development and monitoring as well as reform and legislative projects, guidelines and recommendations supporting their implementation are defined in the programme. The aim of the programme is to reduce social exclusion and increase municipal inhabitants' involvement, well-being and health. It also aims to diminish inequalities in well-being and health between population groups and to reduce regional inequalities.

The objectives set to strengthen social inclusion and decrease social exclusion are as follows:

- The number of children placed in foster homes will begin to decrease,
- The share of young people with a basic level education will remain below 10 per cent in the age bracket 17-24 years,
- The number of young people (17-24 years) receiving income support will be halved
- The number of long-term unemployed will be reduced under 30,000 and
- The number of long-term homeless will be halved.

The objectives set to promote well-being and health and reduce health differences are as follows:

- The total consumption of alcoholic beverages will be reduced to the level of 2003,

[17] Hyvinvoiva Suomi huomennakin – Kunta- ja palvelurakenneuudistus sosiaali- ja terveydenhuollossa. (A prosperous Finland also in the future. The municipality and service structure reform in social and health care). Ministry of Social Affairs and Health brochure 2007:3

[18] KASTE - Hyvinvointi ja terveys on yhteinen tavoite – Sosiaali- ja terveydenhuollon kansallinen kehittämisohjelma 2008-2011. (KASTE - Well-being and health is a shared objectivce. The national development plan for social and health care service 2008-2011). Ministry of Social Affairs and Health brochure 2008:5

- The share of obese people of working age will be reduced to the level of the years 1998-2001,
- The share of young people (16-18 years) who smoke will be reduced by five percentage points,
- The level of families with children on low incomes will be reduced below 10 per cent,
- The age-standardised functional capacity of the elderly will be improved, and
- The number of accidental deaths at home and in free time, and the number of serious accidents, will be reduced by 10 per cent.

The objectives set for developing services and diminishing regional differences are as follows:

- Satisfaction with the services provided will be increased, based on feedback from the clients and patients,
- Access to care within a reasonable period of time will be ensured,
- The elderly's service need assessments will be realised within a reasonable period of time,
- Adequate and regular home care will be available to 14 per cent of those aged over 75,
- The share of those aged over 75 in long-term inpatient care will not exceed 3 per cent,
- The shortage of doctors and dentists working in primary health care will be decreased,
- The shortage of social workers will be decreased, and
- Regional differences in specialised care efficiency will be diminished.

The municipalities will implement the KASTE programme that includes 39 measures. The objectives set will be achieved by emphasising the role of preventive measures and early intervention, by safeguarding the sufficiency and expertise of personnel and by creating a seamless service system.

Regional projects and development measures are prepared by municipalities, federations of municipalities and regional steering groups. The internal development projects of the concern relate to the cooperation between the Ministry and the research institutes operating under its control (STAKES the National Research and Development Centre for Welfare and Health, the National Public Health Institute and the Finnish Institute of Occupational Health). NGOs are invited to participate in the preparation and implementation of projects realised in the spheres of municipal sports, culture and citizen's services in addition to those in the spheres of social and health care. The initiatives of citizens and NGOs will be integrated into the planning of the implementation of the programme at various levels.

The implementation plan of the KASTE programme will be adopted in November 2008 at the latest. The funding decisions concerning the programme projects will be prepared separately and adopted annually. Over EUR 20 million/ year has been reserved for development projects in the state budget.

2.3 Monitoring and management of strategic targets

The monitoring of strategic targets is presented here according to the grouping of the focal points of the Government Programme's welfare policy.

2.3.1 A rewarding and just social protection system

Strategic targets:

- To enhance employment incentives.
- To reduce poverty.
- To safeguard sufficient minimum social security benefits.

All citizens are guaranteed a reasonable 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 income security consists of earnings-related benefits. For this reason, the level of benefits primarily follows the trend in 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. In addition, retired women in the oldest age group must often 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 a reasonable quality of life. The threat of long-term poverty will be combated through sufficient minimum protection. Client fees for health care and social welfare services will be defined so that their level will not prevent the appropriate use of the services.

Focal areas of action:

- The SATA committee will submit its first proposals to Parliament during the autumn term 2008 and will prepare the basic policy outlines concerning the social security reform by the end of 2008. The committee will prepare more specific policy outlines, including impacts on the economy and employment, by the end of February 2009 and the proposals on the amendments entering into force at the beginning of 2010 by the end of April. The committee's proposal for a total social security reform will be submitted by the end of 2009.
- The level of the national pension has been increased as of 1 January 2008. A model guaranteeing the livelihood of those receiving the smallest pensions will be prepared by 31 December 2009.
- Unemployment benefits will be developed in cooperation with labour market organisations so that they encourage rapid employment. The amendments will be prepared as part of the social security reform.
- As of 2010, the level of maintenance support paid to a recipient of labour market support will be increased to encourage the activity of unemployed job seekers.

2.3.2 Comprehensive and effective social and health services

Strategic targets:

- To decrease health differences between population groups.
- To improve the availability and quality of services.
- To decrease the adverse effects of alcohol consumption on national health.
- To provide improved support to the elderly in order to enable them to live and cope at home.
- To respond to challenges posed by ageing personnel.

The objective is to bring all public policies policy support health and welfare, with their foundation already laid 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 to public health is emphasised.

Improving the health and welfare of the disadvantaged will contribute toward social cohesion. To hold varying risks of social exclusion under control requires effective reconciliation of services and income transfers. In addition, safeguarding the regional equality of the population requires an effective steering model and co-operation between regions, and an extensive utilisation of new information and communication technology.

It is particularly important that the assessment of social and health impacts in all sectors of public policy be increased. Intervention is required in the structures of working and family life. An important objective is to reduce 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 being supported with social service and health care measures.

Mental health problems are being prevented by measures targeting the entire population and identified risk groups. Solutions to mental health risks in the workplace are being elaborated. The need for institutional care can be reduced through a functioning combination of outpatient care, housing services and day activities.

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

Focal areas of action:

- The implementation of the PARAS programme is being continued in order to reform the municipality and service structure. Amendments required under legislation will be realised by 2012.
- The national development plan for social and health care services (KASTE) will be implemented during 2008-2011.

- The Primary Health Care Act and the Specialised Medical Care Act will be merged into a Health Care Act. The Government's proposal will be submitted to Parliament during 2008.
- The use of the municipal service voucher has been extended to home health care as of the beginning of 2008.
- The proposal on reforming the practices for granting state aid to municipalities will be submitted in the spring of 2009 and the reform will enter into force as of the beginning of 2010.
- Increased payments within health care services will enter into force as of 1 August 2008. Ways of realising a just payment ceiling system are being explored in order to alleviate the position of those using the services frequently or taking a lot of medicine. At the same time, the system will be reformed in such a way that patient or client charges do not induce people to select inappropriate forms of treatment.
- The development of electronic information systems will be continued. The objective is to make local patient records compatible with the new national archive by the year 2011.
- Drawing a line between inpatient and outpatient care will be abolished gradually in social insurance. The preparation and implementation of this reform is connected to the reform of the legislation on patient and client charges.
- A forecasting network has been establisheded to assess the need for labour force in social and health care. The term of office of the network will end on 31 December 2010.
- Time limits for key social services will be assessed. For those receiving income support, this will take place in 2008, and for other social services during 2009-2011.
- The Working Group reforming legislation on the use of compulsive measures in services for the elderly has prepared its proposal. The proposal will most probably be presented in the autumn of 2008.
- The transfer of administrative management of informal care support to the Social Security Institution will be explored.
- The possibilities for improving the operating environment of non-governmental organisations will be evaluated.

2.3.3 Equality between citizens

Strategic targets in housing policy:

- To implement the Housing Policy Programme.
- To enhance the prerequisites for economic growth by increasing housing supply in growth centres and to promote the availability of moderately priced housing.
- To create integrated community structures and reduce emissions caused by housing.
- To improve the housing conditions of population groups in a weaker position.
- To create a framework for the good maintenance of residential buildings and development of comfortable environments.

Strategic targets in education and youth policy:

- To reinforce the preventive aspects of pupil and student welfare.
- To speed up transition from basic to vocational education and make it more effective.
- To decrease educational drop-out rates.
- To support young people’s growth and independence and promote their active citizenship.

Other strategic targets to promote equality:

- To improve the social inclusion of the disabled.
- The municipality and service structure reform will be continued in order to increase the municipal inhabitants' possibilities to affect services and their involvement in decision-making.
- To expand citizens' rights to seek care across municipal borders.
- To pass a permanent Act on Job Alternation. At the same time, steps will be taken to determine whether the alternation system can be extended to entrepreneurs.
- To reform the gender equality programme, to diminish the pay gap between men and women and to realise the equal pay programme.
- To advance women's careers and promotion to managerial positions both in the public and private sectors.

Housing policy: Demand for housing has been great after the recession. Housing construction has been vigorous in Finland but has increased outside growth centres in particular, and even decreased in the Greater Helsinki Area in spite of a favourable economic environment and strong demand.

Due to high demand, prices have been rising rapidly for a prolonged period in the owner-occupied housing market. The situation in the rental housing market was temporarily good in the early 2000s and the number of homeless decreased. However, in recent years, the situation in the rental housing market has again become more restricted. On one hand, this has been caused by the creation of new jobs and the ensuing migration to growth centres. On the other, rental apartments have been sold and turned into owner-occupied apartments and the number of new rental apartments produced has been low. The elevated rent and price level of apartments, especially in the Greater Helsinki Area, and the availability of rental apartments have become a problem, especially from the viewpoint of those working in low-wage service professions. The prevailing situation is more and more clearly hampering economic growth and the positive development of employment both in the Greater Helsinki Area and the entire country.

Although the Housing Policy Programme covers the entire country, some of the measures are directed at areas with the highest demand for housing.

Increased housing construction outside growth centres and on the peripheries of growth centres has led to the increased disintegration of the community structure. High prices of apartments and lots in the core areas of growth centres have drawn construction farther away from workplaces. A significant number of one-family houses have been constructed outside the zoned area. Longer commutes and increasing car traffic are imposing costs on both private households and the public sector. This trend is in conflict with combating climate change and promoting sustainable development.

The population of Finland is ageing rapidly. Living at home meets the wishes of older people and is also the best alternative from the viewpoint of the public sector. In addition, the housing stock is becoming older and the number of intensive repairs will double in comparison to the current level. Immigration has increased greatly during recent years and it is expected that this trend will continue. All of the above-mentioned factors are putting pressure on the redevelopment of the existing housing stock and residential environments.

The population continues to concentrate in the biggest cities and many regions, including smaller towns, are losing population. This trend is increasing the economic risks connected to apartments in regions where the population is shrinking and may affect the attractiveness of these residential environments.

The economic well-being of Finns is now at a higher level than ever before. However, well-being is not distributed evenly. There are groups among us that are worse off such as the homeless, those suffering from mental disorders, the disabled and older people who are in poor health. For these groups, there is no supply in the market-based housing market.

Housing solutions and the residential environment significantly affect the feeling of community. To take care of the well-being of inhabitants, preventive attention should be paid e.g. to shared premises, meeting points and street spaces, playgrounds and sports areas. When planning apartments and land use, the challenges posed to the feeling of community should be considered. Everyday exercise is important in promoting health. A safe walkway network encouraging walking and biking is a prerequisite.

Education policy: In addition to learning-related targets, educational legislation addresses taking care of the holistic welfare of children and young people, the safety of the school community, and an 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.

More efficient methods than before are needed to improve welfare at school and prevent social exclusion. A few years ago, the Ministry of Education launched a set of measures with a focus on basic education and the development of the transitional stage in secondary education. The objective of these long-term measures is to develop the school into a community that promotes the welfare of children and young people and to increase early intervention and preventive action.

Dropping out of school is a factor that increases the risk of social exclusion. It is most frequent in the early stages of secondary education. The most common reasons for dropping 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 during which statistics on dropouts have been kept. In the academic year 2005-2006, 9.4 per cent 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 administrative sectors will improve the reconciliation and implementation of decisions with an impact on the growth and living conditions of young people. A comprehensive youth policy would offer 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 a distinct group, and that inequality among young people both within their generation and in relation to other generations is prevented.

Other policies promoting equality: By other policies promoting equality we refer to safeguarding equality of citizens in respect to the availability of services and the promotion of gender equality. Viewpoints relating to these matters have been discussed above in several connections and are dealt with separately in Parts 3 and 4 of the report.

Focal areas of action:

- A separate programme to reduce long-term homelessness will be implemented during 2008-2011.
- The Government will implement a policy programme for the well-being of children, young people and families. The objective of the programme is to reinforce the current extensive policies preventing social exclusion.
- On 5 December 2007, the Council of State adopted a development plan titled Education and Research 2007-2012[19]. According to the development plan, the priorities in basic education are to improve the quality and impacts of education. Group sizes will be decreased and remedial and special needs teaching enhanced in basic education. The focal points in higher education aim to improve the teacher student ratio and the reform of the steering system.
- The amendment to the Primary Health Act concerning school and student health care, aiming at safeguarding equal access to services, was adopted in 2007. A Decree on school and student health care is under preparation. The national KASTE programme includes measures concerning the prevention of social exclusion of children and young people (see above).
- The Government is preparing an overall reform of adult vocational training. A Working Group has been appointed for the preparative work. The term of office of the Working Group lasts until the end of 2010.
- The Government's objective is to reform legislation on non-discrimination so as to better fulfil the requirements set in Section 6 of the Constitution (Equality, Prohibition of discrimination). The proposal will be submitted in the summer of 2010.
- The disability legislation will be reformed during 2009-2010. The objective is to combine the Services and Assistance for the Disabled Act and the Act on Special Care for Mentally Handicapped and to develop the system of personal assistants for people with disabilities, in order to guarantee the equality of people with disabilities and to promote their social inclusion.
- The citizens' right to seek care across municipal borders will be expanded. The Municipality of Residence Act will be amended to create a new inter-municipal compensation system based on actual costs that will allow all handicapped persons and the elderly to choose their home municipality freely.
- In 2010, the Government will issue a report to Parliament on gender equality, in which the measures and state of gender equality policy and long-term objectives and development needs are defined.
- The Council of State has adopted a new Government Action Plan for Gender Equality for 2008-2011. The new action plan is a continuation of the 2004-2007 action plan. The key objectives of the action plan include mainstreaming gender equality, equal pay, alleviating segregation in education, facilitating the reconciliation of work and family life, advancing women's careers and combating violence against women.

2.3.4 Improving employment and developing working life

Strategic targets:

- To reduce long-term and structural unemployment.
- To increase the employment rate in various age groups.
- To extend working lives by a minimum of 2-3 years by 2015.

[19] Koulutus ja tutkimus 2007-2012, Kehittämissuunnitelma, (Education and Research 2007-2012, Development Plan) Ministry of Education (www.opm.fi tai www.minedu.fi)

- To enhance labour productivity and improve the organisation and meaningfulness of work.
- To ensure the availability of skilled labour and become prepared for the labour force shortage due to the changes in the age structure

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

The significance of unemployment security is vital to raising the employment rate. Its primary purpose is short-term protection that supports active job-seeking and promotes the flexibility of the labour market. The 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.

The annual Working Life Barometer describes the quality of and trends in working life from the viewpoint of wage and salary earners. From this viewpoint, the quality of working life slightly improved in 2007 in comparison to previous years. In total, men give higher scores to their workplaces than women. As for encouragement in the workplace, there was no clear difference between the sexes but, with respect to equal treatment in the workplace and the employee's resources in proportion to the requirements of the work, women gave lower scores than men. Sector-specifically considered, most problems were found in terms of the quality of working life in the municipal sector.

Good working conditions improve productivity and represent an important competitive factor. A meaningful job whereby the person’s physical and mental health and safety are guaranteed is a key factor in life quality and welfare. Well-being at work contributes to the degree of employment. Furthermore, 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. Attractiveness of work and opportunities for obtaining work will be improved so that working will be the primary alternative.

The objective of the government programme of Prime Minister Matti Vanhanen's first cabinet (2003-2007) was that all young people be offered a training, work practice, or workshop place after three months' unemployment. More efficient labour market services and various measures for ‘social guarantee for young people’ will focus largely on young unemployed people already in the early stages of unemployment. Employment services will strive to support young people’s training, applications for training, and employment. The implementation of these measures will be continued during the term of office of Vanhanen's second cabinet.

Focal areas of action:

- To enhance productivity and the quality of working life, the Government has launched a policy programme for employment, entrepreneurship and worklife.

- The opportunities of using taxation as a means of encouraging capital investments and the transfer of business skills to start-up enterprises are being explored. The start-up grant scheme has been made permanent and the duration of the period of start-up grant extended as of the beginning of 2008.
- The contents and functioning of the flexicurity model are being explored and developed in cooperation with labour market organisations. The measures required by the national flexicurity model will be prepared in a working group in which labour market parties are also represented. The working group's term of office will last until the end of 2010.
- A Working Group on labour market mismatches has been appointed by the Government. It monitors the preparative work and, when needed, develops proposals for solving problems relating to labour market mismatches and in order to enhance the functioning of the labour market. The Working Group's term in office will end at the end of the Government term at the latest.
- Ways to develop forecasting resources in order to predict labour force and educational needs will be explored separately. A Working Group responsible for the preparative work and acting under the Policy Programme for Employment, Entrepreneurship and Working Life has been appointed.
- The establishment of a new Ministry of Employment and the Economy at the beginning of 2008, assuming the duties of the Ministry of Labour and the Ministry of Trade and Industry, will enable measures relating to the quality of working life to be regionalised and implemented by Employment and Economic Development Centres more efficiently than before.
- The implementation of projects for developing working life will be continued. To lengthen working careers and increase the work contribution, investments will be made in the capacity to work and well-being at work. To promote well-being at work, the Ministry of Social Affairs and Health will realise a forum dealing with well-being at work, based on networking. The MASTO project is one of the special projects included in the Government Programme. This project aims at the prevention of depression leading to incapacity to work.
- As of the beginning of 2008, Tekes – the Finnish Funding agency for Technology and Innovation will be responsible for implementing the Tykes Workplace Development Programme. The current period of implementation of the programme will last until the end of 2009 and, after that, workplace development activities will be continued as part of Tekes' activities.
- A permanent Act on Job Alternation will be passed. At the same time, steps will be taken to determine whether the alternation system can be extended to entrepreneurs.
- Work-based immigration will be promoted and an action plan relating to it will be prepared.
- The availability of farmers' occupational health services will be improved.
- Social security for those living on grants has been improved by amending legislation. The new regulations will enter into force as of the beginning of 2009.
- Legislation on social firms will be reviewed.
- Employment services will be developed so that the customer-oriented approach will be strengthened. Online employment services will be developed so that they respond to the needs of employers better than before.

2.4 Groups Requiring Special Measures and Risk Groups

The long-term unemployed

Improving the employment of the long-term unemployed is related to close co-operation between training, the development of labour market skills, and rehabilitation. Furthermore, appropriate determination of health problems hindering the employment of the ageing long-term unemployed and their rehabilitation, 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 on the open labour market, at least not permanently. Nevertheless, social participation of the unemployed will be safeguarded. The position of the long-term unemployed will be alleviated by developing so-called social employment and intermediate labour market models. Taxation, income transfers, and services will be reconciled in order to reduce structural unemployment so that as many as possible find employment. Co-operation between social services and employment administration is the most efficient way to tackle the causes of long-term unemployment and remove obstacles to integration into working life.

The long-term unemployed **firstly** include people with stable working capacity who would be able to hold down a regular paid job, especially if the person's reduced productivity is taken into account at work. These people need preparatory training for working life and a wage-subsidised job. **Secondly**, this group includes people whose rehabilitation and restoration of working capacity would be likely to succeed. The purpose and target of rehabilitation is to prepare the client directly for taking up a normal job or becoming subject to primary measures by the labour administration. **Thirdly**, the group of unemployed includes people who are sometimes able to work, maybe even to perform to an excellent standard, but who are incapable of holding down a regular job on the open labour market. This group may include e.g. those undergoing mental health and substance abuse rehabilitation. 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. Those in mental rehabilitation have the opportunity to receive sickness allowance. The long-term unemployed with a substance abuse problem are not covered by a sufficient commitment from local authorities to become involved in addiction rehabilitation procedures, and are unable to raise the necessary funds for treatment themselves. **Fourthly**, the group of long-term unemployed includes people who are not at all able to take part in work activities. In respect of life management, it is indispensable for these people that they have somewhere to go and 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.

> **Strategic targets and focal areas of action**: The need for legislative measures will be assessed and realised in conjunction with the social security reform. Some of these measures are included in the Government's policy programmes and special projects.

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 transfer successfully 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 promote the active participation of young people in the activities of society as well as education. 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.

Strategic targets and focal areas of action: Will be implemented in conjunction with the Policy Programme for the well-being of children, youth and families launched by the Government. R&D activities on the issue are promoted by the Advisory Board for Sectoral Research appointed in the summer of 2007. The Academy of Finland will prepare the implementation of a separate research programme during 2009-2012.

The homeless

According to a disquisition prepared by ARA the Housing Finance and Development Centre of Finland, there were approximately 7,300 single homeless and approximately 300 homeless families in November 2007. Previous programmes combating homelessness have had only a limited impact on the situation of the long-term homeless. The number of long-term homeless is estimated to be approximately 2,500, out of which 2,000 (80%) live in the Greater Helsinki Area and 1,500 (60%) in Helsinki alone. The term long-term homeless refers to a group of homeless people whose homelessness has lasted for a prolonged period and has become or threatens to become chronic because conventional solutions concerning housing are not suitable for this group and there are no sufficient solutions responding to individual needs.

Due to the complicated nature of long-term homelessness, decreasing it requires that simultaneous measures be taken at various levels, that is, general measures relating to housing and social policy, and preventing homelessness, and targeted measures to decrease long-term homelessness. The objectives of the programme are

- To halve the number of long-term homeless people by 2011.
- To make measures preventing homelessness more effective.

When organising housing for the long-term homeless, solutions are required that are more targeted and individualised and support that is considerably more intensive than currently, as well as rehabilitation and supervision. The majority of housing solutions would be supported housing based on a lease and a smaller number of housing solutions would consist of housing units providing treatment that may be equated with the service housing referred to in the Social Welfare Act, where personnel provide round-the-clock support and supervision.

Housing in shelters, originally considered a temporary solution, will be wound down gradually and in a systematic and controlled way so that substitutive housing solutions are found for each inhabitant of every shelter that is closed down. It is proposed in the programme that investment grants from Finland's Slot Machine Association be allocated to organisations for renovating shelters.

Novel models of phased release will be developed for prisoners and clients of the Probation Service, such as those taking place during penal servitude or release on parole. This will have a significant impact on the prevention of recidivism in the target group of the homeless.

During the Government's term of office, the programme alleviating long-term homelessness will enable approximately 1,000-2,000 additional apartments or places in institutional housing to be created and a versatile overall social, health and rehabilitation service to be provided to those with less functional capacity. By means of the programme, considerable savings in direct and indirect costs arising from homelessness may be created. Expenditure on institutional care due to alcohol and drug abuse, mental disorders and recurrent prison sentences relating to long-term homelessness may be diminished considerably by introducing more intensive, individualised, rehabilitative and outpatient housing and service solutions.

Housing counselling activities produce direct savings as evictions and unpaid rents decrease. Indirect savings are directed to income support and housing allowance expenses arising from homelessness.

> **Strategic targets and focal areas of action:** A separate programme for alleviating long-term homelessness will be prepared for 2008-2011.
> A total maximum of EUR 80 million of investment subsidy budget authorisation for improving the housing conditions of special groups will be bound to the projects carried out under the programme during 2008-2011.
> The Ministry of Social Affairs and Health will direct a total of EUR 10.3 million of state funding to staff expenses during the programme period 2008-2011. Housing counselling activities provided by municipalities will be supported through the development programme for housing projects during 2009-2011.

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 the related services. In accordance with the decision in principle by the Council of State, the target of the alcohol policy is to reduce the adverse effects of alcohol use on the welfare of children and families significantly and to reverse the trend in the total consumption of alcohol.

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 smoke and that the level of alcohol and drug abuse among young people would be no higher than in the early 1990s. The retail monopoly on alcohol will be retained so that it will be possible to control the availability of alcohol.

> **Strategic targets and focal areas of action:** In 2004, the Government launched a separate Alcohol Programme. This programme was preceded by the Council of State's resolution on the policy outlines concerning alcohol policy. The implementation of the programme will be continued during 2008-2011, its objective being to develop broad-based cooperation aiming at the prevention and reduction of alcohol problems. The measures of the programme consist of joint efforts by the state administration, local authorities and NGOs. Local and regional cooperation will be developed.
> Taxes on alcoholic beverages will be raised according to the Government Programme as an attempt to promote public health. The objective of the tax reform on alcoholic beverages is to decrease the total consumption of alcoholic beverages and social problems re-

lated to the consumption of alcohol. Finland will also advocate an increase in the minimum tax rates for alcohol within the European Union.

The over-indebted

The position of people with serious income problems is improved through social crediting (see previous national plans). The development and expansion of debt counselling promote sustainable and rapid solutions to debt problems. The number of people with debt problems can be reduced, and debt can be prevented, through efficient financial guidance.

Strategic targets and focal areas of action: The Act amending the Act on the Adjustment of the Debts of a Private Individual and the Limitation Act entered into force on 1 March 2008. By virtue of the Act, when drawing up the payment schedule, the limitation of the court order concerning the debt (15 years) must be taken into account. In addition, the debtor may apply for the payment schedule to lapse.
The Government is preparing measures to restrict social problems caused by gambling, to prevent crime and safeguard the related monopoly.

People guilty of a penal offence

In developing the implementation of penalties, a reduction in re-offending has been adopted as the key target of the related measures. 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 penal servitude, supporting successful release. The rehabilitation of convicted people into society and their chances of a crime-free future will be supported.

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

Strategic targets and focal areas of action: The Council of State adopted an Internal Security Programme in May 2008. The focal points of the Programme include issues relating to secure housing, the prevention of organised crime, of domestic violence and of illegal immigration and human trafficking. The programme includes an implementation programme that contains short-, medium- and long-term measures. Industries and enterprises and organisations will participate in the implementation of the programme.

Immigrants under the threat of social exclusion

A general objective of social policy is the effective prevention of the aggravation of cultural conflicts and promoting the inclusion of all ethnic groups. 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. An important condition for integration is learning either of the two national languages - Finnish or Swedish. The independent life management of immigrants will be supported through measures by various administrative sectors. The availability of services in the immigrants' own language and interpreter services is being improved. Good integration will enable employees with an immigrant background to be included in the production of services by which the special characteristics of immigrants and their adaptation to the dominant culture are taken into account. In addition, the needs of children and young people coming from immigrant families should be given special attention. In order to

promote participation, inclusion and integration, it is important that a non-discriminative environment and education be safeguarded.

During 2007, the authorities paid attention to the so-called beggar issue. Rather large groups of beggars, most of whom were Roma from Romania, appeared, especially in the Greater Helsinki Area and larger cities. Begging as such is not illegal and all EU citizens may enter Finland. The problem has been that the groups have included a number of small children, which may require that measures be taken by the social authorities. In addition, many of those practising begging have been in poor health.

On 4 April 2008, the Ministry of the Interior set up a Working Group to assess the national need to harmonise the actions of authorities in dealing with beggars and to prepare any necessary instructions or legislative amendments. The working group was set up based on the proposal made by the Helsinki City Board to the Government. The working group submitted its report on 10 July 2008.[20] The proposals of the working group concentrate in particular on guidance, dialogue and the exchange of information. As regards child welfare, the report states that there is no reason to create a separate system for the temporary accommodation of minors. Child welfare is a social service to which all children residing in Finland are entitled. The powers of Finnish authorities are limited to providing immediate assistance. If the need for welfare services continues, assistance should be sought from the authorities of the person's home country, or in practice from a diplomatic or consular mission of that country.

Strategic targets and focal areas of action: The Government will continue the implementation of the Government Migration Policy Programme prepared earlier. A new programme was prepared in 2006 by the Government and a separate action programme for work-related immigration will be prepared. The Finnish name of the Directorate of Immigration (Ulkomaalaisvirasto) has been changed to the Finnish Migration Service (Maahanmuuttovirasto). The Ministry of the Interior carried out a separate enquiry into immigration policy and the activities of Finnish Migration service during 1 November 2007 – 30 April 2008. Based on this enquiry, work-based immigration, improving the administrative culture and the structural development of administration will be emphasised in the immigration policy.

A more detailed action plan on measures against human trafficking has been prepared. The action plan has been approved by the Ministerial Working Group on Immigration Policy in March 2008. In the action plan the emphasis has been laid on the identifying the victims and on measures to assist them. Human trafficking will be combated by means of education, information and research.

The proposals made by the working group to assess the national need to harmonise the actions of authorities in dealing with beggars will be assessed and implemented.

