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Trends in Social Protection in Finland

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Summary

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Increasing the employment rate a prerequisite for development of social protection

The fact that the post-war baby boom generation is approaching pension age means that we must adjust to a decrease in working-age population. Beginning in 2010, the number of working-age population will start to decrease. The number of population aged 20–59 will start to decrease even earlier. At the same time, the size of those age cohorts that have traditionally had a low employment rate will increase.

The full impact of the ageing of the population on the development of the economic dependency ratio will begin to be felt in the 2010s and 2020s. The economic dependency ratio indicates how many persons are dependent on the income generated by one employed person. The government's aim is to increase employment by 100,000 persons by the year 2007 and to raise the employment rate to 75 percent by 2011. If the government's employment objective is fulfilled, the economic dependency ratio will be strengthened until 2011, after which it will slowly start to weaken. However, despite the ageing of the population, the economic dependency ratio would still be at the same level in 2030 as it was in the year 2000.

The possibilities for developing social protection are significantly dependent on economic growth. An ageing population poses a challenge for the maintenance of economic growth. If the employment rates of different age groups cannot be raised, economic growth will be decreased by the change in the age structure of working age population already in the near future. The situation will change considerably if the government's employment objective is fulfilled. In that event, economic growth will no longer be slowed down similarly by the ageing of the population. In addition to development of society's wealth, this would have a significant impact on society's ability to provide welfare services for its citizens. Social expenditure is mostly financed by taxes and social insurance payments. A positive employment trend would guarantee a positive trend in tax revenues as well. A positive employment trend would also reduce unemployment and pension costs, which would make resources available for the development of social and health care services. This creates a good setting for a positive trend in productivity.

Attaining the employment goal is not an easy task. Success calls for measures aimed at all age groups. The battery of means of economic and welfare policy must be as comprehensive as possible.

Social protection expenditure increasing slightly

After a long decline, the GDP ratio of social protection expenditure started to show a slight increase in the early 2000s. In addition to increased social protection expenditure, this was caused by a slowdown of GDP growth. In recent years, social protection expenditure has grown due to increases in costs related to old age, sickness and health. Taken together, these expenses make up over 50 percent of social protection expenditure. The social protection expenditure in relation to GDP in Finland is on average EU level (EU15). In addition to differences in the size of social protection expenditure between EU member states, there are also differences in expense structure. In Finland, the share of total expenditure made up by service costs is smaller than in Sweden and Denmark, but higher than the EU average.

Social and health care services in the focus of the 2006 budget

The share made up by the main division of the Ministry of Social Affairs and Health in the 2006 draft budget comes to about € 11 billion. The amount is 12 percentage points higher than in this year's budget. Improving the efficiency and accessibility of social and health care services, making financing systems less complicated and securing a sufficient income for all are emphasised in the Ministry of Social Affairs and Health budget.

A total of € 4,021 million is proposed for government grants towards the operating costs of social and health care in municipalities, which is an increase by 9.5 percentages compared to the 2005 level. As part of the reform of the system of government grants to municipalities, some of the criteria for defining government grants for social and health care will be adjusted. The costs due to services for gravely disabled persons will be compensated with a new disability coefficient and the costs due to need of child protection by a new child protection coefficient, which will replace a separate compensation system for large child protection costs. In addition, the criteria for defining the remoteness coefficient will be altered.

As part of the labour market support reform aimed at increasing employment of the long-term unemployed, the norm-based part of social assistance will be detached from the government grant system at the beginning of 2006.

Health insurance financing is reformed as of the beginning of 2006. The aim of the reform is to secure sufficient financing for benefits granted on the basis of illness. For this purpose, the insurance principle of health insurance is emphasised by strengthening the connection between payments and benefits.

Financing through the health insurance fund is divided into two parts, health insurance financing and earnings insurance financing. The central government finances the health care costs covered by health insurance paid to EU member states. In other cases, health insurance is financed by an equal contribution from the insured and the central government. The earnings insurance is financed with contributions from employers, employees, entrepreneurs and the state.

Increasing obesity and alcohol use pose the greatest threats to public health

The state of health of the population is better than ever. The average lifespan has risen, and the number of active, functional years has increased. The greatest threats to this positive development are increasing obesity and a clear rise in alcohol consumption. Both cause significant, manifold and expensive problems to individuals, families, public health and to society as a whole.

Differences in health between population groups remain large, and they seem to be increasing. Half of the differences between population groups are explained by tobacco and alcohol. The most expensive groups of diseases in Finland are cardiovascular diseases, mental health disorders, respiratory diseases as well as musculoskeletal diseases. Together, they account for half of all health care expenditure. Many of the diseases that are common among the population are preventable. The effect of health care on population health is only 10-15 percent. Individual lifestyle and living environment have the greatest impact.

Continuous efforts are called for in order to maintain the positive development trend in public health. It is of the utmost importance to make people aware of the effect of their own choices and lifestyle on their state of health. The foundation of a healthy adulthood and functional old age is laid in childhood and youth. Focusing on prevention and health information is an inexpensive means of achieving significant savings in both health care costs and all public expenditure in the years to come. Prevention of diseases is always cheaper than repairing damage afterwards.

Health differences between population groups can also be affected by general public policy. Public decisions have health impacts, but they are not yet taken sufficiently into account. The impact of decisions on groups with unequal health status, such as children, the disabled, people suffering from mental health problems and the long-term unemployed must be considered in particular. The key is to guarantee equal access to care to all.

The most pressing task from the viewpoint of public health is to bring about a reduction in alcohol consumption and to prevent obesity.

Services for the elderly are tailored according to the client's remaining functional ability

The aim of elderly policy is to maintain functional capacity of the elderly as long as possible. Evaluation of functional capacity is a key element of service need assessment. Services for the elderly are tailored according to the client's remaining functional ability. The services range from community care services compensating for a minor reduction in functional capacity to long-term nursing care of the elderly with the poorest functional capacity in health care centre wards. This guarantees the right to an independent life of the elderly for as long as possible while ensuring the provision of services that are needed and the appropriate targeting of resources.

In order for the goals of elderly policy to be attained, the population share of support for informal care, service housing as well as care in the home must rise, while the population share of more comprehensive services such as long-term care in health care centres and residential homes for the elderly must diminish more than anticipated.

Positive development of working conditions

A positive development of working conditions is a key prerequisite in the process of adapting to the challenges brought about by ageing of the population. Improvement of the qualitative aspects of work increases productivity. Working conditions have improved in many respects. The core objective has been to raise the employment rate of elderly workers, and a clear improvement can be seen in this. The large post-war cohorts have remained at work longer that the cohorts before them. They have also succeeded in keeping their jobs more often than before. However, if elderly workers lose their jobs, it is harder for them to find new employment compared to younger age groups.

Well-being at work and the qualitative aspects of work are key factors that either attach people to work or detach them from it. The quality of working life is a multidimensional phenomenon that also interacts with the ”outside world” outside the sphere of work. There is no single factor that explains why people remain at work or leave it.

According to studies, the great majority of employees are either very satisfied or fairly satisfied with their work, despite the fact that a hectic work pace and mentally taxing work are felt by employees to be relatively common stressors. All in all, the work ability of employees is good: about 40 percent have excellent, more than half have good, while less than 10 percent have moderate or poor work ability.

This positive development is however overshadowed by a persistent trend in structural unemployment. This problem becomes more emphasised as age groups become smaller. An excessive proportion of resources that are needed is left unused. Raising the employment rate, increased productivity and the qualitative aspects of working life seem to be closely intertwined with this phenomenon. There has been a reduction in unemployment, but a persistent core of unemployment still remains. Similarly, the problems of enterprises concerning recruitment seem even to have become worse.

Breaking a long-term circle of exclusion calls for resources and commitment

Both social development trends and individual factors have an impact on the prevalence of social exclusion. It is a question of clustering of different problems and interaction between them, as a result of which the individual is excluded from the common good.

As a whole, the risks for exclusion seem to have increased lately, particularly among children and young people as well as drug abusers. Attempts to decrease long-term unemployment and homelessness from the 1990s level have been successful. Long-term poverty is still a problem that increases exclusion. In order to manage the multiple

problems of people suffering from social exclusion, close cooperation between main divisions of administration has been encouraged.

The efficiency of the individual incentives set is also affected by the multiple problems. The desired effects on behaviour of the economic incentives are based on the assumption of rational economic thinking. The use of incentives calls for good knowledge and understanding of the situation of the target groups as well as their individual motives. Among those at risk for exclusion, both the ability and the motivation-based desire to act in the manner called for by the incentives may be very different from that of the majority of the population. Getting those who are excluded motivated to improve their own situation is a prerequisite for the success of activation measures. The scarcity of the resources available limits the provision of individual support. However, in the long term, the savings in public expenditure attained by prevention of exclusion is a significant advantage, besides the goal of reducing human suffering.

Health care expenditure at a low level internationally

The GDP ratio of health care expenditure started to increase in 2001 after several years with a downward trend. The reason for this, in addition to increased expenditure, was a clear slowdown in GDP growth. Despite the growth in recent years, health care expenditure in relation to GDP is still lower than in the beginning of the 1990s. However, there has been a real increase in health care expenditure since 1995. In addition, health care costs have grown more rapidly than other public expenditure. The increase in medicine costs has been especially fast; medicine costs show a real increase of about 5 percent per year since the beginning of the last decade.

Health care expenses as a proportion of GDP are clearly lower than the EU average. Health care costs per capita are also among the lowest within the EU. The low level of costs can be interpreted in two different ways. According to a positive view, the Finnish health care system is more effective than average, since comprehensive and high-quality services can be provided with a small input. This interpretation can be motivated by the fact that of all EU citizens, Finns are the most satisfied with their health care services.

According to a more critical view, it can be questioned whether sufficient funds have been allocated to health care in Finland in recent years. This view is supported by survey results showing that among all municipal services, most additional resources are wanted in health care.

Increasing need for social and health care services

The need for social and health care services is expected to rise in the 2020s and 2030s, as the number of very old people increases markedly. According to various studies, it does however seem clear that the need for services aimed at the elderly will grow more slowly and less directly than the number of old people. Public health will continue to improve in the future as well, and the elderly will be able to cope independently longer than before.

Expenditure trends can be significantly influenced by rapid adoption of new technology and by reforms of service and production structure. In the case of health care services, supply also creates demand. Supply decisions have a decisive impact on future costs. Based on the results of international comparisons, the demand for health services has increased hitherto with higher education levels and better overall living standards. There is however considerable variation between overall standard of living and health care expenditure, which is to a large extent explained by the way services are provided.

By the year 2010, about one quarter of the current staff working in social and health care services, i.e. 55,000 people, will retire. As the population ages and goes into retirement, new social and health care professionals must be recruited to the field from younger age groups that are smaller than the ones before them. At the same time, an increasing number of clients will add to the burden of a reduced number of staff. The recruitment of competent staff may thus pose a problem in the future, and a shortage of staff may lead to a rapid increase in wage levels. In addition to education, access to competent and highly motivated staff can be ensured by improving working conditions, by having an adequate number of staff to meet clients' needs and by supporting flexible division of labour between staff groups.

New production and financing models for service production

The status of the municipal sector as provider of social and health care services is changing; services must now be produced alongside private service providers. Today, one fifth of social and health care services are provided by private service providers, i.e. organisations and enterprises. Organisations play a larger role as providers of social services, whereas the majority of private health care services are provided by enterprises.

Responsibility for organising service provision will remain with the public sector in the future as well. However, service provision may be arranged via private enterprises or non-profit organisations. The efficacy of services can in some cases be increased by separating provision and commissioning**.** In its present form, the EU service directive that is being prepared will lead to a situation where social and health care services are opened up for foreign competition more extensively than is currently the case.

The financing solution used in Finnish health care is a combination of municipal and state funding, user fees and the private health care service sector supported by health insurance. The way services are arranged, their extent or content is not defined in legislation; the assessment and implementation of these is left to the municipalities. Health care systems based on public financing have been more successful in curbing health care costs than insurance-based systems. In Finland, a rise in the expenditure trend has also been slowed down by moderate centralised wage agreements, which have controlled the rise in labour costs in the field.

Relative poverty remains low, but is increasing

Compared to most other EU member states, the relative poverty rate measuring the share of low-income population remains low in Finland. Relative poverty has however increased since the mid-1990s. The real income of low-income households has also increased, but at a clearly slower pace than that of the rest of the population. Having a low income is most common among single households and single parents. In recent years, having a low income has also increased among young families with children. However, having a low income is still clearly less common among young families with children compared to single households and single parents.

Economic incentives for accepting employment have improved as the replacement rate of benefits have decreased. Based on international comparisons, it seems that economic incentives for employment are even somewhat better in Finland compared to most other countries in northern and central Europe. In some countries, the high cost of or poor access to child day care is an obstacle to both parents' working. In Finland, reasonably priced day care that is available to all ensures for its part a sufficient economic incentive for parents to work. In the case of parents with children under three years old, the effect of this incentive is weakened by child home care allowance. However, when looking at the period after child home care allowance, the economic incentives for both parents to work look very good indeed in an international comparison.

Support for families with children on the rise

The birth rate has remained relatively stable in recent years. From a European point of view, total fertility rate is quite high in Finland. There have been considerable changes in total fertility rates in different age groups. Fertility has decreased among women under 30, while it has increased among women over 30.

The number of families with children has been steadily declining. At the same time, changes have taken place in family structures. The number of cohabiting-couple and single-parent families is rising. There are two trends in evidence in family formation. The number of children in families with children is showing a slight upward trend, but at the same time an increasing number of women remain childless. About 15 percent of middle-aged women are childless. This figure is expected to rise to 20 percent in the future. Childlessness is most common among highly educated women.

Many benefits aimed at families with children have been raised in accordance with the Government Programme. The level of family-policy benefits is nearly equal to that before the cutbacks made in the early 1990s. The income transfers aimed at families with children are not index-linked. This has been seen especially as weakened purchasing power of child allowance and child home care allowance. Despite the raise of the level of child allowance, it is still some 15 percent lower than in 1994, when the family support reform was implemented. After the raise, the real value of child home care allowance is nearly the same as after the 1997 reform, but clearly below the early 1990s level.

As of the beginning of 2005, the minimum level of parenthood allowance was raised by about € 93 per month. The proportion of mothers receiving minimum parenthood allowance has not returned to the low pre-recession level. In 2004, 19.9 percent of mothers received minimum parenthood allowance. A significant reform concerning mothers is that in the case of consecutive pregnancies within a short period of time, the level of parenthood allowance can be defined based on the earnings used to calculate the previous parenthood allowance. The emphasis in maternity and child health clinic work is increasingly on supporting parenthood and the promotion of the psychosocial wellbeing of the entire family. There has been no change in recent years in the number of visits to maternity and child health clinics, whereas the number of visits to school health care has decreased. There are considerable differences between municipalities in the provision and operating practices of school health care services.

Advances in gender equality

The government's gender equality objectives are implemented with the aid of the government's equality action plan, which includes both measures aimed jointly at all ministries and measures aimed at the ministries' own main divisions.

There is very little difference in workforce participation between women and men, with the exception of the years related to starting a family. However, in the labour market men and women are placed in different sectors and different fields. Women are more often employed in the public sector and in care work than men, while men work more often in the private sector and in industrial jobs compared to women. The average relative wage gap between women and men has remained unchanged, but the difference in the prevalence of fixed-term employment contracts has increased. The use of parental leave among fathers has increased.

Women are increasingly taking part in decision-making. Despite this, women are still poorly represented in economic decision-making. A contradictory trend can be observed in violence against women: domestic violence seems to be decreasing, but there has been a considerable increase in violence against women in the workplace.

Keywords: Social protection, economic dependency ratio, public health, work ability, social exclusion, health care, social services, income security, children, gender equality

Foreword

The Ministry of Social Affairs and Health has published the report Trends in Social Protection in Finland since 1996. The aim has been to chart the success of social protection and to provide background for the measures implemented on an annual basis. The structure of the present report is based on the strategic lines of the Ministry of Social Affairs and Health and the social and health care policy objectives set down in the government's strategy document. The aim of this division is to obtain consistency in both setting policy objectives and the monitoring of policy implementation.

The report Trends in Social Protection in Finland has annually covered the entire scope of social protection, in addition to which a special theme has been presented in each report. The main themes in this year's report are incentives and productivity.

Incentives are a more comprehensive concept than is generally thought. Incentives are mostly seen as a purely economical issue, such as the relationship between benefits, taxation and earnings. The focus is in this case on the balance between encouraging people to work and sufficient income for those excluded from work. However, in social policy incentives have a more extensive scope. For example, incentives may be used to encourage people to maintain their health, to have children and to care for them, to use community-care services instead of institutional care, and to use their own initiative. In general discussion, incentives may sometimes involve features of moral judgement that are alien to the ethics of health care and the ideas of social policy. Incentives may also be targeted at social protection actors, such as municipalities. Based on experiences so far, it is apparent that social policy objectives cannot be achieved with economic incentives alone. For example, in order to raise the retirement age, the attraction of work must be increased. This can be achieved by developing management, improving the atmosphere in the workplace and by reforming work tasks.

There has been a lot of talk recently about the productivity of social and health care services. According to studies, the productivity of the entire public sector, including health care, has as a rule decreased all through the 2000s. Productivity in health care has been measured as output per resources. The idea is that more should be achieved with the resources given. This would raise the efficiency of the institution under scrutiny and increase the productivity calculated per employee. The indicator used is useful as such, but it does not describe real impact, i.e. how output performance has decreased the burden of illness, injury or disability of patients, or how it has improved the state of health and functional ability of the population. This is why one should avoid looking at the productivity of social and health care detached from the study of effectiveness when assessing the functionality of the system, the efficacy of an individual institution and the operation of staff.

The functionality of social and health care systems can be promoted by reforming service structures and financing systems. The aim is e.g. to improve the functional ability of the elderly and to promote their possibility to lead an independent life, or to shorten the queues of patients waiting for an operation in hospitals.

The competitiveness of enterprises in the global market is the sum of a number of factors. A healthy and competent staff is not just the result of a firm's own decisions; it is something that is influenced in a decisive manner by all social policy conducted. High employment, brisk productivity growth and a well-balanced population growth cannot be achieved by economic and industrial policy alone; other factors, such as an effective family and gender equality policy, are needed as well. Good social policy and social protection contribute to economic growth and well-being.

Director-General Kari Välimäki

Trends in Social Protection in Finland 2005-2006 Experts

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Contents

Introduction

In 2001, the Ministry of Social Affairs and Health published the document Strategies for Social Protection 2010 on the strategic lines of social and health care policy development. The main objectives of the main division of social and health care are based on the strategic lines and the areas of emphasis in the Government Programme, with focus on the following areas:

- promoting health and functional capacity
- making work more attractive
- preventing and combating social exclusion
- providing efficient services and reasonable income security
- well-being of families with children
- gender equality

The main theme in this report is incentives and productivity. The focus is increasingly on current, significant projects, programmes and reforms. The structure of the report is based on the main strategic objectives of the Ministry of Social Affairs and Health. The updated indicators used for monitoring the implementation and impact of the objectives are found in the appendix.

Incentives

Incentives may be economic, or they may be moral, for example. Social protection can encourage people to e.g. work and use their own initiative, or it may encourage efficient utilisation of the resources of the economy. Incentives can be used in an attempt to affect behaviour even in times of deterioration of ethics and moral in society.

Incentives are often understood as simply involving the lowering of the level of benefits or taxation in order to promote employment. As far as the so-called incentive trap reforms implemented after the mid-1990s are concerned, this holds largely true. However, in recent years other forms of incentives have been emphasised in encouraging people to work, such as adopting a more activating approach in labour policy measures.

Incentives are an extensive concept from the economical point of view as well. In addition to individuals, they can be used in an attempt to impact the operation of entire organisations. For example, a financing system with the correct in-built incentives targets the resources used effectively, focusing them where they are most needed.

In health policy, the use of incentives may adopt features of moral judgement, e.g. when talking about people's responsibility for maintaining their own health. On the other hand, maintenance of functional ability and an independent life among the elderly can be encouraged by reforms of the service structure and financing systems. In both cases, the aim is to impact behaviour in such a way that the health, functional ability and well-

being of individuals is improved while attaining significant economic advantages, as the need for services is reduced.

From the point of view of the individual and the community, incentives work in the right direction when they encourage individuals and organisations to make choices that are good from the viewpoint of society as a whole, and prevent bad choices.

Productivity

On the level of production, productivity refers to the relationship between output and resources. However, measuring productivity without regard to quality of value is a risky foundation for wise policy; the effectiveness of political operation must be evaluated through objectives, resources and impact. In the social policy decision-making process, objectives are set and the resources needed for attaining the objectives are targeted. The decision concerning division of resources between prevention, primary health care and specialised care is an example of this so-called political allocation. The impact of objectives can be monitored with the aid of indicators describing the implementation of objectives. The concepts and definitions of productivity in health care are presented in more detail in chapter 1.6.

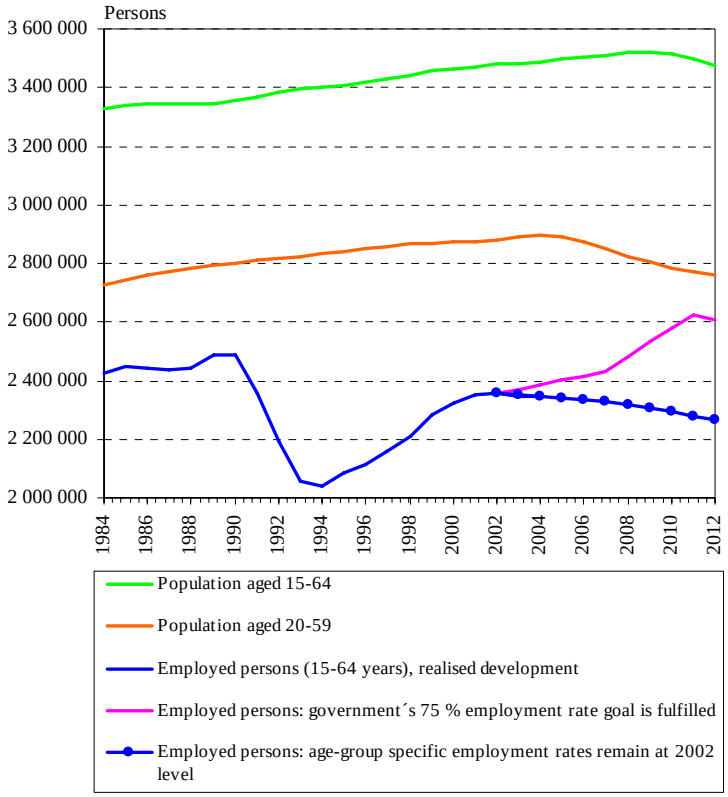
I Social protection and a changing operating environment

The fact that the post-war baby boom generation is approaching pension age means that we must adjust to a decrease in working-age population Beginning in 2010, the number of working-age population will start to decrease. The number of population aged 20–59 will start to decrease even earlier. At the same time, the size of those age cohorts that have traditionally had a low employment rate will increase. In 2010, the number of people aged 60–64 will be fifty percent higher than in 2004.

If employment rates in different age groups remain on the 2002 level, employment will start to decline. By 2011, the reduction would amount to 80,000 people. The age-group-specific employment rates have continued to rise since 2002. However, we still lag slightly behind the 75 percent employment rate set as the target.

The government's aim is to increase employment by 100,000 persons by the year 2007 and to raise the employment rate to 75 percent by 2011. This means an increase of 30,000 to 40,000 employed persons per year, or a total of 330,000 persons compared to 2002. The employment growth rate would be nearly as fast as after the deep economic recession of the 1990s (Figure 1).

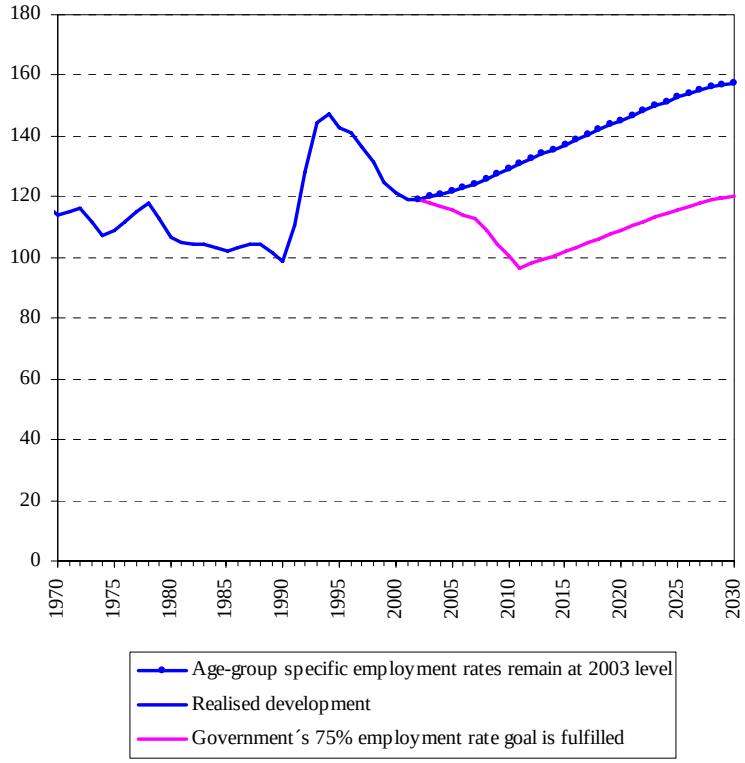
Figure 1. Working-age population and employed persons in 1990–2002 and estimated development in 2002–2012 based on different assumptions



The economic dependency ratio is calculated by dividing the number of non-employed persons by the number of employed persons. The economic dependency ratio indicates how many persons are dependent on the income generated by one employed person. The economic dependency ratio depends on both population age structure and the employment rate of working-age population. The full impact of the ageing of the population on the development of the economic dependency ratio will begin to be felt in the 2010s and 2020s.

If the government's employment objective is fulfilled, the economic dependency ratio will be strengthened until 2011, after which it will slowly start to weaken. However, despite the ageing of the population, the economic dependency ratio would still be at the same level in 2030 as it was in the year 2000. On the other hand, if the age-group specific employment rates remain on the 2002 level, the economic dependency ratio will be weaker than during the deep economic recession in the early 1990s. (Figure 2)

Figure 2. Economic dependency ratio in 1970–2004 and estimated development in 2002–2030, %



1.1 Age structure, employment and economic growth

An ageing population poses a challenge for the maintenance of economic growth. The impact of the change in age structure can be illustrated with the aid of the decomposition shown in Table 1. In the decomposition, GDP growth per capita is affected by work productivity, the proportion of working-age population in the total population, and the proportion of employed persons in working-age population. The impact of age structure on economic growth is examined using two alternative approaches.

In the first alternative, the age-group specific employment rates remain at the 2002 level. In the second alternative, the employment rate increases gradually to 75 percent by 2012 in accordance with the government's employment goal. In both alternatives, the increase in productivity of work is estimated to be 1.8 percent per year between 2004 and 2020.[i] Population age structure (persons aged 15-64/total population) is also assumed to develop in a similar manner in both alternatives.

Table 1. GDP growth per capita 1992–2020, %. Decomposition according to various factors

	Age-group specific employment rates will decline to the 2002 level in 2006					
Average change per annum, %	1992-95	1996-99	2000-03	2004-07	2008-11	2012-20
Productivity of work	3.7	2.3	2.0	2.0	1.8	1.8
Share of working-age population	-0.2	0.1	0.0	-0.1	-0.3	-0.8
Employment rate	-3.3	1.9	0.5	-0.4	-0.4	0.1
Total: GDP per capita	0.1	4.3	2.4	1.5	1.1	1.1
	Employment rate increases to 75 percent by 2012					
Average change per annum, %	1992-95	1996-99	2000-03	2004-07	2008-11	2012-20
Productivity of work	3.7	2.3	2.0	2.0	1.8	1.8
Share of working-age population	-0.2	0.1	0.0	-0.1	-0.3	-0.8
Employment rate	-3.3	1.9	0.5	0.7	2,0	0,1
Total: GDP per capita	0.1	4.3	2.4	2.6	3.6	1.0

Share of working-age population = persons aged 15–64/total population
Employment rate = employed persons aged 15–64/persons aged 15–64
Productivity of work = production per employed person

The decline in the share of working-age population will only weaken economic growth significantly towards the end of the period under study, in 2012–2020 (by -0.8 percent per year). However, if the age-group specific employment rates fall to the 2002 level, economic growth will be reduced earlier. An increasing number of persons of working age will belong to age groups whose employment rate is low at present. This would slow down production growth by 0.4 percent during the periods 2004–2007 and 2007–2011. During the latter period, economic growth would be slowed down by another 0.3 percent by a reduction in the share of working-age population. Despite productivity growth, economic growth would remain modest. The situation will change considerably if the government's employment target is fulfilled. In that event, economic growth will no longer be similarly slowed down by the ageing of the population.

If the average growth of productivity does not reach 1.8 percent in 2008–2020, but is slowed down by one percentage point, it will have a dramatic impact on society's ability to provide welfare services for its citizens. If the age-group specific employment rates remain at the 2002 level, GDP per capita will shrink somewhat all through the 2010s. If we manage to implement the government's employment goal, GDP per capita will still only grow by a few tenths of percent in the 2010s.