[20] Katukerjääminen ja viranomaisyhteistoiminta. Kerjäämiseen liittyvien viranomaistoimien yhdenmukaistamistarvetta selvittävä työryhmä. Sisäasiainministeriön julkaisuja 2008: 21 (Street begging and cooperation between authorities. Working group assessing the need to harmonise the actions of authorities in dealing with beggars. Ministry of the interior publication 2008: 21).

2.5 Good Governance

Preparation of the national report

The report has been prepared in co-operation with various ministries, organisations representing the poor and socially excluded, health organisations, labour market organisations, research institutes, local government representatives, and social work representatives of religious organisations and churches. The draft report has been dealt with by the appropriate EU subcommittees and by the management group of the Ministry of Social Affairs and Health. Separate hearings have been arranged for the participants in the work against poverty and social exclusion in May and June 2008 (non-governmental organisations, religious organisations and churches, local authorities, trade organisations). In addition, those participating in the hearings were given an opportunity to make written comments on the draft report before it was finalised.

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 at 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 with an impact on the prevention of poverty and social exclusion will progress through 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.

Participation of actors

The basis for exerting an influence on decision-making affecting poverty is a functioning, democratic system, a solid judicial system, and good governance that takes citizens views into account. Most decisions that have a direct impact on the position of poor population groups are made at local level. Moreover, municipal democracy and initiatives support local influence in Finland. The administration will act close to 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) form part of 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 through participation and learning in organisations. Such activities prevent the development and deepening of problems and support people's ability to cope 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 partnerships between government and organisations have long traditions in Finland. These activities are important for prevention of poverty and social exclusion and with respect to opportunities for inclusion and participation of socially excluded people. Organisations have played an important role in 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 usually only a few other actors - in addition, special expertise has developed within the organisations.

It is emphasised in the strategy document of the Ministry of Social Affairs and Health that the service provision of the non-governmental 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. These organisations operate in the long term. They contribute to building the connection between national policies against poverty and social exclusion and the local level in co-operation with local authorities, and create forums for expressing the needs of poor and socially excluded people.

Religious organisations and churches engage in social work and have taken part in the hearings. The pastoral and social work of the Evangelical Lutheran Church of Finland has some 800,000 client contacts each year. These operations prevent poverty and social exclusion via concrete measures, through the basic task of alleviating and removing distress and suffering. Solutions to overwhelming debt problems and looking after the rights of the unemployed constitute examples of the church's operations. In situations of over-indebtedness, good results have been gained through 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 in significance as a factor that heightens the risk of social exclusion.

Policy monitoring and assessment

The results of actions against poverty and social exclusion are to be assessed in separately organised events or occasions. In the assessment of practised policies, efforts will also be made to use the available qualitative descriptions on the development of Finnish welfare. The development of poverty and social exclusion will be assessed in connection with the follow-up of the government programme and in the annual reviews of various administrative sectors. The statistical authorities regularly publish information on changes that have taken place in 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 when assessing the development of poverty and social exclusion in separate events.

Better regulation programme

In addition, the Government will also implement a better regulation programme and has prepared a separate plan concerning the most important legislative projects during the Government's term of office, and the projects' scheduling. The aim of the project is to improve the legislative

environment and the clarity of regulations and thus to promote the welfare of citizens and the competitiveness of enterprises.

At the beginning of 2008, the Ministry of Justice has appointed a new ministerial working group on better regulation that provides support for and coordinates the development of legal drafting and acts as a forum for communication and brainstorming promoting good practices in the ministries. The Parliament is represented on the working group. The working group is continuing the work of the working group appointed during the previous Government's term of office.

Part 3 National pension strategy report

3.1 Introduction: Main policy challenges and objectives

The main objective of the Finnish pension system is to ensure that the population is covered against the economic risks caused by old age, disability or death of a family provider. The statutory pension provision for all residents in Finland consists of an earnings-related pension scheme and a national pension scheme. The earnings-related pension scheme provides insurance-based pensions, which ensure to a reasonable degree that all wage and salary earners and self-employed persons retain their level of consumption after retirement, and the national pension scheme provides the whole population with a residence-based minimum pension which complements the earnings-related pension. These two pensions together form the total statutory pension for a pensioner. The statutory pension provision can be supplemented with supplementary pension arrangements.

One of the major objectives of Prime Minister Matti Vanhanen's second Cabinet is sustainable pension policy. The foundation and objectives of a sustainable pension policy are based on "economic growth, general confidence in the stability of the system, just division of resources between generations, and longer working careers. The statutory pension system is based on the national and earnings-related pension schemes."[21]

The challenges for the sustainability of the pension system are linked to population ageing and increased life expectancy. One of the most important objectives of the pension reform that took effect in 2005 is to raise the effective retirement age in the long term by two to three years and to adjust the pension system to the increased life expectancy. Measures to achieve these objectives have comprised, among others, dismantling early retirement pension schemes, encouraging people to stay on at work longer by means of increased pension accruals, and introducing a life expectancy coefficient. Furthermore, the general retirement age was made flexible so that people can retire between the ages 63 and 68. The comprehensive pension provision is considered an important means of ensuring the income of the entire older population and an equitable intergenerational income distribution.

According to the most recent information the objectives of the reform are being achieved. Developments in the retirement age are measured by the expected retirement age. In 2007 the expected retirement age was 60 years in the public sector and 59.7 years in the private sector (in 2004 the average retirement age was 59.1 years). (Cf Figure 1). The employment rate of older employees has also improved. Since 2004 the employment rate for people aged 60–64 years has increased by almost ten percentage units.

[21] See, the Introduction – the Government Programme description

The achievement of the objectives of the earnings-related pension reform is linked with the development of the entire society and economy. The success of the pursued long-term and coherent pension policy has been made possible above all by the favourable economic and labour market situation. If it continues it will enable ageing employees to remain at work longer and postponement of retirement.

Apart from strengthening the economic growth potential, the major policy projects and programmes of the present Government in regard to preparing for population ageing include the above-mentioned reform of benefit systems, promotion of long-term saving and development of services.

As regards the adequacy of pension provision the challenges faced by the Finnish pension system are still linked to the income of pensioners with small pensions. This applies in particular to those receiving only a national pension. This challenge is being addressed by reforms regarding the national pension. Since the previous period of reporting, three general increases have been made to the rate of the national pension in addition to the annual index adjustments.

A considerable reform in view of sustainable funding is the life expectancy coefficient to be introduced in 2010[22], which will adapt the starting pensions to developments in life expectancy. Finland has enjoyed a favourable economic growth, which has reduced pressure to raise the earnings-related pension contributions. The employment rate has developed favourably for several years, and the productivity of labour has improved considerably. A threat to the economic growth is the shortage of labour force. The pressure to raise the earnings-related pension contributions has also been alleviated by the high return on the funded earnings-related pension assets in recent years.

The reform regarding the investment activities and solvency of pension institutions, which came into effect at the beginning of 2007, is an important legislative reform made after the previous period of reporting in view of the sustainability of the pension system. The aim of the legislative reform is to increase the return on the investments of the entire pension system in the long term, thus reducing pressure to raise the earnings-related pension contributions in the next few years.

Measures to reduce sickness absence and early retirement due to disability for work, which both the previous and the present Government have proposed, are also integrally linked with the adequacy of pension provision and sustainability of the pension system. Those are, among others, introduction of partial sickness allowance, making it statutory to provide vocational rehabilitation, and the project to reduce sickness leaves and disability in particular due to depression.

[22] With the pension reform of 2005 the pension system is adapted to the increasing average life expectancy. The increase in life expectancy is prepared for by introducing a life expectancy coefficient. The coefficient will be determined for each age class at the age of 62 years. It is the same for men and women. The coefficient will be determined for the first time in 2009 for those born in 1947, when it will be given the value 1. The first age class whose old age pensions it may affect are people born in 1948. The amount of a pension at outset will therefore depend on the development of life expectancy.

***

The Finnish pension system

The Finnish pension system (the first pillar) is made up of two statutory pension schemes: one is the national pension scheme based on residence that provides a guaranteed minimum pension whereas the other is the employment-based, earnings-related pension scheme.

Voluntary pension schemes (the second and third pillars) play a minor role in Finland due to the lack of pension ceilings and the extensive coverage of the systems.

The statutory schemes are linked together, with the amount of national pension depending on the size of the earnings-related pension benefits. Earnings-related pensions reduce the national pension by 50 per cent. If the amount of the earnings-related pension is above a defined level, no national pension is payable. Payments in statutory pensions amounted to 10.5 per cent of GDP in 2007, of which the employment based earnings-related pensions accounted for 85 per cent and the national pensions for the rest. In the future, the role of the national pensions in the total pension coverage will diminish, as the level of earnings-related pensions will rise. (Cf Figure 1 in Chapter 2.1.)

National pensions are administered by the Social Insurance Institution supervised by Parliament. These pensions are pay-as-you-go financed by contributions of employers (49 per cent) and by the state (51 per cent). The purchasing power of national pensions is retained by annual indexation based on the consumer price index.

The *earnings-related pension scheme* covers all gainfully employed people, including the self-employed. There are various Acts, the Employees Pensions Act (TyEL) forming a kind of framework Act. The pension coverage of the private sector is handled by authorized pension institutions. There are about 50 pension institutions of very different sizes. The Finnish Centre for Pensions is the central body for the earnings-related pension schemes. Its tasks include e.g. maintaining the nationwide pensions register, statistics and research. The Ministry of Social Affairs and Health is in charge of the general supervision of the earnings-related schemes. Employees in central and local government have their own earnings-related schemes. In principle, the pension benefits are similar for all sectors.

The financing of earnings-related pensions is a combination of a pay-as-you-go (PAYG) system and a pre-funded system based on pension contributions from both employers and employees. The PAYG system covers approximately ¾ of the earnings-related pension outlays, and the pre-funded scheme covers the rest. Despite being partially funded Finland's earnings-related pension scheme is of defined-benefit type. The pre-funding of the private sector is individually recognized but collective in the sense that it has no effect on the size of the pension. For the public sector the pre-funding takes the role of collective buffer funds.

The retirement age is flexible (62-68) and pensions accrue from the age of 18 to 52 at the rate of 1.5 per cent of wages a year, from 53 to 62 at 1.9 per cent and from 63 to 68 at 4.5 per cent a year without any cap. There are two types of indexation in the earnings-related pension scheme. The first (pre-retirement index) adjusts past earnings to the present level when computing the pension at the time of retirement. This 'wage multiplier' puts a weight of 80 per cent on wages and 20 per cent on prices. The other index (post-retirement index) aims at keeping the

purchasing power of earnings-related pensions ahead of inflation. This index has a weight of 80 per cent on consumer prices and 20 per cent on wages. The life-expectancy coefficient adjusts the pensions to be paid to the changes in longevity as of 2009.

The financial position in the earnings-related pension schemes is fairly good as the system is running on surpluses. The annual surplus is 3 per cent in relation to GDP. The market value of the pension fund's assets was 68.5 per cent of GDP in 2007.

Statutory pensions are taxed as labour income (progressive tax rate) with special deductions (pension deduction) applying for smaller pensions. The contributions to pension schemes are tax deductable for employers and insured, and investment incomes of the pension institutions are exempted from taxation. The taxation arrangement of earnings-related pensions is of the EET type. Tax treatment of supplementary pensions arranged by the employer is the same as that of statutory pensions, if certain restrictions related to the retirement age are fulfilled. Self-acquired voluntary pensions are taxed in the capital income taxation regime with a flat tax rate, and pension contributions can also be deducted to a certain amount in taxation within the capital income taxation regime.

***

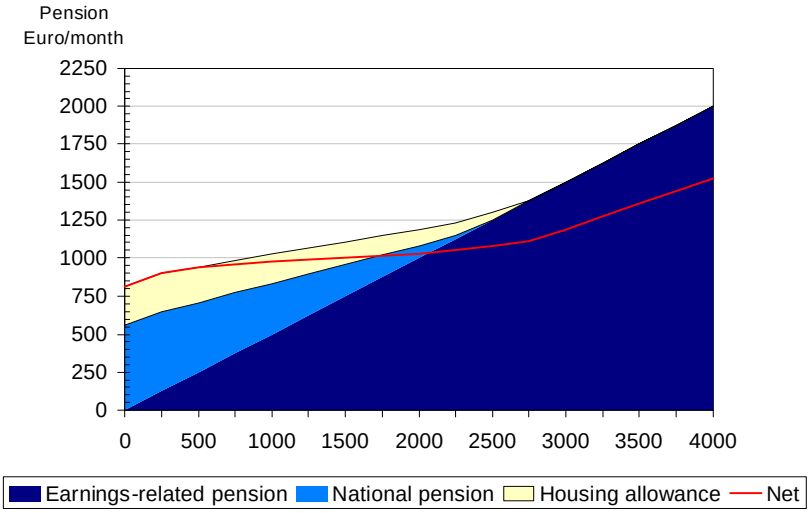
3.2 Adequacy of pension provision

According to the Constitution of Finland all people resident in Finland have a statutory right to social security and equal treatment. The statutory social insurance forms the core of the Finnish income security system. Its purpose is to provide insurance cover for all citizens against loss of income arising from social risks such as illness, disability, unemployment, accidents, old age, spouse's death, or birth of a child. The objective of the Finnish statutory pension system is to guarantee a reasonable level of consumption for pensioners, to maintain a stable income ratio between the retired and the working population and to prevent the risk of poverty for pensioners. It is possible to complement the statutory pension provision by voluntary supplementary pensions.

3.2.1 The structure of statutory pension provision and total pension

In Finland the earnings-related and national pension schemes constitute the statutory pension provision. The purpose of the earnings-related pension is to guarantee that the level of consumption acquired during active working life is maintained to a reasonable degree after retirement. The statutory earnings-related pension scheme covers all wage and salary earners and self-employed persons. The residence-based national pension, which supplements the earnings-related pension, ensures a minimum income for all pensioners resident in Finland. Pensioners who receive no earning-related pension at all or whose earnings-related pension is less than EUR 1,154 per month are entitled to a national pension. The pension scheme is supplemented, as necessary, by pensioners' housing allowance, pensioners' care allowance for supporting living in the own home and independent coping, special tax treatment of small pensions, and public social and health care services. In Finland pensions are individual and the income of the spouse is not taken into account in the determination of a pension. The amount of the national pension depends on the applicant's family relations.

Figure 1. Earnings-related pension, national pension and pensioners' housing allowance 2008 (Source: Finnish Centre for Pensions)



In 2007 statutory earnings-related pension was received by about 94 per cent of all pension recipients. [23] This figure includes besides the recipients of pensions in one's own right also the recipients of survivors' pensions. A national pension was received by 48 per cent of all pensioners. The number of pensioners in receipt of an earnings-related pension only has increased considerably. During the previous round of reporting their share was about 47 per cent of all pensioners. In 2007 their share had risen to 52 per cent. Correspondingly, the number of those in receipt of both an earnings-related pension and a national pension has diminished (cf. Figure 2). In 2003 their share was 45 per cent of all pensioners and in 2007 their share had fallen to 42 per cent. In 2007 about 6 per cent of the pensioners did not receive any other pension than national pension. In 2004 a national pension only was received by 8 per cent of the pensioners. The above-mentioned trend has been influenced in particular by the amendment according to which the national pension became entirely proportional to the earnings-related pension in 1996. Also the gradual entry into force of the earnings-related pension scheme, the higher earnings level and the increased labour market participation of women have had the effect that a greater proportion of the income in retirement consists of an earnings-related pension and that the role of the national pension as income supplementing the earnings-related pension income has diminished. The decline in the number of national pension recipients has mainly concerned old-age pensions. The number of disability pension recipients has remained almost unchanged.

There are differences in the structure of the total pension between the genders (cf. Table 1). For men the proportion of the earnings-related pension of the total pension is higher than for women, which is mainly due to men's higher wage and salary levels and longer working careers. On the other hand, for women the national pension is a more important source of income than for men. In 2006, 70 per cent of the persons aged 65 and over in receipt of an old-age pension under the national pension scheme were women. In the same year, 66 per cent of the persons receiving both an earnings-related and a national pension were women. The number of women who do not receive any other pension than national pension has been declining since the beginning of the

[23] Pensioners resident in Finland

1990s. This means that the pension level for women of retirement age has risen as a result of their increased labour market participation.

3.2.2 Coverage of pension provision

The statutory pension provision in Finland is comprehensive. As a rule, all paid work and self-employment in the private and public sector is covered by earnings-related pension insurance, and pension accrues in practice from all earned income and from several unpaid periods, such as periods of study and childcare.[24] Self-employed persons and farmers are guaranteed the same pension benefits as wage and salary earners. A small earnings-related pension is complemented by a national pension accrued based on residence.[25] The coverage of the earnings-related pension provision in the private sector was improved at the beginning of 2005. The lower limit of earnings from which pension accrues is EUR 47 per month in 2008. In the public sector there is not limit for earnings that accrue pension. The statutory pension system and the pension legislation for the private sector were streamlined and simplified in 2007 by merging the most important pension acts for wage and salary earners into a new Employees Pensions Act. That also concerned the pension acts for self-employed persons, farmers and seamen that are covered by the earnings-related pension scheme. (Cf Figure 3)

The need for supplementary pension provision has been relatively limited in Finland, and its role in the entirety of pension provision is small. This is, among others, because in the statutory earnings-related pension scheme pension accrues for wage and salary earners from all earnings without an upper limit. Neither is there a quantitative upper limit for the pension. Entrepreneurship is covered by the Self-Employed Persons Pensions Act if the reported income is on average at least EUR 6,186.65 a year (in 2008). The maximum reported income under the said Act may not exceed EUR 140,500 a year.

Collective supplementary pension arrangements based on either labour market agreements or employer related pension schemes cover about 25 per cent of employees in the private sector. Almost all of them have however been closed, and new employees can no more be included in them.

In 2007 about 18 per cent of the households had individual supplementary pension insurance. The popularity of individual pension insurance has increased in recent years, and this trend is expected to continue.

3.2.3 The relative level of pension provision

The adequacy of pension provision can be examined by proportioning pensions to the general earnings level. The relative level of pensions reflects the pensioners' level of income compared to that of people in employment. When evaluating the income of people of retirement age, account should be taken not only of the level of pensions but also of the role of direct taxation and income transfers other than pensions. Furthermore, it is on average more common in Finland for people

[24] As regards accrual of pension from unpaid periods, see the Pension Strategy Report of 2005: 2.2.5.
[25] The amount of the national pension is adjusted to the length of the person's residence in Finland, except if the applicant has lived at least 40 years in Finland between ages 16 and 64.

of retirement age than for people of working age to live in owner-occupied housing, which essentially improves the relative income of older people.

In 2006 the average total pension of the pensioners who received a pension in their own right (earnings-related and national pensions, including survivors' pensions) was EUR 1,194 a month (gross). This was about 48 per cent of the average earned income of wage and salary earners and of the self-employed [26] in 2006. The pensioners' average pension in their own right (does not include survivors' pensions) was EUR 1,113 a month in 2006, about 45 per cent of the median income in the said year. In 2006 the average pension in their own right (earnings-related and national pensions) of those who had retired in that year on an old-age pension was EUR 1,558, about 63 per cent of the average income for people in employment. (Cf. Table 2.)

The level of the old-age pensioners' total pension compared to the income of economically active people has remained fairly stable, at about 50 per cent, since the beginning of the 1990s. On the contrary, the pensions of recipients of a disability pension has reduced in relation to the pensions of those in employment from 1992 to 2007 (cf. Figure 4).

The minimum level of the income of pensioners is formed of the full amount of the national pension and the statutory supplements payable to it (cf Table 3). In 2008, the full national pension of a single pensioner is EUR 558.46 a month and that of a married or cohabiting pensioner EUR 495.35 a month.

After the previous round of reporting three general increases have been made to the national pensions, in 2005 (EUR 7 per month), in 2006 (EUR 5 per month) and in 2008 (EUR 20.50 per month). In 2008, the general increase was received by 643,000 national pension recipients. Furthermore, in 2008 the impact of the municipality of residence on the amount of pension was abolished, and consequently the monthly pension for 480,000 persons increased by about EUR 50. An additional amendment is that the national pension is no more reduced when the pensioner is in institutional care. Furthermore, an index increase of 2.5 per cent was made to the pensions in 2008.

The general increases have improved the position of all recipients of small pensions. As a result of the increases and the increased pension income tax deduction granted in municipal taxation the net incomes of more than 900,000 pensioners have increased.

3.2.4 Taxation of pensions and indexation

Taxation

The statutory national pension and earnings-related pension are taxable income. Some of the supplements payable to the national pension are non-taxable income. The taxation of pensions differs from the taxation of earned income e.g. so that the pensioner may be granted pension income deduction from the pension. The pension income deduction alleviates the taxation of pensioners on small incomes so that the pension for those who only receive a national pension is non-taxable income. The taxation of pension income was alleviated at the beginning of 2008 by

[26] Average income of economically active wage/salary earners and self-employed in 2006 (EUR 2,483 per month. Source: Income distribution statistics 2006)

raising the pension income deduction in national taxation. In 2008 the full pension income deduction in national taxation is EUR 11,060 for both single and married pensioners. In 2007 the maximum pension income deduction in national taxation was EUR 1,590. This deduction is not granted at all if the income exceeds EUR 31,928 a year. After the amendments the tax rate for pension income is, as a rule, at all income levels no higher than the tax rate for the wage and salary earners.

The pensions paid to wage and salary earners on the basis of supplementary pension insurance taken out by their employer are still taxable earned income for the wage and salary earners. If the wage or salary earner pays himself/herself part of the contribution to the collective pension insurance arranged by the employer, the wage or salary earner may deduct these contributions up to 5 per cent of the pay, however no more than EUR 5,000 a year. The insurance contributions paid by the employer are tax-deductible.

Voluntary pension insurance savings have been taxed since 2005 within the capital taxation regime, instead of the earned income taxation regime as before. In the new system the insurance contributions are deducted from capital income. The pension payable on the basis of an insurance policy is taxed as capital income. The minimum age of retirement on an old-age pension required for tax deductibility was raised by two years from 60 to 62. The aim of the reform was a more appropriate targeting of the tax benefit at the different income recipient categories, as well as to simplify the system and to increase the transparency of the tax benefit.

Indexation

The value of statutory pensions is retained through indexation. The index adjustments are made automatically every year. The aim of index adjustments is to ensure the purchasing power of the pensions. In addition, the earnings-related pension index compensates for a part of the real change in wages and salaries.

The wage coefficient applied in the case of earnings-related pensions in adjusting the earnings made during a person's career is a coefficient in which the weight of the earnings index is 80 per cent and the weight of the consumer price index 20 per cent. All earnings-related pensions under payment are adjusted by an index in which the weight of the earnings index is 20 per cent and the weight of the consumer price index 80 per cent.

National pensions are adjusted yearly by the national pension index that follows changes in consumer prices. Benefits linked to the cost-of-living index guarantee the purchasing power of pensions. In recent years the real value of the full national pension has developed in about the same way as the real value of earning-related pensions. The real value has been raised by the general increases made to the national pensions. (Cf Figures 5 a and and 5 b.)

3.2.5 Income of pensioners

Today the income of an increasingly greater number of pensioners is mainly based on earnings-related pensions. Social exclusion and poverty are best prevented through achievement of employment targets. The pension reform that came into effect in 2005 has improved the

incentives to stay longer at work and at the same time the opportunities to obtain adequate pension provision. [27]

Employment is a vital factor in view of the adequacy of pension provision. The employment rate in the age group 55–64 years has increased drastically since the end-1990s, and it already exceeded the target of the EU Employment Strategy (50 per cent) in 2004. The increase has been chiefly based on the longer working careers, since the unemployment rate among older employees is still high. The employment rates for both women and men in the age group are approximately equal. It is positive that the employment rate has increased at all education levels. [28]

In recent years the retirement age has risen in accordance with the objectives of the pension reform of 2005. The longer working careers also increase the level of earnings-related pensions and affect favourably the adequacy of pension provision. [29]

The level of income for people in pensioner households in relation to the income of the entire population was over 80 per cent in 2004. The level of pensioners' income in relation to that of economically active people was about 70 per cent in 2004. (Cf Figure 6)

According to theoretical replacement rate calculations, the total statutory pension (earnings-related pension + national pension) for a wage/salary earner with average income who retires in 2006 would be about 64 per cent of the wage level preceding retirement (gross replacement rate). The net replacement rate, where the effect of income tax was taken into account, was about 69 per cent for wage and salary earners with average income. In the calculations, the length of the working career is presumed 40 years and as the age of retirement 65 years (cf. Table 4).

The real replacement ratios of pensions have been examined on the basis of the extensive material based on the national income distribution statistics 2007.[30] The study covered people who retired in 2003. The results of the study indicate that the gross pension of a person with average income who retired in 2003 was about 62 per and the net pension 67 per cent of the preceding earnings level (cf. Table 5). In the public sector the replacement rates were higher than in the private sector.

The relative risk of poverty of people of retirement age (65+)[31] is 22 per cent when as the risk of poverty is considered income level that is less than 60 per cent of the median equivalized income of the entire population (cf. differences in risk of poverty between women and men 4.2.1). This information does not cover computed housing income. According to the national statistical data[32], when taking into account the computed housing income, the income for 13.9 per cent of people aged 65 and over remained under 60 per cent of the median income in 2006 (cf. Table 6). Among those aged from 65 to 74 years 11 per cent and among those aged 75 and over 18 per cent were on small incomes. The lower income level of those aged 75 and over is partly due to the gradual entry into force of the earnings-related pension scheme. If the risk of poverty is placed at the level

[27] As regards the pension reform of 2005 see the Pension Strategy Report 2005: 2.2.5. Earnings-related pension reform
[28] For more information about the development of employment see Part 3: Sustainability of pension schemes
[29] For more information about the results of the earnings-related pension reform see Introduction
[30] Rantala, J. & Suoniemi, I. (2007): Tulojen muuttuminen eläkkeelle siirryttäessä (Change of income in retirement). Finnish Centre for Pensions 2007
[31] SILC(2006) Income data 2005
[32] Statistics Finland 2008

of 50 per cent of the median income, the relative risk of poverty of the pensioners will decline. A large share of the elderly have an income between 50 and 60 per cent brackets.

In 2006 the poverty gap[33] was smaller for people aged 65+ on small incomes than for other people on small incomes (cf. Table 7). Compared to the previous round of reporting the poverty gap among pensioners has remained unchanged.

A fixed at-risk-of-poverty threshold can also be applied to the examination of low income; in this case, the income limit (the threshold) remains the same. With a fixed 60 per cent indicator (for the 2000 level), it may be noted that the risk of poverty for the over-65s has declined quite steadily from 1993 to 2006. (Cf Table 8). The risk of poverty for the elderly remains lower than that for the population as a whole.

Compared to the previous report the level of national pensions has been improved essentially by general increases. In addition, the SATA Committee preparing a total reform of social protection has considered different alternative models to ensure the income of people living on the smallest pension incomes better than at present.

Despite the increases that have been realised the risk of poverty of those living on a full national pension is still greater than that of other pensioners.

A full national pension is less than half of the median income of 60 per cent. In practice, all recipients of the national pension are thus living below the relative poverty line unless they obtain income from other sources. The risk of poverty is greatest for older women in receipt of a national pension whose working career has been short or there has not been any working career. Women also live longer than men, and consequently also the period of retirement is longer for them. A major part of them are, in addition, living as singles whose risk of poverty is greater than for persons living in households of several persons.

The higher risk of poverty also applies to persons who become disabled for work at a young age and for whom no earnings-related pension has therefore accrued. In the oldest age groups the number of national pension recipients is declining. There is no comparable development among the younger age groups in receipt of disability pensions.

3.3 Financial sustainability of the pension schemes

3.3.1 Objectives and challenges

The criteria for a sustainable pension policy are outlined in the Government Programme of Prime Minister Matti Vanhanen's second Cabinet. The objectives of a sustainable pension policy are economic growth, general confidence in the stability of the system, just division of resources between generations, and longer working careers.

The challenges for the financial sustainability of the pension system are associated, above all, with the ageing of the population. The Finnish economy has developed favourably, and partly for this reason there has not been any need to raise the pension contribution under the Employees Pensions Act in the short term. The employment rate has developed favourably for several years,

[33] Distance of the median income of low-income recipients from the low income line

and the productivity of labour has improved considerably. The pressure to raise the earnings-related pension contributions has also been alleviated by the high return on the earnings-related pension assets in recent years.

The aim of the Government is to increase the number of the employed during its term in office by 80,000 – 100,000 persons, in which case the employment rate would rise to 72 per cent, and to reduce the unemployment rate to less than 5 per cent. In 2007 the employment rate was in Finland 69.9 per cent and the unemployment rate 6.9 per cent. Important objectives to achieve the employment targets are to strengthen the economic growth and participation on the labour market and to improve the match of labour supply and demand. The incentives for work and labour supply will be increased by lighter taxation of work. The adult education system will be developed to ensure access to skilled labour force, the vocational qualifications of young people will be strengthened, graduation periods will be made shorter and labour market entry accelerated. Special emphasis will be placed on regional policy measures particularly in areas undergoing difficult structural change. Further aims are to increase the regional mobility of labour and work-related immigration.

In consequence of the pension reform of 2005 the pension provision for employees of the private sector, the central and local government employees and seamen, entrepreneurs and farmers accrues according to roughly similar criteria, although the funding is organised in somewhat different ways in the different sectors.

In order to ensure the financial sustainability of the pension system the objective is still a higher effective age of retirement. In order to achieve this objective the rules on accrual of earnings-related pension have been adjusted by raising the wage-based earnings-related pension accrual from 1.5 to 1.9 per cent starting from the age of 53 years and to 4.5 per cent from the age of 63 years. An employee may choose to retire on an earnings-related pension that he or she has accrued at the age of 63 years or continue to work until the age of 68 years. As a result of the pension reform implemented in 2005, old-age pension accrues from the age of 18 years. In the context of the reform the unemployment pension and early disability pension were abolished. Since the reform people retire on pensions approximately six months later than before it.

The life expectancy coefficient, which aims to prevent a growth in pension expenditure as a result of the increased life expectancy of those aged 62 and over, will decrease the amount of old-age pensions whose payments starts in 2010 and thereafter. The life expectancy coefficient will reduce the monthly pension, but it does not reduce the total sum of pensions payable during the entire period of entitlement to an old age pension. Therefore future developments in life expectancy do not essentially affect the pension expenditures or pension contributions. In 2025 the value of the life expectancy coefficient is expected to be 0.9 and in 2075 about 0.8. Employees can compensate for the decline in monthly pensions due to the life expectancy coefficient by staying longer at work. (Cf Figure 7)

The legislation on occupational supplementary pensions under the second pillar will likewise be developed. Law amendments are also being drafted to enable, in addition to the present benefit-based arrangements, contribution-based occupational supplementary pension arrangements not only in life assurance companies but also on the basis of the legislation on pension funds and pension foundations. Citizens are also encouraged to prepare for retirement on their own initiative. The premium income from individual voluntary pension insurance under the third pillar has been increasing for several years.

3.3.2 Employment and unemployment

The financial sustainability of the pension schemes is based on the favourable employment development. The working-age population in Finland is expected to diminish as from the 2010s, which will also weaken the supply of labour force. The major long-term objective of employment policy with a view to ensuring the availability of labour force is to raise the employment rate to 75 per cent. Besides a strong economic growth, an active employment policy is needed for that. The most important methods are to intensify the operation of the labour market, to prolong working careers, to accelerate young people's access to education and employment, to develop worklife and worklife skills, and to increase incentives for work. Reducing the unemployment rate on a sustainable basis below 5 per cent requires in particular measures to improve the match of labour demand and supply and to reduce structural unemployment. The prerequisites for access to employment for unemployed people are improved by means of training, employment services and mobility. The employment policy objectives also include prevention of exclusion, increased employment of foreign labour force, and higher productivity of labour. In order to reduce dependency on benefits, efforts are also made to improve the job opportunities of people with disabilities, and of those in receipt of sickness allowance or disability pensions.

3.3.3 Pension expenditure

The statutory pension expenditure in ratio to GDP is about 11 per cent in 2008. The percentage of this expenditure of GDP is increasing and the peak year will be, according to the most recent calculation of the Finnish Centre for Pensions, [34],around 2030 when the percentage of the statutory pension expenditure of GDP is expected to be about 15 per cent. Thereafter pension expenditure is expected to fall gradually by 1.5 percentage units until 2075. (Cf Figure 8)

In 2007 the total pension expenditure was EUR 19.6 billion, the proportion of the earnings-related pension expenditure being about EUR 16 billion thereof. The expenditure on earnings-related pensions corresponds to about 9 per cent of GDP; old-age pensions account for 70 per cent, unemployment pensions for 4 per cent, part-time pensions for 1 per cent, survivors' pensions for 9 per cent and special pensions for farmers for less than 1 per cent of that. Pensions under the National Pension Act were paid up to about EUR 2.8 billion, and compensations under employment accident insurance, motor third party insurance and the Military Insurance Act and the Military Accidents Act (so called SOLITA pensions) were paid amounting to EUR 0.5 billion. In addition, unregistered supplementary pensions (optional pensions) were paid up to EUR 0.2 billion.[35]

The pension expenditure under the Employees Pensions Act is at present about 19 per cent of the total payroll. It is estimated that it will rise gradually until 2030 to about 30 per cent and to remain at that level as a result of population ageing.

The projection regarding earnings-related pension expenditure until the 2030s has not changed much compared to the previous report. In the 2007 report of the Finnish Centre for Pensions the long-term projection regarding the pension expenditure percentage was roughly 2 per cent lower than in the projection made in 2004. The growth of the total payroll has been estimated to be

[34] Statutory pensions. Long-term calculations 2007, Reports of the Finnish Centre for Pensions 2007:2
[35] It is question of supplementary benefits registered under the Employees Pensions Act and the Self-Employed Persons Pensions Act

higher than in the previous calculation because of the higher fertility rate and immigration. In the new calculation the real return on the pension assets is estimated to be 4 per cent, which is half a per cent higher than in the previous calculation.

In the system under the State Employees Pensions Act the proportion of pension expenditure of the total payroll is over 50 per cent in 2008. This is because some state organisations have since the 1990s been transferred to the domain of private pension insurance. The pension liabilities accrued previously however remain the responsibility of the state. As late as in 1990 the proportion of pension expenditure of the total payroll of the state was about 25 per cent. The level of the other earnings-related pension scheme will be regained in about 50 years when the adaptation measures in accordance with the Government Programme are no more reflected in the state's pension liabilities.

The local government's pension expenditure of the total payroll is at the moment a bit less than 21.4 per cent. It is expected to rise to about 38 per cent by 2030. After that it will decline gradually to about 35 per cent of the total payroll by 2050. The assumed real investment return used in the calculations is 4 per cent, and the real growth assumption regarding the earnings level is 1.5 per cent a year.

In Finland the proportion of voluntary occupational supplementary pension arrangements is about 2 per cent of the total pension provision, although supplementary pensions may at the individual level constitute a considerable part of the total pension. The supplementary pension schemes are voluntary benefit-based arrangements in pension foundations and pension funds, for the financing of which employers are responsible. In pension funds also the insured can take part in the financing of them. In 2006, these funds and foundations paid supplementary pensions amounting to about EUR 225 million. In 2006 the total premium income of the Finnish life assurance companies was about EUR 0.8 billion. Old-age pensions, other compensations and surrender values were paid up to about EUR 0.6 billion, i.e. about EUR 0.2 billion more than occupational supplementary pensions. (Cf Tables 10 a and 10 b)

3.3.4 Financing of pensions

According to a calculation made by the Finnish Centre for Pensions the pension contribution under the Employees Pensions Act (TyEL) will rise from its present level of 21 per cent by about 4 percentage units by the beginning of 2030, after which the contribution is not expected to change to any greater extent. During the same time, the earnings-related pension expenditure under the Employees Pensions Act will increase by 12 percentage units. In relation to the present level of contributions the need to raise the contribution under the Employees Pensions Act is estimated at about 3 percentage units in case the level would be raised immediately. At the level of the entire earnings-related pension scheme the need to raise the total contribution level is estimated to be less than 1 percentage unit of earned income. (Cf Figures 9 and 10.)

The private and public sector earnings-related pensions are financed by contributions collected from the employers and the insured employees. The state contributes to financing the pensions of seamen, farmers and self-employed persons. In Finland the earnings-related pension scheme is based on partial funding. This system is complemented by the pay-as-you-go system. The pensions of self-employed persons and farmers are not funded.

In the Finnish benefit-based earnings-related pension scheme that is based on partial funding the return on the investment of the funded assets affects the level of the pension contribution. The return on investments does not affect the amount of individual pensions.

In 2008 the earnings-related pension contribution in the private sector is on average 21.1 per cent of the wage or salary. In the local government sector the total contribution is 28.2 per cent of the total payroll. The percentage of the total contribution collected from the employees and employers covered by the scheme under the State Employees Pensions Act is 24.7 per cent. In addition, pension expenditure under the scheme is financed directly out of the State budget.

In 2008 the pension contribution of self-employed persons and farmers is 20.6 per cent for people aged below 53 years and 21.7 per cent for those aged 53 and over. Farmers' pension contribution is calculated on the basis of the insured person's individual reported income. According to an estimate of the Finnish Centre for Pensions, farmers' average pension contribution is about 11 per cent. In recent years the state has financed about 80 per cent of the pension expenditure for farmers' pensions.

The insurance premium percentage under the Seamen's Pensions Act is the same for all employees, irrespective of the employee's gender or the size of the enterprise. Both the seamen and their employer pay a contribution of an equal amount to the Seamen's Pensions Fund. The portion of both parties is 11 per cent of the total payroll in 2008. The state takes part in financing the seamen's pensions by paying about one third of the pension expenditure for each year.

The national pension complementing the earnings-related pension provision is financed partly by tax-like contributions. Those are collected from employers in the form of employers' national pension contributions that the Social Insurance Institution receives. The state guarantees the adequacy of the financing of basic security and is responsible for the expenditure on national pensions as far as the contribution of the Social Insurance Institution does not cover them. The national pension contribution is graded according to the capital intensiveness and total payroll of the employer. The average national pension contribution collected from the employers was 1.66 per cent in 2007. (Cf Table 9.)

The occupational supplementary pensions, which are administered by pension foundations and supplementary benefit funds, are as a rule totally funded. Most supplementary benefit funds are at the moment closed, and new insured persons cannot therefore be included in them. The proportion of the occupational supplementary pensions thus arranged of the total pension provision is therefore declining.

3.3.5 Funding of pensions and investment of pension assets

Funding

In the private sector 0.5 per cent of the pensionable pay earned between the ages of 18 and 54 years is funded for covering old-age pensions. About 13 per cent of the old-age pensions paid in 2006 were pre-funded.

The funding percentage of statutory pensions in the private sector is a good quarter of the capital value of the earned pension rights. When calculating the technical pension liabilities as the

discount rate is used 3 per cent. Pensions are funded in the same pension institution in which the employee's earnings-related pensions are insured. The pension institution that has insured the employee's last employment relationship however pays the entire old-age pension to the pensioner, even if part of it had been funded in other pension institutions. The differences that arise in regard to a pension institution's actual financing liability are corrected in the context of the equalisation system by applying the collective procedure developed for that purpose.

The aim of the return on the funds administered by the Local Government Pensions Institution is to keep the pension contributions below 30 per cent of the total payroll. The purpose of the State Pension Fund is to collect funds by which the cost burden resulting from retirement of the baby-boom age classes in the coming years can be relieved. These are buffer funds by nature.

The employers and employees covered by the state pension scheme pay pension contributions to the State Pension Fund. The new liability for the statutory earnings-related pensions accrued during a year under the State Pensions Act is covered by those contributions. The liabilities that arose before the establishment of the payment system in 1990 are covered out of the State budget. Yearly 40 per cent of the annual pension expenditure is transferred from the fund for covering the State budget.

Investment of earnings-related pension assets

The Act on calculation of the solvency margin for pension institutions and covering of technical provisions (1114/2006), which entered into force on 1 January 2007, lays down provisions on the investment operations and solvency of insurance institutions in the private sector. The main aim of the Act is to define the solvency margin of insurance institutions on the basis of the actual risks of its investments. An important aim is also to clarify the rules concerning the covering of the technical provisions. The Act applies to the pension institutions transacting statutory pension insurance: authorised pension insurance companies (administering earnings-related pensions), pension funds, pension foundations, the Farmers' Social Insurance Institution and the Seamen's Pensions Fund. The aim of the legislative reform is to increase the return on the investments of the entire pension system in the long term, thus reducing pressure to raise the earnings-related pension contribution in the next few years. The general rise in the risk level related to the investments of the authorised pension institutions was approved in that context. The new legislation enables less restricted investment than before outside the OECD area.

At the end of 2007 the investment portfolio of the authorised pension insurance companies was about EUR 74 billion. The Local Government Pensions Institution's investments amounted to about EUR 24 billion and the value of the assets administered by the State Pension Fund to about EUR 12 billion. Interest-bearing investments constituted roughly 40 per cent of the investments of the authorised pension insurance companies and the Local Government Pensions Institution, whereas the interest-bearing investments of the State Pension Fund constituted more than half of the investment portfolio. Half of the Local Government Pensions Institution's investment portfolio consisted of equity investments, whereas the share of equity investments in the authorised pension insurance companies' and the State Pension Fund's investments was about 40 per cent. Investments in real estates constituted about 10 per cent of the investments of the authorised pension insurance companies and the Local Government Pensions Fund. The State Pension Fund did not have much real estate investments. Only authorised pension insurance companies had to a considerable extent other investments than those mentioned above. The

proportion of other investments is less than 8 per cent of the investment portfolio. With the new legislation investments in countries outside the euro area have increased. (Cf Figure 11.)

The authorised pension insurance companies administer more than 90 per cent of the earnings-related pension assets of the private sector.

The investment portfolio of the pension foundations and pension funds was about EUR 7.1 billion on 31 March 2008. In this group equity investments accounted for about 36 per cent, bonds for about 33 per cent, real estates for 12 per cent and money-market instruments for about 15 per cent of the investments. There were however considerable differences between institutions.

The technical provisions related to the pension insurance under pillars 2 and 3 which are funded in life assurance companies and which consist of mathematical provisions and provisions for claims outstanding amounted to EUR 13,2 in 2006. The liability is based on total funding.

3.4 Modernization of pension schemes in response to the changing needs of the economy, society and individuals

3.4.1 Compatibility of pension schemes with flexibility of the labour market

Current situation

Under the statutory earnings-related pension scheme, pension accrues, as a rule, from all wages and salaries and from all earnings from self-employment starting from the age of 18 years. Pension also accrues from certain unpaid periods that are comparable to working life (e.g. periods of child care). Employers must arrange statutory earnings-related pension provision for all their employees irrespective of the length of the employment. Short-term or other atypical employment contracts are also covered by pension provision. It was agreed in the context of the pension reform of 2005 that the duration of employment relationships does not affect pension benefits but pensions are based on annual earnings. From the beginning of 2007 the lower limit of earnings covered by the earnings-related pension insurance liability was reduced essentially, to EUR 47 a month. The value of statutory pensions is maintained through indexation.

For self-employed persons, pension provision is governed by specific pensions acts that guarantee them, as a rule, the same pension benefits as wage and salary earners. Self-employed persons shall insure their gainful activity in accordance with the Self-Employed Persons Pensions Act, while the pensions of farmers, fishermen and people engaged in reindeer husbandry are governed by the Farmers Pensions Act.

The preservation of pension rights is ensured in Finland appropriately. The earned pension rights are maintained by means of the so called paid-up policy technique: if a person's employment relationship or self-employment in accordance with earnings-related pension acts ceases before a contingency entitling to pension, the person retains the right he or she has earned to earnings-related pension provision. Since the earned pension rights are retained the pension system does no hinder flexible movement of labour force from a branch/employer to another. This also applies to the pension provision of self-employed persons, also when a wage or salary earner becomes self-employed or the other way round.

Challenges

Because of the ageing of the labour force, recent challenges for the Finnish pension policy have been integrally linked with the operation of the labour market and supply of labour force.

The goal of the present Government is to promote productivity and improve the availability of labour. The supply of labour force should increase and labour resources should be used as soon as possible to fill in vacancies. The achievement of the goal requires a high level of professional qualifications of the diminishing age classes as well continuous maintenance and development of the skills of adult population. The aim is to make graduation periods shorter and to reduce the number of persons with no vocational education. A further aim is to reduce labour market mismatches. The methods available to labour policy include an early intervention in unemployment and prevention of exclusion, as well as improved effectiveness of the policy. Life-long learning and development of qualifications at all stages of worklife are supported. Staying on at work is encouraged.

The pension reform of 2005 responds to this challenge by encouraging ageing employees to stay on longer at work by financial incentives and a flexible retirement age. The objective in the long term is to postpone retirement by at least three years. The employment of ageing employees (55 to 64 years) has indeed improved essentially over the last ten years. Furthermore, the age of retirement is now higher.

According to studies regarding staying on at work[36] factors that affect it are, among others, perceived health, spouse's employment, significance of work and family life, and factors related to wellbeing at work and management of work. It has also been observed that influencing people's attitudes plays a major role for remaining in worklife. Action programmes to promote wellbeing at work have been started in different sectors, and those have according to studies essentially influenced people's attitudes. Several factors have contributed to the change in attitudes, including the earnings-related pension reform, the debate in the media, and the debate at workplaces on ageing and supporting wellbeing at work. Projects to develop working life comprise e.g. the National Programme for Ageing Workers (1998–2002), the Wellbeing at Work programme (2000 – 2003) and the VETO programme (2003-2007) to increase the attraction of working life.[37]

The change of attitudes among the working-age population appears for instance from the results of a questionnaire study carried out by the Finnish Pension Alliance TELA in 2007 among persons who are still in working life. In 2001, 36 per cent replied to the question "If you were aged 63 years, would you retire or continue in working life" that they were willing to remain at work, whereas in 2007 44 per cent were willing to remain at work. (cf. Figure 12).

In recent years much attention has been paid in particular to rehabilitation as a channel of returning to work after a period of disability (more about rehabilitation in paragraph 4.3.). Attitudes seem to have developed in a favourable direction in this respect, too: two out of three employees are today willing to continue on the labour market through rehabilitation.[38]

---

[36] E.g. Janne Pelkonen, 2005: Vanhimpien palkansaajien työssä jaksaminen työeläkeuudistuksen jälkeisessä valintatilanteessa (Wellbeing at work among the oldest wage earners after the earnings-related pension reform). Reports of the Finnish Centre for Pensions 2005:1

[37] As regards other programmes to develop worklife, see the National Pension Strategy Report 2005

[38] Source: Työeläkeasenteet 2007 (Attitudes towards earnings-related pensions) TNS Gallup Oy 2007 PGraphic

A further challenge is to find a balance between retaining the high employment rate of women and family policy related objectives.

Future prospects

The attraction of working life will be promoted in accordance with the relevant objectives recorded in the Government Programme. A priority is to encourage full participation in working life and to improve the incentives for work in all situations. This presupposes development of the working conditions, high quality occupational health care, and incentive social security that supports staying on at work longer than at present. The most important aim is longer working careers during lifetime. This aim is supported by the Policy Programme for Employment, Entrepreneurship and Worklife, cross-sectorally and in particular by the pension reform of 2005.

3.4.2 Equality between women and men

Current situation

Finland's comprehensive statutory pension system ensures equal treatment for men and women. The benefits, contributions and entitlements under the earnings-related pension scheme are individual and do not depend on the gender of the recipient. The national pension scheme has a key position in the provision of personal, independent minimum pension for those who have remained outside working life. The national pension also provides supplementary pension provision for persons whose earnings-related pension is small because of small earnings or short working career. In this way it equalises the differences in pension incomes between women and men.

In 2006, the average total pension of female pensioners based on their own career (earnings-related and national pensions, including survivors' pensions) was EUR 1,063 per month (gross), which was approximately 49 per cent of the average monthly earnings of female wage and salary earners. [39] The corresponding average total pension for men was EUR 1,362 a month, i.e. about 47 per cent of the median earnings for male wage and salary earners. In 2006 the average pension for women in receipt of old-age pension based on their own career (survivors' pensions are not included) was EUR 932 a month and for men EUR 1,453. Women's average pension in their own right was thus about 64 per cent of men's average pension. When looking at the total pensions of women and men in receipt of old-age pensions, survivors' pensions included, the differences in the pension level between women and men are smaller. Then women's pensions were about 74 per cent of men's pensions.

The average pension for those who had retired on an old-age pension based on their own career was about EUR 1,178 per month for women and EUR 1,752 for men in 2006. Women's earnings-related pension was thus about 67 per cent of the average earnings-related pension for male pensioners with old-age pensions. In the total old-age pension portfolio women's average old-age pension based on their own career was about 59 per cent of men's corresponding pension.

[39] Median income of female wage/salary earners EUR 2,162/month in 2006, median income of male wage/salary earners EUR 2,873/month (Source: Income distibution statistics 2006)

Women's total pension, national pension included, was about 78 per cent of men's total pension in 2006.

There is a considerable difference in the risk of poverty between older women and men. The risk of poverty of women aged 65 and over is 16 per cent [40] and that of men 11 per cent. [41] There is a marked difference in particular among women and men aged 75 and over. The risk of poverty for these women is 22 per cent, whereas for men it is the same as for men aged 65 and over. The reason for the high risk of poverty of women aged 75 and over is mainly their shorter working careers due to which their pensions are small. With the longer careers and higher pension level the position of older women is going to improve in the future. The relative risk of poverty for men aged 65 and over is 11 per cent, and there is no difference in the risk of poverty between women and men.

There are still major differences in pensions for men and women both as regards the pension accrued based on one's own career and the total pension. Reasons for the difference in old-age pensions are e.g. women's lower wage level and men's longer careers. Women's wages/salaries are about 80 per cent of those of men's, and women's careers are on average 1 to 2 years shorter. One reason for women's lower wage level is the highly gender-segregated labour market. Due to childcare periods there are often more breaks in women's gainful employment than in that of men. Women also have more often part-time and fixed-term jobs or work as leased employees. The differences between the genders in the level of pensions thus are not due to the pension system but, as a rule, to the pay gap between women and men. On the other hand, gender-based differences in pensions are equalised by survivors' pensions, most of which are paid to women.

The new provisions in pension acts regarding unpaid periods promote the equality of employees. In the context of the pension reform of 2005, pension accrual was improved e.g. for childcare periods[42], as a result of which pension now accrues from periods of caring for children under 3 years with home care allowance. This can be considered to have increased gender equality in the pension schemes since women take the major part of parental leaves. Men are also entitled to childcare leaves, and thus also to the pensions that accrue for these unpaid periods. The share of fathers of all parents' allowance days taken in 2007 was 6.1 per cent.

Further, it has been possible to compensate since 2005 for the inconsistent career due to years of child care and the lower pension accrual as a result of it by the incentive accrual of 4.5 per cent gained from the age of 63 years.

Under the Finnish pension system, pension entitlements are not divided between spouses in case of divorce.

---

[40] Income level below 60 per cent of the median equivalized income of the entire population

[41] Income distribution statistics 2006 (Statistics Finland), includes computed housing income

[42] The earnings-related pension provision for unpaid periods was improved considerably by the pension reform of 2005. Unpaid periods from which pension accrues are periods of entitlement to unemployment, parents', training, sickness and rehabilitation allowance, compensations for loss of income under the motor and employment accident insurance, job alternation compensations and adult education grant, studies for a degree depending on the degree, and home care allowance for children for the first three years of the child. See more about the theme in the National Pension Strategy Report 2005

Challenges

The Finnish pension system is characterized by equal treatment of men and women. The challenge is, however, to retain women's high employment rate, reduce the pay gap and ensure a comprehensive pension provision and adequate pension level. A further challenge is to promote a more equal distribution of family leave between men and women.

In addition, the risk of poverty among older women living on national pensions is still a challenge, despite the improvements to the national pensions made in the last few years.

Future prospects

Gender equality is a central value in Finnish society. The Government undertakes to make determined efforts to promote equality in all its decision-making. Men and women must have equal opportunities in all spheres of life. The Government's goal is to clearly reduce the differences in pay between men and women during its term of office. The aim of the equal pay programme of the Government and labour market organisations is to reduce the pay gap between women and men to 15 per cent by 2015. The equal pay programme aims to reduce the difference in pay e.g. by reducing the segregated division of labour between men and women, developing the pay system and supporting women's career development. Promotion of equal pay also requires measures related to wage and agreement policies. Additionally, the Government will support measures designed to diminish the gender-based segregation of the labour market. The reconciliation of work and family life is promoted in all decision-making, and men are encouraged to take family leave.

3.4.3 Transparency and adaptability of pension schemes and the action policy on pension reforms

Current situation

Since earnings-related pension provision in Finland is based on work and pay, issues regarding earnings-related pensions are prepared together with the key labour market organisations. The role of labour market organisations is central in the preparations owing to, among others, the high degree of organisation and the fact that the negotiations are conducted at the central organisation level. From the very beginning, decisions on the earnings-related pension scheme for the private sector have been made at negotiations between the labour market central organisations and the Government. Parliament adopts pension acts based on the Government proposal. Studies have shown that the agreements on pensions have achieved a broad consensus in society. In recent years the solutions to develop the private-sector pensions scheme have been implemented in the public sector as well, where applicable. Tripartite agreements between labour market organisations and the Government on pension policy reforms bring stability and predictability to the system. The tripartite decision-making model has also contributed to the implementation of reforms of the pensions system. Reforms have been carried out by stages since the beginning of the 1990s. The most recent important reforms are those regarding earnings-related pensions from 2005 and 2007. The National Pension Act was revised considerably at the beginning of 2008 by streamlining and clarifying certain provisions and concepts.

A new actor in the field of pension policy has been since the beginning of 2008 the Pensions Forum set up by the Ministry of Social Affairs and Health to monitor and assess the implementation of the pension reform of 2005. The Pension Forum will assess the implementation of the pensions policy in particular from the perspective of preparing for population ageing and promote the dialogue on pension issues between the bodies involved. The purpose of the forum is to gather together a broad representation of the bodies that decide on, implement and assess the Finnish pensions policy.

The sustainability of the pension system and the adequacy of pension provision are monitored by both follow-up and separate studies. A set of specific indicators has been established for the monitoring of the implementation and effectiveness of the goals of the pension reform, such as expected retirement age, employment rate of ageing employees by age group, average earnings-related pension contribution, and percentage of the assets of the pension funds of GDP.

Transparency of insurance data for the insured

Services for the insured have further been developed lately.[43] An insured person can get information on matters related to his or her earnings-related pension for instance through the Internet.

The most important amendment to the Employees Pensions Act that entered into force at the beginning of 2007 from the point of view of employees is the pension data record sent annually to the employees. This increases the awareness of the insured persons of the level of their pension provision. Pension companies and institutions send annually a pension data record to all private sector employees aged 18 to 67 years who are resident in Finland. The pension data record contains information on the person's employment relationships and on the earnings on which the future pension is based, as well as information on the pension accrued so far. The record shows the expected accrued amount of pension for persons aged 50 and over at retirement age of 63, 65 and 68 years. By means of the pension data record the employees can check the correctness of their earnings-related pension provision. According to plans the record will include as from 2011 information on employment in the public sector as well.

It is also possible to order the record by phone and through the Internet. In addition, specific theme days are organised to present pension schemes and they are also presented at various fairs. Furthermore, the insured are served by, for instance, the offices of the Social Insurance Institution and pension companies.

The Social Insurance Institution investigates annually on the basis of its registers which persons might be entitled to a national pension although they have not applied for it. In the investigation in 2008 about 40,000 such persons were found.

According to studies people have a fairly realistic view of their future pension level.

[43] See the National Pension Strategy Report 2005 for measures to promote the transparency of insurance data

Other planned reforms: challenges and future prospects related to disability for work

According to the figure for 2006 altogether 256,276 persons received a disability pension. Their percentage of the population aged 16 to 64 years was about 7.4 per cent. The three most important reasons for retirement on a disability pension were mental health disorders (43.9 per cent), diseases of the musculoskeletal system (24.0 per cent) and diseases of the circulatory system (7.3 per cent).

It appears on the basis of a recent study that drastic changes in everyday wellbeing and changes in working life are probably contributory factors to disability caused by depression. Depression is one of the most important reasons for early retirement, long sickness absence spells and disability for work. According to studies the prevalence of depression as an illness has not increased over the recent decades. Although the number of persons with depression has not increased, people take sickness leave or retire on a premature pension due to depression clearly more often than before. In 2006, about 4,000 Finns had to retire on a disability pension due to depression. More than a half of them were women. The number of disability pensions granted on the basis of depression started to increase in the middle of the 1990s. In 2006, the pension expenditure on these disability pensions was EUR 324.4 million.

The Ministry of Social Affairs and Health has started a project to reduce disability caused by depression (the MASTO project). Its aim is to support wellbeing at work and return to work in the context of depression, and to reduce depression-related disability for work. Several national programmes and projects are under way that can contribute to a reduction in depression-related disability. The MASTO project works in a close cooperation with those development projects. The project started in October 2007 and continues until 2011.

The purpose of the **partial sickness allowance** introduced at the beginning of 2007 is likewise to lower the threshold for return to work after a lengthy disability, and thus to encourage staying on at work instead of retiring on a disability pension. Before 2007 it was not possible to pay sickness allowance for a part of the day. The purpose of partial return to work is to support the restoration of work ability and functional capacity and to lower the threshold for returning to work after a long absence. Return to part-time work is a voluntary arrangement presupposing the consent of both the employee and employer.