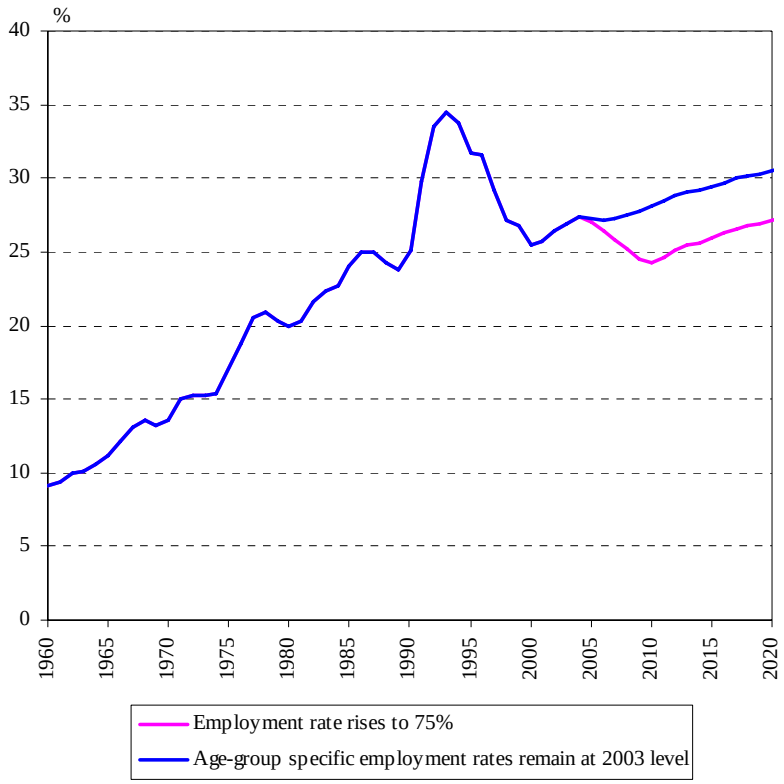
Employment and social expenditure

A positive economic development trend means better employment and a reduction in the number of cash benefit recipients. This provides more scope for the development of

welfare services. At the same time, it is also easier to guarantee a reasonable level of income security benefits, including pensions, when the number of recipients is smaller. [ii]

In 2004, social expenditure came to 27 percent of the GDP. If age-group specific employment rates remain at the 2002 level, the employment rate will fall to 65 percent in 2010. This would mean an increase by one percentage point of the GDP ratio of social protection expenditure in accordance with current legislation. With the ageing of the population, the GDP ratio of social protection expenditure would exceed 30 percent by the year 2020 (Figure 3). If the GDP ratio of tax revenue is assumed to remain at the 2002 level, the financing balance of the public sector would be weakened by a sum corresponding to the increase in expenditure.

Figure 3. GDP ratio of social protection expenditure in 1960–2004 and estimated development until 2020, %



If Finland succeeds in raising the employment rate to 75 percent, the GDP ratio of social protection expenditure will go down to 24.3 percent in 2010. The high employment alternative would thus mean that the GDP ratio of social protection expenditure would be almost 4 percentage points lower than in the low employment alternative.

Social protection expenditure is primarily financed by taxes and social insurance payments. This means that in the high employment scenario, the tax rate could be lower than during low employment. A positive employment trend would also guarantee a positive trend in tax revenues at a lower tax rate. A positive employment trend would thus decrease social protection expenditure while increasing tax revenue. This would

create leeway for tax cuts, which would help lessen the heavy tax burden on labour in Finland. Another alternative is to use the latitude in public sector economy to develop social protection.

If production growth slows down by one percentage point from the estimated 1.8 percent while employment remains unaltered, GDP growth will also slow down by one percentage point. This would mean a weakening of the basis of tax revenue and social protection payments. The former eats away at the financing basis of public services and the latter that of pensions, whereas an upward trend in productivity results in a positive spiral, where the financing of services supporting economic growth is secured.

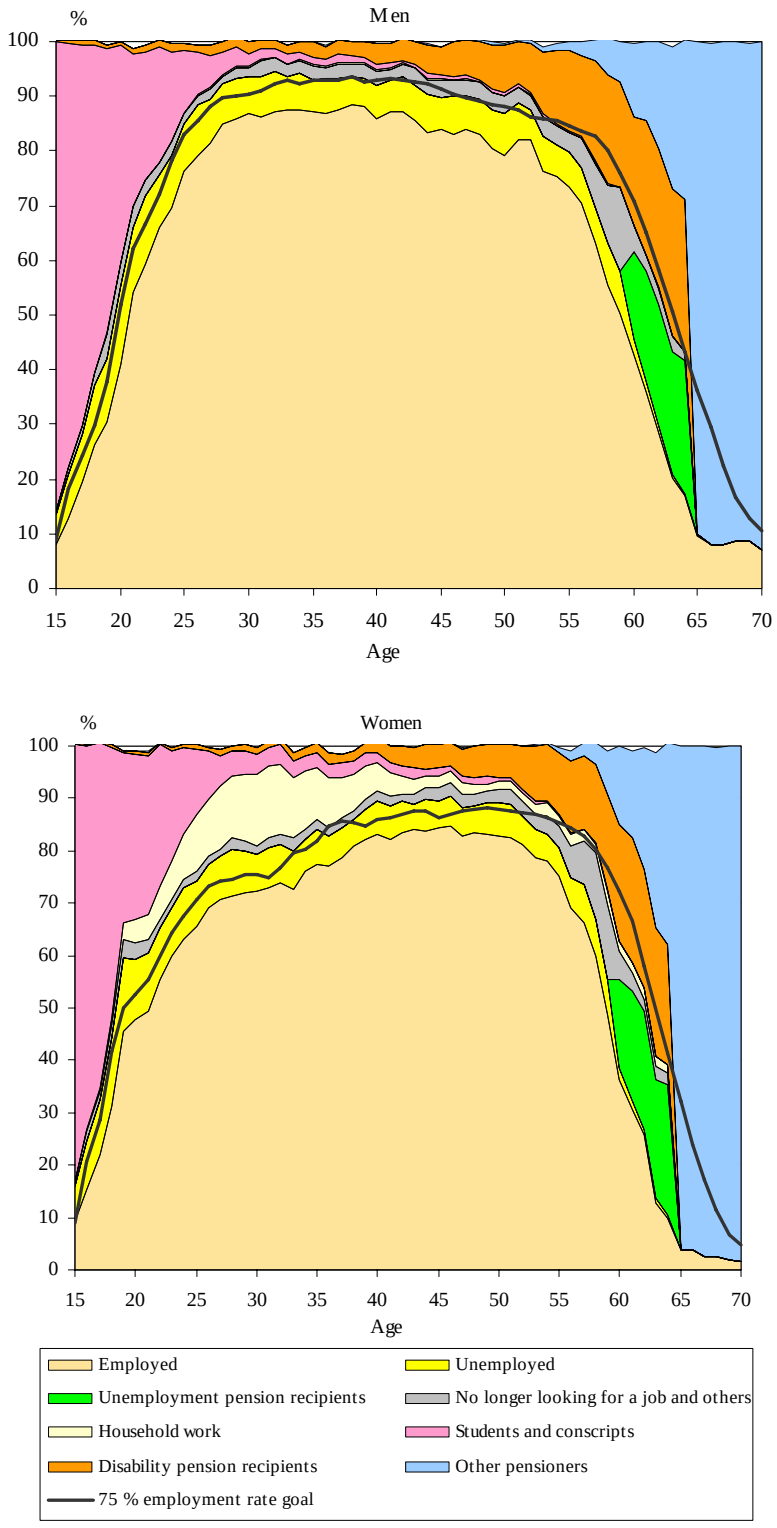
> The GDP ratio of social protection expenditure is a very crude and insufficient indicator of social protection. Differences in age structure of the population or in the phase of business cycle, for example, may make it harder to make comparisons between countries or between different points in time. There may also be considerable differences in the efficiency of provision of social and health care services. Service users are mainly interested in the availability and quality of services, not in the input used to provide them.
>
> Social expenditure statistics do not take into account differences in taxation between countries, either. In Finland and the other Nordic countries, the majority of social security benefits is taxable income, and their gross level is correspondingly higher. The significance of social tax deductions used in lieu of income security benefits is also smaller in Scandinavia than in many other countries. In traditional social protection expenditure statistics, this support given through the tax system is not taken into account. The OECD has carried out comparisons of so-called net social expenditure, in which an attempt has been made to take into account differences in taxation. Measured in terms of net social expenditure, the differences between countries are smaller than in traditional comparisons based on social protection expenditure (see Trends in Social Protection in Finland 2004, p. 40).

What does attainment of the employment goal require?

Figures 5 and 6 look at age-group specific employment among men and women in 2004, comparing it to the government's 75 percent employment goal. In addition to the employed, the figures also show the distribution of the rest of the population by their main type of activity. The figures show clearly how challenging the employment goal is. Compared to the year 2004, attainment of the employment goal would e.g. require that nearly all unemployed and hidden unemployed, those who have given up job-seeking and those receiving unemployment pension would be employed by the year 2011.

Achieving this objective calls for a number of measures. Studies must progress more efficiently and study times must be made shorter. The possibilities for flexible reconciliation of work and family life must be improved. The work ability of the population must be taken care of in all age groups. The possibilities and economic incentives of ageing workers to stay on at work must be ensured.

Figure 4. Distribution of men and women aged 15–70 according to their main type of activity in 2004, %



Source: Statistics Finland, labour force survey

1.2 Municipal economy and the state budget for 2006

On the level of the country as a whole, municipal economy weakened clearly in 2004 compared to the year before. This was due particularly to the greater than estimated growth of operating costs. The 1.3 growth in tax revenue was also insufficient, although government grants as a whole grew by nearly 10 percent in 2004. The aggregate annual margin of municipalities fell by some € 150 million from the year 2003.

The number of municipalities with a negative annual margin rose to 138 from 63 the year before. Having a weak annual margin continues to be most common in municipalities with a small population. According to the basic services programme, the financing situation of municipal economy is expected to improve somewhat in 2005. This is due particularly to the estimated growth of tax revenue by 4.5 percent.

In 2006, tax revenue is expected to rise by nearly 4.5 percent. The financing balance of municipal economy will continue to improve in 2006, but the annual margin will remain somewhat lower than the write-off of fixed assets. Municipal economy is estimated to gain balance in 2007–2009, so that the annual margin will be sufficient to cover write-offs. Despite the growth of annual margin, it will remain smaller than net investments throughout the period under study.

The change in population age structure increases the demand of services as well as municipal spending. Migration also increases costs in fast-growing municipalities, while making it harder to maintain the service structure in municipalities with a diminishing population.

The differentiation of municipalities is expected to continue in the years to come as well. According to a Ministry of the Interior estimate, annual margin will improve from 2004 to 2006 in municipalities with more than 6,000 inhabitants, while it will deteriorate in municipalities with less than 6,000 inhabitants. Weakening of the annual margin will mostly be seen in municipalities with a population under 2,000. During the same period, the annual margin will grow most in municipalities with more than 100,000 inhabitants.

Table 2. Key indicators of economy of municipalities and joint municipal authorities, € billion

	2003	2004	2005	2006	2007	2008	2009
Operating margin	-16.3	-17.1	-18.0	-18.7	-19.1	-19.8	-20.5
Tax revenue	13.5	13.7	14.2	14.7	15.3	15.9	16.5
Central government grants for current expenditure	4.3	4.7	5.1	5.5	5.8	6.0	6.2
- of which the share of the Ministry of Social Affairs and Health	2.9	3.4	3.8	4.0	4.2	4.4	4.4
Annual margin	1.6	1.4	1.5	1.7	2.0	2.2	2.3
Investments, net	2.3	2.5	2.4	2.4	2.4	2.4	2.4
Total outstanding loans	5.6	6.6	7.3	7.9	8.2	8.4	8.6

The figures in the table are based from 2005 onwards on preliminary data or estimates
1) According to the municipalities' own accounts

Source: Advisory Board for Municipal Administration and Economy, 2005

Measures implemented by the central government have diminished the differentiation trend between municipalities. In rural municipalities and those with a population under 6,000, government grants make up on average about 40 percent of municipal income. In municipalities with more than 100,000 inhabitants, government grants constitute less than 3 percent of municipal income generation. From the viewpoint of municipal economy, the most problematic category consists of municipalities with a negative annual margin during several consecutive years and whose income financing is not sufficient to cover expenses. These municipalities typically have a small number of inhabitants, they suffer from migration loss, the municipality structure is rural, and they have a high tax rate as well as a poor financing situation. The cost of service provision in these municipalities is also well above the national average.

According to the Government Programme, the financing balance of municipalities' tasks and obligations is improved by a basic services programme between the state and municipalities and an annual basic services budget linked to it.

The basic services budget is used to time and target the annual implementation, costs and financing of the measures in accordance with the basic services programme. The first phase of the reform of the government grants system will be implemented as of the beginning of 2006. In the reform, the division of expenses between the state and municipalities will not change on general level.

There is increasing pressure to curb municipal expenditure. Securing basic services calls for continuous evaluation of operating methods and service structures on the part of municipalities, in addition to readiness for structural changes that make it possible to operate more economically and efficiently. Particularly the implementation of the National Health Care Project and the National Development Project for Social Services calls for municipalities' own input when it comes to improving their welfare services. Securing the availability and quality of basic municipal services with a reasonable tax and payment burden calls for investment in a functionally capable and viable municipal structure.

Main lines of the project aimed at restructuring municipalities and services

In its meeting held on 28 September 2005, the ministerial basic services groups made a decision on the lines of the regional phase of the project to restructure municipalities and services. During the regional phase, three simplified restructure models will be discussed in accordance with the proposal made by the working group on restructuring municipalities and services. The three models are the Basic Municipality Model, the District Model and the Regional Model.

The District Model

The District Model of social and health care addresses only social and health care services. The model does not call for municipal restructuring or for other sectors to join the service structure, but it does not exclude these alternatives, either.

The starting premise is to ensure that there is a network of services in the country that is able to respond efficiently to current and coming challenges. The administrative framework must make it possible to make sure that the services

network is comprehensive, demanding care is centralised and the availability of staff and competence is secured, while ensuring the implementation of rational investment and care practices, rapid dissemination of good practices and an effective data network. Because the situation differs in different parts of the country, the model must also allow for differences.

In the district model, social services, primary health care and specialised care are integrated within the same organisation. The aim is to achieve rationalisation of operation and to raise productivity. The responsibility for arranging services is transferred to social and health care districts.

In the district model, the population base should be at least 100,000, preferably 150,000–200,000. The primary task of the social and health care district is to act as purchaser in arranging services, making sure that the supply of appropriate services is guaranteed. The social and health care district also has its own service provision. It compares its own provision to services produced by other providers. Particularly demanding medical care is concentrated in a few national units.

The social and health care district is divided into basic care areas with a minimum population base of 20,000. The basic care areas do not necessarily follow the current boundaries between municipalities. Basic services can be produced in a decentralised manner according to local needs. The main part of the financing of the social and health care district is based on a population-based payment defined in advance. Part of the financing may be based on the use of services. In order to encourage preventive work, a system of over- and under-use pricing may also be adopted. The client fees are debited to municipalities. The payment shares of municipalities and government grants adjusted in accordance to population base are debited to the district. Municipalities make the payment to the district, and the district must adapt its operation according to this financial framework. Within the district, decisions on the social and health care service network and the expenditure framework are made by elected officials.

The Regional Model

According to the Regional Model, a total of 20-25 regional municipalities are set up in Finland. The present municipalities will become “local municipalities”. The operating model to be adopted in the capital region will be solved separately. Regional municipalities are responsible for arranging services. The responsibility for service arrangement does not mean centralisation of service provision and distribution; services will be produced in the regional municipalities in a decentralised manner, in accordance with local needs and prerequisites. Responsibility for the arrangement of part of the services may be delegated through legislation to local municipalities. Regional municipalities can also delegate tasks to local municipalities.

The regional municipality would act as the basis of representative democracy and direct citizen participation. Regional councils and other joint municipal authorities can be abolished as their tasks are transferred to regional municipalities. Tax revenue and government grants are directed to regional municipalities. As the regional municipality delegates services to the local municipality, they are

implemented through service productisation based on a system of contract steering. As regards tasks assigned to municipalities by legislation, financing for their provision can be directed to local municipalities: e.g. as a fixed percentage of the local municipality's tax revenue, a task-specific supplement, an incentive supplement or other possible solutions.

The possibilities provided by new technology are utilised in the organisation of services by regional and local municipalities. Cooperation between local municipalities is needed when agreeing on national division of tasks, e.g. in the field of specialised medical care. Special local characteristics and language issues can be taken into account when defining the boundaries of local municipalities and/or dividing tasks between regional and local municipalities. The formation of areas, including regional municipalities, that are sufficiently uniform e.g. in terms of the language spoken must be made possible.

The Basic Municipality Model

The basic municipality model consists of an area where people go to work or some other type of functional entity. The objective is to have a minimum of 20,000-30,000 inhabitants in the basic community. The municipalities would be responsible for both financing and organisation of services. The area would also act as the basis of representative democracy and direct citizen participation. If the municipalities lack the prerequisites for setting up a new municipalities, responsibility for the organisation of basic services must be transferred to a basic services district comprising 20,000-30,000 inhabitants under a transition period. If the municipalities are unable to reach a decision on municipal fusion or setting up a basic services district, the Council of State can make a decision on the measures needed.

Municipalities or service districts purchase more demanding specialised medical care and social services that require a wider population base from hospital districts or other service providers, making use of competitive tendering. The number of hospital districts is reduced, and particularly demanding care is concentrated in districts with a population of 1,000,000.

2006 budget

The proportion made up by the main division of the Ministry of Social Affairs and Health in the 2006 budget comes to about € 11 billion. The amount is 12 percentage points higher than in the 2005 budget.

The greatest increases in appropriations in 2006 are caused by the abolishment of rendering of VAT returns totalling € 1.0 billion to the health insurance and national pension fund as well as lowering of the social security payment by the state employer's office and an increase in government grants. Index adjustments to social security benefits will increase state expenditure by about € 43 million. As part of the measures included in the Ministry's main division proposed to provide support to those who are most vulnerable, the proposal includes raising the level of national pension and the benefits linked to it, use of a rehabilitation allowance for the long-term unemployed

during participation in drug rehabilitation and abolishing the deductible on housing fees from social assistance.

A total of € 4,021 million is proposed for government grants towards the operating costs of social and health care in municipalities, showing an increase by some 9.5 percentage points compared to the 2005 level. Of the increase, € 55 million comes from a transfer of compensatory payments for large child protection costs that were previously paid from a different budget sub-item, € 63 million is related to a readjustment of cost division between the central government and municipalities, and € 94.7 million to a raise of government grants by 2.4 percent due to changes in cost level.

Of the increase in government grants, € 73 million is related to the development of municipal health care systems in accordance with the National Health Care Project and development of the social services system as defined in the National Development Project for Social Services. Of this raise, € 9.9 million is used for ensuring continuous education of municipal social services staff, € 4.0 million for the development of informal care and family care, and € 59.2 million for raising the level of central government grants by 0.48 percentage points. Crime settlement will become statutory in the entire country as of 1 March 2006. In 2006, the compensation allocated for settlement costs amounts to € 5.3 million.

As part of the reform of the system of government grants to municipalities, some of the criteria for defining government grants for social and health care will be adjusted. The costs due to services for gravely disabled persons will be compensated with a new disability coefficient, and the costs due to need of child protection by a new child protection coefficient, which will replace a separate compensation system used for large child protection costs. In addition, the criteria for defining the remoteness coefficient will be altered.

As part of the labour market support reform aimed at increasing employment of the long-term unemployed, the norm-based part of income security is detached from the government grant system at the beginning of 2006. As a result of this, € 144.2 million has been deducted from government grants to municipalities, because in future, basic social assistance will be paid from a separate budget sub-item, and its financing will be divided equally between municipalities and the central government. In order to compensate the increase in costs to municipalities caused by the labour market support reform, the government grants towards social and health care operating costs will be increased by € 67.5 million. The raise will increase the level of government grants by 0.56 percentage points.

As part of the measures implemented aimed at supporting those who are most vulnerable, the housing fee co-payment will be abolished from social assistance as of 1 September 2006. The extra costs caused by this (€ 40 million on annual level) will be fully financed by state funds.

The level of government grants towards municipal social and health care operating costs will increase from its present level of 32.99 percent to 33.32 percent in 2006.

The Ministry proposes € 55.2 million in government subsidies to municipal social and health care projects. Of this appropriation, € 30 million would be used for development

projects supporting the National Health Care Project. The rest of the sum would be targeted at projects related to the implementation of the National Development Project for Social Service and the Alcohol Programme.

Health insurance financing undergoes reform as of the beginning of 2006. In the reform, the insurance principle of health insurance is emphasised by strengthening the connection between payments and benefits. Financing through the health insurance fund is divided into two parts, health insurance financing and earnings insurance financing.

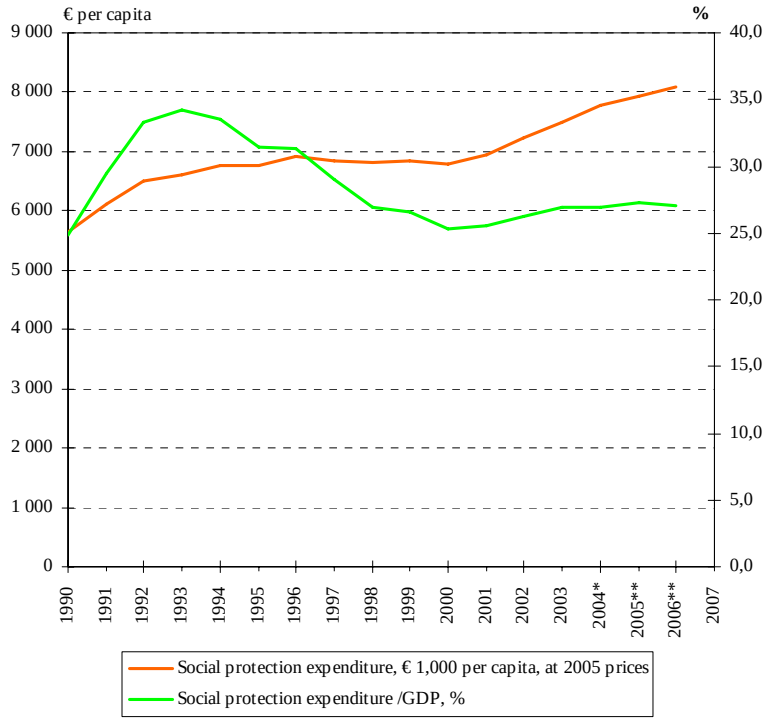
The state finances the health care costs covered by health insurance paid to EU member states. In other cases, health insurance is financed by an equal contribution from the insured and the state. The earnings insurance is financed with contributions from employers, employees, entrepreneurs and the state. The state finances minimum-level sickness and parenthood allowances as well as rehabilitation allowances. In addition, the state finances part of the occupational health care costs of farmers and entrepreneurs. In 2006, employers finance 73 percent of other earnings insurance costs, while 27 percent comes from employees and entrepreneurs.

In the 2006 budget, the costs of earnings insurance and health care insurance are estimated at € 1.8 billion and € 2 billion, respectively. The total cost of sickness insurance is thus estimated at € 3.8 billion. The government grant for 2006 is estimated to total € 1.1 billion, with € 86 million going to minimum-level earnings insurance allowance and € 5 million to occupational health care for farmers and entrepreneurs. In earnings insurance, employers' contributions would make up € 1.3 billion and those of wage earners and entrepreneurs € 0.5 billion.

1.3 Social protection expenditure and its financing possibilities

After a long decline, the GDP ratio of social protection expenditure started to show a slight increase in the early 2000s. Besides a rise in social protection expenditure, this was caused by a slowdown in GDP growth. The decline of the GDP ratio of social expenditure in the latter part of the 1990s is also partly explained by the rapid growth in GDP. Social expenditure per capita did not change appreciably during the same period (Figure 5).

Figure 5. Social spending as a proportion of GDP (%) and social spending per capita (at 2000 prices) in 1990–2005



In recent years, social protection expenditure has grown due to increases in costs related to old age, sickness and health. Taken together, these functions make up over 50 percent of social protection expenditure. Despite the increase in recent years, sickness and health-related costs still constitute a smaller share of total social protection expenditure than in the late 1980s and early 1990s (Table 3).

Employers are the biggest financers of social protection expenditure, contributing to pensions, unemployment security and health insurance. The insured also contribute to these benefits. Basic cash benefits, such as basic unemployment allowance, child allowance, housing allowance as well as government grants to municipalities for social welfare and health care services are mainly financed by the central government. Municipalities bear the main responsibility for financing social and health care services. Other financing comes primarily from capital income from funds (yield from funds).

Table 3. Social expenditure by function, percentage shares in 1990 and 1995–2006, %

Year	Sickness and health	Disability	Old age	Survivors	Families and children	Unemployment	Housing	Other social protection	Administration	Total
1990	27.5	15.0	28.6	4.0	13.0	5.9	0.7	1.8	3.5	100.0
1995	20.3	14.5	28.1	3.8	13.0	14.0	1.5	2.0	2.8	100.0
1996	20.7	14.3	29.0	3.8	12.1	13.5	1.2	2.3	3.1	100.0
1997	21.3	14.3	29.1	3.9	12.3	13.0	1.2	2.4	2.7	100.0
1998	22.0	14.0	29.5	3.8	12.4	11.7	1.4	2.1	3.1	100.0
1999	22.4	13.8	30.3	3.9	12.4	11.0	1.5	2.1	2.6	100.0
2000	23.1	13.5	30.8	3.9	12.1	10.2	1.4	2.0	3.1	100.0
2001	23.7	13.3	31.6	3.8	11.7	9.5	1.1	2.1	3.0	100.0
2002	24.1	13.0	32.0	3.8	11.3	9.5	1.1	2.1	3.2	100.0
2003	24.3	12.8	32.2	3.7	11.1	9.6	1.1	2.1	3.2	100.0
2004*	24.6	12.6	32.1	3.5	11.1	9.8	1.1	2.1	3.2	100.0
2005**	25.0	12.4	32.2	3.5	11.1	9.5	1.0	2.1	3.3	100.0
2006**	25.3	12.2	32.8	3.4	11.1	9.0	1.0	2.0	3.3	100.0

* Preliminary data **Estimate. Source: National Research and Development Centre for Welfare and Health, preliminary data/estimate, Ministry of Social Affairs and Health

The distribution of the financing burden is hard to assess on the basis of a formal categorisation of sources of funding. The incentive effects of different means of financing are not revealed either when using this approach. The share of both central government and municipalities is ultimately financed by tax revenue. The central government in particular gets tax revenue from a variety of sources and types of taxes. The government grants to municipalities entered under central government financing are primarily calculatory, i.e. they are not based on the actual costs of individual municipalities. Their use is not tied to a particular purpose either. The social insurance contributions paid by employers and the insured are mainly based on wages paid, but part of the payments is based on other factors as well. For the distribution of the payment burden, the division into contributions made by employers and the insured (employees) is not necessarily particularly important.

The GDP ratio of social protection expenditure in Finland is on average EU level (EU15). Data of the new member states that joined the EU on 1 May 2004 are not included in the comparison shown in Figure 8. In most of the new member states, social protection expenditure is clearly below the Finnish level. In addition to the size of social protection expenditure, there are also differences in expenditure structure between EU member states. The large social protection expenditure in Sweden and Denmark is partly due to the high level of expenditure on services; these countries actually use less money for cash benefits than some other EU member states. In Finland, the share of total expenditure made up by service costs is smaller than in Sweden and Denmark, but higher than the EU average.