Another measure to reduce the risk of disability is **vocational rehabilitation**. The Social Insurance Institution and authorised pension institutions have been obliged since 2004 to organise vocational rehabilitation for persons who are at risk of becoming unemployed. Vocational rehabilitation was made a statutory right, and the decision on it may be appealed. A typical rehabilitee who is provided rehabilitation to avert disability for work and retirement is a person from the private sector aged on average 45 years who suffers from a disease of the musculoskeletal system. As a method of rehabilitation is usually used rehabilitation at work or training for a new job or occupation. In 2006, 69 per cent of the persons who completed their rehabilitation came to the rehabilitation from worklife and 67 per cent likewise returned to work. Correspondingly, 31 per cent of the persons who came to rehabilitation were pension recipients – mainly of an disability pension, and 43 per cent of them returned to worklife. The number of rehabilitees who have returned to worklife has increased year by year; this applies to both rehabilitees coming from worklife and in particular those in receipt of a pension.

Occupational health care services play an important role in the prevention of disability forwork.[44]

The life expectancy coefficient will be applied for the first time to the old-age pensions whose payment starts in 2010. The life expectancy coefficient also reduces the pension of persons moving from a disability pension to old-age pension, when the latter will be smaller than the preceding disability pension. This is experienced a problem in particular among persons who have been pensioners for a long time. Furthermore, those in receipt of a disability pension and an old-age pension thereafter have small opportunities to improve their pension by working. On the other hand, for recipients of a small earnings-related pension who also receive a national pension the latter partly compensates for the effect of the life expectancy coefficient on the earnings-related pension. It is being discussed how this situation could be remedied.

[44] For more information about occupational health care see Part 4 in National Strategy Report, National plan for health care and long-term care

Part 4 National strategy report on public health care and long-term care

4.1 Key challenges and targets

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

The public health service is based on preventive health care and well-functioning health services available to the entire population. The health policy emphasises a functioning primary health care and occupational health service, the correct division of tasks between primary health care and specialised care, an appropriate ratio between outpatient and inpatient care, and the improvement of environmental health.

According to national and international assessments, the Finnish health policy has been realised as defined in the policy. The health of the population has improved but there are still health differences between population groups. In addition, the regional differences in availability and quality of services pose challenges to health policy.

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 the elderly for as long as possible. In order to achieve the objectives set for the policy on ageing, municipalities are required to draw up their own old-age strategy safeguarding the social rights of the aged. This strategy is complemented by a development plan concerning service structures, the starting point of which is the good quality of life of the aged, the right of self-determination and independent coping irrespective of their functional capacity. Services must be customer-oriented and cooperation between relatives and various service providers must be seamless.

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

The objective of the Government Programme for 2007-2011 is to safeguard stable funding and the availability of services. According to the Government's policy, responsibility for the provision of the services will continue to rest with municipalities, and funding must primarily be based on central government transfers and the taxes raised by the municipalities. The objective is to strengthen quality and impact assessments of activities and services and the monitoring and steering system of services.

The implementation of the ongoing municipal and service structure reform will be ensured. In conjunction with the reform, legislation on health care will be reformed so that the barriers between primary and specialist health care are lowered and cooperation is improved. The aim is that the proposals for amendments are given during 2008. Primary health care and social work,

emergency care, mental health services and care for substance abusers will be especially developed in order to implement the service structure reform. The equality of citizens will be secured by upholding the rights of service users. Moreover, the uses of municipal service vouchers will be extended as appropriate to include social and health care services. Based on this policy, these service vouchers have been accepted in home-based nursing since the beginning of 2008.

In order to guarantee the availability and quality of services, the funding base also needs to be reassessed with regard to client charges. A more just payment ceiling system will be introduced in social and health care services in order to alleviate the position of those using the services frequently or needing much medication. At the same time, the system will be reformed in such a way that patient or client charges do not induce people to select inappropriate forms of treatment. The system of reimbursement for medicine costs will be reformed to hold rising costs in check.

The care guarantee realised in health care in 2005 will be assessed and required changes will be realised. In addition, social service guarantee will be realised by gradually introducing time limits for service needs assessment concerning key social services.

The Government Programme pays special attention to the prediction of nationwide and regional demand for labour. In the social and health care sector, the availability of sufficiently qualified personnel will be ensured by means of on-the-job training, competitive payroll systems, developing the content of work and management systems, and by offering opportunities to learn and improve oneself and have a say in the assignment of duties.

4.2 Health Care

4.2.1 Challenges and responding to them

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 2008, there were 399 municipalities in mainland Finland. The province of Åland is responsible for organising health care services in the Åland Islands.

The law contains general, but not detailed, prescriptions concerning the arrangement of services, and in most cases organisational methods 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 abroad, or by distributing service vouchers to the service's users for purchasing the services from a private provider approved by the local authority. In June 2008, a Working Group appointed by the Ministry of Social Affairs and Health proposed that the uses of the service voucher would be extended and that the regulations concerning the uses of the voucher would be gathered in an act on the uses of the service voucher. This reform would make the service structure of municipalities more versatile and increase municipal inhabitants' possibilities to choose between publicly and privately provided services.

Primary health care is organised in health centres, which 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, care of the elderly, oral health

care, physiotherapy, occupational health care, and local patient transport services. Challenges faced by school health services are being explored e.g. in conjunction with the policy programme for the well-being of children, youth and families launched by the present Government. Health centres provide health care services in co-operation with other municipal services, such as basic education and day care.

The regional functioning of services has been improved e.g. by means of the municipal and service structure reform (the PARAS project). The framework act on the reform of the municipal and service structure that entered into force in February 2007 obliges municipalities to organise central social and health care services for the entire population. The starting point for the reform is the promotion of health and well-being and strengthening the population base through the organisation of services. Its objective is to create a minimum population base of approximately 20,000 inhabitants. Although structures will be reformed and the population base for organising services broadened, the objective is not to centralise the provision of services. The availability of local services will also be safeguarded in the future. The municipalities submitted reports on cooperation and implementation plans on the organisation of services to the Council of State in late 2007. These implementation plans have been analysed in the Ministry of Social Affairs and Health and municipalities have been given feedback on them.

Specialist care is arranged in hospitals at either an outpatient clinic or an inpatient ward. Public hospitals are run by municipal federations, i.e. the hospital districts. There are 20 hospital districts in Finland. The population base of the hospital districts varies between 61,000 and almost 1.5 million residents. Activities in some hospital districts are becoming more and more varied due to the PARAS project.

The national development plan for social and health care services (KASTE) was launched at the beginning of 2008. This plan utilises e.g. the new method developed during the implementation of the national health care and social service projects that ended in 2007. The KASTE programme explores reform needs and realises reforms needed in cooperation with interest groups and actors in the field, especially with municipalities. The objective of the programme is that social exclusion be reduced, municipal inhabitants' involvement, well-being and health increase, inequalities in well-being and health between population groups diminish, the quality, effectiveness and availability of services increase and regional inequalities be reduced. The programme will strengthen municipal development activities so that the possibilities of promoting these extensive objectives increase.

Primary health care is being reinforced through the KASTE programme and the Health Centre 2015 action plan. These include e.g. the new Health Care Act supporting and reinforcing primary health care and strengthening seamless cooperation between, and the patient orientedness of primary health care and specialised medical care. In addition, the objective is to found a national development centre for primary health care and a network of developer-health centres operating in close cooperation with the national development centre for primary health care, institutes of general practice of universities and units of general practice of hospital districts. One of the objectives set for the KASTE programme is to decrease regional differences in the effectiveness of specialised medical care. This will be realised by following the treatment chains of certain diseases (myocardial infarct, hip fractures, medical care for low birth weight newborns, cerebral palsy, breast cancer, artificial joint surgery and schizophrenia).

The Working Group preparing the new Health Care Act submitted its proposal in June 2008. This proposal includes two models for organising health care services. According to the first model, the responsibility for organising specialised medical care would rest with the municipality or a cooperation area and partly with a hospital district with a broad population base. After making a referral to the hospital district, responsibility for organising services would shift from the municipality or the cooperation district to the hospital district. In addition to primary health care services, health centres or cooperation areas should organise basic-level specialised medical services, such as outpatient department reception, minor operations and day surgery. A hospital district should have a population base of at least 150,000 inhabitants, and the municipalities or cooperation areas responsible for organising primary health care should have a population base of at least ca. 20,000 inhabitants. According to the second model, municipalities could form a health care district instead of a cooperation area. This district would be responsible for the organisation of primary health care and specialised medical care. Such an option would be the primary option for provinces with less than 150,000 inhabitants. Both models would be realised so that cooperation between health care and social welfare and their common structures would be supported. In addition, the promotion of health and well-being and the prevention of health problems are emphasised. A municipality should, alone or in cooperation with other municipalities, draw up a plan on measures and services promoting the health and well-being, and preventing the health problems, of municipal inhabitants and the resources needed for this purpose. The implementation of the plan would take place in conjunction with the preparations of the municipality's strategy and budget.

In addition to the municipal system, private health care services are available as well. The services most commonly provided by the private sector include physiotherapy, dentists' and doctors' surgeries, and occupational health care. To a great extent, appointments with a private doctor are with specialists, although private consultations 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.

Medicine and travel expenses and private medical fees are partly reimbursed by statutory sickness insurance. Reimbursements for the costs of medicine are graded; the client's share is 58 per cent in the basic reimbursement category and 18 per cent or 2 per cent in the special reimbursement category (2007). 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. The growth in reimbursements of medicine costs based on statutory sickness insurance has slowed down during recent years (the amount of reimbursements was EUR 1,1 billion in 2007 - this amount had grown by 3.8 per cent in comparison to the previous year while in 2006 the corresponding figure was 2.2%).

Public authorities fund the municipal health services, mainly through tax revenue. The state participates in this funding by paying the local authorities a general, but not earmarked, state subsidy, which is, on average, 33 per cent (2008) 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 2006, the percentage of funding for households of the operating expenses for social welfare and health care was 7.4 per cent.

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, the

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. If desired, the employer may also arrange for medical and other health care services. Entrepreneurs and other self-employed people can arrange their own health care on a voluntary basis. Occupational health services are financed through earnings security insurance. Employees are responsible for 23 per cent and employers for 77 per cent of earnings security insurance. Payments are collected in a sickness insurance fund that reimburses approximately 50 per cent of the total expenses arising from the arrangement of occupational health care to the employer. In 2006, the number of employees within the sphere of the system was about 92 per cent of all wage- and salary earners.

4.2.2 Availability (target j)[45]

The target of Finnish health care policy is to enhance human health and functional life expectancy through 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 legislative amendment that came into force at the beginning of 2006.

At local level, responsibility for organising health care services is decentralised. The legislation gives 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 patients, it is essential that high-standard services be received 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 terms of access to services. In regional structures, the organisation of services and the promotion of health, functional capacity and social safety are taken into account.

Free occupational health care services are available for the working population, which, on the other hand, has been regarded as increasing inequality of access to care on the level of the entire population (e.g. the 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 time limits for access to non-emergency treatment. This system is assessed by health care authorities. Each hospital district's joint municipal board is responsible for the organisation of specialised medical care within its area based on uniform medical grounds. Harmonised principles underlying access to non-emergency care have been prepared for the treatment and examination of around 200 diagnoses. Doctors decide on patient care together 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, around 66,000 people were on waiting lists for specialised care; at the end of 2005, the number was 20,000; in June 2006, there were some 12,000 people on waiting lists and at the end of 2007 some 9,700. At the end of April

[45] The symbol j refers here to the objectives set in the 2007 Joint Report. Later on, the objectives k and l are also referred to. Cf. Joint Report on Social Protection and Social Inclusion 2007. European Commission, Brussels 2007

2008, there were 4,563 patients in hospital districts that had been on the waiting list for specialised care for over six months, equivalent to some 7 per cent of all patients on the waiting lists. The number of those that had been on the waiting lists for more than six months had been halved in four months.

Almost 60 per cent of those who had been on the waiting lists for over six months were awaiting surgical care, 13 per cent were awaiting ophthalmological care and 8 per cent otorhinolaryngological care. Although the number of patients on waiting lists is still greatest in surgery, this number, too, was halved after the end of 2007 when the previous assessment was carried out. The waiting lists for orthopaedics and plastic surgery are the longest. Access to care has improved significantly in ophthalmology, where the number of those awaiting care for over six months has decreased by 71 per cent and now totals slightly over 600 patients. For example, the waiting time for cataract operations has become shorter. The number of those waiting for otorhinolaryngological care has decreased by 62 per cent to 375 patients. This implies, among other things, that older people receive hearing aids faster than before.

By virtue of the Act, assessment of the need for treatment must be started within three weeks of the hospital receiving the referral. In the case of 3 per cent of referrals, the need for treatment has been in practice assessed only after three weeks of the district hospital receiving the referral.

The National Research and Development Centre for Welfare and Health Stakes collects data on the waiting time for first visits. Some 76 per cent of patients made their first visit within three months and 8 per cent had to wait for over six months. There are significant differences between hospital districts.

The care guarantee has clearly reformed, and improved access to, treatment, including in primary health care. Practices have been changed and services improved. Results have been gained by centralising telephone services, developing the division of tasks, and utilising technology – i.e., organising Internet guidance. Special reception and emergency duty activities carried out by nurses have been developed further. Less than one third of health centres provide joint doctor-nurse receptions but their share is slowly increasing. Many health centres are planning to introduce doctor-nurse collaboration.

The situation in health centres is now significantly better than before the care guarantee was instituted. On the other hand, the system still needs to be developed further. According to a follow-up study carried out in April 2008, over a third of the population lives in an area where there are occasional problems in making immediate contact with the health centre. However, assessment of the need for treatment is mainly carried out within three working days in the entire country (in 95% of cases). It has become more common that the waiting time for an appointment with a doctor due in a non-emergency case exceeds two weeks. Over a third of the population (37%) lives in an area where the waiting time for an appointment with a doctor exceeds 14 days if the need is non-urgent. This situation has deteriorated within the last two years, because in February 2006 the corresponding figure was 19 per cent.

Situations where making an appointment with a doctor is not possible at all have become rarer. In April 2008, approximately one fourth of the population (27 %) lived in an area where an appointment with a doctor could always be made when the need for care had been stated. One year earlier the corresponding figure was 16 per cent. Some 12 per cent of the population still

lives in an area with everyday situations in which making an appointment with a doctor is not possible.

In March 2007, only 17 per cent of health centres stated that they published data on access to care every six months or more often. In April 2008, already 73 per cent stated that they published the data as required by the Public Health Act. The most common channel for distributing information is the Internet. Some 10 per cent of health centres have not published any data on waiting lists so far.

The health centres suffering from a lack of appointment times with doctors reported that they had taken a number of measures in order to safeguard the availability of appointment times: 43 per cent stated that they would hire temporary personnel and 36 per cent were going to purchase services. Other measures included directing non-emergency patients to emergency departments when needed, reorganising workloads with nurses, regional cooperation, developing processes, increasing the amount of guidance over the phone and self-care of patients as well as extended work hours.

Immediate contact with the oral health care staff of the health centre is available almost everywhere. Average waiting times have increased in comparison to the situation prevailing in October 2006, but the number of those who had waited for oral health care for over six months had halved during the past 12 months. As for oral health care, the Act allows that the time limit of three months for organising treatment and care, prescribed by the care guarantee, may be exceeded by a maximum of three months.

The waiting times for an appointment with a dentist or an oral hygienist have slightly increased. In March, an appointment with a dentist due to a non-emergency need could be made within less than three months in 63 per cent of health centres. Six months earlier the corresponding figure was 69 per cent. In every second health centre an appointment with an oral hygienist could be made in less than three weeks, whereas in all other health centres the waiting time was extended and could even be three months.

Only one fifth of the population lived in the district of health centres where the lack of personnel did not affect the fulfilment of the care guarantee. Some 62 per cent of health centres stated that the lack of dentists impeded the fulfilment of the care guarantee. The situation has worsened from October 2007. The majority of health centres use temporary workforce, purchased services or both. Service vouchers had been introduced in one health centre. In only one fifth of health centres operations relied solely on the health centre's own personnel.

Patient co-payments

In Finland, most municipal health services involve a fee for the client. These fees have two main purposes: to fund operations and 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.

The proportion of funding for households of operating expenses varies with the services involved so that in 2006 it was in average 11.4 per cent for social welfare services, for primary health care (excluding oral health care) 7.6 per cent, for oral health care 20.4 per cent, for specialised care 4.3 per cent, and for inpatient care for the elderly 17.1 per cent. In the case of individual services and

service users, the proportion of client co-payments of funding of the total production costs of the service may vary between 0 and 100 per cent. In households' share of funding, the proportion consisting of medicine costs is considerable. The municipal system and sickness insurance system use several separate payment ceilings, which reduce the cost burden on clients.

The client fee system has been reformed as of 1 August 2008. The objective is to adjust the fees to reflect the actual development of cost levels while taking consideration of the requirements that social and health care services continue to be available to all, irrespective of place of residence or income and that the fees do not induce people to select inappropriate forms of treatment and services. The objective is that fees' share of funding remains stable and reasonable from the viewpoint of clients. The reform is discussed in further detail in section 4.3.4.

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 through client orientation, good and versatile services, sufficient services for the elderly, and a sufficient number of skilled employees. Quality is being made an increasingly integrated part of the operation of service organisations. Municipalities use national quality recommendations for different social welfare and health care services. The recommendations can also be utilised by other service providers. National evidence-based Current Care Guidelines have been prepared for the treatment of various diseases (the total number of these Guidelines was 90 in the autumn of 2008). Quality recommendations have been prepared e.g. for health promotion, mental health care services, substance abuse services, services for older people and for pupil and student health care. The utilisation of assessments and feedback from clients and patients has 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 follow-up data for the service providers are emphasised. In 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 a reduction in the prevalence of national diseases and their risk factors are influenced through different policy means. To an increasing extent, health is being adopted as a principle that directs decision-making at different levels of policy: in international co-operation and on national, regional, and local level. In decision-making, effects on human health and social welfare are assessed in advance, and the gender effects of decisions are also evaluated. People's independent initiative in the maintenance and promotion of their health and welfare is being supported by making sure that the environment and conditions promote healthy options. Health inequalities are being diminished, especially through an impact on groups with the highest health risks, such as those exhibiting smoking, alcohol abuse and obesity.

Health promotion brings undeniable benefits to society, the economy, workplaces and to private individuals. Thus, it has been considered that the perspective of health promotion must be adopted widely, in societal decision-making and in the service system as well as in business, at workplaces, in organisations and in private life. The objectives of the Policy programme for

Health Promotion, launched by the Government in 2007, are 1) reinforcing the structures of health promotion, 2) achieving lifestyle changes that contribute to the prevention of public health problems (reducing overweight among children, adolescents and the working-age population, reducing intoxicant use and smoking), 3) development of working and living conditions that promote healthy lifestyle choices, 4) strengthening the basic services of social welfare and health care and the development of new work patterns for health promotion, 5) reinforcing the activities and role of organisations that provide support for health promotion, especially as concerns participation and inclusion, 6) promoting the health and functional ability of older people, and 7) narrowing health inequalities.

The policy programme has the following strategic areas of emphasis: recognition of the social and economic importance of health promotion at various levels of decision-making, and the distribution of information promoting health, strengthening the structures of health promotion when legislation is revised and during the project to restructure municipalities and services, the collection, commercialisation, distribution and bedding down of existing knowledge, best practices and the most rewarding projects and reinforcing competence.

Reinforcing the position of service users

Patient rights are protected, for example, under 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 must be treated based on mutual understanding, which requires that patients are entitled to sufficient information about their health status and treatment alternatives. The patient's right to self-determination will be reinforced by an amendment to the Act.

People requiring urgent treatment must be given medical treatment regardless of their place of residence. 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). According to the proposal made by the Working Group preparing the new Health Care Act, the opportunity for clients to choose their place of treatment across municipal borders would be increased. The patient's right to choose the health care unit where he or she is examined would be significantly increased. The patient would also have the right to choose, in cooperation with the doctor responsible for his treatment, the unit of specialised medical care where he or she would be treated. The right to choose a doctor or the nurse would also reinforce the status of the patient or the client.

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. Such compensation is not contingent on negligence by health care personnel.

Legislation safeguarding the patient's position is supplemented through regulations and recommendations on services and treatment, which ensure the 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. Through the versatile assessment of the need for services and individual treatment, service, and

rehabilitation plans, 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 need for services and the resources required for them in the municipality are made visible through treatment, service, and rehabilitation plans. People's independent initiative and self-care possibilities are reinforced by providing information on health, health services and self-care.

Patient safety as part of quality assurance

Quality assurance has long been carried out on 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. Patient safety promotion measures have been implemented at local level; for example, special attention has been paid to the prevention of hospital infections. In 2006, the Ministry of Social Affairs and Health approved guidelines for the national patient safety policy, appointed an official responsible for patient safety matters and appointed a steering group to develop patient safety. The steering group collects and distributes information on good practices and assesses and coordinates patient safety activities. In addition, the steering group supervises the development of the reporting and feedback system concerning patient safety failures and close calls. The national patient safety network began operating towards the end of 2005. This network consists over 100 members representing professionals and units of health care, patients, organisations and authorities.

4.2.4 Sustainability of funding (target l)

In Finland, expenditure on health care services was 8.2 per cent of GNP in 2006. Finland has now started to compile statistics according to the OECD's SHA (System of Health Accounts), which has caused changes in time series and increased the level of expenditure since care for the elderly is now included in the expenditure. Expenditure on health care remains below the average level of the OECD countries, which is approximately 9.0 per cent. Mainly the low level of salaries of Finnish health care workers explains this. According to the new statistics, health care expenditure has grown in real terms since 1993 by approximately 3.3 per cent each year. Expenditure on medicines has grown by approximately 8.0 per cent each year during the above-mentioned period. Dental care expenditure has increased by 5.4 per cent each year. 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. Occupational health expenditure has also grown significantly, by 5.2 per cent each year. Other expenses have grown at a significantly slower pace.

Curbing the costs of medicines

Pharmaceuticals constitute an essential part of modern health care, and their 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 2007. Price revisions of medicines and generic substitution with competing medicines have slightly slowed down the development of reimbursement expenditure. Advanced drug treatment is enabling earlier patient discharge than before. Hospital treatment periods are growing shorter.

According to the Government Programme, the medicine reimbursement system will be overhauled to check rising costs. Particularly with regard to new medicines, their cost-effectiveness will be taken into account in the care of the infirm. Safe pharmacotherapy will be promoted and an extensive pharmaceutical service secured.

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 by promoting rational prescription as well as rational use of medicines and by increasing price competition between pharmaceutical manufacturers. The medicine reimbursement scheme is being developed towards the 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.

In addition to increased cost-effectiveness in drug treatment and the distribution of medicines, 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.

The appointed rapporteur's report on the administration of the supply of medicinal products was submitted at the end of May 2008. The Government Bill on introducing the generic reference price system was submitted to Parliament in the summer of 2008 with the aim that the system be introduced in April 2009. The system would include medicins containing equivalent active ingredients and with a selling permit in Finland and for which a reimbursement category is defined. If the patient buys a medicine whose price does not exceed the reference price, the reimbursement will be calculated on the basis of the entire price of the product. If he or she buys a medicine, the price of which exceeds the reference price, no reimbursement will be made for the part that exceeds the reference price. In cases where the doctor, on medical grounds, considers that the patient needs a certain commercial medicine, the reimbursement would be calculated on the basis of the price of the preparation marked on the prescription by the doctor. The reference price system would complement the existing system of generic substitution. Estimated annual savings would total approximately EUR 85 million.

Sufficiency and expertise of personnel

The sufficiency of health care workers and good professional skills ensure a high-standard service for clients. In the municipal health care service, the shortage of doctors has remained almost unchanged during the 2000s, and there are large regional differences. The lack of doctors particularly concerns remote areas. This 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 ageing and retirement of personnel are still considered a major challenge by the Government Programme. The effectiveness and quality of social and health care services are considerably

influenced by the skills and number of qualified staff. Thus, special attention will be paid to the prediction of nationwide and regional demand for labour. In the social and health care sector, the availability of sufficiently qualified personnel will be ensured by means of on-the-job training, competitive payroo systems, developing the content of work and management systems, and by offering opportunities to learn and improve oneself and have a say in the assignment of duties.

The personal and skills structure is being developed to meet clients' needs and in response to the tasks of the employees. The number of employees is being dimensioned to correspond with clients' and patients' functional capacity and requirements. Good and efficient services require that personnel have extensive general and specialist skills. The skills of personnel in relation to geriatric care are being strengthened in both health care and social welfare. It is being 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 being supported through regular statutory supplementary training. Employees' and work community's preparedness to work in a multicultural environment is being improved, and the integration of foreign-born employees into the social welfare and health care work communities is being facilitated.

4.3 Long-term Care

4.3.1 Challenges and responding to them

In Finland, there is no separate legislation on care for the elderly, including long-term care, but the elderly are mainly entitled to the same services as other residents of the municipality.

A municipality may provide services for which it is responsible alone or in cooperation with other municipalities. In addition, it can organise them by purchasing services from private or public service providers or by distributing service vouchers to the service's users for purchasing the services from a private provider. Long-term care is provided in the inpatient wards of health centres and non-medical long-term care in institutions for older persons. 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.

The National Framework for High-Quality Services for Older People, submitted in February 2008 and designed to help municipalities and cooperation districts in developing and evaluating the variety and quality of their services for older people, stresses the importance of partnership between the public, private and third sectors, and also underlines that opportunities for involvement by all municipal inhabitants, in addition to clients and their families, in developing and assessing services should be increased.

In services for the disabled, the general municipal services have a primary role. A personal service plan is drawn up for a disabled person in order to establish the required service and support measures. This is drawn up by the municipal authorities in consultation with the disabled

person and his or her carer or family members. The service plan increases the client's influence and capability to exercise his or her 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.

The aim is that the needs of both ageing people and the disabled are considered, including when planning social and health care services on a broader basis: they are mainstreamed across all activities.

The ongoing municipal and service structure reform has significant impacts on the service system. Under the framework legislation for the reform of Finland's municipal and service structure, municipalities or cooperation districts with a population of more than 20,000 are required, with certain exceptions, to fulfil social welfare and basic health care functions that include a large proportion of the services used regularly by older people. Thus, municipalities and cooperation districts will bear the responsibility for providing services for older people and be accountable for the quality of the services they themselves provide or purchase from other providers. Municipalities and cooperation districts must also ensure that these services meet the population's needs and are of high quality while being cost-effective.

Since the responsibility for organising both social and health services rests with municipalities, the possibilities of close cooperation and organising integrated services are in principle excellent.

Developing services for older people

Various social and health political documents supporting the Government Programme outline the development of services for older people, including long-term care. The key documents are

- The National Development Plan for Social and Health Care Services (KASTE programme) 2008-2011
- The Government Policy Programme for Health Promotion
- Welfare 2015 programme
- Health 2015 public health programme and
- The National Framework for High-Quality Services for Older People where the objectives set for services for older people in the above-mentioned documents are collected.

Services for older people will be reformed with the aim of developing home care and services supporting such care. In order to guarantee comprehensive old-age care, the integration of care allowance, social and health services, informal care benefits and domestic help credit will be improved to ensure that they complement each other seamlessly. The subjective right of older people to the assessment of the need for services will be extended by reducing the age limit from the current 80 years to 75 years and the assessment procedures will be systemised in order to guarantee uniform practices throughout the country. To promote welfare and health and to reduce differences in welfare and health, a comprehensive nation-wide advice and service network for older people will be created and preventive home calls will be added to services provided by municipalities. In addition, informal care will be developed on the basis of the reports completed to date e.g. by improving care-takers' access to substitutes and by evaluating the potential for developing an informal care relief system in an attempt to achieve better balance between work and informal care.

The National Framework for High-Quality Services for Older People, published in February 2008, outlines strategies for boosting quality and effectiveness in three dimensions: (1) promoting health and welfare and developing the service structure, (2) staffing levels and staff skills and management, and (3) old-age living and care environments. The framework sets national quantitative targets for services for older people that municipalities and cooperation districts can use as a basis for setting their own targets. It underlines the primacy of promoting health and welfare, of giving priority to prevention and support for home living, and of comprehensive assessment of individual needs. It is proposed in the framework that the share of long-term institutional care be decreased from the current 6.5 per cent to 3.0 per cent by 2012. The emphasis of the service structure is clearly on services promoting welfare and health, preventive services and services supporting coping at home (table 1). Such services include e.g. home care and home nursing/combined home services, support services such as meal and wrist alarm services, part-time or 24-hour services provided by day hospitals and day service centres as well as support for informal care. The national framework contains guidelines on safeguarding the quantity and skills of personnel. The framework defines the basis for staffing levels in home and 24-hour care and includes recommendations for minimum and good staffing levels in 24-hour care. The importance of increasing employees' well-being at work, gerontological skills and managerial ability is underlined, because staffing levels, skills and well-being at work are a basis for safeguarding the quality and effectiveness of services.