Figure 6. Financing of social protection in 1990 and 2004, %

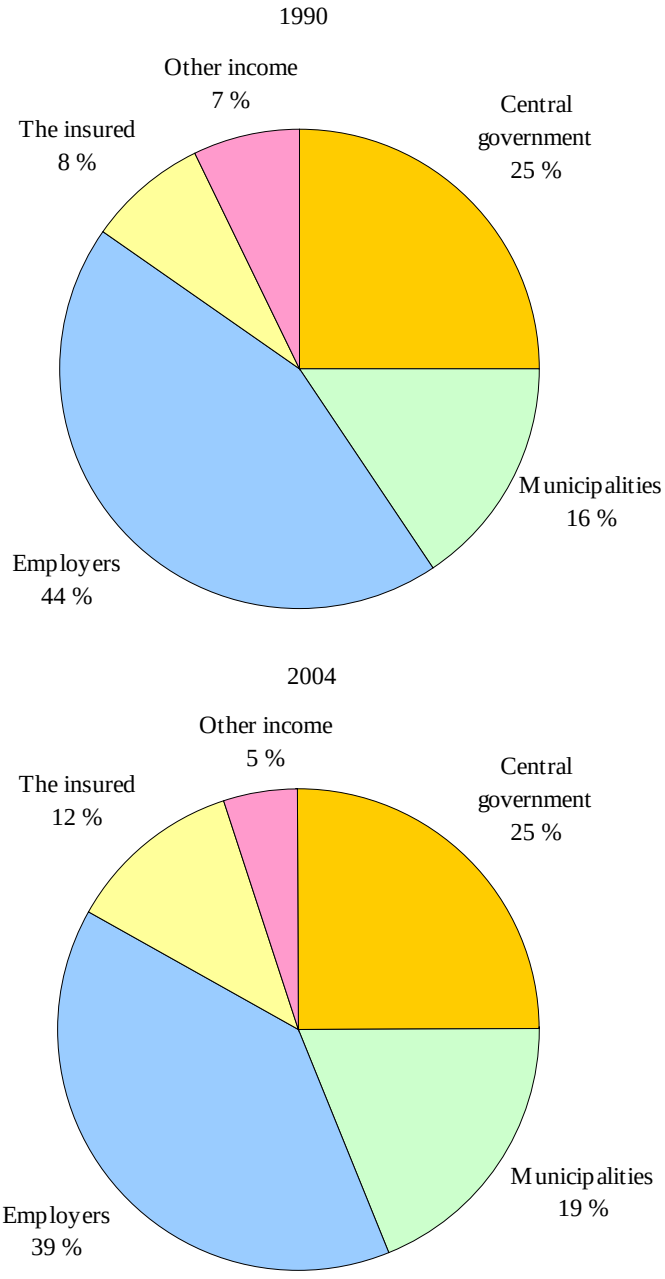
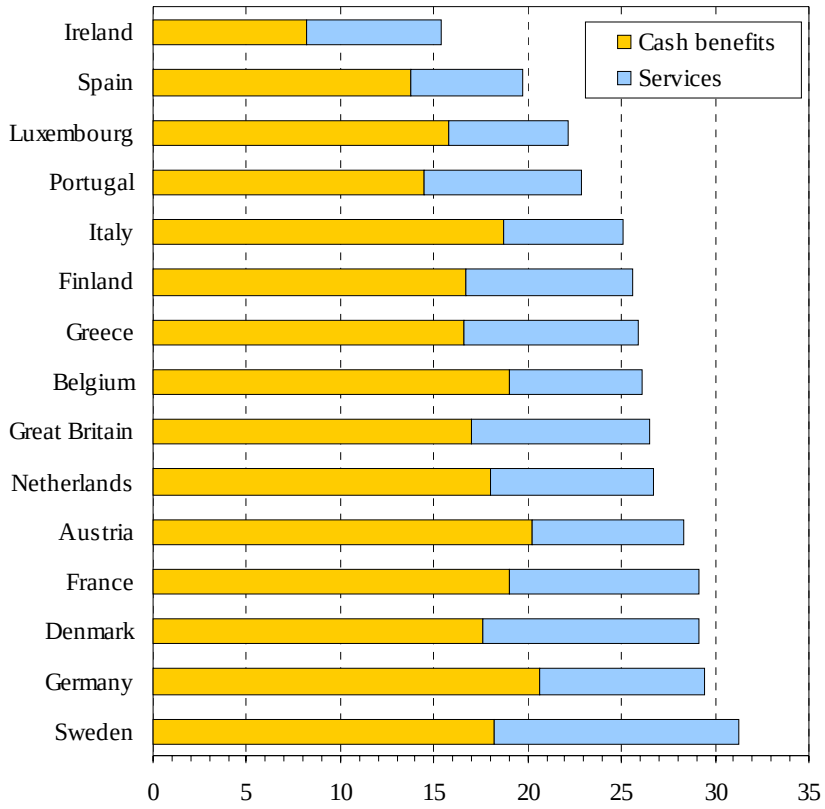


Figure 7. Social protection expenditure in relation to GDP in some EU member states in 2002



Source: Eurostat

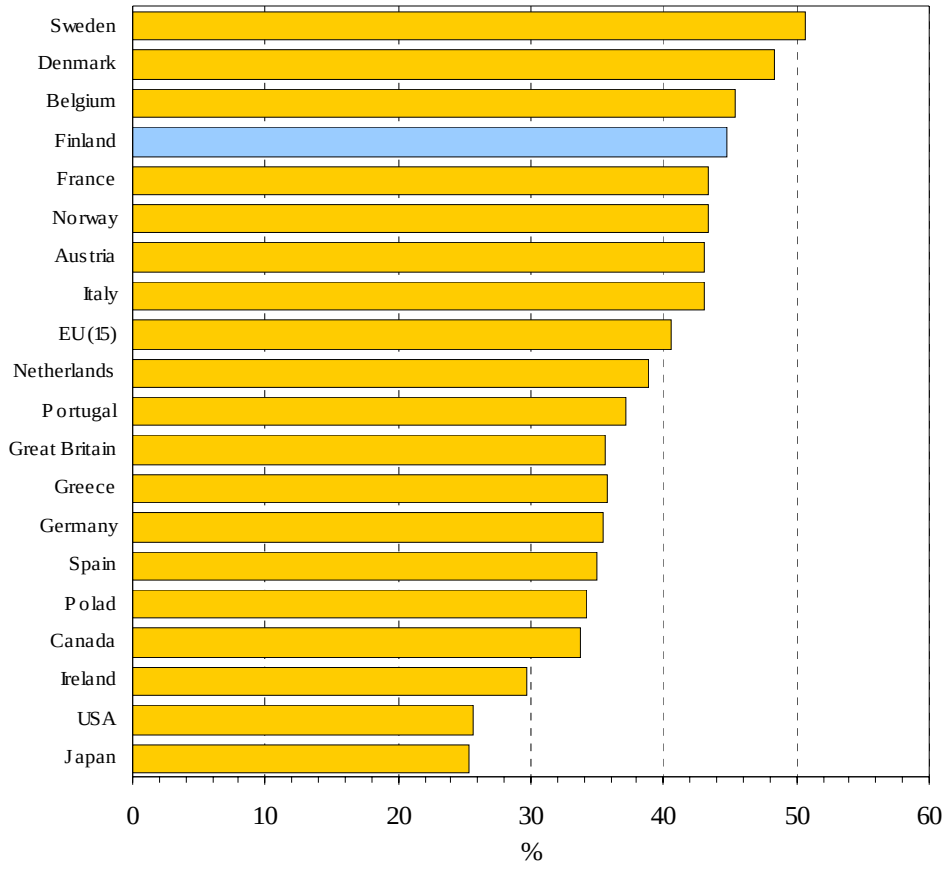
Taxation and tax competition

Even if the GDP share of social protection expenditure were not to rise significantly in the future, the financing of social expenditure may become endangered due to other reasons as well. The tightening of international tax competition may increase the pressure to lower taxes and social insurance contributions and thus endanger the financing of social protection. The impact is largely dependent on how the behaviour of households, enterprises and labour market organisations is affected by taxation. If households appreciate the services and benefits financed through taxes and social insurance payments, people are more willing to accept a somewhat higher tax burden and a lower net income level. This is not necessarily just a question of the benefits or services received by each individual household. The social cohesion guaranteed by social protection and its positive impact on the living environment are a value in themselves. Similarly, the localisation decisions of firms are also affected by a variety of factors. Taxation can ensure a well-functioning infrastructure, a well-educated and healthy labour force as well as social stability. In such cases, minor differences in the level of taxation may not be the primary factor when localisation decisions are being made.

The total tax rate in Finland is higher than the EU average. However, the tax rate in both Denmark and Sweden is clearly higher than in Finland, and the difference between Finland and countries such as France, Belgium and Austria is small. Taxation in the new EU member states in our immediate vicinity is clearly lighter than in Finland.

When assessing future challenges, other EU member states may not necessarily be the only key comparison group. Many EU states are grappling with the same problems of financing social protection as we are facing. In the global economy, the most interesting division lines when making comparisons may therefore be found between EU member states and other countries.

Figure 8. Total tax rate in some OECD countries in 2003, %



Source: OECD, Revenue Statistics 1965–2003, 2004 edition

1.4 Incentive social protection

The aim of the welfare society is to implement the basic rights of the population and to reduce inequality between citizens. Social protection based on comprehensive joint responsibility supports citizens' equal opportunities, integrates citizens into the community and increases a feeling of social belonging, which adds to social cohesion. At the same time, strengthening well-being makes the society more stable and supports productivity, functional ability and the possibilities for economic growth in society. According to studies, poverty and exclusion can be successfully prevented by social and health care services aimed at all citizens as well as a social security that ensures a reasonable income level and basic income security.

The task of social protection is to act as a safety network for citizens during risky periods in their lives. Social policy also involves looking after those who cannot take care of themselves or are unable to assert their rights. According to the Finnish

constitution, everyone is entitled to the protection provided by basic income security in times of unemployment, illness, disability or in old age, as well as due to birth of a child or loss of provider. Many of these situations involve such a high level of insecurity and risks that actuarial insurance operating in the free market is either ineffective or even downright impossible. The society can act as the risk bearer, protecting citizens against insecurity and great risks with the aid of compulsory social insurance.

If the security network functions properly, people dare take risks, such as change professions, jobs or place of residence. They can also improve their competence by participating in training, or stay at home temporarily to take care of their children. That is why the welfare society can also be seen as a system that encourages citizens to act in the right direction. At its best, social protection supports risk taking on the part of citizens, providing a springboard to society and employment, while preventing unnecessary reliance on social protection benefits.

The welfare society can also be motivated from the point of view of efficiency and functionality of the national economy. First, when looking after people's health and maintenance of work ability and functional capacity, social policy supports economic activity. Today, social protection is also increasingly understood as an investment in the labour force. Education has a positive effect on economy as well. In addition to basic education, work experience gained in adulthood as well as continuous education and re-education throughout the career improve work efficiency, postpone giving up work and increase competence capital.

Boosting health and functional capacity as well as employees' competence and work ability are important for the everyday well-being of all citizens and society as a whole. In addition to genetic factors, people's state of health is primarily affected by their lifestyle. That is why individuals bear the greatest responsibility for their own state of health as well as their work ability and functional capacity. It is the government's task to support citizens in the maintenance of health of work ability at all stages of life by reducing the risk factors related to them and by creating environments supporting healthy choices. In the case of illness or weakened functional ability, everyone is entitled to care and nursing services, and those unable to look after themselves are always cared for according to the principle of joint responsibility.

Social protection makes it easier to reconcile work and family life by sharing the responsibility for looking after the welfare of family members. Reconciling work and family responsibilities – whether it involves looking after small children or one's parents – may have a positive impact on both employment and the birth rate. Public welfare services, such as the system of day care for children and school lunches, have made it possible for women to go out to work. As parents have the possibility to choose between different care alternatives for their children, they can have jobs and still be good parents. Besides well-functioning services, individual social insurance rights and separate taxation have been observed to increase the workforce participation of mothers with young children. A high workforce participation rate as well as full-time employment of women are characteristic features of the Finnish labour market.

In the event of social risks, citizens are guaranteed relatively steady purchasing power by social protection. This evens out the changes in demand at different business cycle phases of the national economy. As a whole, social protection has a positive impact on

employment, because beneficiaries' propensity to consume is generally high. Redistribution of income raises the average propensity to consume of the entire economy, leading to increased demand and thereby to increased employment.

The significance of social protection and safety networks is emphasised in a constantly changing operating environment. In an increasingly globalised world, there is a need for social protection that reduces the uncertainty related to change and alleviates the social and economic problems caused by economic restructuring. At the same, a global economy and increasing competition pose ever greater demands on social protection. The welfare society must be more dynamic than ever in order to be able to offer protection in the event of new kinds of social and economic risks as well. In addition, the incentive effect and economic efficiency of social protection and its ability to support balanced economic development are becoming increasingly importance.

Social protection and balanced economic growth

- Social protection increases the well-being and equality of the entire population
- Social protection integrates citizens into community
- Social protection evens out fluctuations in the business cycle
- Social protection encourages employment and independent initiative
- Social and health care is ensured for all citizens
- Social protection helps adapt to the demands of a changing operating environment

Justice vs. efficiency

At its best, market economy can lead to efficient operation, but it does not necessarily result in the implementation of justice. The latter task remains the responsibility of the public sector. On the other hand, as the public sector grows, so does social protection expenditure and thereby taxes and fees as well. Although tax revenue can be used to promote a more even distribution of welfare, an increase in the level of taxation and social protection contributions leads to changes in relative price . This may have a harmful impact on production, investments and employment. The efficiency of national economy is weakened by a high tax wedge, which may for its part lead to a reduction of national production and thereby to a decrease of the total welfare level. However, there is no unequivocal empirical evidence of this (Suoniemi et al. 2003).

Citizens' willingness to pay taxes is dependent on the services and income transfers they feel they get in return for the taxes they pay. The incentive problems in taxation and income transfer policy may thus be alleviated by public service provision. According to opinion polls, Finns hold the Finnish social protection system in high regard and it has extensive public backing.

Economic growth and social development are intertwined in many ways. A smoothly running production and economic system make up a good setting for the operation and financing of the welfare society, while social protection supports a well-balanced development of society and the economy.

An increase of national wealth does not as such guarantee the implementation of justice in society. Taking care of the sustainability of welfare also includes objectives aimed at keeping the tax and payment burden on a reasonable level and ensuring that increasing pension and care costs do not displace other types of vital operation. Furthermore, welfare must have a socially sustainable foundation, and citizens must have a feeling that they are living in a just and fair society. The welfare society operates at its best precisely when both social and economic objectives can be combined in an optimal manner.

On the one hand, the operation of the welfare society should be efficient, so that the GDP ratio of social protection expenditure remains at such a level that social expenditure does not lead to distortions in the operation of citizens and society. On the other hand, social protection should be sufficiently efficient also in the sense that it guides citizens to make wise choices when making decisions. When social protection is being reformed, an important objective to keep in mind is to aim at mutual support between social protection and economic policy. The responsibilities for organising social protection must be clear-cut and functional, the operation must be efficient and it must have a solid financial basis.

In principle, social protection can be organised in two different ways: ensuring a certain level of social protection to all citizens, or targeting only those who are most needy. The appropriate level of social protection must be sought between these two extremes. If the system of benefits is primarily need-based, the problem is that it does not reach everyone and its administration costs are high. On the other hand, universal social protection that compensates for nearly all risks is expensive, because even those who do not need benefits receive them.

The level of taxation is generally higher in countries with universal social protection. On the other hand, when comparing health care expenditure in the Nordic countries and the United States, for example, it can be seen that the total per capita costs of public and private health care are higher in the US than in Finland. Public health care provision thus appears to be a less expensive alternative, in addition to providing coverage to all citizens.

Why public social insurance is needed

Private, voluntary insurance cannot alone cover the risks related to e.g. unemployment, because the insurer does not have full knowledge of the behaviour of the person insured, and thus it cannot estimate the likelihood of unemployment, which is a key factor in terms of determining the insurance fee. Private unemployment insurance involves both the risk of adverse selection and moral hazard.

Firstly, if someone has a high risk of becoming unemployed, he also has more reason to acquire unemployment insurance. If the insurer cannot assess the risk level of the insured, it is not possible to levy individual insurance fees based on different risks. That means that the same fee based on average risk level must be levied from all the insured. If a private insurance company were to offer unemployment insurance, it would have to set a relatively high level of payments in order to generate profit. This would scare away potential clients with a low risk level.

This adverse selection of the insured leads to a situation where part of the population is unable to obtain full insurance coverage in the private insurance market. The problem can be solved partly by making the insurance a social insurance that is compulsory to all. This way, increased efficiency in society is made possible by public provision of unemployment insurance.

Secondly, insufficient knowledge on the part of the insurer concerning the behaviour of the insured may lead to the problem of moral hazard, as the insured can themselves affect risk implementation and the expected extent of damage. [1] For example, if the compensation received from unemployment insurance is good, an employee who has lost his job may be tempted to remain unemployed for a longer period of time. At the same time, it is difficult for the insurer to determine when the employee is genuinely unemployed. This leads to overinsuring and causes inefficiency from the viewpoint of society. The problem concerns both public and private unemployment insurance, but the problem is more difficult in the case of private insurance, because is difficult to see unemployment insurance as an attractive business opportunity. The task of organising compulsory social insurance against unemployment is thus left with the public sector, although the problem of moral hazard cannot be fully eliminated by the public sector, either.

In the case of health insurance, information is even more incomplete, because it is difficult to define and measure health unequivocally. Insurance against sickness is inefficient due to the moral hazard problem because of two reasons: Firstly, people with complete insurance coverage have a lower tendency to look after their health than if they had to bear the full risk themselves. Secondly, if the insurance event compensation is paid after the event, close to full value, it encourages both doctors and clients to act as if the treatment were free of charge. The higher the compensation rate, the less the parties involved must bear the consequences of their actions. This leads to excess utilisation of social and health care services, a good example of this being the youth insurance in Finland in the 1980s.

According to Barr (1993), the operation of the entire welfare society is inefficient and costs are hard to control if neither the provider nor the consumer is aware of the costs caused by their actions. The efficiency of welfare service provision is fundamentally dependent on regulation mechanisms.

Furthermore, the operation of the market is not always necessarily efficient because knowledge on the part of health care clients concerning the quality and prices of services is insufficient. Their expertise is usually not sufficient for them to be able to choose between different health care procedures. On the other hand, due to the nature of medicine, doctors cannot always be sure of the success of treatment. The need of monitoring of the quality of public administration can thus be motivated by incomplete information and the greater cost that may be caused by poor choices.

As a rule, competition in the market lowers costs while increasing efficiency and flexibility and providing more choice for the consumer. However, both theory and practical examples show that health care and insurance against social risks organised exclusively by the private sector would be inefficient and unjust. On the other hand, just like the free market, the public sector can also operate either efficiently or inefficiently.

Encouraging employment

As the population age structure changes, raising the employment rate and lowering unemployment are key challenges in terms of sustainability of social protection financing. That is why it is increasingly important in an ageing society that employment is always the primary alternative as opposed to social protection. Employment plays a key role in the prevention of exclusion as well.

Welfare policy has created prerequisites for work-force participation for the working-age population. Because benefits are largely tied to gainful employment, citizens are encouraged to work. On the other hand, the high level of taxation and fees may lead to a situation where incentives for employment are weakened.

Incentive traps may appear in two forms. Taken together, earnings-related social benefits, service fees and taxation may lead to an incentive trap: as gross income increases, the tax rate goes up, benefits are reduced and earnings-related fees increase. An unemployment trap is a situation where there is no increase, or even a decrease, in disposable income when a person moves from unemployment security to a job. Threshold wage, i.e. the wage level at which an unemployed person is willing to accept work, depends of the level of social protection and the grounds on which it is granted. The higher the benefits, the higher the threshold wage demand.

An indicator parallel to threshold wage is compensation rate, which indicates how much a person earns while unemployed compared to having a job. The threshold wage and compensation rate calculations depend on family structure, wage, taxation and benefits. Among income transfers, those most likely to cause incentive traps are social assistance, housing allowance and unemployment security benefits.

Income taxation, social benefits and income transfers, fees and services must form a functional whole that encourages people to become employed and stay on at work. Employment must always be an economically attractive alternative, so that the amount of disposable income is increased by getting a job, being employed and returning to work. Social protection, taxation as well as an active employment and family policy must promote training, rehabilitation and other active measures among the unemployed, with a clear aim to improve the work ability and labour market fitness of the people in question, supporting their return to the open labour market.

Together with the reform of the practical employment sector, the aim of incentive social protection is to increase the number of active years at work, to promote work satisfaction, improve work management, promote wellbeing at work and to ensure that employees can retire while healthy. The objective is to encourage citizens to use their own initiative as well as to promote well-being.

When planning measures aimed at increasing the incentive of work, three factors must be taken into account. Firstly, an attempt must be made to increase the supply of labour. The number of unemployment traps, income traps and poverty traps should be decreased in order to encourage labour force participation, raise the employment rate and reduce reliance on social benefits. Secondly, social benefits and earning-related benefits play a significant role in combating poverty. Thirdly, measures aimed at increasing the incentive of work should be cost-effective and in line with budget

limitations. Balancing between increasing the supply of jobs, combating poverty and the budget impacts of measures is a challenging task. If goals are successfully met in the case of one objective, problems may be encountered in the case of the other two. There is no single measure that would increase the incentive of work for everyone and in all situations.

The marginal between wage income and social benefits may be influenced by measures targeting employees' supply of labour (e.g. wages, wage income taxation, employees' social insurance payments, social benefits) and labour demand (e.g. indirect labour costs). Lowering of income taxation and the level of social benefits both lead to relative weakening of the income level of those relying on social protection and an increase in income differences. In the short term, improving incentives may thus be at odds with the basic goals of social protection. The correct balance between incentives and income differences is a matter of choice between different social values – or alternatively, between efficiency and justice.

An activating system includes both incentive and restricting features. Rather than providing ways to exit the labour market, social protection should act as a springboard to employment (*Making work pay*).

Incentive social protection encourages individual initiative and improving one's competence, which are needed more and more in the labour market due to rapid technological development and globalisation. Incentive social protection also supports risk taking that encourages citizens to make successful transitions in the labour market and prevents bad transitions (*Making transitions pay).* It a great challenge for the welfare society to respond to the increasing demand of mobility and flexibility of the labour market, while eliminating the uncertainty these factors cause to employees.

Furthermore, another problem is that there are individual differences in the supply of labour which are not dependent on economic factors alone. In addition, employment opportunities vary according to the phase of the business cycle. If unemployment is primarily caused by lack of demand for labour, the problems cannot be solved solely by providing incentives for work for employees. In such cases, employers' incentives must be improved as well. If unemployment is the result of poor compatibility between labour demand and supply, employees must also be encouraged to improve their work ability and competence, and employers must be encouraged to support this type of activity.

The impact of raising the level of earnings on labour force behaviour are not quite straightforward, either. How does an individual react to attempts to make him work more or stay on at work longer by raising the level of his wage or pension? Increased income has two opposite effects. On the one hand, an increase in earnings makes work a more rewarding alternative economically, and it may increase the supply of labour. On the other hand, the increase in earnings also increases disposable income; an increase in income generally increases the demand for all goods, including leisure, and may thus decrease the supply of labour. It is hard to predict which effect will be the stronger in any given situation. The outcome depends on several factors, the most important factor being the personal values of each individual.

The notion that economic incentives play a role in employment is supported by empirical evidence. If an employee does not get enough economic advantage from work compared to relying on benefits, the supply of labour is weakened and the labour market becomes ineffective. Different types of traps and labour market imbalance may lead to a growing grey job market and tax evasion. Underutilisation of resources means an inefficient operation of the national economy, which makes it harder to finance social protection.

In practice, it is difficult to show how common incentive traps are. Studies are usually based on calculations concerning different types of families used as examples. The results often show that the incentive trap is a problem concerning young families with children in particular. One of the problems with these calculations is how much increased leisure time is appreciated, if the wage is only slightly above the protection level provided by social benefits. Furthermore, based on cases used as examples it cannot be studied how large a group is affected by the incentive traps.

Even though the incentive traps are not large or frequent, it is important that the welfare system incentives work in the right direction. In practice, the incentive system of the welfare society is being tested daily. For example, when an employee becomes unemployed he is faced with the decision of whether to look for a job that matches his education and profession, a temporary position, or whether he should seek additional training, for example.

In recent years, the incentives of social protection have been increased so that it is more efficient in promoting work and employment, maintenance of work ability and functional capacity as well as rehabilitation. Changes have been made to taxation, benefits and the payment system. Income taxation, unemployment benefits, child-care benefits and fees, general housing allowance and social assistance have undergone reforms. Job-seeking has been made more active, the areas where people go to work have been expanded and the commuting deduction has been increased. The flip side of these measures is that the income level of those who are not employed lags behind the development of the income level of those who do have a job.

Incentives in the social and health care sector

Various incentives have an impact on the operation of the social and health care sector as well. Part of the incentives influencing the operation of the service sector are economic, such as financing decisions and the compensation grounds for producers' operation. Factors other than economic ones, such as legislation, sharing of information concerning the results of operation as well as continuing education opportunities have clear incentive impacts as well.

Municipalities and service providers can be encouraged to act in the desired manner by setting objectives, issuing recommendations and providing information and operational models to support local activities. Steering by regulation and resources is used when desired objectives cannot be reached within a reasonable timeframe, or if equal availability of services is threatened.

There is a great deal of pressure to change concerning the organisation of social and health care services. The population is ageing and concentrating around big cities. The service provision network may be adjusted as a result of technological development as well. At the same time, there is also need to increase the size of providers of some services in order to make use of the advantages brought about by specialisation. This trend is likely to be accelerated by potential difficulties in finding competent staff.

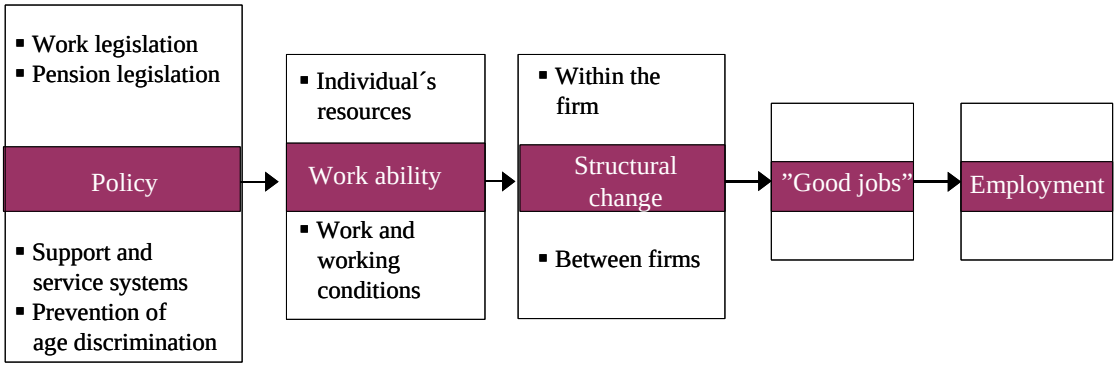
It is expected from a good health care system that services are available to all regardless of income and place of residence, that the care is effective and efficiently organised, and that the quality of services is good. The development of costs must also be kept under control.

When considering new incentives, it is a good idea to point out who is the target of the incentive. Incentives can target service purchasers, providers or users, and the relationship between the three. Incentives may also be used to impact the efficiency of service financing systems. For example, the health insurance system creates the wrong sort of incentives for municipalities and other parties. Because the insurance does not cover the medicine costs of patients in institutions, this encourages municipalities to look for solutions whereby the medicine costs can be transferred to clients and the Social Insurance Institution of Finland.

1.5 Productivity, employment and work ability

More than two thirds of the economic growth in the past few of decades is explained by an increase in labour productivity. Productivity is largely determined by work ability. Work ability refers to the sum of factors related to both the individual and work that are important in terms of the individual's ability to cope at work. Work ability is seen as a process where an individual's resources and work interact. Work ability develops on workplace level, and it can be promoted with various support and service systems, work and pension legislation and society's norms and values. These have an impact on enterprises' recruitment decisions and households' decisions to offer their labour. The employability of an individual is affected by both enterprise- and policy-level measures (Figure 9).

Figure 9. Work ability, employability and employment

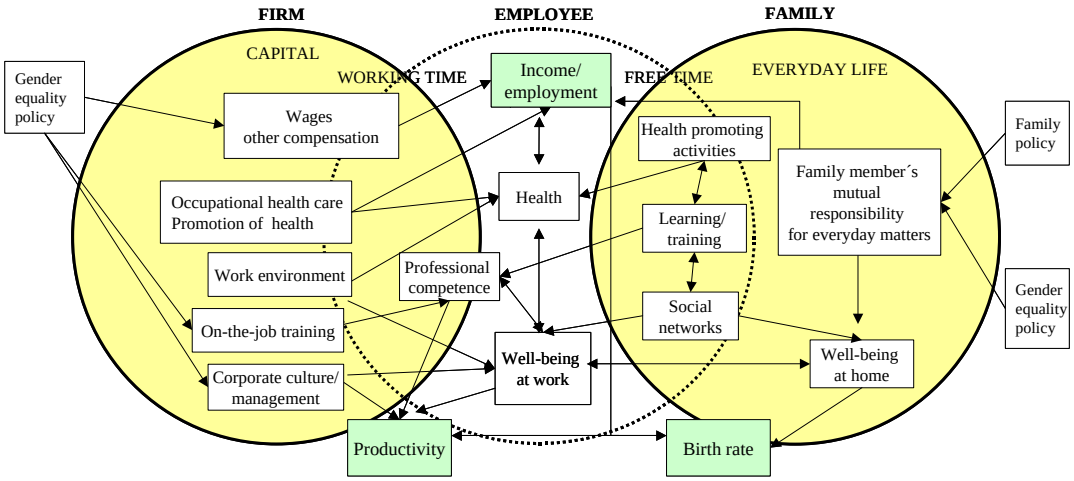


Good work ability among staff promotes the capacity of a firm to adapt to the challenges of globalisation, technology and ageing, which creates good job opportunities and maintains high employment.

Productivity and the competitiveness of a nation are not only determined within firms; welfare policy - social and health care policy as well as education policy - has a significant impact on the success of firms operating in Finland. The welfare policy pursued affects the quality and quantity of labour supply as well as population age structure. Households act as firms' counterparts, with responsibility for labour supply.

Figure 10 illustrates the connections between work and family life. Many of the factors affecting productivity, such as health, professional competence and well-being at work are not only determined within working life; family policy and gender equality policy have a significant impact on these factors that are crucial to productivity.

Figure 10. Reconciliation of work and family life



Corporate-level view

The productivity of a person is dependent on both the employee's characteristics and the firms' ability to make use of and develop its staff. The firm and its staff operate in interaction with each other. Firms invest in their staff, and correspondingly, employees' actions influence not only the success of the firm, but its corporate culture and management strategies as well.

The firm's investments in its staff comprise a) wages and other forms of compensation, b) occupational health and safety investments, investments in the work environment, and c) investments in the development of work skills, includingon-the-job-training, to meet technological challenges. Well-being at work is influenced by corporate culture and management.

Well-being at work may be the single most important factor affecting productivity. Well-being at work comprises the mutual trust between the firm and its staff. Trust is reflected in the way the firm adapts its operation to the challenges posed by age

structure, globalisation as well as technological and economic development. This is partly influenced by pension legislation and other social protection legislation. Job uncertainty affects employees' attitudes and motivation to look after their health and professional competence.

Well-being at work is a decisive factor when an individual makes a decision of whether to stay on at work or whether to attempt to find a way out of working life. According to interviews, well-being at work is a more important factor in encouraging people to stay on at work than wage.

From the firm's point of view, the productivity of an employee must be at least equal to the expenditure targeted at him in the firm's balance sheet. In the normal labour market, there is only room for people showing sufficient productivity.

An employee uses and adapts his resources at work. These resources consist of competence, health and the ability to get along with other people. These are affected by the work community, the work environment as well as the physical and mental demands of work. The impact of these factors is strengthened with age. Among ageing employees aged 55+, health and functional ability explain success at work even more than competence. Health and employees' competence both guarantee positive development of productivity.

Family-level view

The family is an important factor affecting work ability. The effects are mediated through the three dimensions of human capital – physical, mental and social. The wage income received by a family is not the only, nor always the most important factor behind the decision to offer labour. The supply of labour is affected by commitments felt by employees outside the sphere of work. For example, commitment to care for one's parents, children or spouse may be a factor behind the decision to leave work.

Family policy with its day care services for children creates the foundation for women's equal workforce participation. Family members' joint responsibility for everyday matters gives rise to well-being and equality within the family, which has a direct impact on well-being at work

The well-being of families also has an impact on the birth rate. It is more common for women to have temporary part-time jobs, which makes women's commitment to work more difficult. Having children is increasingly postponed. Education level also has an impact on the age women given birth. While some 85 percent of middle-aged women have children, the number among highly educated women of corresponding age is 77 percent. Childlessness is predicted to increase in the future.

Well-organised basic family tasks allow all family members to engage in health-promoting activities, get an education and maintain their social networks. These have a direct effect on the variables explaining work ability, such as health and professional competence. From the viewpoint of socially sustainable development, the division between time dedicated to work, everyday chores and relaxation must be well-balanced. This balance varies during the course of a person's life.

Within the family, there should be balance between working time, leisure time and everyday chores. This provides an opportunity for well-balanced coordination of work and family life. Family and gender equality policy promote the finding of the correct balance. Family and gender equality policy are key instruments in the attempt to attain brisk productivity growth, high employment and a balanced population structure.

1.6 Concepts and definitions of productivity

According to the productivity concept of national accounts, the productivity of the public sector has declined in recent years. According to many studies, the productivity of both specialised medical care and health care centres has decreased in recent years as well. In studies, productivity is measured by the volume of output achieved by the sum of money given. The activities measured include operations, visits to the doctor or treatment episodes. In the comparison, an attempt is made to standardise factors such as patients' age structure and how demanding the treatment is. If there are large differences in costs per unit between different production units, the units shown to have inefficient cost management should consider whether their production methods are rational, or whether resources are being correctly targeted. The method is well suited for the evaluation of unit cost efficiency.

Table 4. Development of productivity of services provided by the state and joint municipal authorities

	Expenditure[1] 2003 € billion	2000	2001	2002	2003	2004
			productivity change %			
State	9.9					
Total productivity		-0.7	2.8	-1.4	-2.1	0.0
						..
Joint municipal authorities	12.6					..
Health care centres	2.6	-0.9	-3.4	-3.7	-3	..
Specialised care	3.6	..	-2.2	0.1	-0.3	..
Institutional elderly care	1.2	..	-6.4	-0.5	-0.5	..
Total productivity of municipalities		-1.8	-2.5	-3.2	-1.5	..
Educational services	5.5	-1.3	-1.5	-3.4	-0.9	..
Comprehensive school	3.2	-2.2	-1.6	-3.7	-0.3	..
Upper secondary school	0.5	-2.9	-2.9	-5.7	-1.6	..
Vocational school	0.4	1.0	1.8	-4.0	-3.4	..
Library services	0.3	-0.5	-0.5	0.3	-0.5	..
Social services	6.8	-2.7	-4.5	-3.2	-2.3	..
Children's day care	2.0	-2.8	-3.8	-3.6	-1.4	..

[1]State expenditure according to national economy accountancy, municipal operating costs according to municipal accountancy.
Source: Economic Review 2005, Ministry of Finance

Productivity figures of this kind are suitable for the assessment of *economic **efficiency***, when measuring output per resources, i.e. the costs per unit of the activity. Unit costs have been used an in indicator of productivity. When measured like this, the result has invariably been the weakening of productivity during the period under study. However, this method does not tell very much about the quality of operation.

Measuring productivity in health care

Allocative efficiency = efficient grouping of resources (e.g. geographically or operationally)
Economic efficiency = output per resources, output cost per unit
Technical efficiency or yield = output per production unit (e.g. operations per team or theatre)
Quality = correspondence between objectives/recommendations and performance
Benefit = the impact of resource use on population health

In addition to the productivity assessments mentioned above it is necessary to look at the realisation of the goals of social and health care services.

The objective of social and health care is to reduce social problems and the burden caused by illness, injury or disability and to improve and maintain the well-being, state of health and functional ability of the population.

The extent to which output promotes health and alleviates suffering among clients describes the impact or quality of each activity. Social and health care productivity indicators do not e.g. explain how the efficiency of social protection has been increased as clients are increasingly being treated in the community instead of being in institutional care. However, evaluations should give an idea of how well our health care system is working.

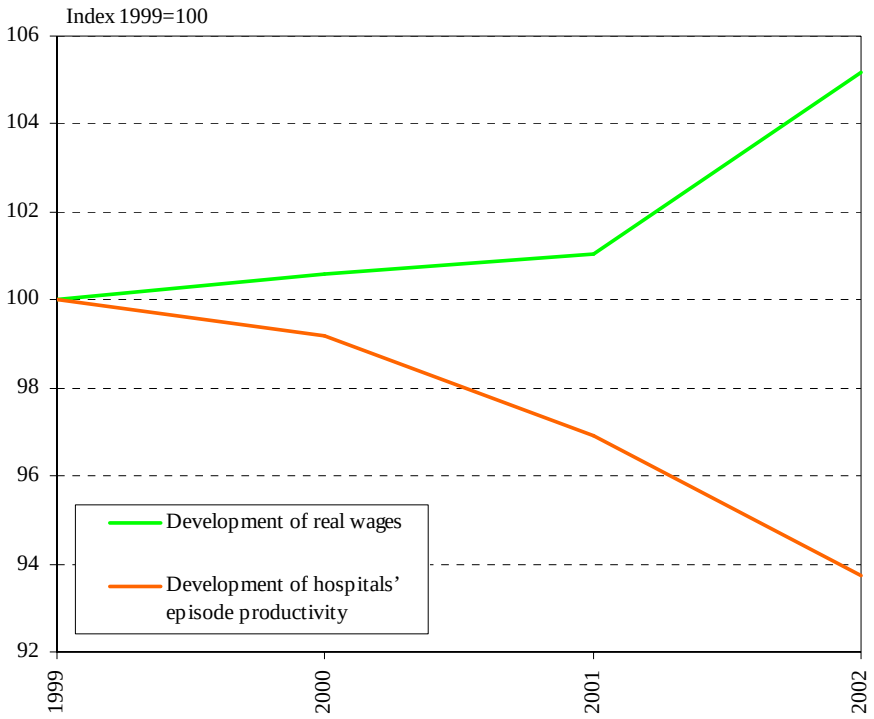
Measuring the productivity of social and health services, and public services in general, is divided into two categories:

1) measuring the impact of the activity, i.e. doing “the right things”
2) the activities are implemented as efficiently as possible

Restricting the scope of study to just one of the two does not provide a full picture of the functional ability of the service structure. The aim should thus be that ***the right things are done as efficiently as possible.***

Measuring productivity often involves a number of technical problems, which make it hard to assess the development of productivity. For example, the quality of health services is much more difficult to measure compared to market production. An efficient health care system provides services without unnecessary delays, and it has an impact on people’s well-being and health. There are little statistical or research data available on how these factors have evolved over time or how they vary between health care centres, and it has therefore not been possible to take them into account in productivity calculations. In addition, it seems that at least as of 1999, the episode productivity of hospitals is to a large extent explained by the development of real wages in specialised care. (Figure 11)

Figure 11. Development of hospital productivity and development of real wages in specialised care in 1999–2002



If a (service) firm operating in the commercial market measures its own operation without taking into account quality, only output, it will soon get into trouble, because clients can tell the quality of its products. Insufficient measuring may thus easily lead to incorrect policy recommendations.

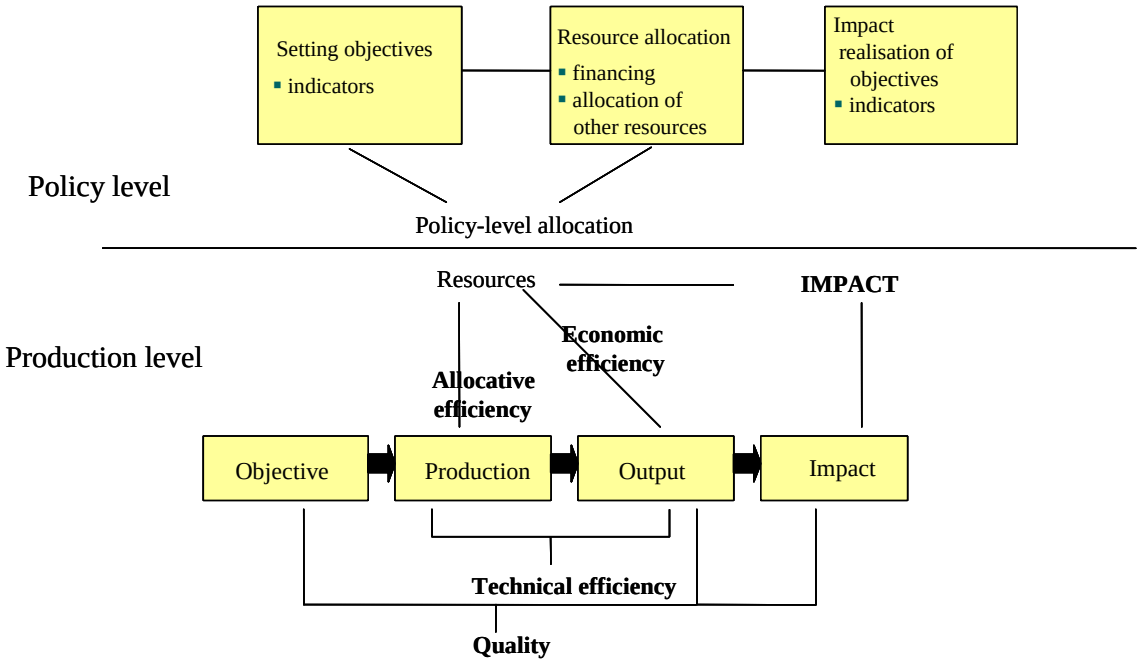
At Helsinki University Central Hospital, for example, neurology is the weakest specialty measured in terms of episode productivity, although the prognosis of brain infarction patients has improved at HUCH, and 80 percent of patients manage without expensive further treatment, while mortality has decreased to a lower level than anywhere else in Finland. However, the improvement of the quality of treatment is not taken into account in productivity indicators, such as episode productivity.

Impact

The impact of activities on patients and the economic efficiency of activities help the production unit in targeting resources for different lines of operation. The assessment is based on the needs of the institution's (hospital's) clients. When the scope of study is expanded to cover the entire population in the area, decision on resource allocation e.g. between outpatient care and institutional care must be made on political level.

Political decision-makers mostly get information about the benefits of health care through the efficiency and impact indicators mentioned above. Based on these, decision-makers set targets and allocate resources for health care. The question is whether the resources are targeted on national and/or municipal level so that the benefit for the entire population in the area is as big as possible.

Figure 12. The health-policy decision-making process and types of production-level efficiency



Allocation

On political level, resources are allocated on the basis of estimated population health benefits. This is thus a question of political allocation, with political priorities. Political-level allocative efficiency is sought for e.g. by decisions concerning resource allocation between prevention, primary health care and specialised care. Attempts to reach allocative efficiency can also be made on geographical and operational level. An example of this is the ongoing municipal and service structure reform project. The level of allocation may be defined by the technology used; for example, regional centralisation of expensive magnetic imaging equipment is sensible, while cheaper x-ray equipment may be placed in every health care centre. On production level, allocative efficiency refers to efficient grouping of resources aimed at optimising the production process.

When assessing the productivity of the entire health care system, the following aspects must be taken into consideration: how are resources allocated, what is their operative efficiency, how are processes managed, how do objectives and performance meet, and what impact does the use of resources have on population health.

II Promoting health and functional capacity

Impact goals of promoting health and functional capacity

- Reducing health differences between population groups
- Reducing accidental and violent deaths among young men
- Reducing public health hazards caused by alcohol
- Improved working and functional capacity among working-age people
- Improved functional capacity among those over 75
- Improved opportunities for the elderly to live and cope at home
- Improved employment opportunities for the disabled

The average life expectancy has risen, and the number of years with good functional capacity has increased. The state of health of the population is better than ever. People's state of health has primarily developed in a positive direction in both genders and in all age groups.

The greatest threats to this positive trend are increasing obesity and a clear rise in alcohol consumption. Both cause significant, manifold and expensive problems to individuals, families, public health and society as a whole.

Differences in health between population groups remain large, and they seem to be increasing. Half of the differences are explained by tobacco and alcohol. The most expensive groups of diseases in Finland are cardiovascular diseases, mental health disorders, respiratory diseases as well as musculoskeletal diseases. Together, they account for half of all health care expenditure. Many of the diseases that are currently very common among the population are preventable. The effect of health care on population health has been estimated to be only 10-15 percent. Individual lifestyle and living environment have the greatest impact. At least 80 percent of coronary artery disease and over 90 percent of type 2 diabetes cases could be prevented by a healthy lifestyle. About one third of all cases of cancer could be prevented by a healthy diet and exercise, and the majority of respiratory cancer could be prevented by not smoking.

Continuous efforts are called for in order to maintain the positive development trend in public health. It is of the utmost importance to make people aware of the effect of their own choices and lifestyle on their state of health. The foundation of a healthy adulthood and functional old age is laid in childhood and youth. The development of many diseases can be prevented by adopting a healthier lifestyle. Focusing on prevention and health information is an inexpensive means of achieving significant savings in both health care costs and all public expenditure in the years to come. Disease prevention is always cheaper than repairing the damage afterwards. Health differences between population groups can also be affected by general social policy and by guaranteeing equal access to treatment to all. Primary health care services that are wholly or nearly free of charge constitute the starting premise.

Nearly all decisions made by society have health impacts. That is why the effects of plans and decisions on citizens' health as well as health discrepancies must be taken into account better than is currently the case. The effects may be individual, local, national and international, and they may differ between population groups. The impact of decisions on groups with unequal health status, such as children, the disabled, people suffering from mental health problems and the long-term unemployed must be considered in particular.

2.1 The health of working-age population

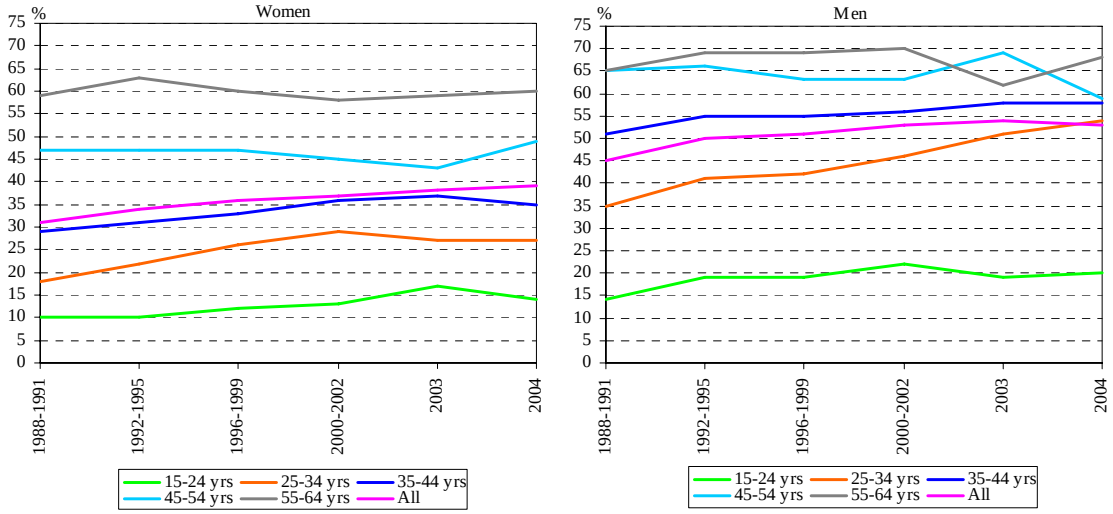
The health of working-age people has generally developed in a positive direction. Mortality due to coronary artery disease and cancer has declined significantly, and blood cholesterol levels have come down considerably. In a long-term perspective, men have clearly cut down on smoking. It is particularly positive that smoking has become less common among young men. On the other hand, smoking among men aged 35–54 seems to have increased clearly in 2004. No significant changes can be seen in smoking among women, but it does seem that the prevalence of smoking started to increase among young women in 2004.

Self-assessed physical and mental work ability among people of working age has remained more or less unchanged. Among men, taking up disability pension decreased clearly in 2004. The change is probably mainly due to a rise in the age limit of individual early retirement, but the trend in work ability may also play a role. The number of new disability pensions granted to women has remained more or less unchanged. However, the number of new disability pensions granted annually is still significantly higher than the number of new old-age pensions. In 2004, 21,909 persons took up old-age pension, while the corresponding number taking up disability pensions was as high as 28,386. A little over one third of all disability pensions are granted on the grounds of mental health problems, and a little under one third on the grounds of musculoskeletal diseases. The prevalence of diseases or disability impairing work ability and functional capacity among the elderly has declined in recent years. Depression is an increasingly common reason for granting disability pension, even though studies show that the prevalence of mental health problems has not increased as such. However, the demands of work are nowadays so high that those with mental health problems are more likely than before to experience the situation as being too difficult and seek disability pension.

Obesity is one of our biggest public health problems. It causes significant health problems: type 2 diabetes, hypertension and arthritis. Obesity has become more common among adults. In 2004, 53 percent of Finnish men and 39 percent of Finnish women were overweight. Obesity is most common among people with the lowest education. The differences in the prevalence of obesity between educational groups are particularly clear among women. Those with better education are more interested in their health and more receptive to health information.

A reduction in the amount of physical exercise people get at work and during everyday chores is a significant factor contributing to obesity. Other reasons for the growing prevalence of obesity mainly include increased alcohol consumption and the fact that food serving sizes and packages are bigger than before, as well as an insufficient amount of exercise. A significant proportion of Finns exercise too little as far as health and prevention of obesity is concerned.

Figure 13. The proportion of overweight persons among adults in 1988–2004



Source: National Public Health Institute

Sleep deficiency among working-age population increases the risk for disease. Work-related sleep disorders and changes in lifestyle are key factors affecting population health. Work fatigue, a lot of time spent working overtime as well as problems in reconciling work and family life make people susceptible to weight gain. The link is clearer among women compared to men. Work-related sleep disorders have rapidly become more common in recent years due to increased stress at work and irregular working times. In 2003, as many as 36 percent of women and 27 percent of men reported having sleeping difficulties at least once a week. The prevention of sleep problems calls for more efficient time management and solving problems related to the amount of work. The importance of sleep should be more highly valued in society as a whole. In public health work, sleep and recovery must be adopted alongside traditional lifestyle factors as part of disease prevention.

It is important to change people's lifestyle into a healthier direction by increasing the amount of exercise and by reducing energy intake. A balanced diet, reasonable serving sizes of food and moderate alcohol consumption as well as a non-sedentary lifestyle are key factors in the battle against obesity. It is possible to attain a significant improvement in functional capacity and health and to prevent weight-gain by increasing the amount of exercise. A weight reduction of only 5-10 percent brings considerable health benefits. The most recent exercise recommendations aimed at preventing obesity advice people to exercise at least one hour each day.

In recent years, the food industry has introduced a number of different light products with an energy content clearly below that of corresponding normal products. However, the same amount of the light products as of the corresponding normal products must be consumed in order to reduce the intake of energy and to lose weight. On the other hand, some light products may contain more energy than other, naturally low-calorie foods. Thanks to persistent informing, attempts to get both consumers and the food industry to reduce the use of salt have been successful. The same result must be aimed at in the prevention of obesity.

Healthy foods should also be favoured by pricing. However, the current trend is quite the opposite. Taxes on fat, sugar and sweets have been abolished. Sausages and meat products are also become cheaper after Finland joined the EU. At the same time, fruit prices have remained unchanged. The possibility of issuing a decree concerning the health and nutrition claims of foods is currently being studied within the EU. This would enable unified practices in all member states.

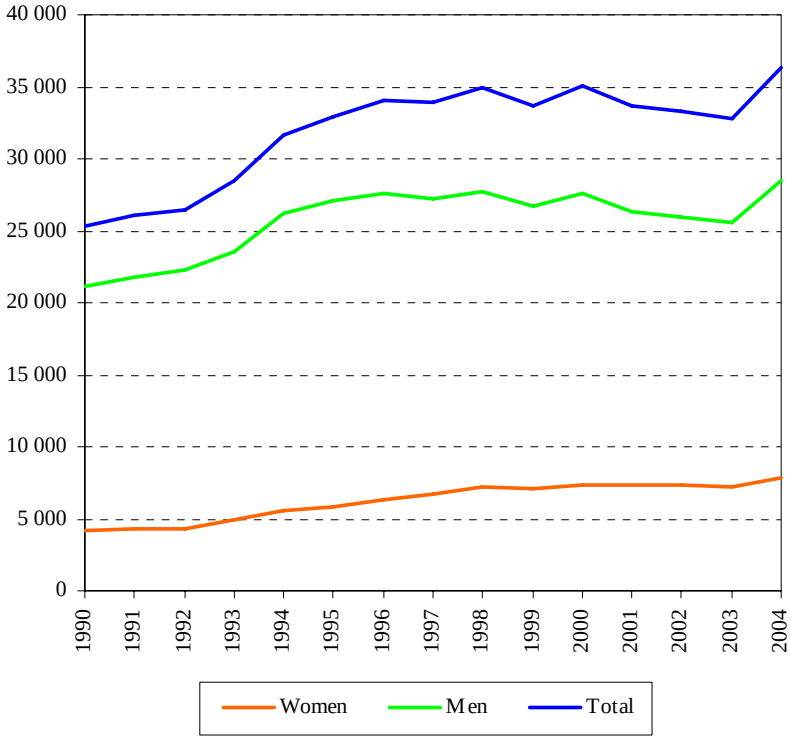
The conditions of work and giving up work are looked at in more detail in the chapter Making work more attractive.

2.2 Alcohol programme 2004–2007

The aim of the alcohol programme is to reduce the negative effects of alcohol use, and especially to bring about a reduction in alcohol consumption. The key objectives have been defined in the government resolution on strategies in alcohol policy. The programme is implemented in cooperation with several administrative sectors, municipalities, churches, organisations and the business sector. In autumn 2005, the number of cooperation partners outside central government administration was 124. The partners involved in the Alcohol programme take responsibility for the reduction of the harmful effects of alcohol in their own respective fields.

Heavy long-term alcohol use poses a serious health risk. The risk of accidents and the likelihood of violent crime is significantly increased by being heavily drunk; 60–70 percent of all violent crime is committed while under the influence of alcohol. Even a small amount of alcohol reduces functional capacity and increases the risk of accidents in traffic, at work, in the home and during free time. In 2003, about 42,000 alcohol-related accidents occurred in Finland. This was four percent of all accidents.

Figure 14. Periods of care in hospital due to alcohol-related diseases[iv] in 1990–2004



Source: Stakes

The number of periods of care in hospitals due to alcohol increased rapidly in the early 1990s. After that, the number stabilised at just below 35,000 periods of care per year. In 2004, the number of care periods increased significantly. The rise was particularly rapid among men. The number of periods of care due to alcohol among women has risen steadily each year. The number of those who have died as a result of alcohol use has also risen – alcohol disease or poisoning is increasingly common as a cause of death. Alcohol has for quite some time been the second most common cause of death among men. In 2002, it became the second most common cause of death among working-age women as well. On the other, the number of men who have died as a result of alcohol-related accidental or violent death has decreased.

2.3 Health-promoting and health-incentive measures

Health is much more than just the absence of illness. It is mental, physical and social well-being, something that the health care system cannot offer on its own. Maintaining and achieving good health calls for a varied and healthy diet, weight maintenance, being a non-smoker, restricting the intake of alcohol, a sufficient amount of exercise, good human relations, meaningful work and sufficient rest.

Primary responsibility for one's state of health lies with each individual. The boundary conditions of an individual's characteristics and health are defined by genetic factors. However, personal lifestyle and choices still have a major impact on health; the effect of health care is secondary. However, some people lack the capacity, will and possibility to receive health information and to adapt to health recommendations. People who have

not had the energy to study and make an effort for their jobs and standard of living do not see health as something to strive for, either. People make their choices largely in accordance with the models of their background group and social class. The million-dollar question of health information and education is how to get these groups of people interested in their own health and to make an effort to maintain it. This calls for continuously looking for new methods of health informing, because traditional methods do not lead to desired results. Children and their parents are a particular target group for health information efforts, because lifestyle choices adopted in childhood are very permanent.

An individual's health and functional ability may be shattered in an instant by an accident. In such cases, the measures implemented by society play a major role in attempting to restore him back to health and full functional capacity.

Municipalities can promote citizens' health in many ways. A key element in this is securing sufficient health and drug abuse services for all and to invest in preventive measures. This calls for professionally competent staff. In order to make preventive work more effective, the aim is to change the Primary Health Care Act as of the beginning of 2006 so that the status of health promotion is improved. In the Act, the tasks of the municipality related to promotion of health are comprehensively defined. Municipalities are obligated to monitor the state of health of the population and to make sure that health aspects are taken into account in all municipal operation.

Many actors outside the health care sector have an impact on the development of citizens' health as well. Municipalities must develop the environment so that it encourages people to exercise. People of different ages are encouraged to get moving and to exercise if there are good, safe and extensive paths for cyclists and pedestrians, varied and safe playgrounds as well as many kinds of indoor and outdoor exercise facilities available. The correct placing of the above-mentioned facilities may be influenced by zoning decisions. It is the task of environmental health care to ensure that the quality of drinking water and food is appropriate.

The young should be seen as special target group. This is why schools have a significant role in disseminating health information and forming eating and exercise habits. However, weight problems among the young should be addressed with great caution, because those in age group 12-18 are at particular risk of developing eating disorders. Instead of diets, the importance of a healthy lifestyle should be emphasised, and young people should especially be encouraged to exercise. The goal is to get children and young people used to regular, varied exercise by letting them get acquainted with different sports, thus helping everyone find the type of exercise that is right for them. However, the model provided at home by the parents has the greatest impact on the health-habits and alcohol use of young people.

Population health trends can also be impacted by many activities on the part of society. Tax and price policy has a significant impact on people's choices and the decisions to buy food and alcohol. Legislation provides a common framework for the operation of society, and operation according to law is ensured by monitoring. All choices and decisions made by society are ultimately influenced by prevailing attitudes and values. If health is valued sufficiently, it is taken into account in all choices and decisions made by citizens and society.

Table 5. The elements of health and the means of different parties to impact the promotion of health and functional ability

	Individual	Municipality	Society
Food	healthy eating habits	school lunches, curricula, student welfare, nutrition education	legislation food production, marketing, product information, trade, tax and pricing policy
Exercise	sufficient exercise (to and from work, free time)	varied exercise opportunities, good cycle and pedestrian paths, playgrounds and sports parks, sports education	supporting workplace exercise, varied exercise possibilities, supporting exercise
Substance use	moderate alcohol use, no drugs	comprehensive preventive substance abuse work, sufficient services for substance abusers, professional staff, cooperation between different professions, health education (against substance abuse)	general culture and attitudes, legislation, taxation, nicotine replacement treatment
Tobacco	not smoking giving up smoking	health education (against smoking), support group for quitting smoking	general culture and attitudes, legislation, taxation nicotine replacement treatment
Rest	sufficient rest, balance between work and rest	-	attitudes and culture: appreciation of rest
Human relations	enough time for human relations	supporting those who are alone family counselling clinics	balance between work and leisure time, attitudes and culture communality
Work	work in balance with free time and human relations	-	occupational health care, employees' possibilities to impact their own work, work atmosphere, management practices
Social and health care services	seeking treatment at the right time	sufficient services available at uniform grounds, importance of preventive services that are free of charge, professional staff	legislation, sufficient resources
Environment - water - air	speed limits are followed, public transportation is favoured	safe traffic routes, traffic education in schools	safe traffic routes, traffic culture, speed limits, developing and supporting public transportation and rail traffic, development of technology

A summary of the adverse effects of challenges to health and functional capacity:

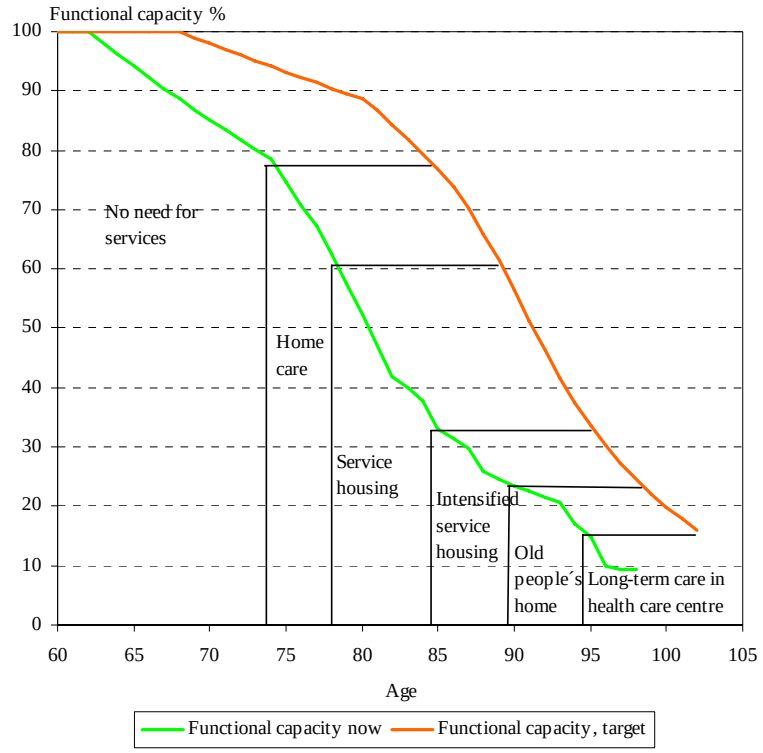
Challenge	Adverse effects
Obesity	Premature deaths
	Weakened work ability and functional capacity
	Several diseases such as type 2 diabetes, coronary artery disease, hypertension and arthritis
Poor condition, weakened work ability and functional capacity	Increased susceptibility to diseases
	Decreased autonomy and coping
	Increased tendency to accidents
	Increased need for institutional care
Problem-use of alcohol	Premature deaths
Drug abuse	Weakened work ability and functional capacity
	Several diseases such as: liver diseases, HIV, hepatitis C, brain diseases
	Increased tendency to accidents and injuries
	Increased violence
	Disturbances of work and family life
	Increased problems and insecurity among children
	Endangers foetal and child development
	Social exclusion
Smoking	Premature deaths
	Weakened work ability and functional capacity
	Several diseases such as: respiratory diseases, cancer and coronary artery disease
Mental health problems	Weakened work ability and functional capacity
	Increased number of disability pensions
	Increased number of suicides
	Social exclusion

2.4 Promoting health and functional capacity – an example of setting objectives

Evaluation of functional capacity is a key element of service need assessment. Services for the elderly are tailored according to the client's remaining functional capacity. The services range from community care services compensating for a minor reduction in functional capacity to long-term nursing care of the elderly with the poorest functional capacity in health care centre wards. This guarantees the right to an independent life of the elderly for as long as possible while ensuring the provision of services that are needed and the appropriate targeting of resources.