The attainment of the targets set in the framework are monitored and regularly assessed at national level. The framework provides monitoring indicators that can be used to obtain regular annual information on the progress made in key areas. The National Research and Development Centre for Welfare and Health (STAKES) SOTKAnet Indicator Bank[46] provides free-of-charge indicators for monitoring services for older people, enabling monitoring at national level and for each municipality separately. In addition, a separate nationwide assessment will continue to be needed to evaluate the impact of the framework and its effectiveness as a tool of informative guidance.

Developing services for the disabled

It is stated in a report on the welfare and living conditions of disabled persons[47] that citizens with disabilities are often not equal to other citizens. Equality can be increased by positive attitudes, services, an accessible society, accessibility and rehabilitation. Although accessibility has improved, this and equality can be still promoted in many ways. Equality is lacking e.g. in the spheres of education, employment and subsistence: the risk of disabled persons having a low level of education is great and the employment rate of disabled persons of working age is low. Ways of implementing legislation on the disabled vary, and in regard to services disabled persons are in an unequal position, depending on their place of residence. Those representing a linguistic minority and certain other groups are excluded from services more often than others.

[46] www.sotkanet.fi

[47] Haarni I. 2006. Keskeneräistä yhdenvertaisuutta. Vammaisten henkilöiden hyvinvointi ja elinolot Suomessa tutkimustiedon valossa. Sosiaali- ja terveysalan tutkimus- ja kehittämiskeskuksen raportteja 2006:6 (Incomplete equality. Welfare and living conditions of disabled people in Finland in the light of research data. Reports of the National Research and Development Centre for Welfare and Health 2006:6. In Finnish).

The Finnish disability policy is based on the following three main principles:

- The right of persons with disabilities to equality.
- The right of persons with disabilities to inclusion and
- The right of persons with disabilities to the necessary services and supportive measures.

Regarding persons with intellectual disabilities, the objective and strong development trend is transfer from long-term institutional care to more individual housing solutions. A report published in 2007[48] proposes the following recommendations for developing services:

- The housing concept regarding persons with intellectual disabilities should differentiate between the housing solution, flat and services needed in support of housing.
- The provision of housing for persons with disabilities should be planned carefully and the needs for housing and support should be examined in the long term. Service planning that gathers together different plans will provide the basis for the needs assessments made by municipal authorities.
- The system of residential institutions should be abolished. There should be a shift from the institution-intensive service system to non-residential services over the next ten years. The few institutions that will remain in operation should focus on special issues and have a limited capacity, and in the end they should be integrated into the health care system.
- To replace residential care and respond to other housing needs, 600 flats should be acquired per year in Finland.
- The services needed for housing should be provided from the perspective of individual assistance and support. Specific systems of assistance should be developed and introduced gradually.
- Issues regarding children with disabilities should be taken into particular consideration. The most essential issue in regard to the housing of children is to support their families.

The objective of Prime Minister Matti Vanhanen's second cabinet is an accessible society that offers equal opportunities to all. The Government has committed itself to continue the measures, to be carried out in stages, to combine the Services and Assistance for the Disabled Act and the Act on Special Care for Mentally Handicapped Persons and to develop the system of personal assistants for people with disabilities. All preparative work carried out on the matter has demonstrated that the personal assistant system is the development target preferred by disabled persons themselves, which best realises the equality, right of self-determination and inclusion of disabled persons. However, alternatives to the current model based on the disabled person as an employer are needed; not everybody can or wants to be an employer to the assistant. A number of disabled persons are currently excluded from the service or receive too few hours of assistance, considering their needs.

The legislation on the services for the disabled is being reformed. This reform concentrates on developing personal assistance. Personal assistance is defined as a general concept in the Services and Assistance for the Disabled Act, covering assistance and support organised by various means for a severely disabled person on the basis of his or her individual need for assistance. Assistance will be directed at severely disabled persons. A severe disability with respect to assistance needed and those functions for which personal assistance must be provided will be defined under legislation. Severely disabled persons, irrespective of their diagnosis, may receive personal

[48] Niemelä M. & Brandt K. (eds.) 2007. Individual Housing for Persons with Disabilities. From long-term residential care to individual housing. Reports of the Ministry of Social Affairs and Health 2007:73.

assistance. This covers both sheltered housing provided by virtue of the Services and Assistance for the Disabled Act and those disabled persons in sheltered housing provided by virtue of the Act on Special Care for the Mentally Handicapped.

Ways of organising assistance are defined in an individual service plan prepared for a severely disabled person. In addition to the personal assistant system based on the disabled person as an employer, personal assistance may also include assistant services purchased by a severely disabled person as an outsourced service or as a member of an assistant cooperative. Moreover, assistance may include assistance provided by the personnel of the sheltered housing unit, home care or home nursing personnel or by a relative.

The objective of the reform is to improve the opportunities of severely disabled persons in sheltered housing provided under the Services and Assistance for the Disabled Act to receive the personal assistance they need outside their homes so that the assistance provided by the sheltered housing unit in daily tasks is complemented by a personal assistant when needed (a supportive measure) or by assistant services (a purchased service). Another objective is to safeguard adequate personal assistance and support outside the sheltered housing unit for disabled persons in sheltered housing in individual tasks in which assistance and support are needed.

The importance of a service plan will be emphasised under legislation. Methods of organising personal assistance which take consideration of the individual need for assistance and situations of a disabled person are defined in a service plan. In the same context, the provision on the right to a service needs assessment without delay will be extended to cover the disabled and those who are chronically ill. It is planned that the Government Bill amending the Act be submitted to the Parliament in the autumn of 2008 and that the new Act enter into force as of 1 September 2009.

To safeguard the equal position of the disabled, a national disability policy programme will be prepared to guide disability policy actions in the coming years. This work has already been started. The aim is to strengthen the funding of services for the disabled in conjunction with the municipal and service structure reform and to develop ways of organising and providing services in order to realise the right of people with disabilities to equality.

Support for informal care

Developing support for informal care is important from the viewpoint of both older people and the disabled and has aroused a great deal of public interest within Finland. The Government Programme of Prime Minister Matti Vanhanen's second cabinet includes various objectives relating to developing informal support. This system was introduced in 1984 and the Informal Care Act entered into force as of the beginning of 2006. The Act is an important milestone in reforming the system. It defines support for informal care as an entity encompassing services necessary to the client, compensation for the informal carer as well as leave and support services for the carer that are defined in the care and service plan. As of the beginning of 2007, the act was amended so that the number of caregiver's statutory days off was increased from two to three days per month. The minimum amount of support for informal care is EUR 317.22 per month. If the carer is unable to become gainfully employed during a transitional stage, and if the nature of the care given is heavy, the support for informal care is at least EUR 634.43 per month. This support is classified as taxable income. A carer with an agreement with the local authority is covered by an earnings-related pension provision for his or her work, provided that he or she has not already retired. The local authority also provides for the informal carer’s accident insurance. A person

receiving support for informal care is entitled to have at least three days off in any month during which the nature of the care is extremely restrictive. The local authority provides for the care during the statutory time off and 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 must pay a maximum of nine euros per day for home help services arranged via a service voucher.

A study of support for informal care and variations in it in 1994–2006 was published in 2007. Approximately 30,000 caregivers received municipal support for informal care in 2007. The number of caregivers has risen steadily since 1994. The persons cared for by means of support for informal care in 2007 numbered slightly over 30,000. In regard to one third of those cared for, the main need for care and attendance was due to a long-term physical illness or injury and, with regard to one quarter, due to reduced physical functional capacity in old age. Dementia was the factor that necessitated care for about one fifth. The care intensity was high since almost half of those cared for by means of support for informal care needed care and attendance constantly and to a fairly great extent, and every third on a 24-hour basis. It was estimated in the study that without a caregiver approximately 11,600 people would be placed in institutional care. Three quarters of the caregivers were women, mainly the spouses and children of those cared for. The average of all fees paid as support for informal care was EUR 416.32/ month. Regionally, the average varied from EUR 356 to 555. Most often, the services provided to clients consisted of assistive device services, home nursing, short-term institutional care and transport services. The most common services provided for informal caregivers were days off, service guidance, training and advice and peer activities.

The major challenges for developing support for informal care are, according to the above-mentioned report, related to the following:

1. Promotion of the quality of life of the persons cared for and the caregivers;
2. Development of varied services, such as recreation and rehabilitation services, to maintain and promote the caregivers' physical, emotional and social functional capacity through extensive cooperation between various actors such as municipal authorities, non-governmental organisations, parishes etc;
3. Development of appropriate options for organising respite care in the client's home during the caregiver's statutory days off;
4. A comprehensive evaluation of functional capacity and resources in regard to both the person cared for and the caregiver so that the necessary help can be directed appropriately and purposefully, as laid down by the care and service plan;
5. Development of informal care as an integral part of the service structure on a long-term basis, including increased coverage of support.

The role of organisations in supporting caregivers is very important in Finland. The activities of organisations are funded by Finland's Slot Machine Association. In 2008, funding was granted for approximately 100 development projects in the field of informal care, totalling approximately EUR 8.87 million.

4.3.2 Availability (target j)

From the viewpoint of older people, exactly which services are available, and where, is an essential consideration. In terms of availability, services can be divided into local services,

regional services and services demanding an extensive population base. Older people need them all, but in their everyday life it is local services that are crucial. Local services are delivered to their home, or are produced close by. These include preventive services (such as preventive home calls), the assessment of service needs, home care, support for informal care and gerontological social work. Regional services are needed, for instance when special skills are required or their production regionally rather than locally yields some other added value. Examples are special services for those with dementia symptoms, units specialising in psychiatric care for the aged, or units that can provide gerontological expertise. In sparsely populated areas, mobile services that visit clients are recommended.

By virtue of Section 19 of the Finnish Constitution, everyone who is in need of services or other support has the right to social security, such as adequate social and health services. Special provisions on the right to the assessment of the need for social services within a certain period of time apply to older people. In 2006, the Social Welfare Act was amended so as to include provisions on the municipalities' responsibility to organise the assessment of the need for social services. In urgent cases, the need for social services must be assessed without delay. In non-urgent cases, persons over the age of 80[49] and recipients of the Social Security Institution's highest care allowance are entitled to an assessment of their need for welfare services within seven days of contacting a local authority. This amendment does not affect the municipality's responsibility to organise social services but does specify how services are accessed. According to a separate study, approximately 18,000 persons aged over 80 had exercised their related right during 2007.

The coverage of services has developed in Finland as follows: at the end of 2006, 90.1 per cent of over 75s were living at home. This calculation excludes all those in long-term hospital care, old people's residential homes and housing with 24-hour assistance. In 2005, 11.5 per cent of over 75s received regular home care and 3.7 per cent received informal care support, 3.9 per cent were living in sheltered housing with 24-hour assistance, and 6.5 per cent were in long-term institutional care.

During recent years, the volume of long-term care has significantly decreased and its structure has changed: traditional long-term institutional care has been replaced, especially by intensified sheltered housing. This change reflects older people's own wishes to live in a homely environment, such as sheltered housing units with 24-hour assistance, which has also been revealed in studies. (Table 2)

There are, however, significant regional differences (cf. Table 1) When the data given in Table 2 is compared with the objectives set in the National Framework for High-Quality services for Older People (in brackets), it can be stated that the objectives have been attained in the municipalities in 2006 as follows:

- The share of those living at home: the target (91-92 %) was reached by less than 50 per cent of municipalities
- Regular home care: the target (13-14 %) was reached by less than 50 per cent of municipalities
- Informal support: the target (5-6 %) was reached by every third municipality
- Sheltered housing with 24-hour assistance: the target (5-6 %) was reached by approximately one third of municipalities

[49] The aim is to extend the right to service needs assessment to persons aged 75 years as of 1.1.2009.

- Long-term institutional care: the target (less than 3%) was reached by every seventh municipality.

Equal treatment of disabled people, the 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 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 the rest of the population.

Services provided under the Services and Assistance for the Disabled Act have developed as presented in Table 3.

4.3.3 Quality (target k)

In addition to quantitative objectives, qualitative objectives have also been set for developing services in the National Framework for High-Quality Services for Older People. High-quality services 1) are client-oriented and allow clients and their families to participate in service planning, decision-making and assessment, 2) are based on a comprehensive assessment of service needs, the living environment and client resources, assessing the individual's physical, cognitive, mental, social, linguistic and cultural needs and resources, as well as environmental factors, 3) are goal-oriented and regularly assessed against a single written plan for care, rehabilitation and/or services, 4) are based on a work method that promotes functional capacity and rehabilitation, 5) are implemented in cooperation with the client, the various service providers, and relatives and friends, 6) are given in a safe and timely manner, 7) utilise existing research results and information on good practices, and 8) are effective, i.e. attain the individual and social targets set for the services.

Increasing the volume of rehabilitation and making its contents more versatile forms a significant qualitative challenge to developing services for older people. Rehabilitation must be understood widely, both as a separate, target-oriented service and professional activity and as a mode of operation among personnel, family and relatives.

Responding to the service needs of the disabled so that quality services are provided requires that social welfare and health care experts' knowledge and understanding of disabilities are increased and that 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 planning, decision-making, and development activities.

The challenges related to the improvement of the functional capacity of the disabled will be met through new operating and cooperation models and by developing rehabilitation and improving socially responsible planning. 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.

4.3.4 Sustainability of funding (target l)

In the near future, Finland will see a more rapid ageing of its population than most other countries. Longer life expectancies and falling birth rates are resulting 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 begin declining near the end of the 2020s. This change in the age structure will have an impact on the whole of society. Above all, it poses a significant challenge to the sustainability of the public sector economy since, 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 cost containment, evidenced by the small share of health care expenses in relation to gross national product. In 2005, the share of health care expenses in relation to gross national product was 8.3 per cent, which is below the average level of OECD countries (in 2005, 9.0%).[50]

It must be remembered that the change in the age structure of the population includes opportunities (the silver economy). Moreover, calculations of the related 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 a mere increase in the number of the elderly. A Government foresight report lending support in preparing for these changes was published in 2004. Progress in implementing the policies presented in the report will be assessed in 2008.

In the funding of social welfare and health care services, user fess will be dimensioned so that services are available for everyone and people are guided towards the appropriate use of the services. The needs for reforming the funding 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 services 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 be harmonised and that charges for the care of minors be abolished. In home services, a fee determined by the duration of care specified in the care and service plan should be adopted instead of visit-based charges.

The revision of the payments charged for social and health care services has progressed according to the proposals: the objective is to create a system under which the charges will be adjusted to reflect the development in the actual costs while simultaneously ensuring that high-quality services are available to all.

---

[50] A statistical reform concerning expenditure on, and the funding of, health care was realised in STAKES during 2006 -2007. The aim of the reform was to create a new system based on the definitions and classifications of the OECD's SHA (System of Health Accounts) that responds to the needs of both national and international reporting.

The maximum percentages of hospital charges paid by those in long-term institutional care were raised as of 1 January 2008 so that the payment percentage of single persons rose from 80 per cent to 82 per cent and that of spouses in institutional care whose income is higher than the income of the spouse not in such care from 40 per cent to 41 per cent. Simultaneously, the minimum of disposable funds (after the deduction of patient charges) for those in long-term institutional care was raised from EUR 80 to EUR 90. This reform relates to the reconciliation of social security of those in non-institutional and institutional care, and it was initiated by eliminating the reduction in the national pension of those in public institutional care lasting over three months and whose national pension exceeded a certain amount.

As payments charged for social and health care services have not been revised since 2002, an amendment to the act has been adopted and it entered into force on 1 August 2008. The objective of the reform is to adjust the charges to reflect the development of actual costs during 2002-2006.

The increases have been calculated based on the price index for social and health care and are on average approximately 16 per cent. However, all payments will not rise to the actual level of 2002. For future adjustments of client charges and income limits to meet cost developments, an index revision system will be introduced whereby a certain benefit, payment, income limit and amount of money are revised according to changes in an index defined in advance. Health care service charges are bound to the national pension index because it best describes the developments taking place in the financial standing and incomes of the largest user groups of public health services, that is, pensioners on low incomes and the unemployed. The income limits on which monthly charges for home care are based will be revised in the future according to changes in the earnings-related pension index. Index revisions will be carried out every second year and the revised amounts in euros will enter into force as of the beginning of the year. The first revision will enter into force as of the beginning of 2010.

As the charges were revised, the payment ceiling for social and health care services, was not raised. This will safeguard the position of those using the services frequently. A number of payment ceilings are used in social and health care, such as those for health centre charges, serial treatment charges and reimbursements for travel and medicine costs. Based on the Government Programme, the objective is to introduce a more just and homogenous payment ceiling system in order to alleviate the position of those using the services frequently or taking a lot of medicine. The committee preparing the overall reform of social security is responsible for the preparations for the payment ceiling system.

Part 5 Annexes to the report

Common annexes to the report

- Good practices (3)
- Indicators
- Characteristics of the social security system in Finland

Annex to the report: Good practices

Name of Policy/Project	Member State
City of Turku: Intersectoral welfare policy programme on children and youth	**Finland**

End Purpose of the Initiative

The objective of the programme on children and youth, coordinated by the Social Services Department of the City of Turku, is to create a good environment for children and young people in which the child-oriented aspect is strengthened and considered in all horizontal activities and decision-making.

- Life management of families, especially young families' ability to cope in everyday life, prevention and treatment of special problems, employment and reconciliation of working life and family life
- Responsible parenthood but "it takes a village to raise a child" as well
- Participation of children and young people
- Services for children and young people seamlessly integrated to support their growing up and development, the availability, adequacy and timing of services taken into consideration
- Special attention paid to transition points, and enhanced service coordination and needs for special support taken into consideration when normal services are provided.
- Integration of immigrant children and youth
- Monitoring of the new Child Welfare Act
- Assessment of impacts on children, a budget for children and youth
- City resources directed at children and young people monitored as an entity.
- In addition to the Social Services Department, the following departments to participate in the implementation of the programme: the departments of environmental and city planning, health care, education, youth services, Turku Vocational Institute and the department of culture services.
- The third sector, i.e. NGOs' involvement in the programme
- A House for Children, Young People and Families established in Turku as a concrete result of the programme.

Main Results

The project, based on strategic partnership between the Social Services and Health Care Departments of the City of Turku and child welfare organisations operating in Southwest Finland, collects dispersed services for children and young people under one service centre. Seamless service chains are created across organisational, professional and administrative borders.

The project implements the objectives set in the strategy and welfare political programme of the City of Turku and it is implemented parallel with the project aiming at the integration of the City's social services and health care departments.

A regional database called PALVE, providing information for both clients and employees, has been set up in cooperation with the Central Union for Child Welfare. Descriptions of services provided by the public sector and non-governmental l organisations may be found in the form of comparable PALVE cards e.g. from the regional internet service. The project has resulted in an increased number of multiprofessional and interadministrative forms of cooperation. Increased transparency has enabled the coupling of services provided by organisations with developing social and health care services as a natural part of service chains.

Targeted Beneficiaries		**Policy Focus**	
General Population	☐	Social Exclusion	x
Children	x	Healthcare	☐
Single-parent families		Long-term Care	☐
Unemployed		Governance	☐
Older people	☐		
Young People	x	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	
Ethnic Minorities		Regional	x
Homeless			
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]		**Coordination:**	
Children, youth and families	x	Social Services Department of City of Turku Others: Environment and city planning, health care, education, day care, youth services, culture services, Turku Vocational Institute, organisations	

Context/Background to the Initiative

Interadministrative cooperation on welfare issues was started at the turn of the millennium. Based on positive experiences gathered during cooperation, a further plan on welfare political programme work was drawn up. The reformed programme considers the following documents and projects:

The Child and Youth Policy Development Programme 2007–2011, adopted by the Council of State, the Policy Programme for Health promotion adopted by the Council of State in 2007, the committee to promote and support the health and welfare of children and young, appointed by the Council of State, the Working Group on developing care and treatment for pregnant women involved in substance abuse, appointed by the Ministry of Social Affairs and Health, the new Child Welfare Act, the committee on private social and health care services for promoting private services as a functioning part of social and health care services, appointed by the Council of State. Other programmes: the SATA committee, KASTE programme and PARAS project.

The idea behind establishing the house for children, young people and families was the desire to develop cooperation between the public and third sector, to integrate databases and to develop spatial and environmental planning. The partners began planning the project in 2003 in cooperation with the Harava project implemented in Southwest Finland and in conjunction with the Ministry of Social Affairs and Health's trial of case management and service coordination for children and young people with long-term illnesses or disabilities, and their families. The description of activities and assessment of the projects are based on the CAF model. In addition, the impacts of the project have been assessed based on actor and client surveys.

All aspects of accessibility will be considered in spatial and environmental planning. The project aims to create a novel operational model based on a partnership that can be utilised nationwide. In addition, development activities will be modelled and educational programmes prepared. The project and research activities relating to it will act as a national pilot project, and the information provided may be utilised irrespective of the municipal structure and cooperation model.

Annex: Best Practice example

Name of Policy/Project	Member State
Kaiku Programme to promote occupational wellbeing	**Finland**

End Purpose of the Initiative

The KAIKU Programme to promote occupational wellbeing is intended for state agencies and institutions; it is one of the many national programmes to promote wellbeing at work and longer careers.

The aim is to raise the age of retirement:

- to derive the priorities for wellbeing at work from the norms and strategies defining it;
- to anticipate the impacts of changes on staff; and
- to establish the promotion of wellbeing at work as a part of the management and everyday work of every state workplace so that a greater number of employees will stay on at work motivated and in good health until the actual retirement age.

The most important objectives of the KAIKU programme are the following:

1. to integrate wellbeing at work into performance guidance and other management instruments;
2. to establish a KAIKU developer network and to train superiors and professional developers into experts in wellbeing at work for state workplaces; mutual networking of developers;
3. to model, productify and disseminate good practices;
4. to gather a service provider network in support of the development of workplaces.

Main Results

The KAIKU Programme is involved in the general and diversified efforts to restructure state administration and to enhance its productivity by influencing the development of the content of programmes, stressing the opportunities of the staff to influence their work and by producing more material in support of the restructuring.

It can be considered that the promotion activities have been successful. The awareness of the activities to promote wellbeing at work and their significance as a value creator and a prerequisite for performance capability has increased considerably among state employees during the years the programme has been under way – not to forget the intrinsic value of wellbeing at work in producing services provided by people to other people.

The development up to 2006 was especially favourable: the percentage of new disability pensions dropped from 0.73 per cent in 2003 to 0.69 per cent in 2006. According to the preliminary information for 2007, the development has now stagnated, which could at least in part be a result of the pressures to reduce the number of personnel. The frequency of sick leaves has not increased considerably, however, although the mean age of employees has risen and the challenges for change have increased (in 2002: 8.8 days on average; in 2006: 8.9 days while the percentage of short sick leaves remained unchanged).

People in state service have been motivated to avail themselves of the opportunity to postpone retirement to a later age as a result of the pension reform of 2005: In 2006 as much as 70 per cent of the people who achieved the retirement age of 63 years availed themselves of the opportunity. In 2007 the net benefit of the postponements, measured in the number of person-years was 306, which is more than double the number in 2005 and 2006.

In 2006 the expected retirement age was 61 years and 7 months. The increase from 2005 was four months. From 2004 to 2006 the expected retirement age increased by seven months. The number of person-years that has been saved has been considerable (in 2005: 137 person-years;

2006: 147 person-years).
It is mentioned in the preliminary results of the ongoing impact assessment, among others, that the KAIKU Programme has also contributed to forming the content and to dissemination of the wellbeing at work concept at the national level. The material produced within the framework of the programme is, as a rule, distributed through the open web site, www.kaiku-tyohyvinvointipalvelut.fi.

Targeted Beneficiaries		**Policy Focus**	
General Population	☐	Social Exclusion	☐
Children	☐	Healthcare	☐
Single-parent families		Long-term Care	☐
Unemployed		Governance	☐
Older people	☐		
Young People	☐	**Geographical Scope**	
People with disabilities	☐		
Immigrants / Refugees	☐	National	X
Ethnic Minorities		Regional	
Homeless			
Specific Illness/disease	☐	**Implementing Body**	
Other [Please specify:]			
Employees at the government institutions (appr. 123 000 employees)	X	- KAIKU occupational wellbeing services team (5 persons) - KAIKU developer network trained for state administration (301 persons, working in addition to their actual job) - superiors employed in state administration	

Context/Background to the Initiative

The State Treasury started the KAIKU Programme in September 2002 in order to continue the measures carried out earlier in state administration to promote work ability and wellbeing at work, including, in particular, early rehabilitation and training to promote the maintenance of work ability intended for state organisations. An issue that has been in the interests of this state pension institution is, above all, to control the number of new disability pensions. Since January 2005 the activities have continued in the form of support services under the KAIKU Programme, and there has been a stronger link between it and the national programmes to develop worklife and wellbeing at work.

Annex to the report: good practices

Name of Policy/Project	Member State
City of Tampere: Promoting health and functional capacity	**Finland**
End Purpose of the Initiative	
The core process of promoting health and functional capacity creates the prerequisites for, and supports and activates, citizens in achieving as good health and functional capacity as possible. Activities are directed at the individual, community and environment. The main objectives of the process are prevention, early detection and intervention and high-quality care and treatment, rehabilitation and social support. The core process consists of the following service entities: primary health care outpatient services, specialised medical care services, substance abuse and mental health services, social support services and services for the disabled. The objective of primary health care outpatient services is to promote health and prevent diseases, detect those in risk groups as early as possible and provide those suffering from diseases with high-quality care and rehabilitation. The service entity consists of regional health centre services, physical examinations, emergency clinic services, patient transportation, operational and consultative services, communicable disease control, services provided by specialists, oral health care services for those aged over 18, rehabilitation services for outpatients as well as environmental health care and veterinary services. The objective of specialised medical care services is to guarantee high-quality services by either purchasing or providing them. The service entity includes conservative treatment (internal, contagious and rheumatic diseases), operative treatment (surgery, operations and consultations carried out by otologists, ophthalmologists, gynaecologists) and services requiring intensive specialised medical care. A special feature of Tampere in comparison to the rest of the country is that the share of specialised health care services provided by the city is high in relation to purchased specialised medical care services (approximately one fourth). The objective is to gain the best synergy between purchased services and those provided by the city itself. The objective of substance abuse services is to prevent and decrease substance abuse problems, the social and health disadvantages relating to them and to promote the health, functional capacity and feeling of safety of substance abusers and their relatives and friends. The objectives of mental health services are to promote an individual's mental welfare and functional capacity and the development of his or her personality as well as to prevent mental disorders and provide care and treatment for them. Psychiatric outpatient care provides and develops services promoting the mental health and functional capacity of Tampere residents and adequate specialised medical care services. Moreover, it participates in educational, research and development activities. The service entity of substance abuse and mental health services includes mental health day hospital services, mental health outpatient care, other mental health services, substance abuse outpatient care and housing services as well as rehabilitation services for substance abusers, institutional services and assisted housing.	

The objective of social support services is to promote the social security and well-being of individuals, families and communities. Special emphasis is laid on the promotion of life-management and the functional capacity of those in the weakest position and at risk of social exclusion. The service entity includes social work with adults, income support, services for immigrants and integration services for refugees. Social support services are complemented through cooperation with the third sector.

Services for the disabled support disabled persons' independent coping, while promoting equality and removing disadvantages and obstacles to participation due to disability. The emphasis has been laid on developing outpatient care and supporting independent coping among the disabled. The service entity includes services and supportive measures for the disabled, housing services, supportive measures and day centre activities as well as outpatient and inpatient services provided for the mentally disabled.

Main Results

The core process of health and welfare promotion provides citizens with adequate and high-quality social and health services.

The operational units responsible for client coordination are as follows:

- Medical rehabilitation office, which is responsible for the organisation of medical rehabilitation services and rehabilitation services for veterans
- Loisto, the client counselling unit for substance abuse and mental health services, which is responsible for client counselling relating to substance abuse and mental health services
- The social welfare office for the disabled, which is responsible for organising services under the Services and Assistance for the Disabled Act and for granting financial support to disabled persons.