The figure shows the hypothetical current status and target status of functional capacity. In practice, service need is not necessarily as consequently targeted as in the figure; e.g. home service and home nursing can also respond to the service need of those with poor functional ability. The seamless operation of the service chain has also become more and more important as clients are increasingly moving from one type of service to another. For example, patients often return to care in the home after a period of care or rehabilitation at a health care centre.

Figure 15. Service supply according to client's functional capacity, hypothetical situation



The figure illustrates the two main objectives set on the basis of the main lines of elderly policy of the Ministry of Social Affairs and Health: on the one hand, maintaining the functional capacity of the elderly for as long as possible, and on the other hand, reforming the incentives of the financing system so that it steers towards efficiency and the provision and use of appropriate services in accordance with the client's functional capacity. The projects aimed at turning the elderly policy action plan into concrete measures must for their part support these two main objectives.

In the elderly policy action plan of the Ministry of Social Affairs and Health, the projects implemented within the main division of social and health care have been grouped according to six main lines of elderly policy: 1) improving health and functional capacity, 2) supporting living and coping at home, 2) improving the quality of services, 4) strengthening and clarifying clients' rights, 5) ensuring a reasonable income and 6) ensuring the sufficiency of service and income security financing.

The projects related to the main lines promote autonomy and coping among the elderly and the reduction and postponement of the need of institutional care. The financing of services should support the concept that elderly people get the care that corresponds to their functional capacity. The aim is also to secure high-quality services provided by multiple operators; besides the municipality's own service provision, with the aid of volunteer work, organisations and enterprises.

III Making work more attractive

Impact goals of making work more attractive

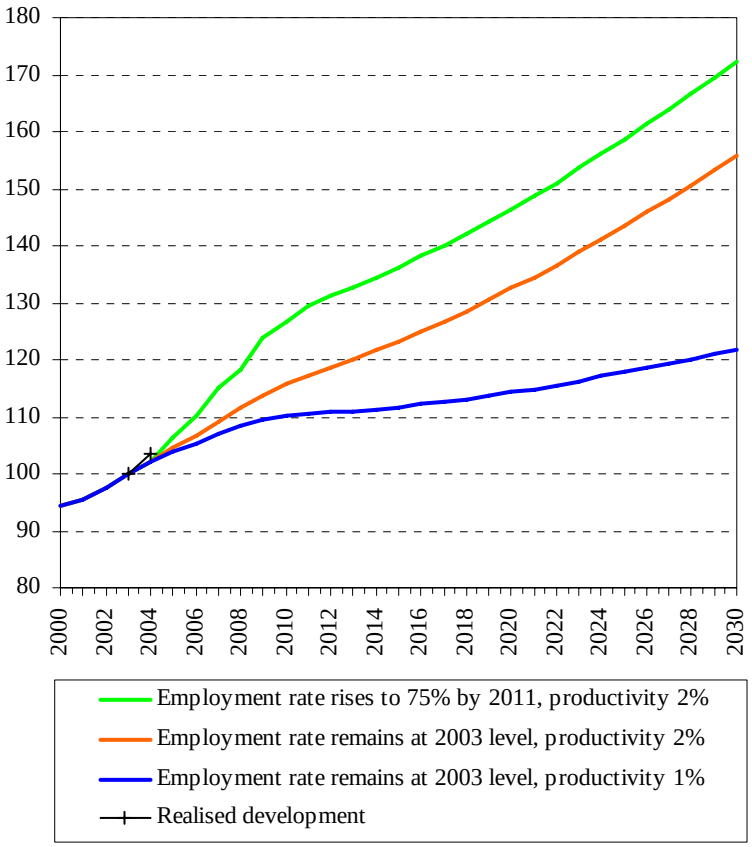
- Employment rate increases in different age groups
- By 2010, working careers are extended by 2–3 years
- Improving incentives in social protection
- Reduction of absenteeism due to illness
- Better reconciliation of work and family life
- Frequency of work-related accidents is reduced; the onset of occupational diseases is reduced, and their degree of severity is lower than before
- Availability and quality of occupational health care is improved; more efficient cooperation with rehabilitation

The age structure of the population will change permanently from that seen in the past decades, because people live longer and fewer children are being born than before. Finland is facing the challenges brought on by ageing of the population earlier than the rest of Europe. Raising the employment rate of older age groups is not sufficient; well-balanced social development calls for improved employment of all working-age cohorts. At the same time, productivity must be emphasised as well.

In a long-term scenario of potential economic growth, the employment rate will gradually increase to 75 percent from the 2003 level, and productivity will grow by two percent. Slower economic growth scenarios have been illustrated by two alternatives: a) employment rates remain at the 2003 level and productivity grows by two percent, or b) employment rates remain at the 2003 level and productivity grows by only one percent. The latter productivity scenario is entered gradually.

The message of Figure 16 is clear: Employment and productivity must be improved parallelly. If employment rates remain at the 2003 level and productivity grows by two percent, production remain 15 percent below the potential production level by the year 2011. After that, production would grow at an equally brisk rate. But if productivity were only to increase by one percent, the growth of economy would be dramatically slower in the 2010s and 2020s than its potential development rate. In the latter alternative, production would remain 35 percentage points below the potential level of economy in 2030. The greatest impact, two thirds, would come from productivity growth in the 2010s and 2020s that would be one percentage point slower. The fact that employment rates remained at the 2003 level would explain nearly one third.

Figure 16. GDP per capita in 2000-2003 and projections for 2030, index 2003=100

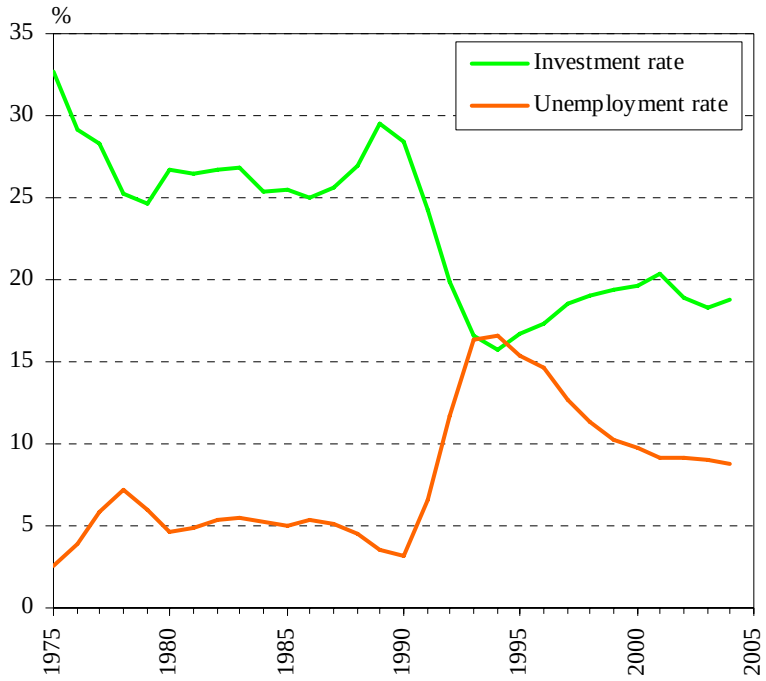


3.1 Progress towards high employment

Free movement of international capital has strengthened the globalisation process. The search for return on capital is conducted on a global scale. Functional income distribution changed clearly in the 1990s in favour of capital income. The share of gross value added made up by wages and employers' social protection payments has stabilised at the level of 55 percent in the early 2000s.

Finland has traditionally been a country of capital-intensive production and a high investment rate. The GDP ratio of investments has varied between 25 and 30 percent. Now the GDP share of fixed investments seems to have stabilised at a clearly lower level than in the past decades. Strengthening of capital income has not led to large investments in Finland. The reduction in investments by Finnish companies has not been replaced by direct foreign investments in Finland, which partly explains the persistently high rate of unemployment. When using structural indicators measuring competitiveness, Finland is at top level internationally. This gives rise to expectations that an increasing amount of direct international investments will come to Finland.

Figure 17. Investment rate and unemployment rate in 1975–2004, %



Extension of working careers

The employment rate of ageing (55–64 yrs) employees rose in 1997–2003 by 15 percentage points, while the average employment rate during the same period grew by nearly 4.5 percentage points. Employment among ageing workers has increased in Finland at a faster rate than in any other European country.

Table 6. Employed persons and employment rate by age group in 1997 and 2004

Age	1997		2004		Change 1997-2004	
	Employed	Employment rate, %	Employed	Employment rate, %	Employed	Employment rate, percentage points
15-24	212,800	33.3	247,700	38.1	34,900	4.8
25-54	1,753,800	77.5	1,754,000	81.0	200	3.5
55-64	187,600	35.8	342,600	50.9	155,000	15.1
15-64	2,154,200	62.9	2,344,300	67.2	190,100	4.3

Source: Statistics Finland

Members of the baby boom generation have remained at work and kept their jobs better than previous cohorts at the same age. In the future, exit from employment will be postponed by changes in unemployment and pension security, decisions on which were already made during the previous government. Reducing the number of routes to retirement and strengthening incentives that encourage staying on at work have contributed to the positive development trend.

According to a survey among ageing workers conducted by the Finnish Centre for Pensions in 2005, half of the respondents intended to continue working after turning 60 and one fourth after turning 63. According to OECD studies, people are not in the habit of staying on at work after having been offered the possibility to take up a pension. In the pension reform, this was taken into account by rewarding staying on at work so that it gives a better pension later on.

Working careers can also be extended from the beginning, by speeding up the entry into employment of young people. However, making the education system more efficient is not the work of a moment. It has been estimated that the measures aimed at speeding up university studies will lower the age of onset of studies by one year by 2008, and the age of completing studies by one year by 2012.

Matching of job seekers and jobs

The most problematic sub-group of structural unemployment consists of the uninterruptedly long-term unemployed. In practice, only a small minority of them are able to find employment in the open job market without special measures. The number of long-term unemployed seems to have stabilised at just above 70,000. Structural unemployment and extensive unemployment also seem to have stabilised at high level, close to 290,000 and 375,000 persons, respectively.

Table 7. Structural unemployment in January-December 1997, 2002, 2003 and 2004

-	2004	2003	2002	1997	2004-1997 change	2004-1997 change %
a Long-term unemployment	73,000	72,400	77,700	124,600	-51,600	-41.4
b Repeated unemployment	41,900	42,700	43,700	63,200	-21,300	-33.7
c Unemployed after measures	39,500	40,400	36,700	58,200	-18,700	-32.1
d Repeated participation in measures	13,200	18,600	15,600	22,600	-9,400	-41.6
Limited structural unemployment (a+b)	114,900	115,100	121,400	187,700	-72,800	-38.8
Structural unemployment (a+b+c)	154,400	155,500	158,100	245,900	-91,500	-37.2
Extensive structural unemployment (a+b+c+d)	167,600	174,100	173,700	268,500	-100,900	-37.6
Unemployed job-seekers, total	288,400	288,800	294,000	409,000	-120,600	-29.5
Measures, total	87,300	86,800	79,300	123,400	-36,100	-29.3
Extensive unemployment, total	375,700	375,600	3,733,300	532,400	-156,700	-29.4

Source: Ministry of Labour

The aim of the government programme is to provide all young people education, practical training or a workshop position after three months' unemployment, and we are getting close to reaching this goal. Various "social guarantee for young people" measures are targeted broadly at young unemployed persons already during the first stages of unemployment. The youth unemployment rate has continued to fall uninterruptedly since 1993, while the average duration of periods of unemployment has also been shortened.

The labour-market position of poorly employable persons can be improved by labour service centres, employment support reform and social enterprises. This is however not enough to decrease structural unemployment. The demand of labour in the open job market should be focused more strongly on this group of job-seekers. This is why reforms aimed at increasing the demand of labour and lowering the employment threshold of firms have a strategic role in the prevention of structural unemployment.

The development in recent years indicates that employment has become selective: some unemployed persons are able to find employment more easily than before, but the average duration of unemployment is longer. At the end of the 1980s, unemployment still resulted relatively often in employment; more than 40 percent of unemployed found a job in the open job market within a year. When the recession was at its deepest, only 20 percent of unemployed were able to find a job within a year. The situation has not improved much after the recession. It has been typical for the development of the Finnish labour market that growth industries and decreasing industries have been very different as to their occupational structure and skill demands. Labour has been recruited to the new fields among new age groups or among those already at work, but there has been very little recruitment among the unemployed. The fact that open jobs and the unemployed do not match is partly explained by this.

Figure 18. Beveridge Curve in Finland in 1956–2004 and projection when the 75 percent full employment target is met in 2012

The structural problems of the Finnish labour market can be illustrated by comparing the open-job rate and the unemployment rate. A higher than before unemployment rate corresponds to a given rate of open jobs. Structural problems became acute as the economy sank into a deep recession in 1992–1994. After that, structural unemployment decreased rapidly until 2001, after which it has only diminished slightly. The new cohorts entering the labour market in Finland have been better educated than their predecessors.

If the employment rates in accordance with education remained at the 2004 level, employment would rise about percentage point. The new growth fields have recruited labour from their ranks. As the cohorts become smaller, this old recruitment model cannot be applied on the same scale as before. Unless competent labour can be recruited among older age groups as well, there is a danger that jobs in high-productivity fields will be transferred

elsewhere. Jobs in low-productivity fields will also move elsewhere if the cost level is too high. The "disappearance" of low-productivity jobs may as such be a positive phenomenon, if they are replaced by better jobs. However, a sufficient supply of well-educated labour is a prerequisite for the creation of such jobs.

The connection between labour-market rigidity and the age structure has been little studied. As the number of ageing employees increases in the labour market, a senior labour market is emerging. This should be taken into account in developing labour services. An increasing number of the clients of occupational health care are ageing employees as well.

The Finnish labour market is considered to be rigid. Sufficient labour force mobility within and between firms, regional and professional mobility, continued updating of competence and adaptation to insecurity are prerequisites of a growing and developing economy. In the case of young people of working-age, different types of mobility have long been an everyday phenomenon. Young people are more willing to change their jobs, professions and place of residence compared to older age groups.

An all too early retirement from the workforce and difficulties in finding work in the event of unemployment have been considered problems as far as ageing employees are concerned. With the emergence of a more extensive seniors' labour market, more attention will have to be focused on mobility as well. Rigidity may become an obstacle to keeping one's job and finding new employment.

It is problematic from the viewpoint of social policy that low-productivity jobs have often been a clear alternative to unemployment. However, Finland's position in the international division on labour will continue to be based on a high level of competence, research and product development in the future as well. In addition, measures promoting job creation in fields demanding less education are also needed.

Problems of labour availability increased during the economic boom of the late 1990s. A little over one in four establishments reported having experienced recruitment problems. The situation seems to have stabilised on this level. Problems of labour availability are still regarded as being relatively moderate. They may however increase in the coming few years as a result of a changing population age structure and accelerating economic growth. Expectations of problems in the availability of labour may weaken businesses' willingness to invest in Finland. Demands to ensure the availability of competent labour quickly become stronger once the employment situation has improved.

The situation illustrated by the work ability index

In public debate and work-related studies, employees' well-being and coping at work have been underlined as the key factors impacting staying on at work. According to the work ability index survey conducted in 2004 (Peltoniemi 2005), the level of work ability of employees, entrepreneurs and farmers is good. The most important factors of the work ability index are the respondents' own assessment of their work ability compared to their lifetime best, the number of physician-diagnosed illnesses and absenteeism due to sickness.

With age, work ability naturally decreases somewhat, but the work ability of wage earners and entrepreneurs over 54 is still good. It is only among farmers that the level work ability is

reduced to moderate. There are no significant differences in work ability between genders among wage earners and entrepreneurs. The work ability of women working as farmers is moderate, whereas that of men is good.

In a more detailed analysis, the picture is as follows: about 40 percent of wage earners have excellent, more than 50 percent have good, while less than 50 percent have moderate or poor work ability. Among entrepreneurs, about 50 percent have excellent, 40 percent have good, and some 10 percent have moderate or poor work ability. The work ability of farmers is somewhat poorer than that of wage earners and entrepreneurs.

The work ability index does not lend support to the idea that various work-related demands, such as a tight working schedule, stress and insecurity would have weakened work ability to a significant degree. If weakening of this kind had occurred, employees' work ability should have been close to excellent a few decades ago. This was very likely not the case. However, it must be taken into account when interpreting the results that respondents may overestimate their own work ability. The idea of weakened well-being at work is largely based on surveys where employees assess such factors of work that are the responsibility of employers or other parties than the employees themselves (Peltoniemi 2005).

3.2 The Veto Programme

The Veto Programme is a policy programme focusing on the labour force and immaterial production factors. The Veto Programme does not only aim at attaining high employment, but also at creating prerequisites for brisk productivity growth.

An attempt is being made to promote these goals by a battery of instruments used in the main division of the Ministry of Social Affairs and Health, which include both reformed legislation and its implementation. For example, when the potential exit routes from work are staked out by pension legislation and the pension system, incentives and development of the employment sector are used in an attempt to regulate the speed of exit from work. This calls for development of the implementing organisations. Some of the instruments are limited within the employment sector, while some are included in measures aimed at promoting public health.

The Veto Programme is used to influence factors of both labour force demand and supply. These are affected by a number of factors. The following are factors having a key impact on labour demand:

- Economic policy, particularly pension policy
- Staff policy in the workplace and ways of organising work
- Labour market issues such as employment situation, unemployment and lay-offs

The following individual factors are related to staying on at work or retiring from work:

- Working conditions
- Health and work ability
- Personal values and work appreciation
- Social duties outside work
- Attraction of work

Five goals, some of which are very concrete, and four instruments are listed in the Veto Programme. These are as follows:

1. Time at work is extended, and people stay on at work 2-3 years longer than at present (comparison between 2002/2010)
2. Absences due to sickness start to fall in number, decreasing by 15 percent from the current level (comparison between 2002/2007)
3. Frequency of work-related accidents and the onset of occupational diseases is reduced by 40 percent from the current level, and their degree of severity is lower than before (comparison between 2002/2010)
4. Smoking and alcohol consumption among working-age people starts to decline clearly (from 2002 on)
5. Average start of working career occurs at an earlier age compared to the present situation (change seen from 2004 on)
6. A comprehensive family policy programme is created and implemented (approved in 2003–2004)
7. The quality and availability of occupational health care is improved, and cooperation with rehabilitation becomes more efficient (throughout the programme period)
8. Increased use of incentives in income security and pension programmes, staying on at work and returning to work becomes more common (throughout the programme period)
9. A change of atmosphere and public attitudes that enables approving and reaching the content goals of the programme (2004–)

Goals 1-5 of the Veto Programme are directly linked to the Government's 75-percent employment goal. Some of the goals do not only emphasise reaching the high employment objective, but also the number of working hours completed and compensations to employees due to sickness by employer. Goal 6-9 are instruments used by the Ministry of Social Affairs and Health to promote attainment of the above goals.

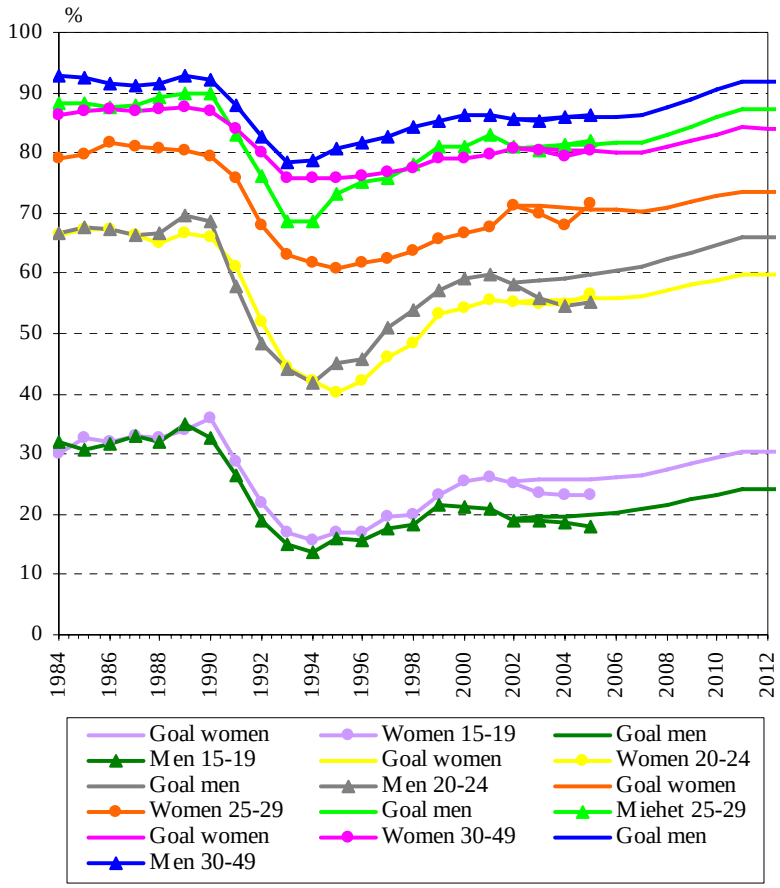
Some of the indicators of the Veto Programme are divided into sub-categories based on age, gender and/or social status. The goals are more easily illustrated than the means. That is why a strong effort will have to be made in the future to describe the means.

The indicators are primarily constructed so that 2002 is the baseline year of the Veto Programme. The success of the programme is evaluated by using two alternatives. The first alternative includes a scenario based on the government's employment goal, while the second alternative includes a scenario where employment rates remain at the 2002 level.

Some of the indicators of the Veto Programme are discussed elsewhere in this publication. Smoking and alcohol consumption among people of working age is discussed in chapter 3. Family policy is discussed in chapter 6, income security issues in chapter 5, and incentives to work in chapter 1. This chapter focuses on the remaining indicators, i.e. numbers 1-3, 7 and 9. Before moving on the actual Veto indicators we will take a look at the programme's background indicators.

3.2.1 Background indicators

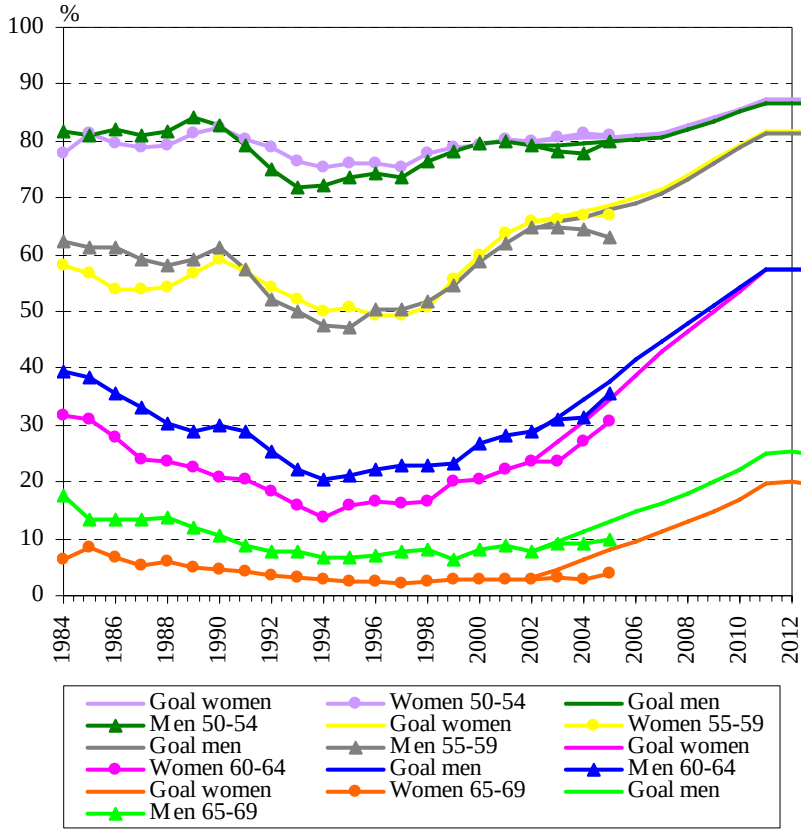
Figure 19. Development of employment rates among men and women aged 15–49 in 1984–2005 and the target employment rate of 75 percent until 2012, %



In order for the 75 percent employment rate target to be attained, the employment rates of men aged 25–49 would have return to the level of the 1980s. The employment rates of both men and women in age group 15–24 would remain slightly under the 1980s level due to longer education times. Permanent attachment to the labour market would still be harder for young women aged 25–29, and the difference compared to men of the same age would increase somewhat compared to the 1980s.

In order to reach the 75 percent employment rate target, employment rates among all age groups should be higher than in the 1980s. The improvement should be the most marked in the 60-to-64 age bracket. Employment rates would also have to increase significantly among those age 65–69. Key measures aimed at improving employment should still be targeted at the over-50 age group.

Figure 20. Employment rates among ageing men and women in 1984–2005 and the 75 percent employment rate target until 2012, %



Figures 19 and 20 show that the potential for staying on at work is well illustrated by the age-group specific employment rates of employed persons, because education correlates strongly with employment, and particularly with coping at work among ageing employees.

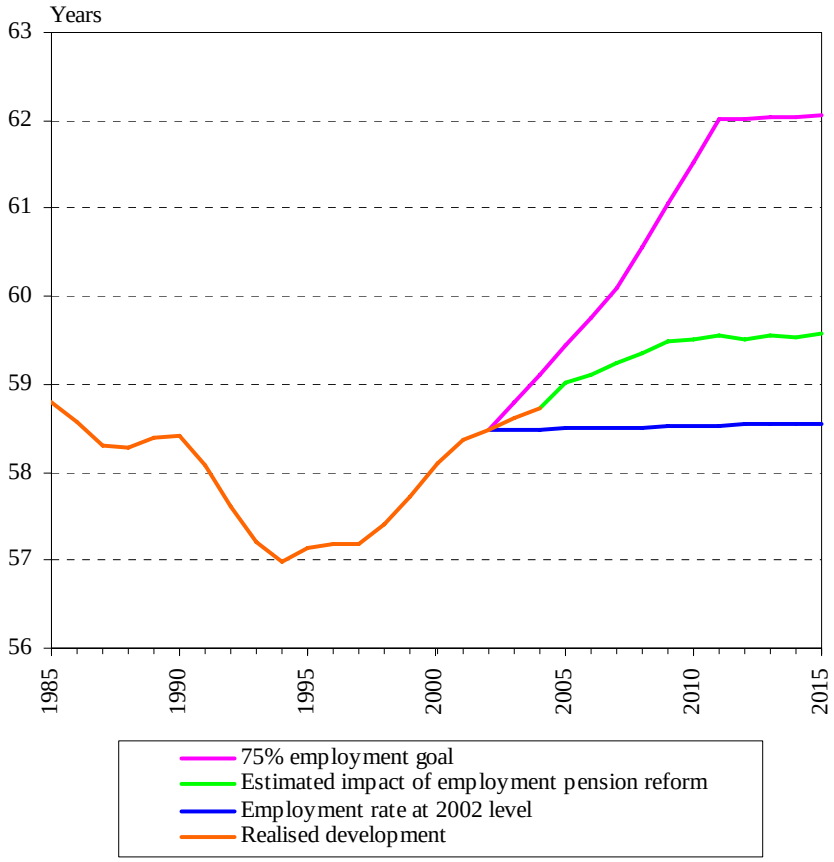
Increased education would boost employment of ageing workers by a total of tree percent. The increase among ageing women and men would be 4 and 1.5 percent, respectively. This contributes towards attaining the goal of high employment. Getting those over 50 to stay on at work is still the key employment challenge of the 2000s.