Targeted Beneficiaries

General Population	x
Children	
Single-parent families	
Unemployed	x
Older people	
Young People	
People with disabilities	x
Immigrants / Refugees	x
Ethnic Minorities	
Homeless	x
Specific Illness/disease	x
Other [Please specify:]	
Children, youth and families	x

Policy Focus

Social Exclusion	x
Healthcare	x
Long-term Care	x
Governance	x

Geographical Scope

National	
Regional	x

Implementing Body

Coordination:
City of Tampere,
The Board for promoting health and fitness, Deputy Mayor Riitta Ollila, Erkki Lehtomäki, City of Tampere, Department of Social Services and Health Care

Context/Background to the Initiative
The City of Tampere joined the Terve Kunta (Healthy Municipality) network in 1996 by virtue of a decision adopted by the City Board. The network has been set up by STAKES, the National Research and Development centre for Welfare and Health and forms part of the WHO's Healthy Cities network. In the cities and municipalities that have joined the network, health is understood widely as a dynamic state of complete physical, mental and social well-being, according to the WHO's definition. The objective of network activities is to promote the welfare and health of the population and to prevent diseases. Municipalities that have joined the network are developing the strategic management of health promotion and operational models at local level. As of the beginning of 2007, the City of Tampere reformed the organisation of its activities and introduced the mayor model and purchaser-provider model. The objectives of the new operational model are citizen-oriented management and the provision of services by means of intersectoral process thinking. Health promotion plays an important role in the organisation of services. By the beginning of 2007, nine municipalities (Jyväskylä, Kerava, Kittilä, Kolari, Kuopio, Pori, Tampere, Turku and Vantaa), two regions (Järviseutu and Oulunkaari) and the area of the Kainuu governance experiment had joined the Terve Kunta (Healthy Municipality) network.

1 ECONOMIC EXCLUSION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007

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 per cent of median income each year. Poverty risk indicators by main occupation, by gender and by type of household have been published on-line; see www.stat.fi/tk/el/hyv_031.html

Number of low-income persons																		
Persons in households below the poverty level																		
-- number	395 000	389 000	356 000	323 000	347 000	362 000	431 000	420 000	501 000	520 000	576 000	576 000	587 000	591 000	629 400	661 000	652000	
Poverty level eur/consumer unit/year	9939	10078	9565	9122	9182	9358	9593	9826	10197	10517	10622	10890	11246	11533	12050	12502	12464	
Poverty risk – relative poverty level																		
-- total. percentage of population	7.9	7.8	7.1	6.4	6.9	7.2	8.5	8.3	9.8	10.2	11.3	11.2	11.4	11.5	12.2	12.8	12.5	
-- men	6.5	6.9	6.6	6.5	7.2	7.4	8.6	8.4	9.7	9.8	11.0	11.3	11.6	11.4	11.8	12.4	11.8	
-- women	9.3	8.6	7.5	6.4	6.6	7.0	8.4	8.1	10.0	10.6	11.5	11.2	11.2	11.6	12.5	13.1	13.3	
Poverty risk among children																		
-- % of population aged 0 to 15	5.0	5.5	4.7	4.9	4.5	4.4	5.9	6.0	7.9	9.0	11.9	11.8	11.8	12.2	12.3	11.3	12.2	
-- % of population aged 0 to 18	4.9	5.6	4.8	5.0	4.5	4.7	6.0	6.2	8.0	9.1	11.6	11.8	11.7	12.2	12.1	11.6	12.3	
Poverty risk among young people	11.2	15.2	17.2	15.3	18.3	19.4	23.3	22.4	22.4	22.8	21.1	23.6	23.8	23.8	26.7	25.9	23.4	
-- % of men aged 16 to 24	9.3	13.6	16.4	13.7	16.6	18.0	21.8	19.8	18.8	19.6	19.6	22.1	22.3	21.3	24.0	23.4	21.2	
-- % of women aged 16 to 24	13.1	16.8	18.0	17.0	20.0	20.8	24.8	25.1	26.3	26.1	22.7	25.2	25.3	26.5	29.6	28.6	25.6	
Poverty risk among the middle-aged	4.6	5.3	5.0	5.4	5.8	5.9	7.3	7.5	8.6	8.5	9.9	9.7	10.4	10.1	9.8	10.6	10.9	
-- % men aged 25 to 49	4.8	5.3	5.7	6.4	7.3	7.2	8.1	8.8	9.6	8.9	10.0	10.4	11.5	11.3	10.2	10.9	10.9	
-- % women aged 25 to 49	4.5	5.3	4.4	4.4	4.2	4.7	6.5	6.3	7.5	8.1	9.8	8.9	9.3	8.7	9.2	10.3	10.8	
Poverty risk among the ageing	8.7	7.0	5.4	4.4	4.8	5.5	6.0	5.0	7.2	8.0	8.0	7.2	6.8	7.1	7.9	8.6	8.8	
-- % men aged 50 to 64	8.7	7.8	6.6	5.9	6.1	7.1	7.9	6.0	8.1	8.5	9.2	8.1	7.8	8.0	9.2	10.2	9.2	
-- % women aged 50 to 64	8.8	6.3	4.3	3.0	3.7	3.8	4.3	4.0	6.3	7.5	6.8	6.4	5.8	6.2	6.6	7.0	8.3	
Poverty risk among the pensioners	18.7	13.7	10.9	6.6	6.8	6.7	6.9	6.4	9.0	8.9	10.5	10.1	10.4	10.7	12.7	15.2	13.9	
-- % men aged 65+	10.4	6.6	3.6	1.9	2.8	3.7	3.6	4.1	6.7	5.9	6.4	6.2	7.3	7.3	8.4	10.7	10.6	
-- % women aged 65+	23.5	17.6	15.0	9.4	9.1	8.6	8.9	7.8	10.5	10.8	13.1	12.7	12.4	13.0	15.6	18.3	16.1	
Poverty risk of population aged 65 to 74	14.6	10.5	7.9	4.9	3.6	4.8	4.5	4.4	7.9	7.3	8.3	7.5	9.3	7.2	8.7	12.3	11.0	
-- % men aged 65 to 74 *	8.5	5.3	3.4	2.3	2.6	2.6	3.0	4.2	7.4	6.7	6.6	5.9	7.4	6.9	7.5	11.1	10.4	
-- % women aged 65 to 74	18.4	13.9	10.8	6.7	4.3	6.3	5.6	4.6	8.3	7.7	9.6	8.8	10.8	7.5	9.7	13.3	11.5	
Poverty risk of population aged 75+	26.1	19.6	16.4	9.9	12.7	10.5	11.1	9.9	11.1	11.7	14.2	14.4	12.1	16	18.8	19.6	18.1	
-- % men aged 75+ *	14.2	10.1	4.0	0.9	3.4	6.6	5.1	3.9	4.8	3.8	6.0	6.8	7.1	8.2	10.2	10.0	11.0	
-- % women aged 75+	32.1	23.5	21.8	13.9	17.0	12.2	13.9	12.5	13.7	15.2	18.0	18.0	14.4	19.8	23.0	24.5	21.7	
Poverty risk of single parents *	9.5	10.8	10.9	12.1	7.5	8.2	8.2	12.0	14.9	22.5	22.3	22.7	25.4	25.6	26.8	25.4	25.2	
Poverty risk among the unemployed, percentage of total unemployed																		
-- % of unemployed	27.1	21.6	16.9	15.1	19.0	19.8	23.7	24.8	32.4	34.2	38.3	37.8	40.1	37.8	40.5	44.4	43.7	
-- % unemployed men	32.2	23.4	17.5	17.2	23.1	23.6	29.0	30.4	39.6	41.3	48.0	43.4	47.0	44.4	45.3	50.0	47.8	
-- % unemployed women	18.9	18.8	16.0	12.1	13.7	15.4	18.1	19.1	25.6	27.5	29.1	32.6	32.3	30.1	34.9	38.1	39.3	
Poverty risk among wage-earners, percentage of total wage-earners																		
-- % of wage-earners	1.9	1.9	1.4	1.2	1.2	1.5	2.3	2.0	2.2	2.3	2.8	2.5	2.8	2.8	2.4	2.7	2.7	
-- % wage-earning men	1.8	1.7	1.5	1.3	1.1	1.4	2.4	2.1	2.6	2.0	2.7	3.0	2.7	3.0	2.3	2.8	2.9	
-- % wage-earning women	2.0	2.1	1.4	1.1	1.4	1.5	2.1	2.0	1.7	2.7	2.9	1.9	2.8	2.7	2.5	2.7	2.5	

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1.10 Individual poverty rate before income transfers																		
Percentage of persons living in households below the poverty line, based on net factor income + pensions (%)																		
-- % of the population	16.2	19.4	23.6	25.6	26.4	25.8	24.8	24.8	23.5	23.0	21.8	26.7	26.7	26.6	26.2	26.3	26.0	
Percentage of persons living in households below the poverty line, based on net factor income alone (%)																		
-- % the population	32.9	35.7	40.3	43.3	43.9	43.0	42.6	42.1	40.6	39.9	39.0	39.3	39.3	39.6	39.1	38.7	39.0	
1.11 Persistent poverty																		
Percentage of persons below the 60% poverty llevel at least three out of four years (%)																		
-- % the population									4.7	5.3	5.9	6.5	6.9	7.3	7.6	7.9	8.4	
1.12 Inequity of income (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	2.9	2.9	2.9	3.0	3.2	3.4	3.6	3.7	3.6	3.6	3.6	3.7	3.8	3.9	
1.13 Poverty gap: difference between the poverty level and the median income of those below the poverty level, as % of the poverty level																		
-- Median income of those below the poverty level. eur/year	8600	8550	8180	7820	7920	8090	8380	8410	8780	9140	9210	9300	9570	9920	10220	10630	10580	
-- total	13.5	15.1	14.4	14.2	13.7	13.5	12.6	14.4	13.8	13.1	13.3	14.6	14.9	13.9	15.2	15.0	15.1	
-- men	13.4	14.9	16.5	18.0	15.1	14.3	13.6	13.8	14.0	12.3	12.5	14.5	15.9	14.3	15.1	15.9	16.0	
-- women	13.5	15.9	12.0	12.6	12.2	12.9	11.9	15.3	13.7	14.4	14.7	14.6	14.1	13.7	15.2	13.9	14.4	
1.14 Poverty rate at various relative poverty levels																		
-- 40% of the median	1.3	1.6	1.4	1.5	1.2	1.4	1.5	1.7	1.8	1.6	1.4	1.9	2.1	2.0	2.2	2.0	2.1	
-- 50% of the median	3.4	3.7	3.2	3.0	3.0	3.1	3.5	3.7	4.3	4.3	4.5	5.0	5.3	4.8	5.5	5.7	5.8	
-- 70% of the median	16.1	15.6	14.0	13.9	14.6	15.2	16.7	17.2	19.3	19.0	20.0	19.7	20.1	20.4	20.3	21.2	21.0	
1.15 Poverty rate at fixed poverty level (poverty level inflation adjusted for 1995 and 2000: 60% of the median)																		
-- poverty level, inflation adjusted for 1995	6.0	5.7	6.4	7.4	7.4	7.2	7.5	6.5	6.7	5.8	6.0	5.8	5.2	4.2	4.0	3.2	3.4	
-- poverty level, inflation adjusted for 2000	11.1	9.7	11.3	13.8	14.0	13.4	13.4	12.1	11.6	10.7	11.3	10.1	9.1	8.2	7.3	6.3	6.4	
LAST-RESORT SOCIAL WELFARE BENEFITS																		
1.16 Social assistance																		
-- persons receiving social assistance t during the year	314 000	396 100	464 600	528 100	577 300	584 100	609 700	593 800	534 900	492 700	454 400	443 200	429 800	424 100	401 000	377 400	358 400	349 600
-- percentage of persons receiving social assistance, % 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	6.8	6.6
-- households receiving social assistance during the year	181 600	222 700	258 900	292 600	329 300	339 000	349 600	344 700	313 300	292 000	271 7000	264 100	262 600	261 400	251 000	238 800	226 600	221 100
-- percentage of single-parent households, % of households receiving social assistance	..	..	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	25.2	23.9	
-- households receiving social assistance 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	57 000	55000	

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
-- percentage of households receiving social assistance for 10 to 12 months of the year, % of the households receiving social assistance	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	24.1	24.5	
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	4.5	4.2

* NB. Since estimates for some variables are based on a small sample, caution is required when interpreting the figures

2 HEALTH PROBLEMS	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
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	11.0	10.5	8.1
- 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	7.1	7.4	7.8
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	..	16.5	..	16.0	..	
- women, %	..	..	..	30.3	..	25.6	..	29.5	..	27.7	..	27.4	..	26.0	..	26.4	..	
SOCIAL-BASED HEALTH DIFFERENCES																		
2.3 Life expectancy of 35-year-olds by social groups (managers= 100)																		
-managers, men	100.0	..	..	..	..	100.0	..	..	..	..	100.0	..	..	..	..	100.0		
-white-collar workers, men	94.5	..	..	..	..	94.9	..	..	..	..	94.7	..	..	..	..	95.0		
-blue-collar workers, men	86.4	..	..	..	..	86.7	..	..	..	..	86.5	..	..	..	..	86.7		
-farmers, ment	92.1	..	..	..	..	93.2	..	..	..	..	92.1	..	..	..	..	93.5		
-managers, women	100.0	..	..	..	..	100.0	..	..	..	..	100.0	..	..	..	..	100.0		
-white-collar workers, women	97.7	..	..	..	..	98.1	..	..	..	..	98.2	..	..	..	..	97.4		
-blue-collar workesrs, women	94.0	..	..	..	..	93.9	..	..	..	..	93.4	..	..	..	..	93.2		
-farmers, women	94.9	..	..	..	..	95.9	..	..	..	..	95.0	..	..	..	..	94.4		

3 EXCLUSION FROM THE LABOUR MARKET	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	**2006**	**2007**
UMPLOYMENT																		
Umployment 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	7.7	6.9
-- 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	7.4	6.5
-- woman	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	8.1	7.2
Umployment rate among forelgners, %																		
-- total	..	..	..	..	53.0	49.0	48.0	44.0	39.0	37.0	31.0	31.1	28.4	28.6	29.0	28.0	24.0	20.0
-- men	..	..	..	..	..	..	..	..	..	..	..	25.8	24.0	24.6	..	21.0	19.0	17.0
-- women	..	..	..	..	..	..	..	..	..	..	..	37.7	34.0	33.7	..	31.0	28.0	25.0
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	18.7	16.5
-- 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	19.0	16.4
-- 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	18.4	16.6
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	1.8	1.6
-- 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	2.0	1.7
-- 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	1.7	1.4
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	64 793	52 037
-- 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	28 860	24 937
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	67 000	66 100
-- % 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	12.6	13.4
Distribution of regional emloyment rates (NUTS2 level)																		
-- total	..	..	..	..	..	..	7.4	7.1	7.4	6.7	6.8	7	6.7	6.1	5.5	5.5	5.4	
-- men	..	..	..	..	..	..	7.8	7.6	7.0	6.5	6.2	6.4	6.3	5.7	5.2	5.1	5.1	
-- women	..	..	..	..	..	..	7.6	7.2	8.4	7.4	7.8	8.1	7.6	6.7	6.2	6.1	5.9	
MEASURES TO PROMOTE EMPLOYMENT																		
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	38 100	38 700
-- 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	58.0	56.4
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	29 400	30 700

NON-PARTICIPATION IN WORK

3.10 Rate of non-participation during the year

According to Income distribution statistics

Total number of 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 (exluding student households).

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	**2006**	**2007**
-- total	3.4	4.8	8.4	11.5	12.9	11.3	10.5	10.3	9.2	9.0	8.8	8.0	7.8	8.2	8.1	7.6	7.5	
-- men	3.3	4.8	8.2	11.8	12.8	11.0	10.1	10.4	8.9	9.1	8.9	7.8	7.5	8.0	8.1	7.4	7.0	
-- woman	3.5	4.9	8.5	11.2	12.9	11.5	10.8	10.3	9.5	8.9	8.8	8.2	8.0	8.4	8.1	7.8	7.9	
-- children (aged 0-17)	2.1	3.9	8.0	10.5	11.8	9.9	8.9	8.8	7.6	7.9	8.4	7.6	7.0	7.1	7.4	6.7	6.4	

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

-- total	..	..	..	..	..	..	..	..	..	..	..	..	..	10.9	11.0	10.5	9.5	
-- men	..	..	..	..	..	..	..	..	..	..	..	..	..	11.6	11.2	11.0	10.1	
-- women	..	..	..	..	..	..	..	..	..	..	..	..	..	10.3	10.9	10.0	9.0	
-- children (aged 0-17)	..	..	..	..	..	..	..	..	..	..	..	..	..	5.7	5.7	6.6	4.9	

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

** Variation coefficient fro regional employment rates (15 to 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	**2006**	**2007**
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	10.1	9.9	9.7
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	19.5	18.9	18.4
4.3 Households 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 number 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	7 399	7303
-- immigrants	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	1 647	1474
-- outdoors, in temporaty shelters or night shelter	3 690	3 340	3 030	2 410	2 170	2 110	2 110	2 450	2 350	2 390	2 415	2 080	2 080	1 644	1 547	1563	1 575	1596
-- temporarely with friends of 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	4 177	4233
-- women, %	..	..	..	..	..	..	18.7	25.6	19.6	18.2	17.5	17.5	17.3	19.2	19.0	19.3	18.3	19.6
-- under 25, %	..	..	..	..	..	..	15.7	22.0	19.8	18.4	17.5	16.8	16.7	19	18.6	18.4	18.9	18.2
4.5 Homeless families																		
-- total	800	700	570	250	380	560	360	600	820	780	780	780	770	415	357	355	295	305
-- immigrants	..	..		..	..	..	..	..	..	..	..	130	210	79	80	50	42	47

5 EXCLUSION FROM EDUCATION	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
INADEQUATE EDUCATION																	
Not completed comprehensive education																	
-- dropouts. those receiving a leaving certificate and those who left without a certificate	*)	*)	*)	*)	*)	*)	*)	*)	193	210	191	161	178	218	178	152	
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	9.3	8.3
-- men			..	..	..	..	11.4	9.1	8.6	12.0	9.8**	13.0	12.6	10.1	10.6	11.3	10.4
-- women			..	..	..	..	10.8	7.0	7.2	7.9	5.1**	7.7	7.3	6.5	6.9	7.3	6.4

*) no comparable data for 1990 - 1998

** 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	2006	2007
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	19000	No data available	
-- % 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	5.9		
-- 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	6.2		
-- 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	5.6		
Persons aged 20-24																		
-- number	..	..	..	..	..	25 000	24 000	19 000	18 000	18 000	17 000	17 000	18 000	18 000	18 000	18000		
-- % 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	5.3		
-- 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	5.5		
-- 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	5.1		
6.2 Children subject to child welfare																		
Children and young people in open care	..	..	..	24 700	27 800	30 700	33 300	35 800	39 666	43 679	49 351	49 610	54 326	56 379	59 912	59 101	59 058	62 485
Children and young people placed outside the home																		
-- total	..	8 700	9 400	9 700	10 200	10 955	11 374	11 836	11 979	12 294	12 861	13 521	14 182	14 380	14 829	15 351	15 774	16 059
-- children palced 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	1.2	1.2
-- number of the above taken into custodial care	..	6 200	6 400	6 400	6 400	6 389	6 509	6 785	6 810	6 946	7 327	7 509	7 991	8 412	8 786	9 295	9 605	10 207

* Time series is corrected. Those in military service or in pension are left out.

CRIMINALITY, SELF-DESTRUCTIVENESS, INTOXICANT PROBLEMS																		
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	3 577	3 888	3 778	3 551
-- 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	6.2	6.5	6.9
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	33 372	33 609	37 554
-- rate per 10000 persons	52.8	50.1	45.4	43.1	44.9	48.8	53.4	53.7	55.0	55.7	58.8	57.9	58.9	60.8	62.6	63.7	63.9	71.2

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	**2006**	**2007**
6.5 Youth crime																		
-- persons aged 15 to 20 suspected of crimes investigated by police	126 227	114 130	122 188	111 726	109 817	118 470	111 290	102 749	101 963	103 896	113 242	110 422	107 596	107 718	110 810	111 266	101 148	107 671
6.6 Suspects in narcotics-related crimes																		
-- rate per 10000 persons	4.6	4.5	6.4	7.8	11.5	18.8	16.9	18.6	18.6	23.5	27.7	30.9	28.9	28.8	29.6	29.5	25.6	28.9
-- 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	15 425	13 453	15 231
-- 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	2 527	2 139	2 338
6.7 Suicides																		
-- number																		
-- men	1198	1189	1156	1107	1080	1080	965	1038	962	954	873	933	824	815	812	724	803	
-- women	322	304	296	291	307	309	282	284	266	253	292	271	271	260	252	270	259	
Age-adjusted mortality per 100000 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	27.0	30.0	
-- 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	9.6	8.9	
ALCOHOL																		
6.8 Alcohol-related deaths	2500	2475	2535	2476	2467	2541	2257	2251	..	2474	2411	2454	2431	2507	2830	3011	3033	
-- alcohol ailment or similar as primary cause of death	1417	1341	1341	1372	1326	1483	1316	1246	1503	1428	1477	1490	1465	1560	1864	2033	2032	
-- deaths by accident or violence while intoxicated	1036	1074	1123	1059	1097	1020	901	967	..	1001	879	887	913	896	966	978	1001	
-- total number of deaths directly or indirectly caused by alcohol									3 581	3 593	3 578	3 566	3 648	3 754	4 271	4 527	4640	
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	no data available		
-- 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	no data available		
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*	174	183	
6.11 Persons treated in hospital for drug-related ailment																		
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	no data available		
-- 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	no data available		

	1990	1991	1992	1993	1994	1995	1996	1997	1998	19991	2000	2001	2002	2003	2004	2005	2006	2007
6.12 Clients in open intoxicant care during the year																		
-- Alcohol out-patient 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	42 700	44 300	46 00
-- 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	5 800	5 300
INTOXICANTS																		
6.13 Persons treated in hospital for intoxicants per 1000 persons																		
total							4.0	4.0	4.0	4.0	4.0	3.9	3.9	3.8	4.0	4.0	4.0	
men							6.2	6.1	6.2	6.0	6.1	5.8	5.7	5.6	6.0	5.9	5.8	
women							1.9	1.9	2.0	2.0	2.1	2.1	2.1	2.1	2.2	2.2	2.2	

Annex to the report: Characteristics of the social security system in Finland[51]

The Finnish statutor social insurance is intended by law to protect everyone (usually all residents) from the financialy impact resulting from old age, work disability, sickness, unemployment and the death of dependents. The aim of social insurance benefits is to secure a reasonable income if such a risk is realised.

Social insurance comprises the coverage provided by pension insurance, sickness insurance, unemployment insurance and accident insurance. Taken together they make up the statutory system of social insurance. In addition, vehicle owners must pay traffic insurance. Another form of insurance is group life insurance for employees, which is not statutory but practically universal. Benefits based on social insurance may be grouped into two groups: some are based on working and their amounts are earnings-related, some are minimum benefits guaranteeing a minimum level of security.

In addition to compulsory insurance coverage, there is voluntary additional insurance intended to complement statutory insurance. In addition to insurance-based income benefits, the Finnish system includes organisations, NGOs and parishes, a so-called third sector complementing statutory benefits mainly by providing services and some financial support as one-off payments.

During recent decades, social insurance benefits have developed into insurances that take people's consumption levels during employment into consideration and which are proportionate to their earnings level and provide supplementary minimum income support. Earnings related benefits are funded by salary based payments and accident insurance related payments that are proportionate to the risk assessment concerning the insured. Minimum income support is funded mainly by taxation and tax-like payments. Unlike many other countries, the right to minimum security does not require the payment of insurance contributions.

Who is covered by the Finnish social security system?

The Finnish social security system consists of benefits based on residence and employment. The Finnish statutory social security system covers all persons permanently resident in Finland. Further conditions are attached to the award of some benefits, relating mainly to duration of residence. The earnings-related pension scheme and accident and occupational disease insurance are areas of social security based exclusively on employment.

Financing of Social Security

As a rule, the State finances basic security benefits and earnings related security is financed through employers' and employees' insurance contributions. Benefits based on the Sickness Insurance Act are financed through the insurance contributions of employers, employees and those receiving benefits. In addition, the State participates in financing these benefits. Earnings-related unemployment benefits are financed through the unemployment insurance contributions of employers, entrepreneurs and employees, and for a small part by the State. Sickness insurance based on residence in Finland is financed by the insured and the state. The local authorities finance healthcare services through local taxation and fees paid by clients. In addition, the

[51] Toimeentuloturva kehdosta nojatuoliin, Sosiaali- ja terveysministeriön esitteitä 2007:10, s. 4-8 (The Finnish Social security system from the Cradle to the Grave. Brochures of the Ministry of Social Affairs and Health 2007:10, pp. 4-8.)

government pays central government transfers for the funding of social and health services to local authorities.

Earnings-related pensions are financed through the insurance contributions of employers and employees. Contributions from the State ensure that self-employed persons, farmers and seamen are entitled to the same earnings-related benefits as wage and salary earners.

National pensions are financed through employers' insurance contributions and State funding. Health Employment accident and occupational disease insurance is based on employers' contributions.

Earnings-related unemployment benefits are financed through the unemployment insurance contributions of employers and employees, the unemployment funds' membership payments and government funding. Basic unemployment allowances are financed by the State and partly by those not participating in unemployment funds. Labour market support is financed by the state and local authorities.

Administration and organisation

The Ministry of Social Affairs and Health is responsible for social security legislation and the general development of the social security system. This system is run by a variety of organisations. A particular feature of the social insurance system is that some aspects of it are handled by private insurance companies that act like government officials.

Social security benefits based on residence are administered by the Social Insurance Institution (Kela). This is an autonomous body under public law supervised by the Finnish Parliament. Kela is the primary source of information for those seeking more information on benefits.

Earnings-related pension system and employment accident and occupational disease insurance are not based on residence but on work, and private insurance institutions are responsible for them.

Pensions

The Finnish Centre for Pensions (ETK) is the coordinating agency for the earnings-related pension insurance scheme falling under so-called intermediate public management. International pension and insurance matters also fall within its jurisdiction. Earnings-related pension insurance for private sector employees is handled by pension insurance companies, pension funds and pension foundations.

Insurance and pension institutions are supervised by the Insurance Supervisory Authority.

The pension schemes of State employees are administered by the State Treasury and those of local authority employees by the Local Government Pensions Institution. The Finnish Social Insurance Institution (Kela) is responsible for the national pension system complementing the earnings-related pension system as well as for family pensions.

The Seamen's Pension Fund is responsible for implementing the pensions of seamen, the Farmers' Social Insurance Institution (Mela) for implementing those of farmers and the Central Fund of the Evangelical Lutheran Church of Finland for implementing the pensions of those working for the Evangelical Lutheran Church.

Accidents

Accident insurance institutions are responsible for the accident and occupational disease insurance of private sector employees. The State Treasury administers the accident insurance of State employees. The Federation of Accident Insurance Institutions is the umbrella organisation.

Sickness insurance

There are two parallel systems concerning health and medical care in Finland: Kela is responsible for reimbursements to patients for the costs of treatment based on sickness insurance, and the related daily allowances, and local authorities are responsible for public health care services.

Unemployment

The Social Insurance Institution is responsible for basic unemployment provision. Unemployment funds, operated in conjunction with trade unions, are generally responsible for the administration of earnings-related unemployment benefits. Membership of such funds is voluntary.

Appeal

A person obtains decisions relating to social security in writing, and at the same time he/she receives appeal instructions in writing. If the person is dissatisfied with a decision, he or she may appeal against it. An appeal against a decision may be lodged with the authority that made the decision. This authority must ensure that the appeal is handled by the institution in order to self-correct the decision or that it is referred directly to the appeals board handling the matter.

The appeals system concerning social security matters is mainly a two-stage process. The first instance of appeal is usually the appeals board. An appeal against a decision made by the appeals board may be lodged with the Insurance Court. The Insurance Court is the supreme appellate level in cases other than those relating to employment and military accident insurance, where an appeal may be lodged with the Supreme Court. With respect to compensation concerning traffic and patient accident insurance, pharmaceutical injury compensation and voluntary insurance, the appeals system is a three-stage process, where the first instance of appeal is the District Court. An appeal against a decision made by the District Court may be lodged with the Court of Appeal (second appellate level) and the Supreme Court (the supreme appellate level).