3.2.3 Monitoring indicators

Working career

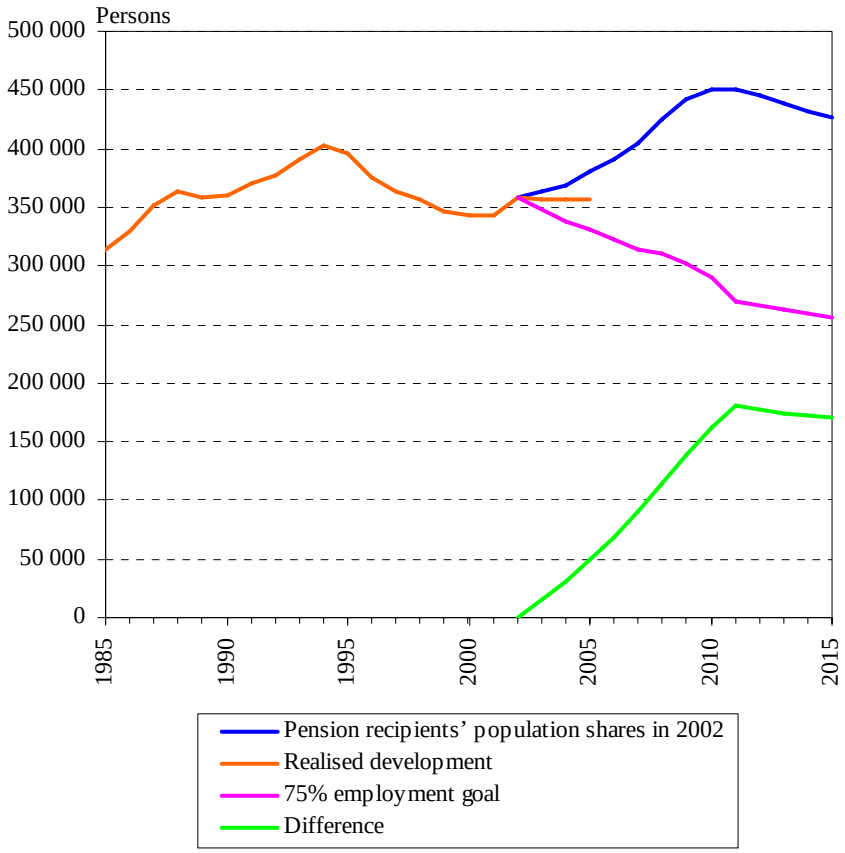
The goal of the Veto Programme is to increase the work participation rate among different age groups and to extend working careers by 2-3 years from the present. This is aimed at by simultaneous improvement of both well-being at work and the economic incentives of work.

Figure 21. Expected age at leaving work of a 50-year-old in 1984–2005 and the 75 percent employment goal by 2015



In order for the 75 percent employment goal to be fulfilled, working careers should be extended by a good three years, and the unemployment rate should fall below 3 percent. The latter would mean full employment or maybe “exceeding” it. Based on experiences from Iceland, Denmark as well as Sweden, it is possible to progress towards this goal in principle. The trend seems to follow the predicted scenario of the impacts of the pension reform drawn up at the Ministry of Social Affairs and Health (Figure 21). However, this development is not sufficient from the viewpoint of the government’s employment target.

Figure 22. The number of pension recipients under 65 reconciled with the 75-percent employment goal and the 2002 proportion of pension recipients.

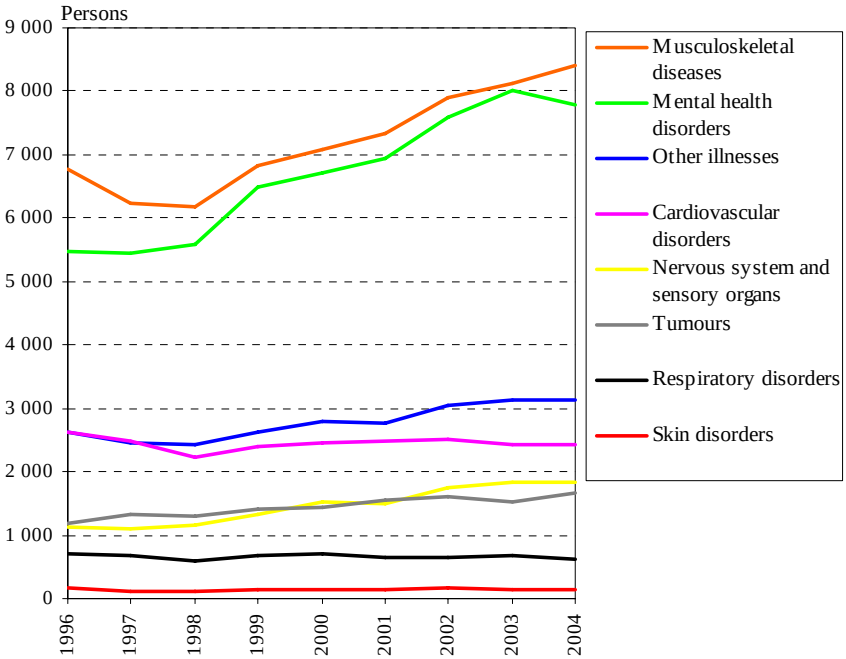


The development of the number of pension recipients under 65 seems to have stabilised, despite the change in the age structure. However, in order for the 75-percent employment goal to the fulfilled, the number of pension recipients should decrease cumulatively by nearly 200,000 persons by the year 2012.

The number of persons taking up pensions due to musculoskeletal disorders has increased steadily. Taking up pensions on mental health grounds has increased as well. The prevalence of depression of varying degrees of severity has increased; if untreated, it may in the worse case lead to disability.

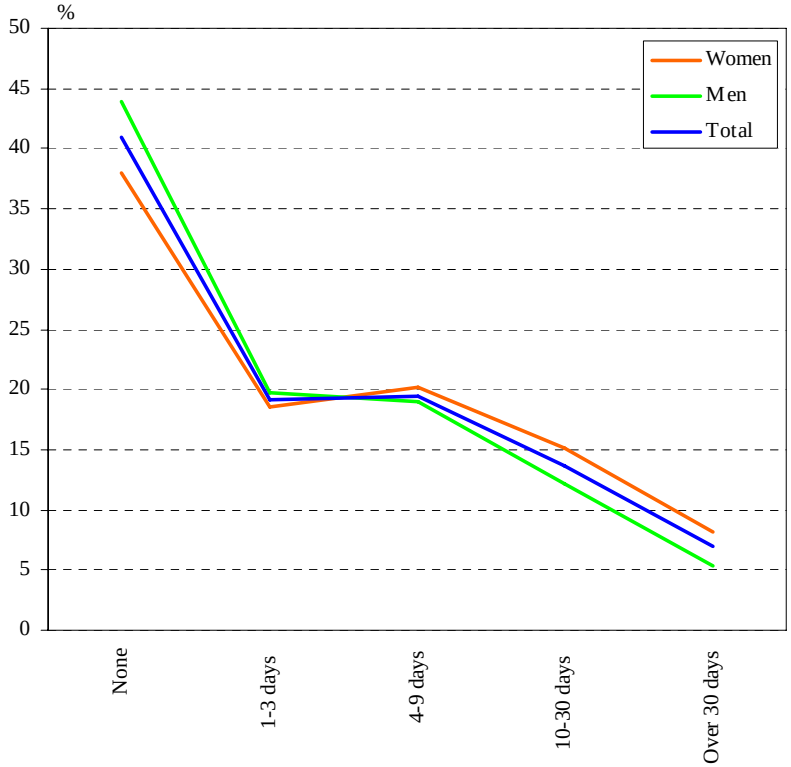
In addition to being an important means of postponing retirement, rehabilitation also promotes return to work after long-term illness. Rehabilitation is a rapidly developing service segment. With new advances in medicine, novel rehabilitation forms are being developed. Attempts have been made to focus particular attention on sufficiently early onset of rehabilitation. This calls for development of the "sensitivity" of the service system. In addition, sensitivity and preparedness is needed to invest in areas where the need of rehabilitation seems to be increasing. Mental health problems have become more common, which is also reflected in the number of people in need of rehabilitation. Compared to other diseases, the number of diabetics in need of rehabilitation is still small, but assessments and predictions of growth in the number of people with diabetes call for increased rehabilitation measures.

Figure 23. Employment disability pension recipients according to reason for disability in 1996–2004, persons



Absenteeism due to sickness

Figure 24. Sickness absenteeism due to own sickness in 2003



The majority of absenteeism due to sickness is of short duration. Long-term sick leave is usually linked to accident or serious illness.

Figure 25. Days off work due to sickness and accidents in 1990–2004 and the goal for 2003–2012, 1,000 days

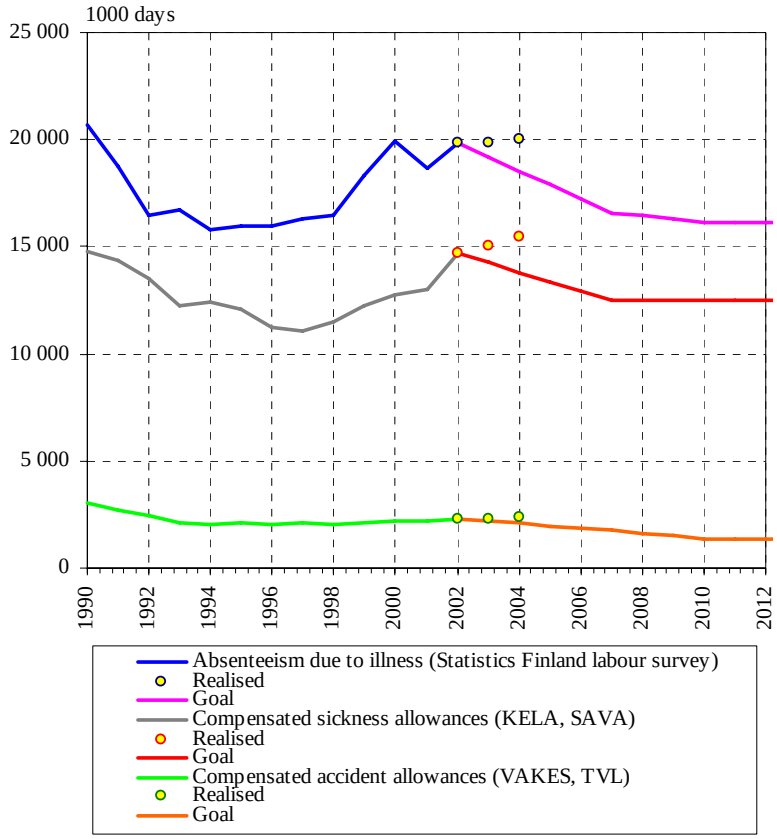
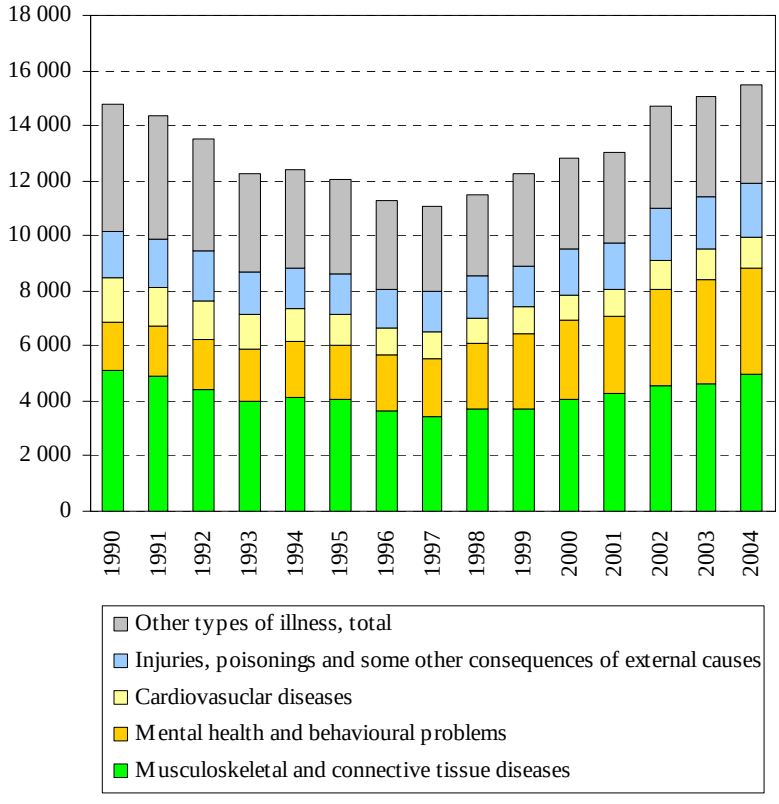


Figure 26. Compensated sickness insurance allowance days by illness in 1990–2004

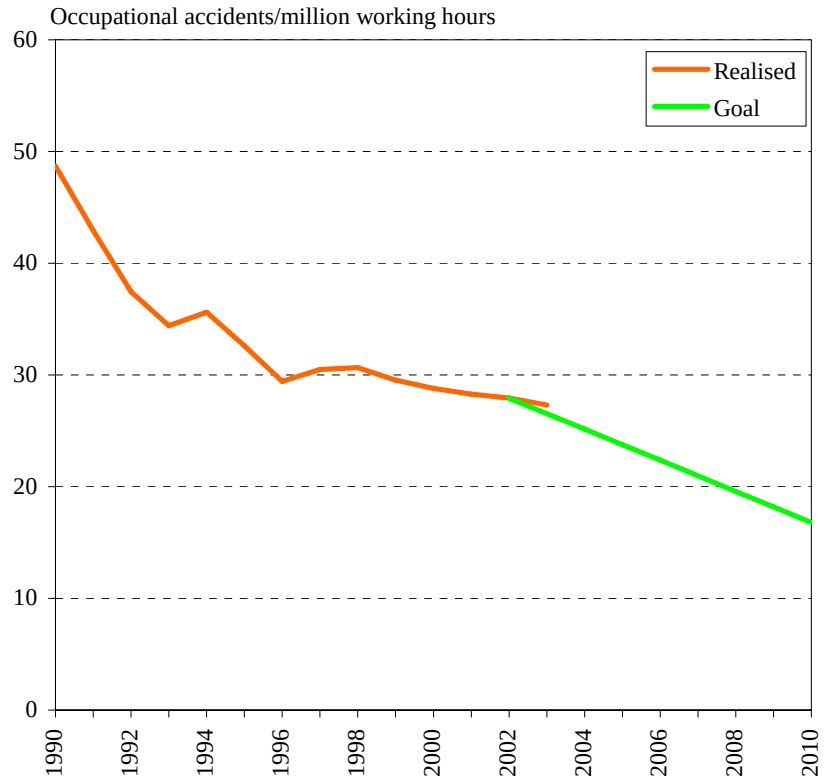


Sickness absenteeism seems to have stabilised at level of 20,000 persons; the declining trend which is the target is thus getting further and further (2.2). The number of sickness insurance allowances compensated in recent years has gone up (2.3).

Occupational accidents and diseases

The frequency of occupational accidents and prevalence of occupational diseases among wage earners as well as the number of accidents in the workplace and on the way to/from work continues to fall, but at a somewhat slower rate than expected by the target scenario. (3.1, 3.2 and 3.3).

Figure 27. Wage earners' occupational accidents per 1,000 wage earners in 1990–2003 and the goal for 2003–2010



The number of wage earners' occupational diseases as well as accidents in the workplace and on the way to/from work has remained more or less unchanged in recent years. As the economic recession eased and economic activity increased, the number of accidents went up, but in recent years, a very slowly declining trend has been reached. Taking into account that the economy has been growing all this time, the number of accidents in relation to the volume of production has declined significantly more clearly. This shows that investing in security has borne fruit. However, a lot remains to be done, particularly in the construction sector.

Figure 28. Wage earners' occupational diseases in 1990–2002 and the goal for 2003–2010

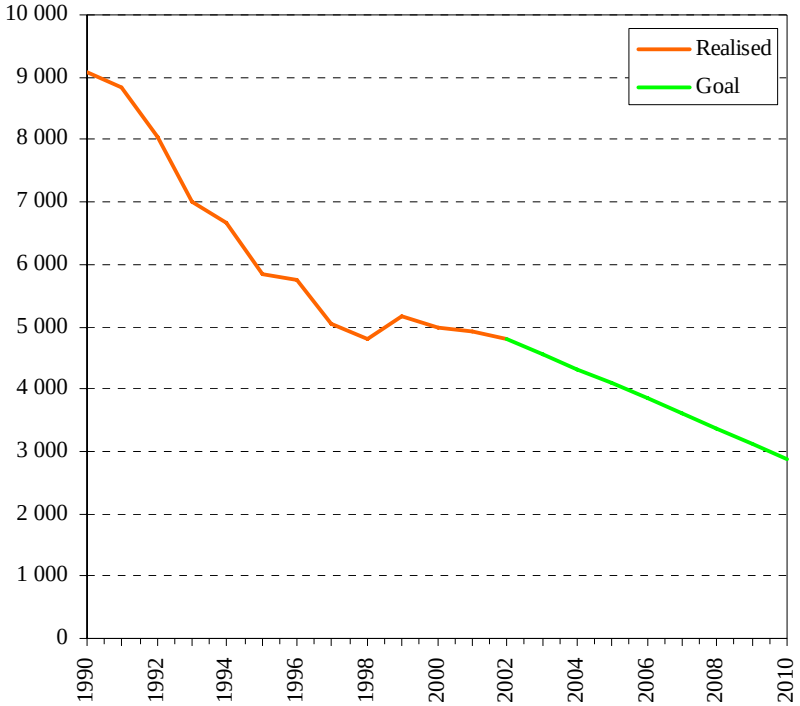
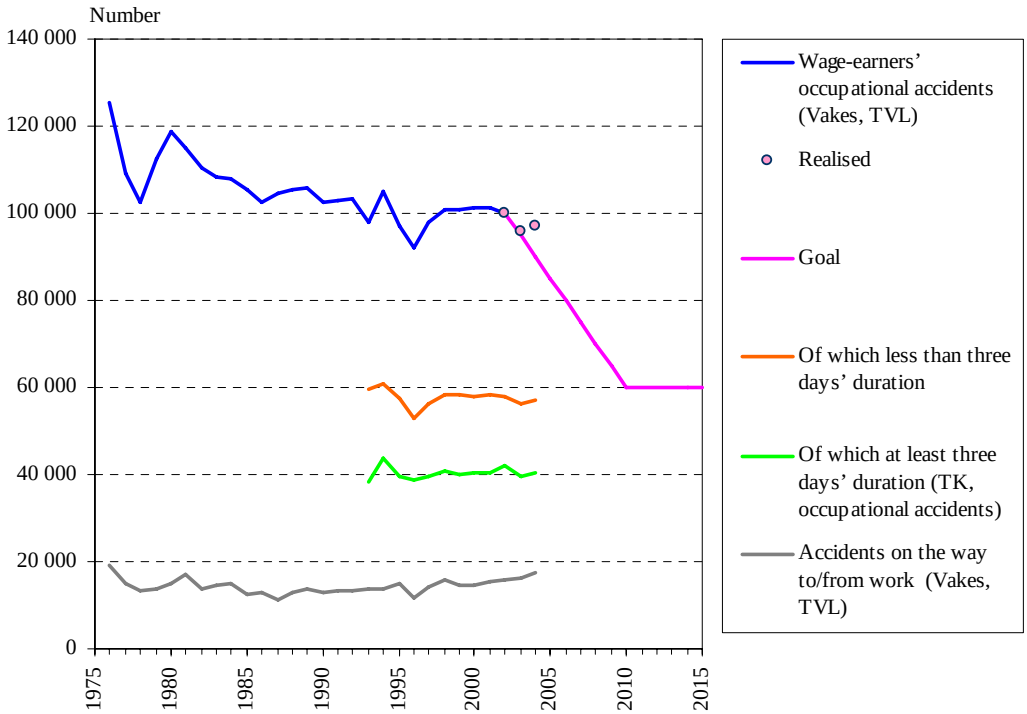
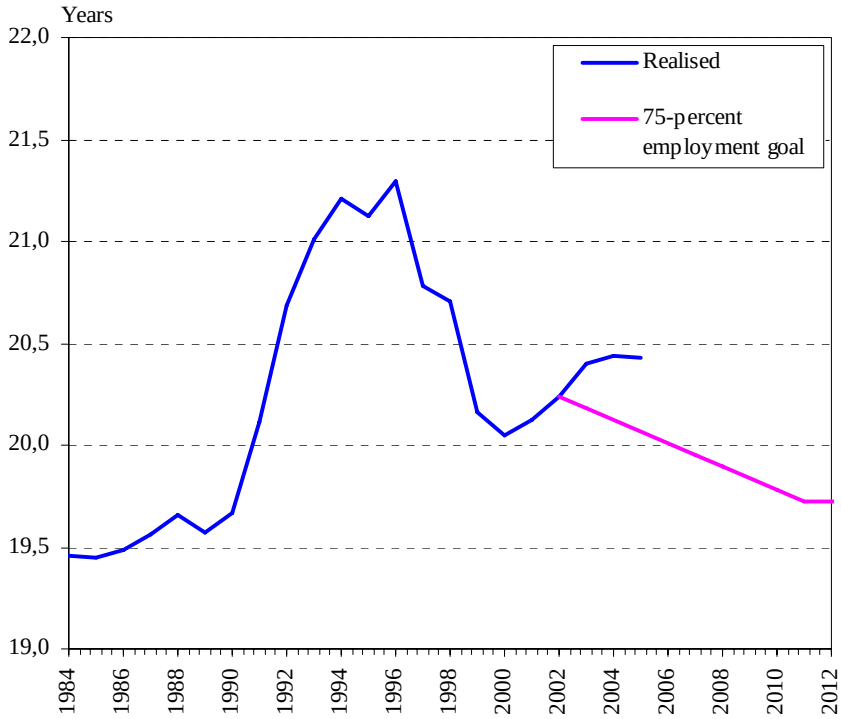


Figure 29. Accidents in the workplace and on the way to/from work in 1976–2004 and the goal for 2003–2015



Entry into the workforce

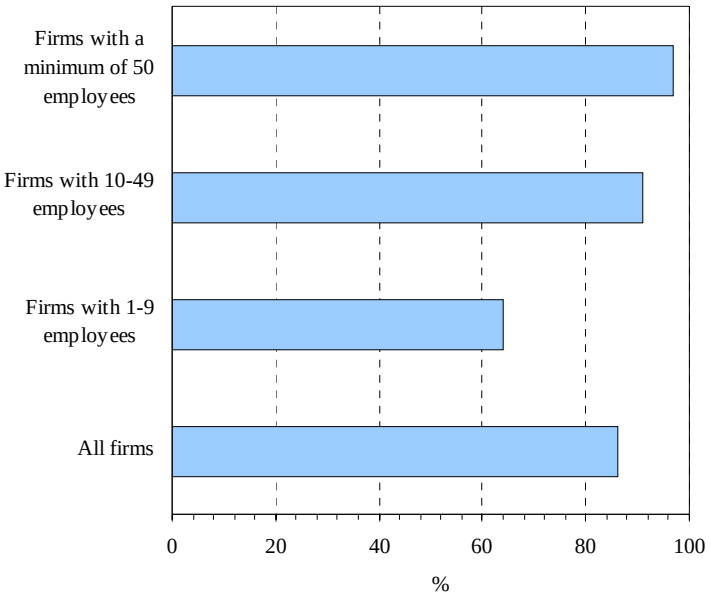
Figure 30. Age at completion of studies and conscription in 1984–2005 and age at completion according to the 75-percent employment goal in 2002–2012



Since the year 2000, the age at entry into the workforce has gone up. Economic growth has slowed down from the years of extremely brisk growth of the latter part of the 1990s. However, the age at entry into the workforce is still almost a year lower than during the years of deep economic recession in 1993–1996. An earlier entry into the workforce is promoted by the fact that by 2008, students will be able to start tertiary education a year earlier. Education policy goals postpone entry into workforce in terms of raising the level of education. A seamless transfer from basic education to secondary and tertiary education, and further on to work, occupies a key position in the coordination of education policy and employment policy goals.

Occupational health care

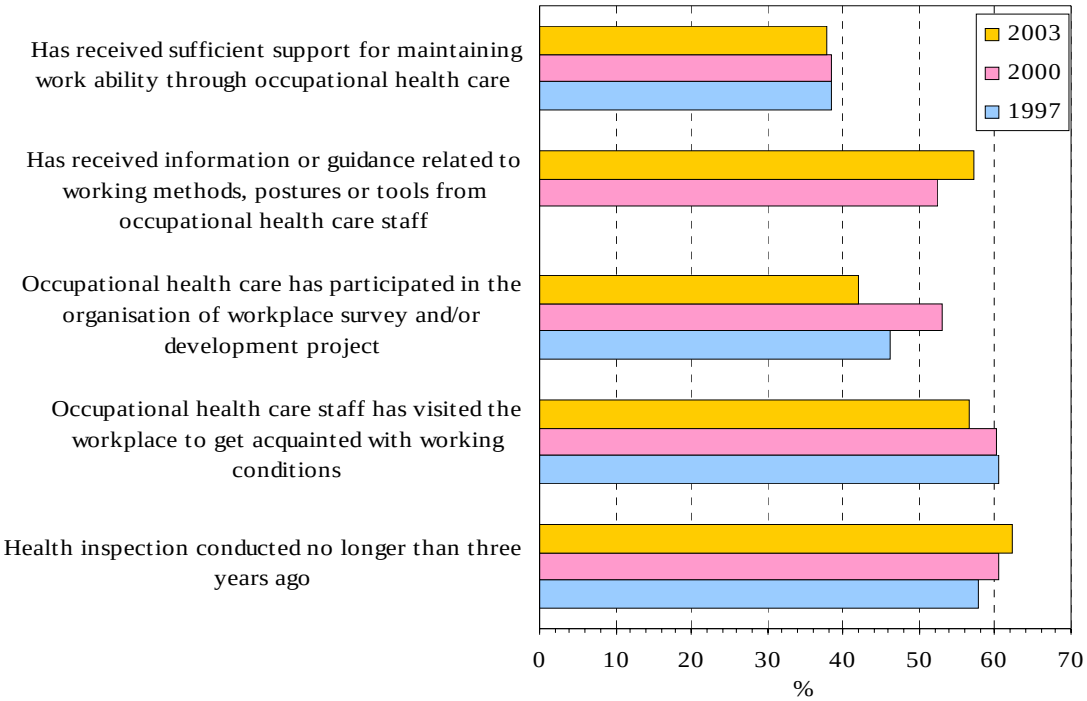
Figure 31. The proportion of firms with occupational health care in 2003 according to firm size



Nearly 100 percent of larger firms are covered by occupational health care, whereas employees working in smaller companies do not yet have universal occupational health care coverage.

In 2002, there were about 226,500 firms in Finland. Of these, 93 percent were micro enterprises employing less than 10 persons. Nearly one fourth of the labour force work in micro enterprises, and over 60 percent work in SMEs.

Figure 32. Indicators of occupational health care in 1997–2003, % of employed

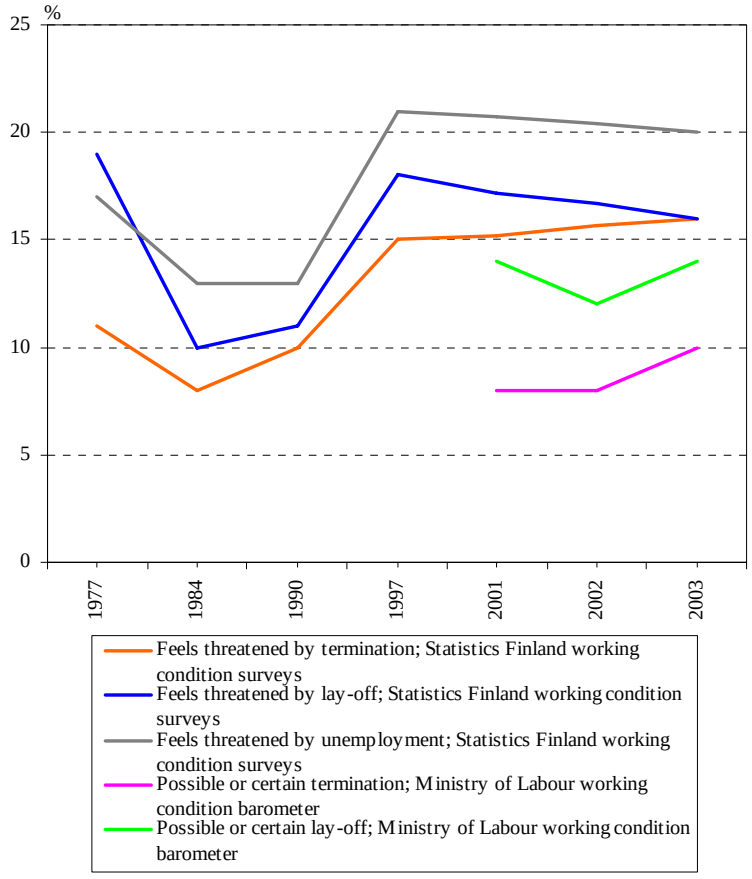


Compared to previous years, the number of health check-ups and guidance of occupational health care staff in relation to working methods, postures or instruments has increased in particular.

General atmosphere and attitudes

The pace of work has increased, but the latest survey shows a slight decrease in how negatively people perceive the fast pace of work. Working overtime without pay increased in the 1990s, but as we have entered the 2000s, it has even decreased slightly. Quite a large number of people are thinking of taking up a pension even before they reach retirement age. People no longer get sufficient information in time about changes in the workplace.