Appeal Boards

- Social Security Appeal Board
- Unemployment Appeal Board
- Student Financial Aid Appeal Board
- Earnings-related Pension Appeal Board
- Employment Accidents Appeal Board
- Traffic Accident Board

Annex 3: Figures and Tables

Figure 1. Expected age of retirement (Source: Finnish Centre for Pensions ETK)

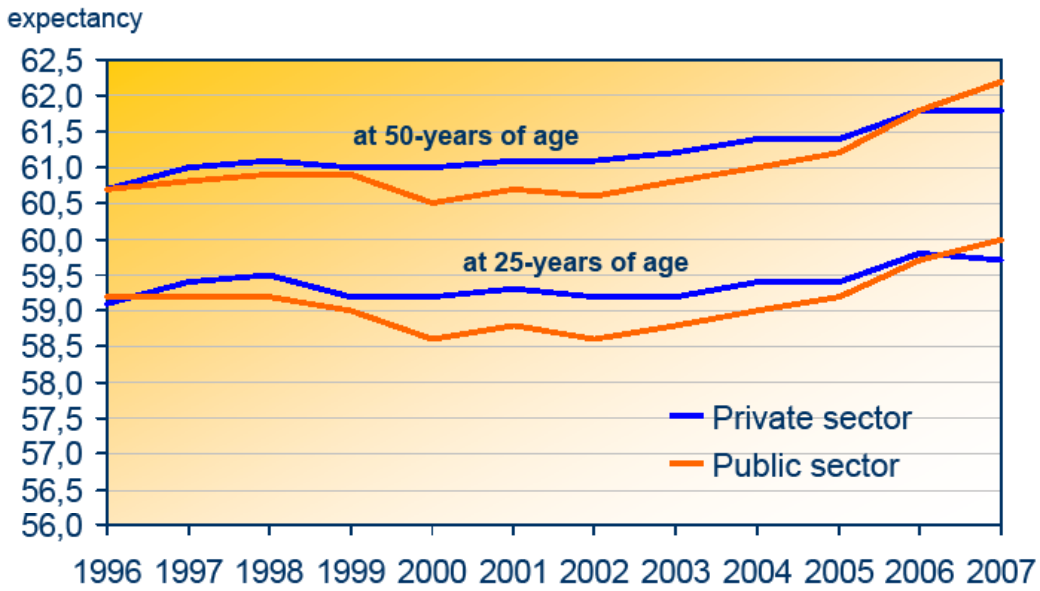


Figure 2. Number of all pension beneficiaries by pension component in 1998-2007 (Source: Finnish Centre for Pensions ETK)

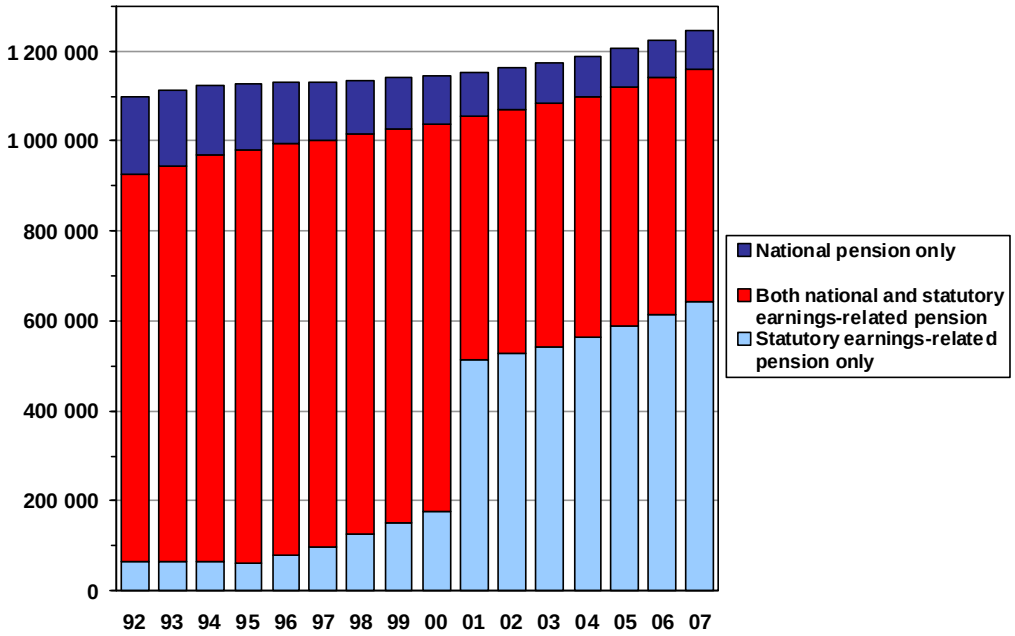


Table 1. Proportion of earnings-related pension, national pension and SOLITA pension[1] of average total pension in 2007 (Sources: Finnish Centre for Pensions ETK and Social Insurance Institution KELA)

	Women	Men	All
Average total pension, EUR/month	1064	1357	1191
Proportion of earnings-related pension of total pension, %	80	88	84
Proportion of national pension of total pension, %	18	10	14
Proportion of so-called SOLITA-pension[1], %	2	2	2

[1] Motor liability insurance, worker's compensation and military injuries (SOLITA)

Figure 3. Number of people who have earned their pensions under different employees pensions acts (estimate) 31.12.2007
(Source: Finnish Centre for Pensions ETK).

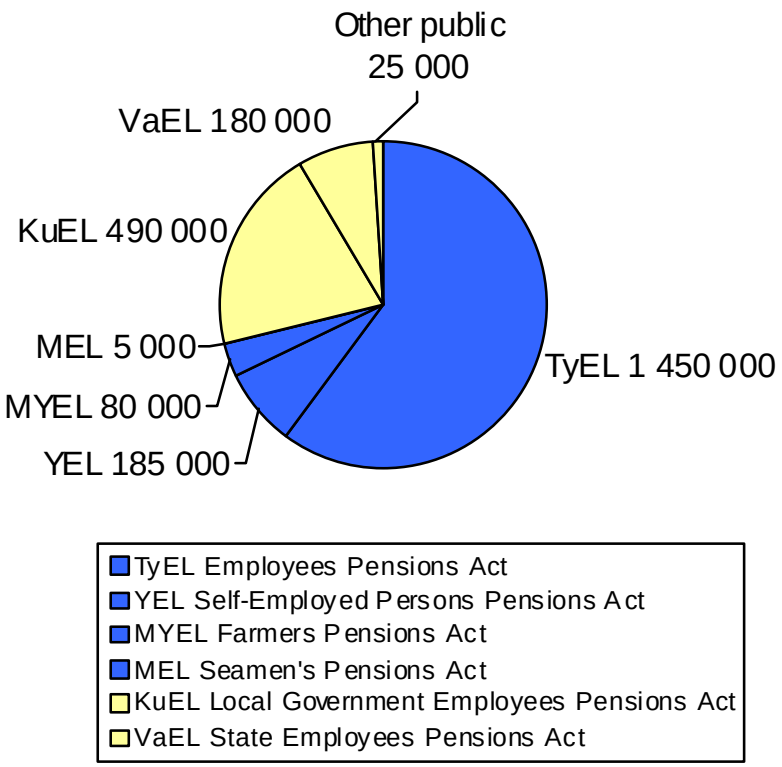


Table 2. Pension in one's own right (earnings-related and national pension) of pension recipients resident in Finland in 2006. (Source: Finnish Centre for Pensions ETK)

	Gross pension €/month	Net pension €/month	Pension % of earnings of economically active	
			Gross	Net
Pension recipients				
Old age pension	1 145	929	46	54
Disability pension	1 014	866	41	50
Unemployment pension	1 136	924	46	54
Special pension for farmers	822	748	33	43
Total	1 113	911	45	53
New retirees				
Old age pension	1 558	1 171	63	68
Disability pension	946	828	38	48
Unemployment pension	1 150	931	46	54
Special pension for farmers	790	730	32	42
Total	1 225	952	49	56

Earnings of economically active in 2006: Gross 2 483 €/month; Net 1 720€/month.

Figure 4. Average pension of recipients of earnings-related pension in 1992-2005, % of average earnings (Source: Finnish Centre for Pensions ETK)

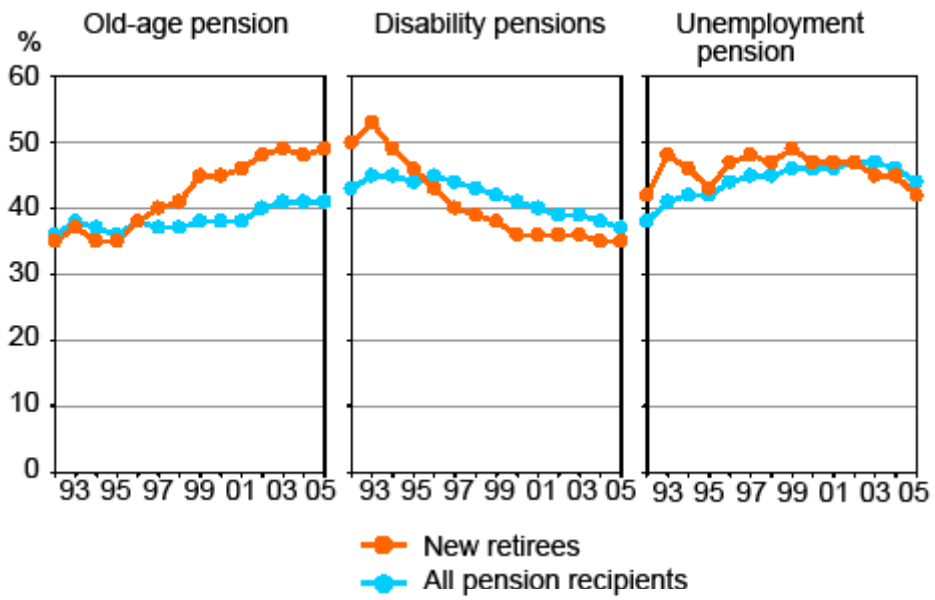


Table 3. Amounts of parts of/ supplements to pension in 2008 (Source: Social Insurance Institution KELA)

Parts of/ supplements to pension (full allowance for singles)	**EUR/month**
National pension	558,46
Front veteran's supplement (tax free)	43,63
Front veteran's additional supplement (tax free)	210,71
Child increase/child (tax free)	19,48
Care allowance for pensioners (tax free)	
- Care allowance	54,80
- Higher rate	136,43
- Special rate	288,49
- Compensation for diet expenses	21,00
Housing allowance (tax free, full amount)	
- Greater Helsinki Area	560,85[1]
- Other Finland	475,28/389,65[1]

[1] The average housing allowance was in 05/08 159,52 EUR/month

Figure 5 a. The real level of wage index, earnings-related pension index and national pensions index 1962-2008, year 1962= 100 (Source: Social Insurance Institution KELA)

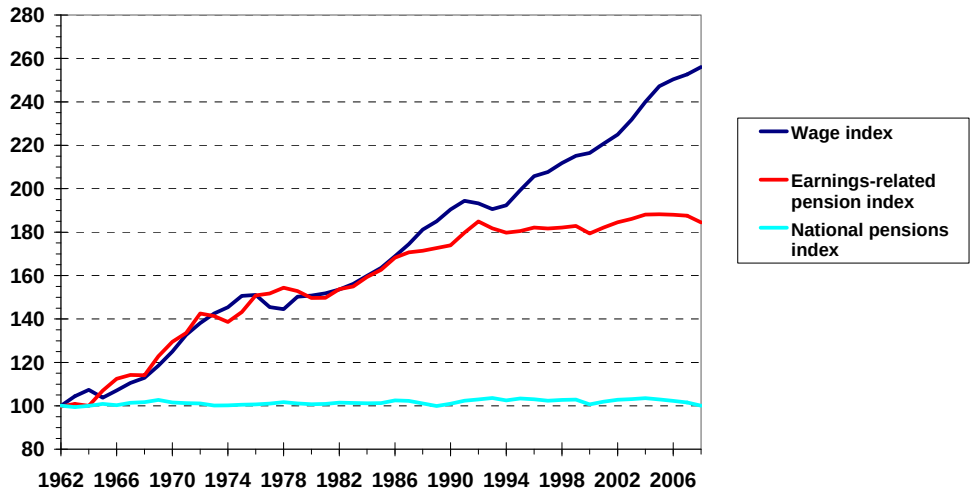


Figure 5 b. The real level of wage index, earnings-related pension index and full amount of national pension 1962-2008, year 1984=100 (Source: Social Insurance Institution KELA)

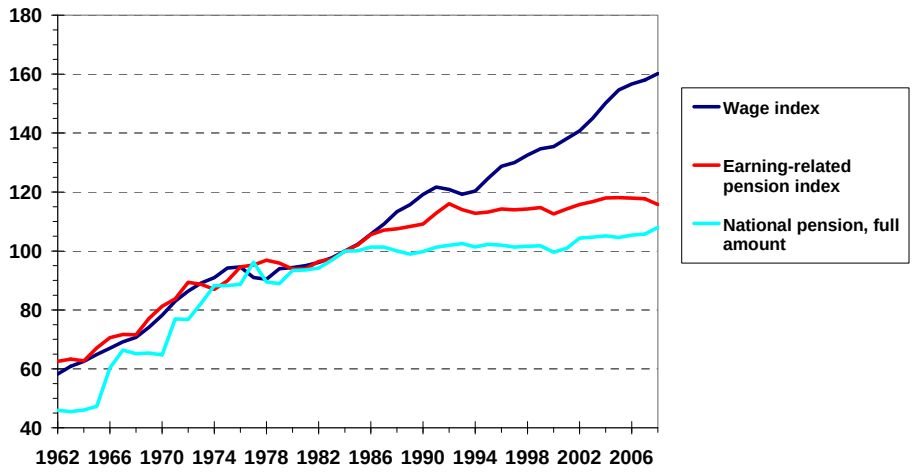


Figure 6.

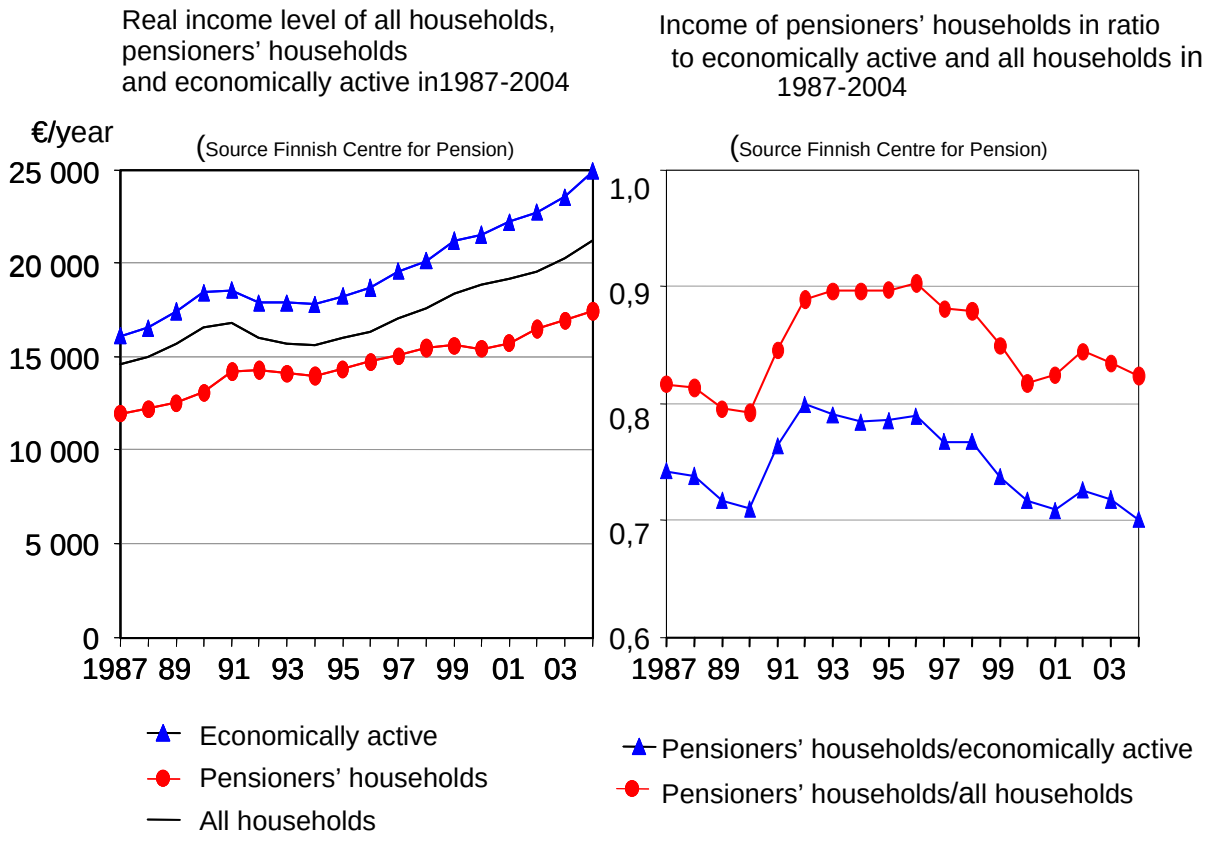


Table 4. Theoretical pension replacement rates in 2006 and projected for 2046, (%)
(Source: OECD, Finnish Centre for Pensions ETK)

	Base case 100 % of average earnings, replacement rate 10 years after retirement	
	2006	**2046**
Gross replacement rate 1st pillar	64	55
Gross replacement rate 2nd pillar	-	-
Total gross replacement rate	64	55
Total net replacements rate	69	61

Theoretical replacement rate of a male worker with a career length of 40 years full-time work at average earnings with contributions to first and second pillar pension schemes, retiring at the age of 65 years.

Table 5. Pension replacement rate of an average wage and salary earner before and after taxes, retired in 2003 (Source: Finnish Centre for Pensions ETK)

	Gross	Net
All wage and salary earners	62	67
Private sector	57	64
Public sector	66	70

Table 6. Proportion of people on low incomes by age and gender in 1993-2006 (Source: Statistics Finland, Income Distribution Statistics 2006)

60 per cent of the median of equivalent income

Gender and age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	6,4	6,9	7,2	8,5	8,3	9,8	10,2	11,3	11,2	11,4	11,5	12,2	12,8	12,5
65+	6,6	6,8	6,7	6,9	6,4	9,0	8,9	10,5	10,1	10,4	10,7	12,7	15,2	13,9
Men	6,5	7,2	7,4	8,6	8,4	9,7	9,8	11,0	11,3	11,6	11,4	11,8	12,4	11,8
65+	1,9	2,8	3,7	3,6	4,1	6,7	5,9	6,4	6,2	7,3	7,3	8,4	10,7	10,6
Women	6,4	6,6	7,0	8,4	8,1	10,0	10,6	11,5	11,2	11,2	11,6	12,5	13,0	13,3
65+	9,4	9,1	8,6	8,9	7,8	10,5	10,8	13,1	12,7	12,4	13,0	15,6	18,3	16,1

50 per cent of the median of equivalent income

Gender and age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	3,0	3,0	3,1	3,5	3,7	4,3	4,3	4,5	5,0	5,3	4,8	5,5	5,7	5,8
65+	1,1	1,0	1,2	1,5	1,9	2,4	2,3	3,4	2,6	2,1	2,8	3,4	3,5	3,4
Men 65+	0,4	0,6	0,4	0,6	1,2	0,4	0,1	1,6	1,4	1,8	1,3	2,3	2,7	3,7
Women 65+	1,5	1,2	1,6	2,0	2,4	3,0	3,0	4,6	3,4	2,4	3,7	4,2	4,0	3,3

Table 7. **Distance from the poverty threshold of the median income for population below the threshold for low income** (Source: Statistics Finland, Income Distribution Statistics 2006)

60 per cent of the median of equivalent income

Gender and age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	14,2	13,7	13,5	12,6	14,4	13,8	13,1	13,3	14,6	14,9	13,9	15,2	15,0	15,1
65+	6,2	7,1	7,3	7,7	7,8	8,1	9,6	8,0	8,1	7,6	9,4	10,4	9,0	9,4
Men	18,0	15,1	14,3	13,6	13,8	14,0	12,3	12,5	14,5	15,9	14,3	15,1	15,9	16,0
Women	12,6	12,2	12,9	11,9	15,3	13,7	14,4	14,7	14,6	14,1	13,7	15,2	13,9	14,4

Table 8. Low income rate with a fixed threshold for low income[1],%
(Source: Statistics Finland, Income Distribution Statistics 2006)

60 % of the median of equivalent income

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
The threshold for low income calculated from the median for each year:	6,4	6,9	7,2	8,5	8,3	9,8	10,2	11,3	11,2	11,4	11,5	12,2	12,8	12,5
Fixed threshold for low income:														
In 2000														
Whole population	13,8	14,0	13,4	13,4	12,4	11,6	10,7	11,3	10,1	9,1	8,2	7,3	6,3	6,4
Population +65	20,5	19,4	17,5	14,5	13,1	11,7	9,6	10,5	8,1	6,1	6,3	5,7	4,3	4,4
Women 65+	26,7	24,2	22,8	19,2	16,5	13,8	11,6	13,1	10,3	7,2	8,2	7,2	4,7	4,4
Men 65+	9,9	11,2	8,7	6,6	7,8	8,5	6,4	6,4	4,7	4,4	3,5	3,4	3,6	4,4

1 Inflation adjusted median income in 2000.

50 %of the median of equivalent income

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Fixed threshold for low income:														
In 2000														
Whole population	5,4	5,7	5,4	5,8	5,0	5,1	4,5	4,5	4,5	4,0	3,5	3,1	2,6	2,6
Population +65	4,8	4,6	4,0	3,4	2,8	3,0	2,6	3,4	2,1	1,3	1,5	1,1	0,5	0,8
Women 65+	6,7	5,9	5,2	4,5	3,8	3,7	3,5	4,6	2,9	1,3	1,8	1,2	0,5	0,7
Men 65+	1,5	2,4	2,0	1,5	1,3	1,8	1,1	1,6	0,7	1,1	1,0	0,9	0,6	0,9

1 Inflation adjusted median income in 2000.

Figure 7. Estimate on effect of life expectancy coefficient on pension level and extra work needed to compensate the effect (Source: Finnish Centre for Pensions ETK, Statistics Finland)

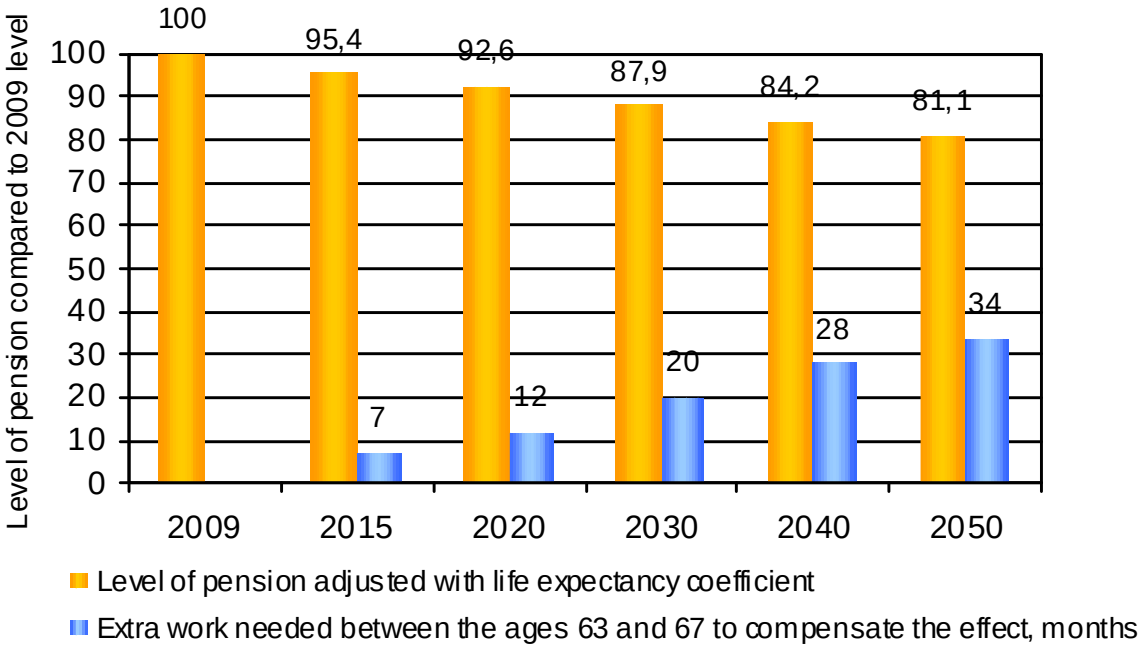


Figure 8. Statutory Pension expenses in percent of GDP in 1960-2075 (Source: Finnish Centre for Pensions ETK)

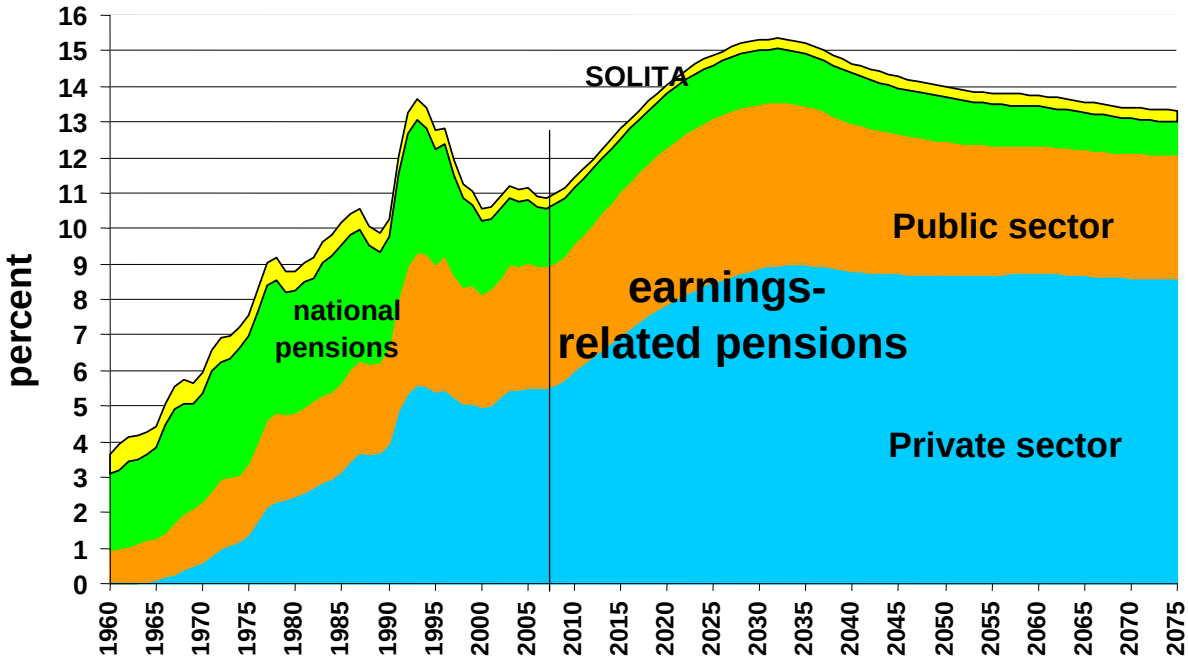


Table 10 a: Pension contributions, pension funds and pension benefits paid in Finland, in ratio to GNP in 2007 (estimates) (Sources: Insurance Supervisory Authority, Social Insurance Institution KELA, Federation of Finnish Financial Services)

% of GDP	*1st pillar: statutory schemes*	*2nd pillar: volontary collective schemes*	*3rd pillar: individual schemes*	***Total***
Contributions	11,1	0,2	0,3	11,1
Funds at end-year	69,8	5,6	5,6	81,0
Benefits paid	10,1	0,3	0,2	9,0

Table 10 b: Income, funds and proportions of pensions in Finland 2007
(Sources: Insurance Supervisory Authority, Social Insurance Institution KELA, Federation of Finnish Financial Services)

	1st pillar: statutory schemes	*2nd pillar: volontary collective schemes*	*3rd pillar: individual schemes*	***Total***
Contributions	95 %	2 %	3 %	100 %
Funds at end-year	86 %	7 %	7 %	100 %
Benefits paid	95 %	3 %	2 %	100 %

Figure 9. TyEL contribution rate by contributor, as a percentage of covered incomes in 2006-2075. (Source: Finnish Centre for Pensions ETK)

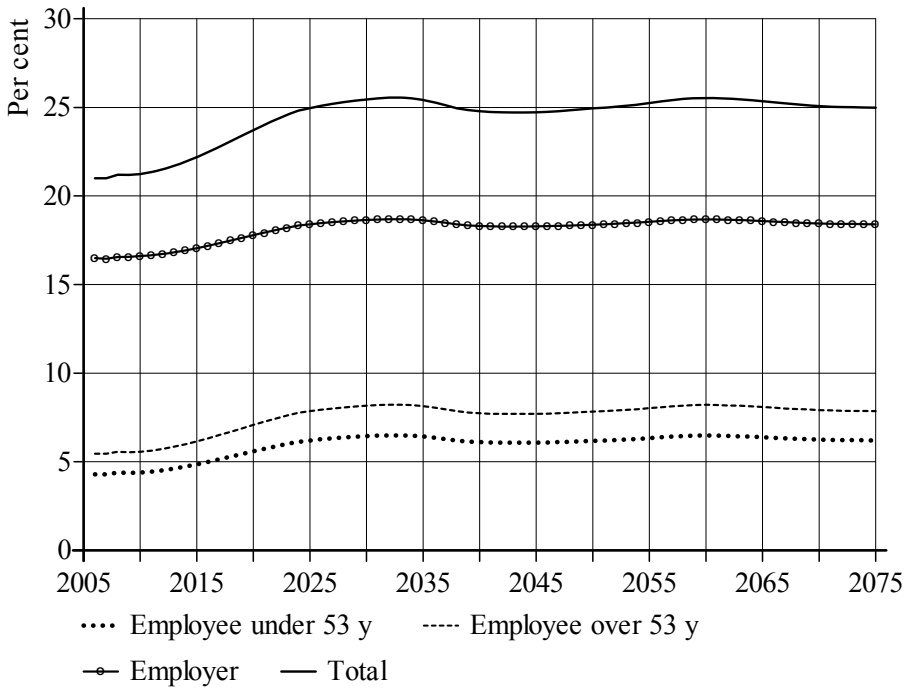


Table 9. Development of the average employer's national pension contribution (Source: Social Insurance Institution KELA)