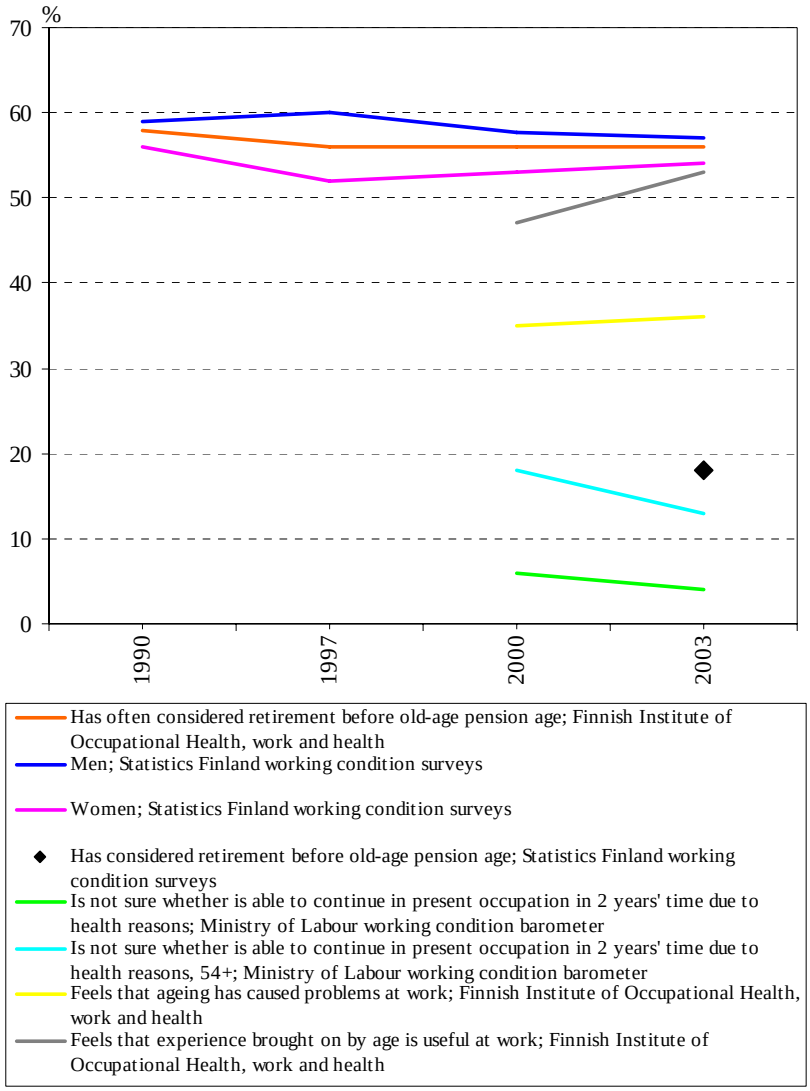
Figure 33. Work-related insecurity factors in 1977–2003



There was an increase in work-related insecurity factors after the recession, but there is now evidence of a slight decrease.

The pace of work has increased, but the latest survey shows a slight decrease in how negatively people perceive the fast pace of work. Working overtime without pay increased in the 1990s, but as we have entered the 2000s, it has even decreased slightly. Quite a large number of people are thinking of taking up a pension even before they reach retirement age. People no longer get sufficient information in time about changes in the workplace.

Figure 34. Proportion of those who have considered taking up a pension before retirement age, 1990–2003



The general atmosphere in society, attitudes toward work, free time and their distribution along a person's life are matters of such importance that impacting them was chosen as one of the goals of the Veto Programme. As a rule, attitudes and values change very slowly, which is why influencing them calls for a very long-term effort. The impact of many incentives is only felt over a longer period of time as well, while some incentives (such as increased pension accrual rates) are limited to a fixed number of years during the career. That is why "general incentives" are needed that have an impact throughout the entire career, and attitudes are precisely that.

IV Prevention and combating of social exclusion

Impact goals of prevention and combating of social exclusion

- Reduction of long-term and structural unemployment
- Reduction of need of long-term social assistance
- Reduction of poverty among families with children
- Increasing preventive health-care services aimed at children and young people
- Increasing services for substance abusers, mental health and child protection
- Improving the availability of drug treatment services
- Closer cooperation between administrative sectors in prevention of exclusion
- Reduction in the number of homeless

In the government's strategy document, the following are listed as the most important means in combating exclusion: reduction of unemployment, sufficient level of minimum benefits and well-functioning services aimed at special target groups. In service provision, the special needs of immigrants are to be taken into account. Because risk factors contributing to social exclusion tend to accumulate, efficient cooperation between administrative sectors is called for. Strengthening of social work, joint services and a genuine multiprofessional approach are the key factors to solve this problem. Measures related to reduction of homelessness are also important for the prevention of social exclusion.

4.1 Multiple problems and social exclusion

Social exclusion refers to accumulated social problems combining long-term or repeated unemployment, problems with low income and life management as well as exclusion from social life. Exclusion may be associated with illness or disability, deviant behaviour, criminality or substance abuse. No single problem leads to social exclusion by itself; it is a question of accumulation of problems and the formation of a kind of vicious cycle of deepening social problems. Social exclusion thus involves multidimensional problems of long standing.

In order to manage the multiple problems of people suffering from social exclusion, close cooperation has been encouraged between main divisions of administration. The instruments to implement this include strengthening multiprofessional working methods, improved exchange of information and changes to the service structure. In development projects, the client-orientation and seamlessness of services that is not dependent on organisational boundaries is emphasised. Close cooperation between authorities is conducted in the new employee service centres helping the long-term unemployed as well as in rehabilitative work activities. Cooperation networks have been developed within local and regional employment strategies and partnership projects.

In social and health care development programmes, officials are trained to spot multiple problems and to guide clients to seek help from services provided by another administrative sector when needed. The development of cooperation between authorities refers e.g. to the following: social and health care units, the Social Insurance Institution of Finland, the police, schools and other educational institutions, employment officials, job centres and the Prison Service. Non-governmental organisations, parishes and firms are also important partners in the work aimed at helping those suffering from exclusion. When detecting and treating multiple problems, individual data protection is at times in conflict with the service system's need of information.

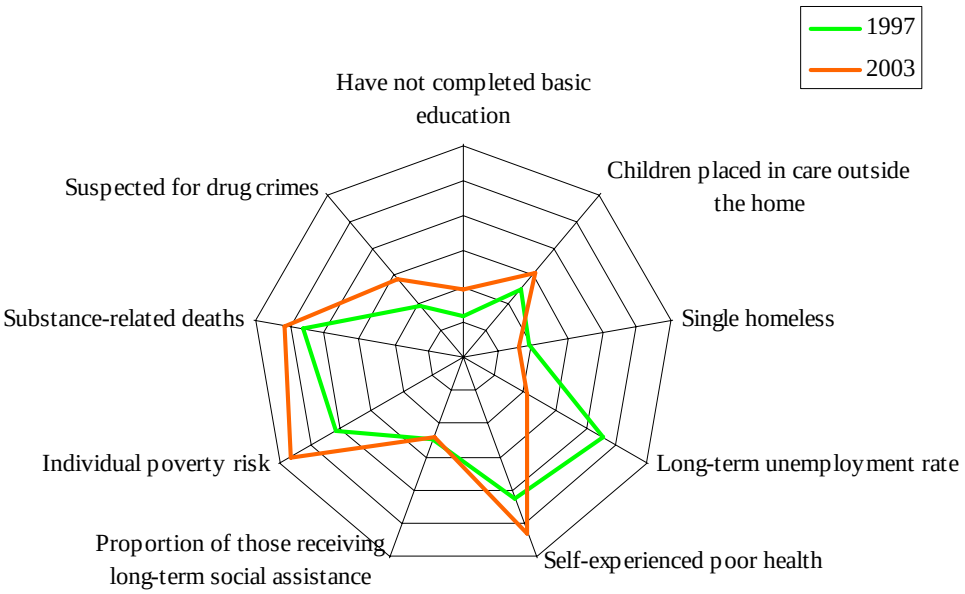
The efficiency of the incentives set is also affected by the multiple problems of those being socially excluded. The desired effects on behaviour of the economic incentives are based on the idea of rational economic thinking. The assumption that people have the capacity and the will to act in accordance with economic rationality is often far removed from the everyday reality of those who are excluded. When life is dominated by mental health problems, illness or substance dependence, economic prudence is easily overshadowed by other worries. The use of incentives calls for good knowledge and understanding of the situation of the target groups as well as their individual motives. Among those at risk for exclusion, both the ability and the motivation-based desire to act in the manner called for by the incentives may be very different from that of the majority of the population.

Getting those who are excluded motivated to improve their own situation is a prerequisite for the success of activation measures. People's belief in their own abilities must gradually be strengthened, and they must be offered hope for the future. The best results in improving the status of those who are excluded and their social rehabilitation have been achieved with intensive individual measures. However, as the number of those suffering from exclusion increases, substantial resources are called for. The development of services aimed at those who are excluded has mainly been the responsibility of municipalities and the third sector. The scarcity of resources available limits the provision of individual support. However, in the long term, the savings in public expenditure attained by prevention of exclusion is a significant advantage, in addition to the reduction in human suffering.

4.1 The development of social exclusion

Based on statistics, the risk factors of social exclusion increased rapidly among the population in the 1990s. A turn for the better was seen in employment in the latter part of the 1990s. After the turn of the millennium, the proportion of those who have been living on a small income for several years has increased. Living on a small income for an extended period of time increases the risk of social exclusion. Prolonged poverty is usually linked to long-term unemployment. The number of long-term unemployed has diminished by almost 50 percent since the peak in the 1990s. A slight decreasing trend can still be observed. As a whole, the risks for exclusion seem to have increased lately, particularly among children and young people as well as intoxicant and drug abusers. However, attempts to decrease long-term unemployment and homelessness from the 1990s level have been successful.

Figure 35. Development of social exclusion risk factors in Finland in 1997 and 2003



4.2 Providing support and encouragement to the excluded

The government's measures aimed at encouraging and supporting those at risk of social exclusion target different population groups as follows:

- The long-term unemployed are encouraged to return to the labour market with various activation and rehabilitation measures.
- Young people at risk of social exclusion are given support and they are encouraged to get sufficient vocational training.
- Access to independent or supported housing of the homeless is improved.
- Attempts are made to maintain and improve the functional ability of the long-term ill and those with reduced functional ability. The possibility of finding employment is supported. When attempting to secure income, pension arrangements are used as the last resort.
- People with substance abuse problems are encouraged to seek help within the service system, and to stop or reduce the use of substances.
- People with income problems are given support in personal economy management and encouraged towards responsible household management.
- Those breaking commonly accepted rules of society are encouraged to earn a living in the legal and normal labour market, and to give up the use of violence or other criminal activities.
- Immigrants are helped to adapt to Finnish society, and their employment is supported.

In the following, measures aimed at promoting the attainment of the above-mentioned goals are presented by target group.

The long-term unemployed

The aim of the **social guarantee for the long-term unemployed** coming into effect as of the beginning of 2006 is to offer a job or measures supporting employment to all those who have received passive labour-market support for more than 500 days. The job-seeker is obliged to accept the job offered, or to take part in active measures. Failure to do so may result in loss of unemployment security. In order to implement the social guarantee, the government is increasing the appropriation earmarked for activating measures and focuses the appropriation reserved for passive unemployment security on activating the unemployed. **Labour-service centres** provide multi-professional services to those in the most difficult position in terms of gaining access to the labour market. The service centres look after job-seekers who in addition to employment services need other services as well, such as municipal social and health care services.

In order to **promote cooperation between authorities,** the financing responsibility of labour market support after 500 passive unemployment days is divided evenly between the state and municipalities as of the beginning of 2006. The financing responsibility of social assistance is always divided between the two. The state and the municipalities thus bear an equal financial burden for the direct costs due to long-term unemployment.

Since 2001, municipalities have arranged **rehabilitative work** activities for the long-term unemployed who are not easily employed. The implementation of rehabilitative work activities in municipalities continues.

The aim of **social enterprises** is both to increase the possibilities of the disabled and long-term unemployed to find employment and to encourage entrepreneurship. The Act on Social Enterprises prepared at the Ministry of Labour came into effect at the beginning of 2004. A social enterprise may act as a channel towards the open labour market and provide permanent jobs for those who are not easily employed. In August 2005, the number of registered social enterprises was 20. At the time of registration, some 100 disabled or long-term unemployed persons worked in these enterprises.

Young people at risk of exclusion

The implementation of the **education and social guarantee for young people** was started in 2005. The aim is that as many young people as possible will complete at least secondary vocational qualifications and that intervention measures are taken in regard to unemployment of all those under 25 years of age as soon as possible. Young people who are left with no job are offered an active solution after three months of unemployment at the latest.

The aim is to set up a **cooperation model** for municipalities, education providers and employment authorities, so that all young people can find a suitable place of study or find employment after leaving comprehensive school. The employment and education of unemployed young people has been supported with **workshop activities and apprenticeship training**.

A continuation plan for the project concerning **early intervention** has been drawn up for 2006–2007. In the coming work, focus is on development and strengthening of coordination structures and methods supporting early intervention on either municipal or regional level.

As they move on from primary education to the next level, young people are provided support with the aid of the 'Ota oppi' model. Its aim is to prevent social exclusion among young people with the aid of multiprofessional cooperation involving various administrative sectors. A separate project has been launched to disseminate the methods tested in the youth rehabilitation experiment to all parts of the country.

The homeless

Investment and operation subsidies aimed at reducing homelessness have been allocated from the funds of the Housing Fund of Finland and Finland's Slot Machine Association in 2002–2005. **The programme aimed at reducing homelessness** will be extended until 2007 in cooperation with cities in the capital region, the Ministry of Social Affairs and Health, the Ministry of the Environment, Finland's Slot Machine Association, the Housing Fund of Finland as well as social service providers and organisations.

The long-term ill and disabled

The project aimed at surveying the **possibilities for rehabilitation and preconditions for pension** of the long-term unemployed (Elma) continues. The operation has spread to the entire country. Employment offices are responsible for the implementation of the project. In 2004, a total of 6,837 work ability assessments were conducted on 4,628 clients. A total of 1,526 positive and 926 negative pension decisions were made. In May 2005, the Act on Pension Support for the Long-term Unemployed came into effect.

The project aimed at developing home help services and home nursing was launched in autumn 2004 and will continue until 2007. In the project, the contents and quality of the services is improved and the operation is made more effective. **The informal care system is reformed** as of the beginning of 2006. Informal care is developed as an integral part of the municipal community care service system. The minimum level of informal care allowance was raised, and a new allowance category was introduced for the demanding transition care phase. The aim is also to increase clients' equality and to make fees more reasonable, particularly in sheltered housing. As of the beginning of March 2005, everyone over 80 as well as all recipients of special care allowance paid by SII are entitled to have their service need assessed within a given period of time.

Substance abusers

The National **Alcohol Programme** for 2004–2007 aims at a significant reduction of the negative effects of alcohol for the well-being of children and families, significant reduction of risk use of alcohol and its negative effects, and a reduction in total alcohol consumption. Development project funding provided by the state is used for the development of substance abuse services. In view of the service need, municipal funding has been insufficient in recent years. The fact that drug substitution therapy is scarce is still a problem.

The means for attaining the objectives of substance abuse care include the development of low-threshold services as well as detoxification and withdrawal treatment, taking multiple substance abuse into account in service provision better than at present, and improving treatment guidance training of the police. In addition, the aim is to develop mental health and substance abuse services as regional entities.

On 5 February 2004 the Government issued its resolution on a **Drug Policy Action Programme** for 2004–2007. The programme is currently being implemented. The implementation of cross-sectoral measures continues, with the aim of reducing the negative effects of drug use. The programme intensifies in particular the cooperation against drugs between different authorities.

People with income problems

Cross-sectoral cooperation aimed at drawing up a debt management programme was launched in October 2003. The working group's **proposal for a debt management programme** has been published. The bill on a total reform of the **Enforcement Act** is currently being circulated for comments, and the Ministry of Justice intends to issue the bill to Parliament during 2006. According to a proposition included in the bill, the debt would be written off when the deadline for execution has passed. In practice, this would mean that the debt is statute-barred, in which case the debtor will regain normal economic freedom of action.

Social credit became statutory on 1 January 2003. The aim of social lending is to prevent economic exclusion and over-indebtedness and to promote independent coping. Social credit may be granted to persons, who due to their low income and limited means are otherwise unable to obtain credit on reasonable terms, and who have the ability to pay back the social credit awarded to them.

The seven percent **co-payment of housing expenses** affecting the basic amount of **social assistance** will be abolished as of 1 September 2006. An attempt will be made to increase the use of **preventive social assistance.** It can be used e.g. for securing the studies and employment of young people and for supporting the hobbies of children and youth. It can also be used in situations where e.g. a person with mental health problems, an inmate released from prison or an over-indebted person or family needs support for rehabilitation, securing their income arrangements, or for improving their social and economic situation. Based on the experiences gained on the use of the assistance, it is particularly useful in acute crises and when used sufficiently early and in a systematic manner.

Offenders

In spring 2005, a working group coordinated by the Ministry for Foreign Affairs prepared a **National Action Plan for the prevention of human trafficking**. The programme was approved by the Government in August 2005. A Ministry of Social Affairs and Health **action plan to prevent domestic and intimate partner violence** 2004–2007 has been published, and it is being actively implemented. A follow-up to the study on female victims will be conducted in 2005–2006. Provisions on trafficking in human beings and aggravated trafficking in human beings have been added to the Penal Code, and they came into effect on 1 August 2004. A new definition of aggravated act regarding procuration was laid down at the same time. In 2004–2005, a project entitled 'Prostitution in Lapland, helping prostitutes and reduction of prostitution' has been underway as part of a joint Nordic project.

The Government bill to **amend the legislation concerning the handling of young offenders' affairs and the sanctions system** is under preparation. The financing of the system is currently being considered. The National Council for Crime Prevention has drawn up a draft for a national programme for the prevention of violence. The Government is likely to issue a resolution on this matter at the beginning of 2006.

Total reform of the Prison Act and the organisation of the Prison Service will be implemented as of 1 October 2006. The key aim is to improve the capability for a crime-free life of those convicted of crimes by increasing the number of target-oriented activities and individual conviction time planning. By 15 January 2006, the **working group on after-treatment of convicts** was to prepare a proposal aimed at development of after-treatment of convicts and taking into consideration the need of support of the clients of criminal care.

A Government bill on crime arbitration has been prepared, and its consideration in Parliament started in autumn 2005. The aim is to make **crime arbitration** an established practice in the entire country, and to make it government-funded operation.

Immigrants at risk of exclusion

The Act on the Integration of Immigrants and the Reception of Asylum Seekers came into effect in 1999. Based on the Act, an **Integration Plan** is drawn up for immigrants entitled to labour-market support or social assistance.

The Integration Act was amended at the beginning of 2006. The aim is to intensify and accelerate the integration of immigrants. A list of measures and services that promote integration was added to the Act. Education has a key role in this process. In the case of those who belong to the labour force, the aim of education is employment. The intent is to intensify the education of those who cannot read or write or who lack sufficient basic education. It is important to draw up individual integration plans especially for young immigrants to intensify the efforts aimed at preventing social exclusion.

V Well-functioning services and reasonable income security

Impact goals of well-functioning services and reasonable income security

- Improving the availability and quality of social and health care services
- Securing the availability of social and health care services in Finnish and Swedish
- Improving possibilities for providing social and health care services in Sami
- Reforming service provision structures
- Strengthening regional cooperation
- Securing sustainable financing of services
- Promoting social participation possibilities among the disabled
- Ensuring sufficient basic income security and reasonable earnings-related benefits
- Securing sustainable financing of social insurance

5.1 Well-functioning services

The aim of the government programme is to develop health and social policy side by side and with parallel aims, e.g. with the aid of the National Health Care Project and the National Development Project for Social Services. The aim is to ensure equal availability, quality and sufficiency of municipal services in accordance with population needs with a reasonable tax and payment burden.

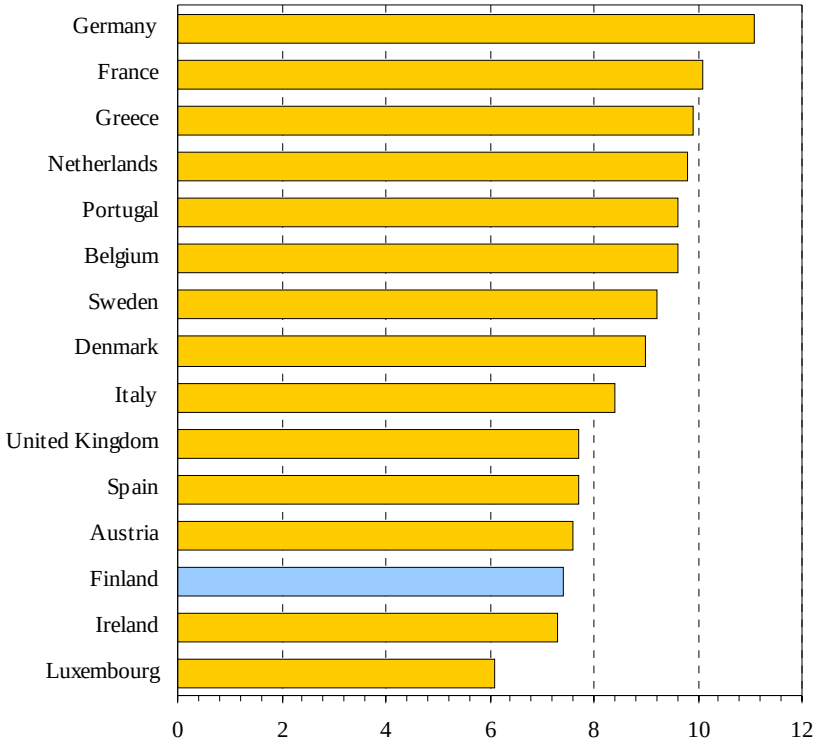
The most important impact goal of social and health care services is the improvement of the availability and quality of services. In the years to come, this calls most of all for securing the sufficiency of staff and sustainable financing of the services. These objectives are also included in the National Health Care Project and the National Development Project for Social Services.

5.1.1 Development of health care expenditure

Total health care expenditure in relation to GDP came to 7.4 percent in 2003, which was 0.1 percentage points more than the previous year. The GDP ratio of health care expenditure started to increase in 2001 after several years with a downward trend. In addition to an increase in expenditure, this was caused by a slowdown in GDP growth.

The health care expenditure to GDP ratio is clearly below the EU average. Health care expenditure per capita is also among the lowest within the EU. The difference is partly explained by the low wage level of Finnish health care staff. Another explaining factor is a difference in institutional elderly care statistics between Finland and many OECD countries. In Finland, institutional elderly care costs are not included as extensively in health care expenditure as in many other OECD countries.

Figure 36. Health care expenditure in EU member states in 2002/2003, as a percentage of GDP



Source: OECD Health Data 2005

Even though the GDP ratio of health care expenditure has diminished compared to the beginning of the previous decade, expenditure has been growing in real terms since 1995. In addition, health care costs have grown more rapidly than other public expenditure.

The growth of medicine expenditure has been particularly fast; on average, medicine costs show a real increase of about 4.5 percent per year since the beginning of the previous decade. Based on the distribution of wholesale pharmaceutical sales, the distribution of medicine expenditure between medicines sold at pharmacies and those used in hospitals has not changed significantly since the beginning of the 1990s; pharmacies continue to account for about 80 percent and hospitals for about 20 percent of the total value of wholesale pharmaceutical sales.

The low level of health care expenditure in terms of GDP ratio and costs per capita can be interpreted in two different ways. According to a positive view, the Finnish health care system is more effective than average, since comprehensive and high-quality services can be provided with a small input. This interpretation can be motivated by the fact that of all EU citizens, Finns are the most satisfied with their health care services.

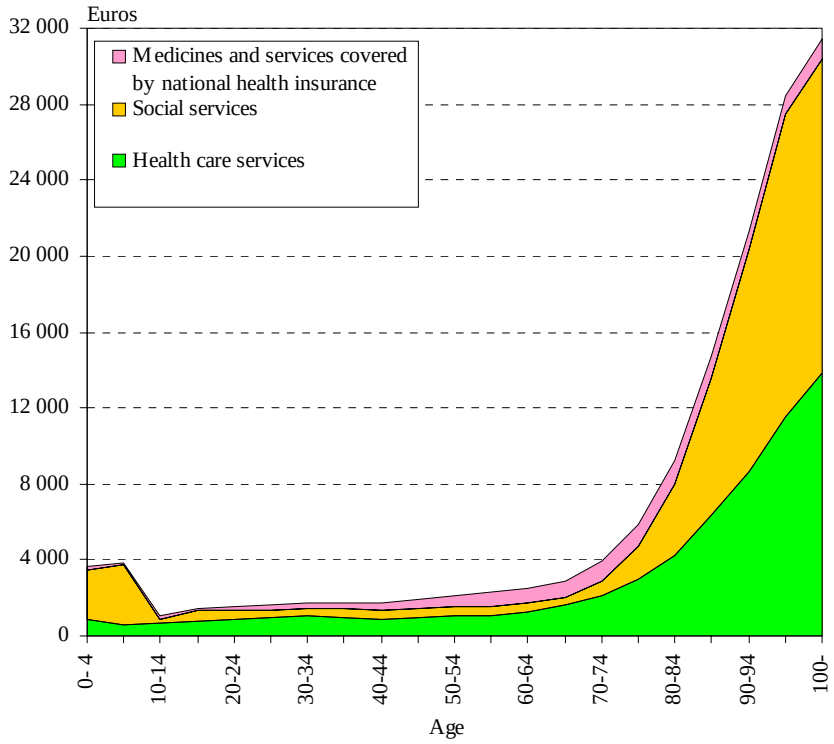
According to a more critical view, it can be questioned whether sufficient funds have been allocated to health care in Finland in recent years. This view is supported by the long waiting times to get specialised medical care in Finland compared to other European countries, as well as survey results showing that among all municipal services, most additional resources are wanted in health care. The increased needs have

also been politically recognised, as the government has allocated more resources to health care within the framework of the government programme and the National Health Care Project.

5.1.2 The need of social and health care services in the future

The ageing of the population increases social and health care expenditure, although the effect is not straightforward. The growing number of elderly people and longer average life spans will increase the need of care as well as service expenditure. Figure 37 shows average age-group specific social and health care service expenditure in 2004. It is noteworthy that expenditure varies considerably between municipalities and regions. In addition, age-group specific expenditure is constantly changing, and the boundary between social services and health care is porous, particularly in elderly care. The expenditure on older age groups – e.g. those in age group 80–84 in relation to those aged 30–34 – is fourfold in health care services as well as in medicines and services covered by health insurance. In the case of social services, the corresponding difference is twentyfold.

Figure 37. Age-group specific social and health care expenditure (including user fees and health insurance co-payments by beneficiaries) according to type of benefit in 2004, €/person



Social and health care service expenditure can be estimated to rise in the 2020s and 2030s, as the number of very old people increases markedly. On the other hand, it must be taken into account that according to several studies, the rise in the number of elderly population has not led and will not lead to a corresponding rise in expenditure. The OECD assessment report on health care in Finland also states that technological change will continue to be the factor with the biggest impact on health care service demand in the future as well. It is likely that public health will continue to improve in the future,

and the elderly will be able to cope independently longer than before. In addition to improved health and functional ability among the elderly, the service needs caused by population change may be alleviated by many other factors as well. A reduction in the number of children makes it possible to transfer resources used for child day care to services for the elderly. An improvement of living conditions reduces the increasing need for services.

Trends in expenditure can also be significantly influenced by service provision solutions, such as the adoption of new, more efficient operation and care methods making use of new technological advances, and by reforming service and production structures. In health care services, supply also creates demand, which is why supply has a decisive impact on future costs.

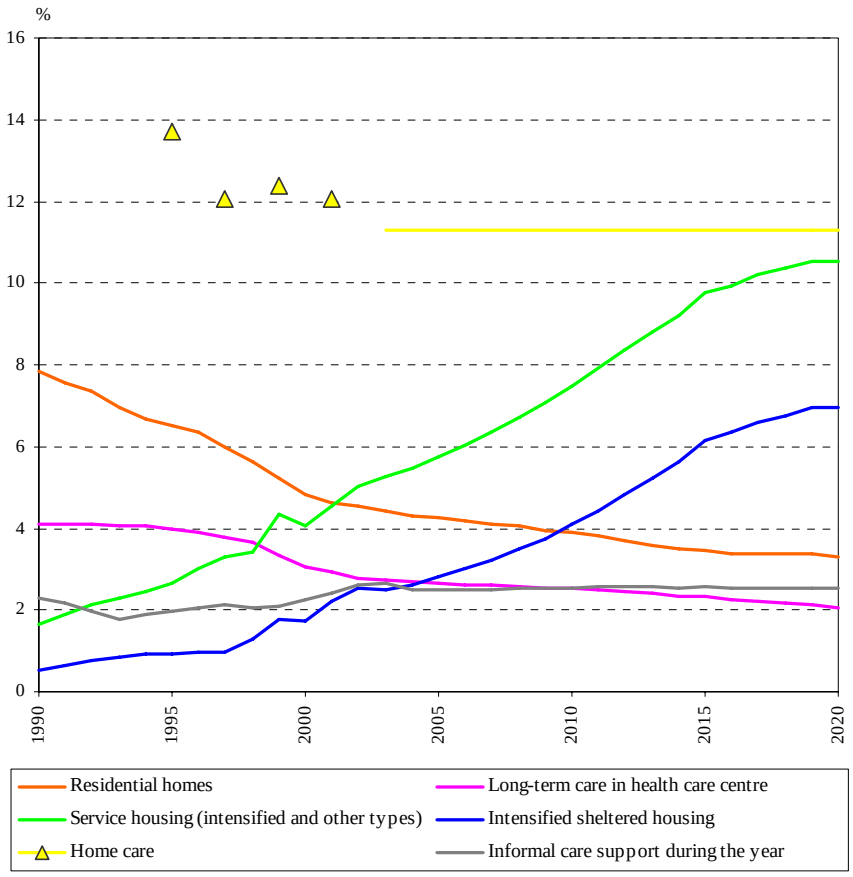
5.1.3 Availability of social and health services

The availability of services is influenced by the sufficiency of economic and staff resources, staff competence, operating practices as well as information and communication methods. In social and health care, availability varies according to both region and disease/client category.

The need and demand for social and health care services is increased by an ageing population structure. Despite the fact that people’s health status remains good longer than in the past, the need for services does increase at some point. In the early stages of ageing, service needs focus mainly on outpatient care services. The change in elderly services structure from institutional care towards sheltered housing also affects service demand.