	2007	2008*	2009*	2010*	2011*	2012*
Contribution category, % of wages and salaries						
I contribution category	0,901	0,801	0,802	0,802	0,802	0,79
II contribution category	2,101	3,001	3,002	3,002	3,002	2,99
III contribution category	4,001	3,901	3,902	3,902	3,902	3,89
State	1,951	1,851	1,852	1,852	1,852	1,84
Municipalities	1,951	1,851	1,852	1,852	1,852	1,84
Church	1,951	1,851	1,852	1,852	1,852	1,84
Employers total, average	**1,66**	**1,51**	**1,49**	**1,47**	**1,46**	**1,43**

*estimate

Figure 10. TyEL-expenditure and contribution rate under different return alternatives, % of wages in 2006-2075 (Source: Finnish Centre for Pensions ETK)

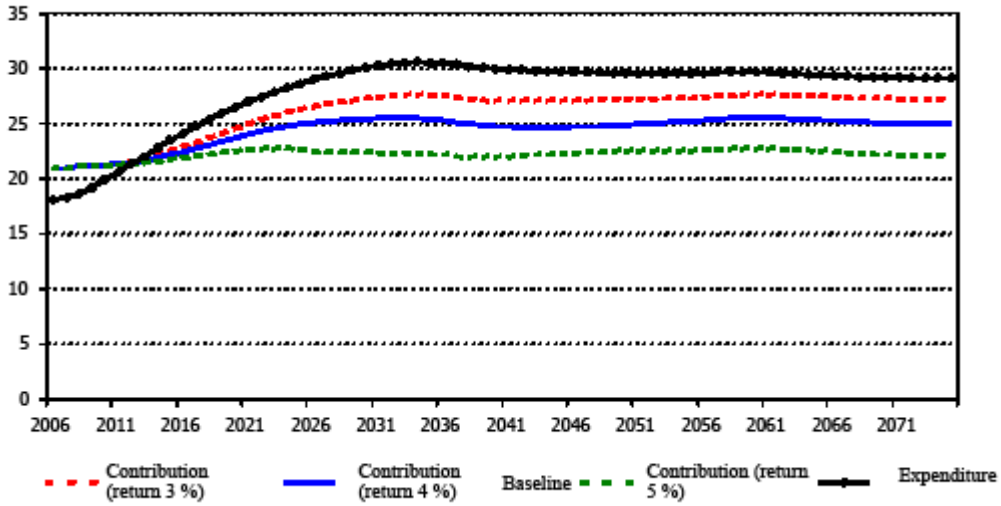
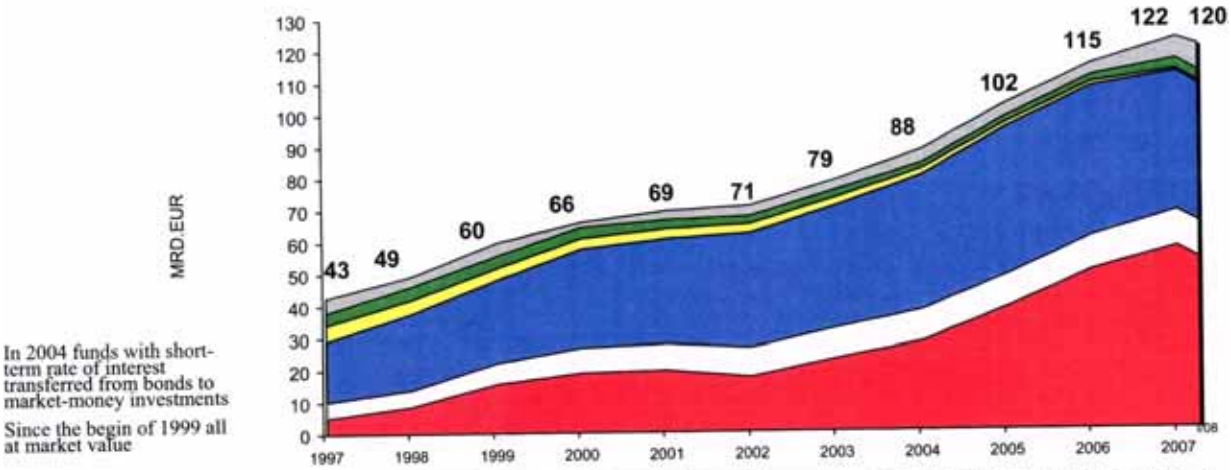


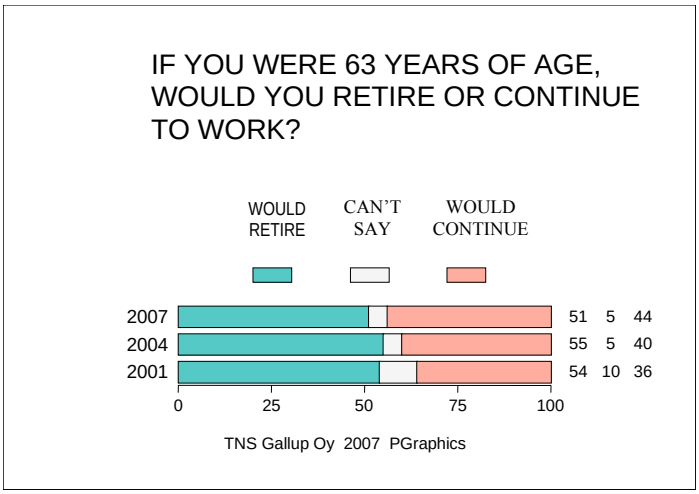
Figure 11.
INVESTMENT PORTFOLIO 1997-2005/Pension Insurance companies, pension funds, pension foundations,*)Etera, Kela, KEVA, KKR, MEK, Mela, Spera and VER



	31.12.97	31.12.98	31.12.99	31.12.00	31.12.01	31.12.02	31.12.03	31.12.04	31.12.05	31.12.06	31.12.07	31.3.08
Market money investments	4,6	3,2	4,1	1,7	2,8	3,3	3,1	4,3	4,1	3,7	6,7	8,3
Lending other than premium loans	3,9	4,2	3,9	3,5	2,8	2,5	2,5	1,8	1,9	2,3	3,3	3,5
Premium loans	5,0	4,4	3,7	3,3	3,1	2,8	2,5	2,0	1,5	1,1	0,7	0,6
Bonds and covertible bonds	18,9	23,8	25,9	30,9	32,9	36,0	38,3	42,2	46,4	47,1	43,7	43,2
Real estates and shares	5,1	5,2	6,5	7,8	8,2	9,1	9,5	9,8	10,2	10,6	11,2	11,4
Shares	5,0	8,5	15,5	18,7	19,4	17,1	22,7	27,7	38,1	49,7	56,6	53,2
	42,5	49,3	59,6	66,0	69,2	70,8	78,6	87,9	102,2	114,5	122,4	120,2

*)**Etera** Mutual Insurace Pension Company/**Kela** – Social Insurance Institution/**KEVA** – Local Government Pension Institution/**KKR** – Central Fund of the Evangelical Lutheran Church of Finalnd/**MEK** – Seamen's Pension Fund/**Mela** – Farmer's Social Insurance Institution/**Spera** – Bank of Finland Pension Fund/**VER** – State Pension Fund
(source: Finnish Pension Alliance TELA)

Figure 12.



Annex: Pension provision in Finland

Pension Provision in Finland				
	Statutory Pension Provision		**Supplementary Pension Provision**	
	Earnings-related Pension	**National Pension**	**Collective and Employer-Specific Occupational Schemes**	**Voluntary Personal Plans**
Major reforms since 1990	2008: Annual sending of pension record to employees started. 2007: Unification and simplification of legislation in the private and public sectors. Reform of the legislation concerning investments and financing of pension schemes in the private sector. 2006: The accrual rate for projected pensionable service was changed. 2005: Flexible retirement age, pensionable earnings calculated on the basis of lifetime average earnings, new accrual rates, unemployment pension was abolished, life expectancy coefficient introduced, changes in indexation. 2004: The employee gained subjective right to rehabilitation. 1998: Short-term employment and small wages became covered by pension insurance. 1996: Pensionable wage calculated on earnings for the last 10 years of each employment contract, index for persons of working age and index for persons of retirement age introduced. 1993: Employees' pension contribution introduced. 1990: Reform of survivors' pension (entitlement to survivors' pension for widowers).	2008: Reform and simplification of legislation. 1996: National pension was made proportional to the earnings-related pension. Levying of pension contribution from the insured and pension recipients was discontinued. 1994: Old-age pension and survivors' pension were made proportional to the time of residence in Finland. 1992: National pension contribution for pension recipients.	2001: The registered schemes were closed to new members.	2005: Benefits are taxed as capital income. 1992, 1999, 2004: Raising of pensionable age.

Coverage	All employees aged 18 to 68. Pension accrues for certain unpaid periods. Special systems for public-sector employees, farmers, self-employed persons, maritime workers, employees of the Evangelical-Lutheran Church, the Bank of Finland, the Social Insurance Institution and the regional government of Åland	Residence-based, income-tested minimum pension. Supplements the earnings-related pension and provides a minimum pension for people with no right to an earnings-related pension.	Employment-based. May be mandatory. On average 25% of employees in the private sector are covered.	May be arranged by the employer or the individual. On average 18% of households are covered (2007).
Administration and Supervision	Private sector: Administration is decentralized and handled by pension insurance companies, industry-wide pension funds or company pension funds. Supervised by the Ministry of Social Affairs and Health and the Insurance Supervisory Authority. Public sector: The Local Government Pensions Institution administers the pension provision for local government personnel. Supervised by the Ministry of Finance. The State Treasury administers the state earnings-related pension scheme. Supervised by the Ministry of Finance.	The Social Insurance Institution of Finland administers the scheme. Supervised by the Finnish Parliament.	Group pension insurance may be arranged with an industry-wide pension fund, company pension fund or as collective supplementary pension insurance with a life insurance company. Group pension insurance arranged by the employer may be free form or registered. Supervised by the Insurance Supervisory Authority.	Personal pension insurance policies are awarded by life insurance companies. Supervised by the Insurance Supervisory Authority.
Financing	Partially funded (except for the Farmers' Pension Scheme and for the Self-employed Persons' Pension Scheme, which are financed through PAYG). About 75% of benefits are financed through PAYG and 25% through funding. Employer and employee contributions. No maximum earnings for contribution purposes. Defined benefit schemes. The state covers the cost	PAYG. Employer contributions based on the amount of total payroll. The state covers about 40% of pension expenditure. Flat-rate pension.	Funded, book reserve. Mainly employer contributions. Also the employee may pay contributions. Defined benefit or defined contribution schemes.	Funded. Financed by the insured or the employer. Pension will be determined on the basis of the accumulated insurance savings.

	not covered by contributions for maritime workers' insurance, for the self-employed and for state employees.			
Benefits	Old-age pension, disability pension, survivors' pension, part-time pension, unemployment pension.	Old-age pension, disability pension, survivors' pension.	Old-age pension, disability pension, survivors' pension, unemployment pension, burial grant.	Benefits may be drawn on the basis of old age, disability, unemployment and the insured person's death.
Pensionable age	63-68 (old-age pension) Early old-age pension at 62, leads to permanent reduction. Postponement beyond age 68 increases the pension.	65 (old-age pension). Early old-age pension at 62, leads to permanent reduction. Postponement beyond age 65 increases the pension.	In group pension insurance at the earliest at the age of 55. If the employee pays contributions, at the age of 60.	62 for insurance policies taken out in 2004 and later (58/60 for insurance policies taken out earlier).
Benefit adjustment	Pensions in payment are revalued automatically on a yearly basis according to a weighted index for changes in consumer prices and wages (80:20). The pensionable earnings and the vested pensions are revalued according to a weighted index for changes in consumer prices and wages (20:80).	Pensions in payment are revalued automatically on a yearly basis according to changes in consumer prices. Overall increases from time to time by decision of the Finnish Parliament.	Benefits paid from registered supplementary pension insurance are revalued regularly in the same manner as statutory earnings-related pensions. Indexation of benefits paid from group pension insurance arranged by a life insurance company is not regulated by law.	Indexation of benefits paid from a personal insurance policy is not regulated by law.
Significance in total pension provision (% of total pension expenditure in 2006)	The statutory earnings-related pension and the national pension form together about 95% of total pension expenditure. The earnings-related pension forms about 80% of the average total statutory pension.	The national pension and the statutory earnings-related pension form together about 95% of total pension expenditure. The national pension forms about 20% of the average total statutory pension.	About 3% of total pension expenditure.	About 2% of total pension expenditure.

Annexes to Part 4 of the report (National Strategy Report on Public Health Service and Long-term Care)

Table 1. Indicators and target levels set for monitoring services for older people as represented in the National Framework for High-Quality Care and Services for Older People. (Available at: www.sotkanet.fi; available also in English)

Indicators (in relation to those aged over 75)	National target levels presented in the National Framework (in relation to those aged over 75)
The share of those living at home (excluding those receiving 24-hour assistance)	91-92 per cent live at home independently or with the support of the appropriate social and health services granted on the basis of a comprehensive service needs assessment
The share of those receiving regular home care[52]	13-14 per cent receive regular home care
The share of those receiving support for informal care[53]	5-6 per cent receive support for informal care
The share of those receiving sheltered housing with 24-hour assistance[54]	5-6 per cent receive sheltered housing with 24-hour assistance
The share of those in long-term institutional care (residential homes, health-centre hospitals)[55]	3 per cent receive long-term institutional care in a residential home or health-centre hospital.

[52] Clients regularly receiving home-care services include those who, on the date of the count, (30 November) have a valid service and care plan. In addition, people who have no service or care plan but who regularly (at least once a week) receive home help or home nursing are included in the count. However, the count does not include those persons who were in institutional care or receiving housing services on the date of the count, even though they had a valid care and service plan.

[53] Support for informal care is defined as services for an aged, disabled or unhealthy person safeguarding his or her care and provision, such services being provided at home, as well as compensation for the informal carer, as defined in the care and service plan. An agreement is made between the carer and the local authority. The number of clients covers all of those for whom support for informal care was received during the calendar year.

[54] There is no official definition of assisted housing. The definitions used for the statistics for social and health care emphasise that assisted housing always includes both housing and the services provided in conjunction with housing. Such services include e.g. services relating to household management and personal hygiene. Some units are residential homes where clients live in their own apartments and some are e.g. group homes.
Regular housing services
Housing services for older people with part-time assistance (staff are available in the daytime only)
Institutional care and housing services with 24-hour assistance (=housing service units for older people where staff are available 24 hours a day). They differ from residential homes e.g. because Kela has approved them as outpatient ward units and the client pays separately for housing and the services used. The count includes those persons who were clients on the date of the count (31 December).

[55] The share of those in long-term institutional care covers all clients aged over 75 in residential homes and all long-term patients aged over 75 in inpatient care in health centre hospitals on the date of the count (31 December).
Care for older people in residential homes
Institutional care for older people provided by the social services.
Long-term care in health centre hospitals
Institutional care provided by health centres includes care provided in the general practitioner led wards of health centres. In addition to municipal health centres, the count includes some other municipal or private service providers who are responsible for health centre activities within a certain district. Long-term care refers to clients to whom a decision has been made on long-term care or who have been in care for over 90 days.

Table 2. Coverage of services for older people during 2000–2006, as % of population aged over 75

	2000	2005	2006
The share of those aged over 75 living at home	89.8	89.6	90.1
The share of those aged over 75 receiving regular home care on 30 November		11.5	
The share of those aged over 75 receiving support for informal care during the calendar year	3.0	3.7	3.7
The share of clients aged over 75 in sheltered housing with 24-hour assistance on 31 December	1.7	3.4	3.9
The share of those aged over 75 in long-term institutional care provided by van-hainkodit or health centres on 31 December	8.3	6.8	6.5

Table 3. Services provided under the Act on Services and Assistance for the Disabled and institutional care and housing services for the disabled in 2000-2006 (number).

Services provided under the Act on Services and Assistance for the Disabled	**2000**	**2005**	**2006**
Transport services for seriously disabled people	66 568	80 937	84 064
Personal assistant services	2 817	4 322	4 548
Interpreter services	3 137	3 530	3 791
Housing alterations	7 032	7 857	8 072
Sheltered housing for seriously disabled people	1 894	2 775	3 088
Institutional care and housing services for the disabled			
Institutions for intellectually disabled*	2 960	2 515	2 496
Home help, intellectually disabled	3 344	4 874	..
Assisted housing: intellectually disabled	2 476	2 649	..
Group homes for disabled people: 24-hour assistance	..	..	5 355
Group homes for disabled people: part-time assistance	..	..	2 341
Service housing and supportive housing for disabled people**	1 510	1 861	1 758
Intellectually disabled in family care***	1 270	1 095	1 253

*As of 2006, data has been collected on ‘institutions for the disabled’, including disabled people other than the intellectually disabled.
**Data was collected separately on the intellectually disabled and other disabled until 2005. Here, the figures have been totalled.
***As of 2006, data has been collected on those ‘disabled in family care’, including disabled people other than those intellectually disabled.

Table 4.

The structure and coverage of services for older people by region in 2006.

	Clients aged over 75 as % of population aged over 75					
	Support for informal care*	**Regular home care****	**Sheltered housing *****	**Of which sheltered housing with 24-hour assistance**	**Residential home *****	**Health centre long term care *****
Total	3.7	11.5	5.7	3.9	4.1	2.4
Uusimaa	3.2	9.9	5.4	4.9	4.3	2.2
Eastern Uusimaa	3.4	10.1	4.4	2.7	5.6	1.5
Southwest Finland	3.1	10.4	4.4	3.2	4.6	1.9
Satakunta	3.3	9.9	5.4	4.1	5.9	1.7
Tavastia Proper	3.1	11.3	5.4	2.7	5.9	1.7
Pirkanmaa	2.3	10.8	4.4	1.6	6.0	1.8
Päijänne Tavastia	3.3	9.8	4.7	3.6	1.9	4.5
Kymenlaakso	4.0	10.0	5.4	4.3	3.4	2.7
South Karelia	3.0	11.0	4.4	3.1	3.6	3.1
Southern Savonia	3.5	15.3	6.9	4.4	3.7	3.1
Northern Savonia	3.7	11.9	5.2	3.6	2.9	2.8
North Karelia	2.9	14.0	6.4	2.6	3.2	3.8
Central Finland	4.0	13.7	6.0	3.3	4.3	2.2
Southern Ostrobothnia	5.7	10.6	7.1	4.0	3.7	2.7
Ostrobothnia	3.3	9.8	7.2	5.1	4.0	2.9
Central Ostrobothnia	5.4	11.9	10.3	7.7	2.6	0.9
Northern Ostrobothnia	6.2	17.4	6.4	4.5	4.0	1.6
Kainuu	6.8	11.8	8.2	6.8	0.5	2.0
Lapland	5.2	13.3	6.8	5.2	2.3	3.0
Åland Islands	5.3	10.8	9.2	3.0	4.6	2.5

* Number of clients/ year
** Number of clients on 30 November 2005
*** Number of clients on 31 December 2006

SOSIAALI- JA TERVEYSMINISTERIÖN SELVITYKSIÄ **ISSN 1236-2115**
SOCIAL- OCH HÄLSOVÅRDSMINISTERIETS RAPPORTER
REPORTS OF THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH

2008: 1 Yhteenveto työterveyshuollon erikoislääkärikoulutuksen rahoitusta koskevan lain vaikutuksista. (Vain verkossa)
ISBN 978-952-00-2510-6 (PDF)

2 Pandemic Influenza Preparedness. Joint Self-Assessment Report. (Vain verkossa)
ISBN 978-952-00-2516-8 (PDF)

3 Terveydenhuollon työsuojelun valvontahankkeen loppuraportti.
ISBN 978-952-00-2517-5 (nid.)
ISBN 978-952-00-2518-2 (PDF)

4 Miten potilasturvallisuutta edistetään? Kysely terveydenhuollon toimintayksiköille ja vanhainkodeille. (Vain verkossa)
ISBN 978-952-00-2519-9 (PDF)

5 Kansallisen terveydenhuollon hankkeen seurantaryhmän loppuraportti. Vuosien 2002-2007 toiminta. (Moniste)
ISBN 978-952-00-2531-1 (nid.)
ISBN 978-952-00-2532-8 (PDF)

6 Sosiaalialan kehittämishanke 2003-2007. Loppuraportti. Salme Kallinen-Kräkin (toim.).
ISBN 978-952-00-2535-9 (nid.)
ISBN 978-952-00-2536-6 (PDF)

7 Mikko Wennberg, Olli Oosi, Kaisa Alavuotunki, Sirpa Juutinen, Henrik Pekkala. Sosiaalialan kehittämishankkeen tavoitteiden saavuttamisen arviointi. Sosiaalialan kehittämishankkeen loppuarviointi. Osaraportti 2.
ISBN 978-952-00-2537-3 (nid.)
ISBN 978-952-00-2538-0 (PDF)

8 Slutrapport. Tillsynsprojekt för arbetarskyddet inom hälsovården.
ISBN 978-952-00-2539-7 (nid.)
ISBN 978-952-00-2540-3 (PDF)

9 Työurat pitenevät. Veto-ohjelman indikaattorit II.
ISBN 978-952-00-2541-0 (nid.)
ISBN 978-952-00-2542-7 (PDF)

10 Teoriasta toimivaksi käytännöksi. Mini-intervention jalkauttaminen terveyskeskuksiin ja työterveyshuoltoon. Kaija-Liisa Seppä (toim.).
ISBN 978-952-00-2543-4 (nid.)
ISBN 978-952-00-2544-1 (PDF)

11 Sosiaali- ja terveysministeriön toimintasuunnitelma vuodelle 2008. (Vain verkossa)
ISBN 978-952-00-2545-8 (PDF)

12 Perhekeskustoiminnan kehittäminen. Perhe-hankkeen loppuraportti.
ISBN 978-952-00-2546-5 (nid.)
ISBN 978-952-00-2547-2 (PDF)

13 Pysytään työssä. Vaikeavammaisten henkilöiden työssä pysymisen tukeminen.
ISBN 978-952-00-2548-9 (nid.)
ISBN 978-952-00-2549-6 (PDF)

14 Kirsi Alila, Tuija Portell. Leikkitoiminnasta avoimeen varhaiskasvatukseen. Avointen varhaiskasvatuspalvelujen nykytila ja kehittämistarpeet 2007. (Moniste)
ISBN 978-952-00-2552-6 (nid.)
ISBN 978-952-00-2553-3 (PDF)

15 Heikki Hiilamo. Promoting Children's Welfare in the Nordic Countries.
ISBN 978-952-00-2554-0 (pb)
ISBN 978-952-00-2555-7 (PDF)

16 Kaarin Ruuhilehto, Jari Knuuttila. Terveydenhuollon vaaratapahtumien raportointijärjestelmän käyttöönotto. (Moniste)
ISBN 978-952-00-2560-1 (nid.)
ISBN 978-952-00-2561-8 (PDF)

17 Sosiaaliasiamiestoiminnan kehittäminen. (Vain verkossa)
ISBN 978-952-00-2562-5 (PDF)

18 Sosiaali- ja terveysministeriön hallinnonalan tutkimustoiminnan tehostaminen. Työryhmän loppuraportti. (Vain verkossa)
ISBN 978-952-00-2563-2 (PDF)

19 Petri Hilli, Matti Koivu, Teemu Pennanen. Työeläkkeiden rahoitus ja sen riskienhallinta
ISBN 978-952-00-2596-0 (nid.)
ISBN 978-952-00-2597-7 (PDF)

20 Lapsella on oikeus osallistua. Lapsiasiavaltuutetun vuosikirja 2008.
ISBN 978-952-00-2598-4 (nid.)
ISBN 978-952-00-2599-1 (PDF)

21 Tapio Kuure, Tom Tarvainen, Antti Pelto-Huikko, Maija Säkäjärvi. ”Kaikki kymmenen tikkua laudalla!” Onnistuvat opit -juurruttamishankkeen loppuraportti.
ISBN 978-952-00-2607-3 (nid.)
ISBN 978-952-00-2608-0 (PDF)

22 Miia Eloranta (toim.) Sosiaali- ja terveysministeriön perhevapaakampanja 2007-2008. Loppuraportti.
ISBN 978-952-00-2611-0 (nid.)
ISBN 978-952-00-2612-7 (PDF)

23 Pirjo Pulkkinen-Närhi, Hanna Hakulinen, Päivi Jalonen, Pirjo Manninen. Kunnallisen työterveyshuoltojärjestelmän kehittäminen. Erilaisten organisointi- ja toimintamallien arviointia (Seutu-hanke). (Vain verkossa)
ISBN 978-952-00-2617-2 (PDF)

24 Isien ja isyyden tukeminen äitiys- ja lastenneuvoloissa
ISBN 978-952-00-2618-9 (nid.)
ISBN 978-952-00-2619-6 (PDF)

25 Työpaikan palkkakartoitus. Tietoa ja kokemuksia. Johanna Matinmikko, Inkeri Tanhua (toim.). (Moniste)
ISBN 978-952-00-2620-2 (nid.)
ISBN 978-952-00-2621-9 (PDF)

26 Segregaatio ja sukupuolten väliset palkkaerot –hankkeen loppuraportti.
ISBN 978-952-00-2622-6 (nid.)
ISBN 978-952-00-2623-3 (PDF)

27 Longer careers? ‘Veto’ programme indicator.
ISBN 978-952-00-2624-0 (pb)
ISBN 978-952-00-2625-7 (PDF)

28 Uusi terveydenhuoltolaki. Terveydenhuoltolakityöryhmän muistio. (Moniste)
ISBN 978-952-00-2628-8 (nid.)
ISBN 978-952-00-2629-5 (PDF)

29 Antti Pelto-Huikko, Juha Kaakinen, Jukka Ohtonen. ”Saattaen muutettava”. Kehitysvammaisten laitoshoidon hajauttamisen seurantaraportti.
ISBN 978-952-00-2635-6 (nid.)
ISBN 978-952-00-2636-3 (PDF)

30 Jussi Huttunen. Lääkehuollon keskushallinnon kehittäminen. Selvityshenkilön raportti.
ISBN 978-952-00-2638-7 (nid.)
ISBN 978-952-00-2639-4 (PDF)

31 Satu Ahopelto, Kristiina Harju, Armiliisa Pakarinen, Johanna Snellman. Uutta naisjohtajuutta Delfoi Akatemiasta –hankkeen analyyttinen loppuraportti. (Vain verkossa)
ISBN 978-952-00-2639-4 (PDF)

32 Palvelusetelin käyttöalan laajentaminen. Palvelusetelityöryhmän muistio.
ISBN 978-952-00-2644-8 (nid.)
ISBN 978-952-00-2645-5 (PDF)

33 Sirkku Kivistö, Eila Kallio, Greta Turunen. Työ, henkinen hyvinvointi ja mielenterveys
ISBN 978-952-00-2648-6 (nid.)
ISBN 978-952-00-2649-3 (PDF)

34 Pirjo Juvonen-Posti, Janne Jalava. Onnistunut työkykyasioiden puheeksiotto – Lupaavia käytäntöjä PK-työpaikoille työhyvinvoinnin ja sairauspoissaolojen hallintaan ja seurantaan
ISBN 978-952-00-2650-9 (nid.)
ISBN 978-952-00-2651-6 (PDF)

35 Tasoitusmäärätyöryhmän muistio. (Vain verkossa)
ISBN 978-952-00-2658-5 (PDF)

36 Sosiaali- ja terveysministeriön hallinnonalan palvelukeskustyöryhmän loppuraportti. (Vain verkossa)
ISBN 978-952-00-2659-2 (PDF)

37 Asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta. Työryhmän muistio (Moniste)
ISBN 978-952-00-2664-6 (nid.)
ISBN 978-952-00-2665-3 (PDF)

38 Kansallinen sosiaalisen suojelun ja osallisuuden strategiaraportti vuosille 2008-2010. (Vain verkossa)
ISBN 978-952-00-2673-8 (PDF)

39 National Strategy Report on Social Protection and Social Inclusion 2008-2010. (Vain verkossa)
ISBN 978-952-00-2674-5 (PDF)