The following figure shows projections of the proportion of elderly persons receiving various types of elderly services based on current policy. The figure shows that the rise of the relative proportion of sheltered housing is in line with the objectives of elderly policy, while the stagnation of the proportion of those covered by home help and the slight decrease in informal care support recipients are in conflict with the objectives. In order for the goals of elderly policy to be attained, the population share of support for informal care, sheltered housing as well as care in the home must rise more than predicted, while the population share of more comprehensive services, such as long-term care in health care centres and residential homes for the elderly, must diminish more than anticipated.

Figure 38. The proportion of persons over 75 receiving public elderly services in 1990–2003 and projections for 2020



On average, the need for regular home-help services begins at the age of 76, and institutional care at the age of 82 years. Of the population, 15.6 percent are over 65, 7.1 percent are over 75, and 1.6 percent are over 85 years old. The ratio of women and men per cohort is such that until the age of 57 there are fewer women, and among older age groups more women than men. The proportion of elderly persons varies by region. In 2003, the proportion of persons over 65 was highest in Etelä-Savo (20.3 percent) and South Karelia (18.8 percent), and lowest in Uusimaa (11.8 percent) and Northern Ostrobothnia (13.1 percent).

The operation of social and health care requires continuous refreshment and maintenance of professional competence. Shortcomings in continuing education undermine the quality of services and cause problems for social and health care staff, employers and clients. In 2003, regulations concerning continuing education were added to the Primary Health Care Act and Act on Specialised Medical Care, and recommendations were issued regarding the content and implementation of continuing education.

Securing access to care

According to the amendments, as of the beginning of March 2005, clients must be able to access health care centres immediately during office hours on weekdays. Patients must get an appointment with a health-care professional at health care centre – not necessarily a physician – for assessment of non-urgent care need within three days of making contact, unless the matter can be dealt with by phone. Patients must access medical and dental care deemed necessary within a reasonable period of time. In primary health care, patients must be treated within three months after need of care has been established. This three-month maximum may be exceeded in dental care or specialised medical care implemented in connection with primary health care by no less than three months, if treatment can be postponed for a good reason without endangering the patient's health.

The law concerning access to specialised medical care within six months came into force at the end of August 2005. In specialised medical care, assessment of treatment need must be initiated within three weeks of receipt of referral at health care unit, such as hospital outpatient clinic. Patients must access medical or dental care deemed necessary within six months after the need of care has been established.

In the case of mental health services for children and adolescents, the regulations now incorporated into the Act correspond to previous regulations included in the Statute. Taking into account the urgency of the need of care, care deemed as being necessary must be provided within three months, unless otherwise indicated by medical or treatment-related reasons.

If care cannot be provided within the time limit set, the municipality or joint municipal authority must purchase care from other service providers, such as another hospital or the private sector, without the user fee paid by the patient being affected. The mutual responsibility of hospital district joint municipal authorities and municipalities is clarified, so that the hospital district is responsible for arranging care for the patients sent to hospital. Services must be arranged according to the same principles to all residents of municipalities belonging to the hospital district. This reform abolishes municipal-specific waiting lines. The possibility to obtain information about access to care is improved by the obligation of health care units to make waiting times public.

The joint municipal authority of a hospital district is responsible for the arrangement of specialised medical care within its area on uniform medical and dental grounds. As part of ensuring access to care, national guidelines on non-urgent care are being drawn up. The aim is to diminish the great regional differences in the arrangement of non-urgent care, so that people can access care with more uniform grounds than is currently the case, regardless of where they live.

With regard to the most important groups of diseases and treatment procedures, lists are compiled of the grounds of admitting patients to care. Grounds of care have been drawn up regarding the treatment and examination of 193 diseases. The grounds are constantly being adjusted and amended. The functionality of the recommendations is assessed and monitored by hospital districts and health care centres. Doctors make use of the recommendations as they decide on the treatment of patients. When making decisions on care, doctors always take the patient's individual life situation and need of care into account, in addition to the recommendation. The doctor makes the decision on care in

cooperation with the patient. When establishing the indications of care, an individual physician or dentist may also deviate from the recommendations, if this is medically well motivated.

The care guarantee has shortened considerably the queues in specialised medical care. In autumn 2002, the central government granted € 25 million towards reducing the queues of patients waiting for specialised medical care. During 2002 and 2003, municipalities financed the reduction of queues with an additional € 25 million. When the number of patients who had waited for more than six months to access specialised medical care was 66,000 on 2 October 2002, the number was down to 34,000 in mid-August 2005. A little over 2,000 of them have been offered treatment elsewhere than in their own hospital, but they had decided to continue queuing for treatment in their own hospital. The queue has thus been reduced by half. According to hospital districts' estimates, the number of those who have been waiting for treatment for more than six months will continue to decline, falling to 15,000 by the end of 2005.

According to calculations by the National Research and Development Centre for Welfare and Health, hospitals and health care centres increased their operating costs by € 145 million in 2005 to ensure access to care. Specialised medical care accounted for € 100 million of this sum. Nearly all of the € 100 million goes towards the treatment of those who have been queuing for more than six months. This means that the expense category is temporary, and in 2006, no extra costs should be incurred to hospitals by the time limits. The share of health care centres, € 45 million, is used for the arrangement of phone services. As the number of patient visits decreases due to phone services, this change in operating practice does not give rise to any permanent additional costs, either.

Access to care cannot be looked at solely in the light of operation queues and waiting times. Patients are not necessary registered in queues in all fields of medicine, even if there are problems with access to care. Insufficient service easily occurs in areas where social and health care services work in cooperation or overlap, such as elderly care and substance abuse care. Shortening the queues is thus only part of securing access to care.

Furthermore, problems in access to care are not only the result of insufficient resources, and allocation of more resources does not necessarily lead to elimination of queues. Attempting to find long-term solutions in improving access to care calls for assessment of care processes and care as a whole, as well as its indications. Equal access to, impact and cost efficiency of services can be secured with the aid of current quality and data systems and those that are under development. A uniform basis for treatment practices and placing patients in queues and the development of joint electronic patient journal systems also enables better management of examination and procedure queues. The aim of quality management is to achieve optimal care process efficiency, besides providing good care for patients while informing them widely of the aims and implementation of care.

5.1.4 New treatment practices and technological development

Thanks to advances in medicine and treatment technology, services can be made more efficient and versatile. Application of new technology can be made use of in health care services at an earlier stage and more extensively than before. The advances in medical technology enable new ways of treatment in the case of diseases where progress has so

far been slow. This creates added expectations and increases service demand on the part of clients and the population.

From the viewpoint of service expenditure, the effects can be two-fold: treatment using new technology may cost more, but on the other hand, the productivity of service provision may increase. This development may increase the prevalence of healthy old age, but it may also lead to longer care periods, as a growing number of diseases can be treated more successfully than before. It is estimated that technological development has decreased the quality-standardised expenses caused by some diseases by one to two percentage points per year; on the other hand, it is likely that as much as two thirds of the growing GDP share of health care expenditure in OECD countries is explained by technological advances (Jones, 2002).

Costs can also be both increased and curbed by new medicines. They may provide possibilities for treatment that is significantly cheaper; on the other hand, new medicines can in some cases be very expensive. Increasing use of more expensive drugs and inclusion of important high-cost medicines in the health insurance refund system has contributed to a rise in medicine expenditure in recent years. The rise of medicine refund expenditure is estimated to continue in the next few years at a faster rate than other health care expenditure.

Generic drug substitution was introduced in Finland at the beginning of April 2003. During the first year of generic drug substitution, i.e. between April 2003 and March 2004, savings came to € 88.3 million, of which drug reimbursements accounted for € 49.1 million. Two thirds of the savings came from a reduction of prices, and one third from generic drug substitution done in pharmacies. However, the increase in drug reimbursements has thereafter accelerated to the level of 10 percent.

It is proposed that the confirmed wholesale prices of medicines be reduced by five percent as of 1 January 2006. Drug reimbursement costs can be immediately influenced by a reduction of wholesale prices. The price of medicines could also be influenced by more precise regulations concerning the confirmation of a reasonable wholesale price. These changes would create a practice where the significance of evaluations used as the basis of price confirmation is strengthened in assessing the reasonable level of wholesale prices. On the other hand, the medicine prices review board would be expected to monitor the cost effects once a medicine is approved for reimbursement.

5.1.5 Health care financing

The financing of Finnish health care is a combination of municipal and state funding, user fees and the private health care service sector supported by health insurance[vi]. The Finnish Slot Machine Association is a significant actor in the funding of disabled and elderly care services[vii] and youth work. Decisions on health care legislation and the financing of health services have been made as a number of separate decisions over the years.

Public financing makes up about three fourths of the total funding of health care expenditure, while the remaining one fourth comes from private sources. From the beginning of the previous decade, the share of private financing has grown by about five percentage points. This has mainly occurred through a rise in the financing share of households. The nineteen-percent financing share of households is among the highest in

the EU. Within the public sector, the government's financing share has been halved, from 36 percent in the beginning of the 1990s to 18 percent in 2003. During that same time, the financing share of municipalities has increased by nearly eight percentage points, and that of the Social Insurance Institution of Finland (SII) by about six percentage points.

Table 8. Financing shares of total health care expenditure in 1980–2003

Year	Central-Government	Municipalities	SII	***Public financing, total***	Employers	Relief funds	Private insurance	Households	***Private financing, total***
1980	38.2	28.9	12.4	***79.6***	1.2	0.6	0.8	17.8	***20.4***
1985	34.0	34.7	10.2	***78.9***	1.3	0.7	1.2	18.0	***21.1***
1990	35.6	34.7	10.6	***80.9***	1.4	0.5	1.7	15.6	***19.2***
1995	28.4	33.8	13.4	***75.6***	1.5	0.4	2.0	20.5	***24.4***
1996	24.1	37.8	13.9	***75.8***	1.6	0.5	1.9	20.3	***24.2***
1997	20.6	41.2	14.2	***76.0***	1.6	0.5	2.2	19.7	***23.9***
1998	18.9	42.5	14.8	***76.2***	1.7	0.5	2.2	19.4	***23.7***
1999	18.0	42.4	14.9	***75.3***	1.7	0.5	2.2	20.3	***24.7***
2000	17.6	42.2	15.4	***75.2***	1.9	0.5	2.1	20.4	***24.9***
2001	17.1	42.8	15.6	***75.5***	1.9	0.5	2.0	19.7	***24.1***
2002	16.9	43.3	16.1	***76.3***	1.9	0.5	1.9	19.4	***23.7***
2003	17.6	42.4	16.5*	***76.5***	2.0	0.4	2.0	19.0	***23.5***

*Includes 5.2 percent central government financing support.
Source: National Research and Development Centre for Welfare and Health, Health care expenditure and financing in 2003. Statistical Summary 4/2005.

A system with separate financing channels calls for good coordination of the service system from the viewpoint of care, costs and the client. If coordination of the service system is insufficient, there are problems in terms of 1) transfer of costs to other actors, 2) lack of coordination of service provision, and 3) increase in service provision costs and 4) user fees.

Municipalities can steer streams of clients between the public and private sector by prioritising their service supply. Particularly in long-term elderly care, the division between outpatient care and institutional care changes financing responsibilities, and municipalities have made use of this possibility to transfer costs to be paid by the Social Insurance Institution and clients.

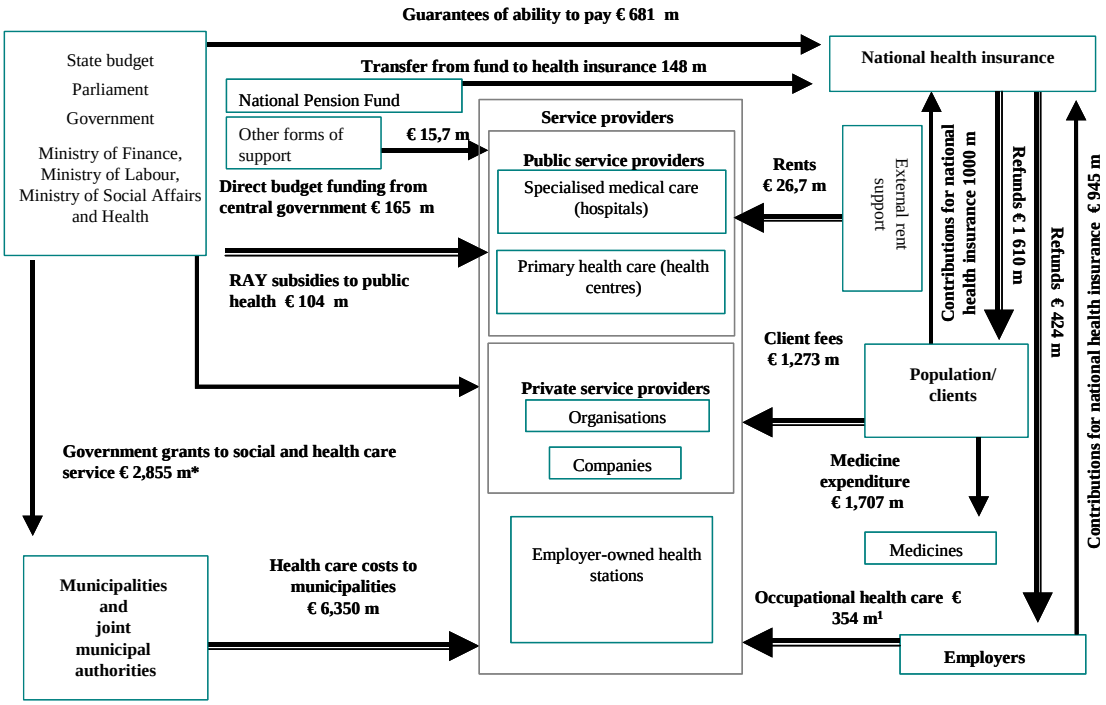
The division of medicine costs is also a key problem in the "multi-channel" system. In outpatient care, the patient is responsible for medicine costs jointly with the Social Insurance Institution, whereas in institutional care, medicine costs are included in the fixed price of care. By transferring patients to outpatient care, the municipality can transfer medicine costs to be paid by the client and the Social Insurance Institution. At the same time, the patient's status changes in terms of social protection.

Queuing costs are a significant negative effect caused by the poor coordination of the health insurance system and public health care services. Municipalities and health care districts do not have a direct interest to impact the costs caused by queuing, such as sickness allowances and medicine costs in outpatient care.

Queues have not traditionally been a problem in countries with an output-based financing system. Queues are mainly a feature of countries where hospitals receive a lump sum agreed in advance. It is thought that queues may lessen productivity, as hospital staff must devote more time to queue management at the expense of actual patient work. A slight, although not statistically significant correlation has been detected in Finland between poor productivity and patient queues (Järvelin 2004). On the other hand, waiting times may decrease both the supply and the demand of services. Particularly in the case of non-urgent public services, queues may actually be well-motivated, as they curb excessive demand.

As a whole, the current financing system encourages the arrangement and implementation of services based on each actor's starting premises. The situation has led to quarrels about who is paying for care, deterioration of the concept of comprehensive client care and problems in regulating the amount and structure of financing. [viii]

Figure 39. Health care financing channels in 2003



*Allocated for both social and health care services
[1] Estimate from 2002

Public financing

In 2003, the cost of health care services provided by municipalities came to € 7.0 billion[ix]. The operating costs of specialised medical care totalled € 4.2 billion and those of primary health care € 2.8 billion. Municipalities purchased services from private service providers to the sum of € 188 million. Municipalities make decisions on how to

provide health care services, and they also have responsibility for financing the majority of the services they provide. However, services provided by municipalities only account for part of total health care expenditure, and the share of total expenditure made up by municipal services has decreased during the past ten years. A significant proportion of medicines and services, such as medicine costs in outpatient care, over-the-counter medicines, part of dental care and private health care services are either paid fully by the client, or jointly by the Sickness Insurance Institution and the client.

The central government participates in financing health care expenditure mainly through government grants to municipal social and health care departments (€ 2.9 billion in 2003) and reimbursements to university hospitals (€ 122 million). In addition, investment and employment subsidies to public health care service providers are channelled through various ministries (about € 40 million in 2002).

Retained profits of RAY (Finland's Slot Machine Association) are also channelled through the state budget to non-profit organisations. In 2003, a total of € 401 million was given to organisations; € 308 million of this sum went to public health and social welfare promotion[x]. The central government also participates in financing health care through health insurance financing support.

In health care systems based on public funding, such as the Finnish one, attempts to curb rising health care costs have been more successful than e.g. in countries where the health care system is based on health insurance. In Finland, the rise of costs has also been restricted by moderate centralised wage agreements. According to an OECD assessment report, the rise in municipal health care expenditure is well under control compared to the rise in medicine expenditure. The report expresses a particular concern over the rapid rise in medicine expenditure. Attention is focused on the fact that health care centre doctors are not subject to any cost restrictions concerning the prescriptions they write; the financing responsibility lies with the client, the Sickness Insurance Institute and thus also with the state.

The tightening of international tax competition may increase the pressure to lower taxes and thus endanger the sustainability of financing. A lower tax rate has been the goal for employment reasons as well.

Insurance-type financing

Insurance-type financing may be based on either statutory social insurance or private insurance. In Finland, health insurance is part of social insurance. In principle, the Finnish health insurance system is financed by health insurance payments from the insured and employers. The financing structure has however changed as the grounds for insurance payments have been lowered, while health insurance expenditure, especially medicine expenditure, has increased. Health insurance costs in 2005 are estimated to total € 3.6 billion, of which payments from the insured account for € 1,009 million and employers' contributions for € 1,010 million. Insurance payments thus make up no more than 56 percent of health insurance costs. The central government's guarantee payment covers € 1,021 of the costs. Health insurance is financed by VAT revenue to the sum of € 600 million. Treatment provided within the public health care system covered by accident and traffic insurance is compensated in accordance with municipal billing, instead of the former full compensation payment. As the payment revenue is

abolished, an added € 52 million has been taken into account in adjusting the level of the appropriation.

In health insurance, the insurer is often left outside the decision-making process concerning the need of care, whereas the patient and the doctor have a common interest. The patient and the doctor want treatment of the highest possible quality. In addition, the doctor's fee is often dependent on procedures and services (the so-called moral hazard problem). The public sector can alleviate the problem of moral hazard by e.g. making use of personal annual limits and taxation. However, the problem is not fully eliminated by these measures either, and the public system is also suffering from moral hazard problems. In order to curb costs, the health-insurance based system needs systematic price and volume regulation.

Private health care services are partly financed through private health insurance. In 2003, the income from private health insurance premiums was only about two percent of the total costs of statutory health insurance. However, the number of private health insurance policies taken by employers for their employees and the income from premiums has risen in particular in recent years (Table 9).

Table 9. Income from premiums and the number of private health insurance policies in 1999–2004

Million euros	1999	2000	2001	2002	2003	2004
Health expense insurance for children	37.6	40.4	43.7	47.5	50.5	..
Private adult health expense insurance	22.5	24.3	25.9	28.1	29.5	31.1
Health expense insurance taken by employer	5.0	6.4	8.0	8.7	12.0	14.7
Total	65.0	71.1	77.6	84.3	92.0	..
Change %		9.3	9.2	8.6	9.1	..
1,000						
Health expense insurance for children	325.9	345.8	359.5	372.7	381.3	385.0
Private adult health expense insurance	155.7	160.5	170.2	179.3	192.7	205.9
Health expense insurance taken by employer	11.7	15.3	18.4	21.6	26.3	30.6
Total	493.2	521.6	548.1	573.6	600.3	621.5
Change %		5.8	5.1	4.7	4.8	4.8

Source: The Federation of Finnish Insurance Companies, personal insurance unit

From the viewpoint of the public sector, the health insurance system has been an inexpensive way of arranging services. The system complements municipal health care and increases clients' possibility to choose. However, there are also problems involved in health care cost compensations. The system creates social and regional inequality. Those in the uppermost income fifth get almost three times as much compensation as those in the lowest income fifth. Private health care services are concentrated in large cities in southern Finland, which is why the compensation for these services shows an uneven distribution within the country. In private health care, the client pays the market price for care, but gets some of it back as health care insurance compensation. It has thus been observed that universal entitlement to health care insurance compensation raises the prices of services.

Client fee financing

Users must pay a fee for the majority of public health care services in Finland. Client fees accounted for about 7.9 percent of total public health care expenditure in 2003, and for 10.2 and 5.0 percent of primary health care and specialised medical care expenditure, respectively. In 2003, households paid a total of € 1.1 billion in various client fees in the public and private sector, and a total of € 1.8 billion in medicine costs[xi]. Households received € 918 million of this sum in refunds through health care insurance in 2003. The final sum paid by households was thus € 918 million. In public health care, € 211 million was paid as client fees for hospital treatment and € 285 million for primary health care. Private service providers received € 655 in client fees.

There are two primary aims with the use of fees: to finance operation and to steer demand. The client fee system was created in the 1980s, and partly even prior to that. After that time, numerous changes have been made to the system. There are currently many personal annual limits in use in health care. In addition to actual annual limits for families, municipal social and health care services use so-called half-way limits for health care centre fees, fees for consecutive treatments and short-term institutional care for those under 18. There is an annual upper limit for rehabilitation travel costs covered by the Social Insurance Institution and travel and medicine costs covered by health insurance. A personal annual limit of client fees was introduced in the municipal sector in 2000.

The financing significance of client fees to service providers is often minor, but the cost burden to households can be significant. At the same time, the matching of client fees is strongly regressive. Among those on low incomes, the impact on service use is great, whereas among those on large incomes it is small[xii]. The fees are not selective in nature, as they reduce the use of both necessary and unnecessary services. In many cases, fee administration costs are large in relation to the revenue. The fee system that has developed over the years has become very complicated, both for clients and other actors. Due to a complicated pricing system, which is thus also expensive in terms of administration, some of the business operation cost benefits that are brought about by a relatively unchanged public sector provision volume are lost.

> The board on client fees in social and health care 1 Jan 2004 – 23 Sep 2005 The board's task was to chart the reform needs of the social and health care fee policy and fee system and come up with a proposal for fee policy lines.
>
> According to the board's view, the current fee system is still mostly functional. The main lines of the current fee system are retained. The financing of services must be based on tax revenue in the future as well. Fee policy must support the social policy objectives of social and health care policy. The municipality decides on the level of the fee levied within the limits defined by the maximum levels of fees stipulated in the Act of Client Fees. However, the fees levied for services must not exceed the costs caused by provision of the services. Flat fees are used in short-term services and earnings-related long-term services. Municipalities' government grants are not reduced by revenue from client fees.
>
> The board's suggestions as to the general principles of the system
>
> Two-tier regulation is abolished – the fee system, fee grounds, maximum amounts and personal annual limits are ***prescribed in the Act on Client Fees***. A fee may be levied from service users only for such social and health care services for which a

fee is charged according to the Act on Client Fees (at present, a fee may be charged if the service has not been stipulated as being free of charge). In the client fee system, no provisions are made concerning the contents or quality of services; however, the principles of normality and general services must be taken into account. The share of client fees in service financing is retained at least at the current level, and the real level of fees is preserved by the introduction of index fixation. The fees must steer the use of services in order to support the implementation of social and health care policy objectives. Administration must be kept as light as possible. Index adjustments

The board proposes that the client fees of social and health care, the income limits on which they are based and the minimum amount of disposable funds be adjusted so as to correspond to development of costs in 2002–2004, in accordance with the development of the index that best describes the trends concerning the fee in question.

Annual personal limits

In order to make the client fee system more clear, the board proposes elimination of the so-called half-way limits used in municipal health care (half-way limits for health care centre fees, fees for consecutive treatments and short-term institutional care for those under 18).

The board proposes launching further preparation, aimed at coming up with a joint annual upper limit or a corresponding model, which would protect those who use a lot of social and health care services from an unduly heavy payment burden, particularly in situations where a service user's personal annual limit on municipal fees and some annual co-payment share in accordance with the Sickness Insurance Act are both exceeded during the same calendar year.

Further preparation of the board's proposals

Further preparation of the board's proposals is launched with extensive circulation for comments of the proposals, which is also extended to client organisations and several municipalities. The appropriate moment for the finalisation of the new legislation on client fees comes after careful analysis of the comments and once the assessments of the impacts of the board's proposals, including aggregate economic impacts, have been completed.

Further preparation of the board's proposals will be carried out in extensive cooperation with the parties represented on the board.

Financing occupational health services

In 2002, employers' expenditure for occupational health services totalled € 319 million. Health care stations owned by employers accounted for € 139 million of the total. In 2001, the Social Insurance Institution paid compensations amounting to € 141 million to employers for occupational health services. In addition, the Social Insurance Institution pays occupational health care refunds for self-employed people (€ 1.3 million in 2002), state contributions to the SII administered farmers' occupational health survey (€ 0.6 million) and refunds for student health care services (€ 17.8 million).

Occupational health services have numerous links with municipal primary health care. However, occupational health services are usually provided in a centralised manner, close to the place of work. In occupational health services, there is also a possibility to

focus on the special problems and working conditions of the domain in question. Employers can also use occupational health care as a staff policy instrument. The differences in health care service utilisation between population groups are partly explained by the fact that occupational health care focuses on employed population.

5.1.6 The relationship between public and private services

The status of the municipal sector as provider of social and health care services is changing; services must now be produced alongside competing service providers. In 2002, municipalities and joint municipal authorities spent € 716 million on purchasing social welfare services from private service providers. The sum has more than doubled in actual value since 1995. In 2002, municipalities used 12 percent of their social sector operating costs towards purchasing services from private service providers, while the corresponding share in 1995 was 6 percent. In health care, services purchased by municipalities and joint municipal authorities play a clearly smaller role than in social services. Most health care services are purchased by households, employers and the Social Insurance Institution of Finland. However, the number of services purchased by municipalities increased nearly 2.5-fold between 1995 and 2002, while those purchased by joint municipal authorities increased by almost one third. In 2002, municipalities and joint municipal authorities bought health care services to the sum of € 162 million; municipalities accounted for € 96.5 million and joint municipal authorities for € 65.4 million of the total sum.

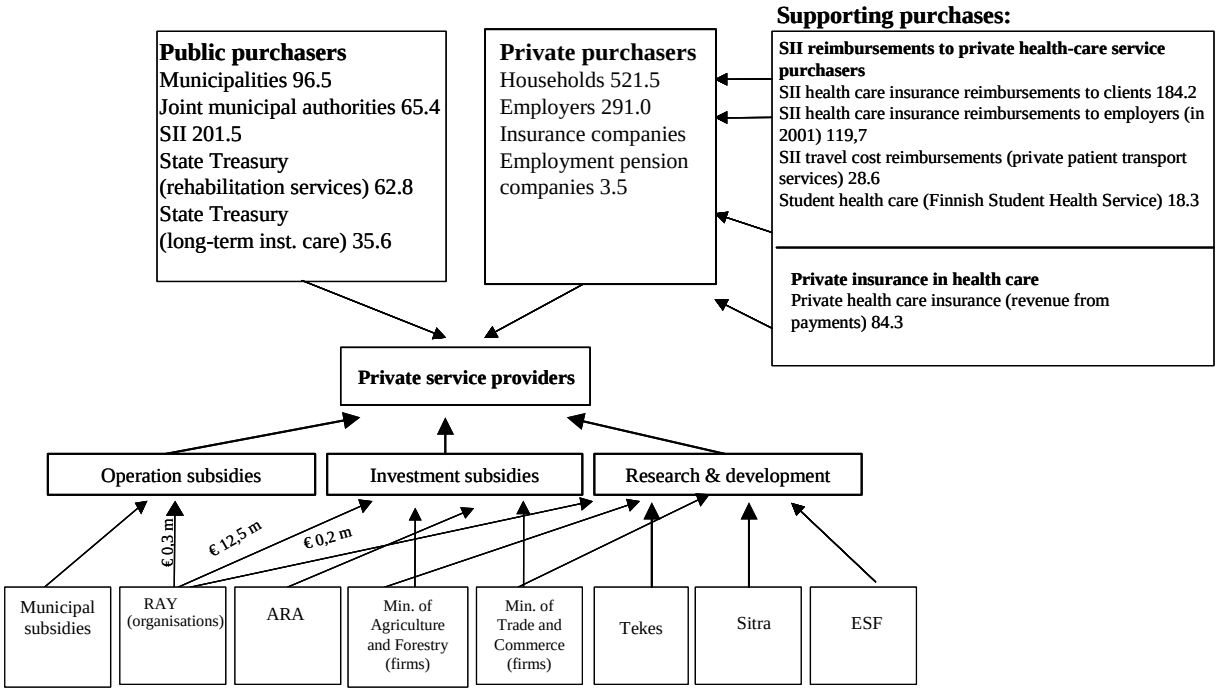
In 2002, private health care expenditure totalled some € 1.7 billion, or about 20 percent of total health care expenditure. Companies stood for about 78 percent and organisations for about 22 percent of total private health care expenditure. The financing of private health care services is primarily implemented through client fees (€ 665 million), services purchased by municipalities and joint municipal authorities (€ 162 million) and Finnish Slot Machine Association subsidies (€ 95 million). Reimbursements from the Social Insurance Institution cover a significant proportion, over 40 percent, of private health care expenditure.

In the year 2002, the number of private health care service providers was about 11,000, with a total number of staff of some 27,000. About 8,000 service providers are self-employed, meaning that they cannot take on other staff besides one assistant. The majority of the approximately three thousand actual private service providers (excluding self-employed persons) are companies. Private hospitals are an exception; a significant proportion are owned by organisations. Private health care service providers are concentrated in southern Finland and in large cities. Big medical centres and private hospitals in particular are primarily located in the largest cities, whereas companies providing physiotherapy services, for example, are found in nearly every municipality.

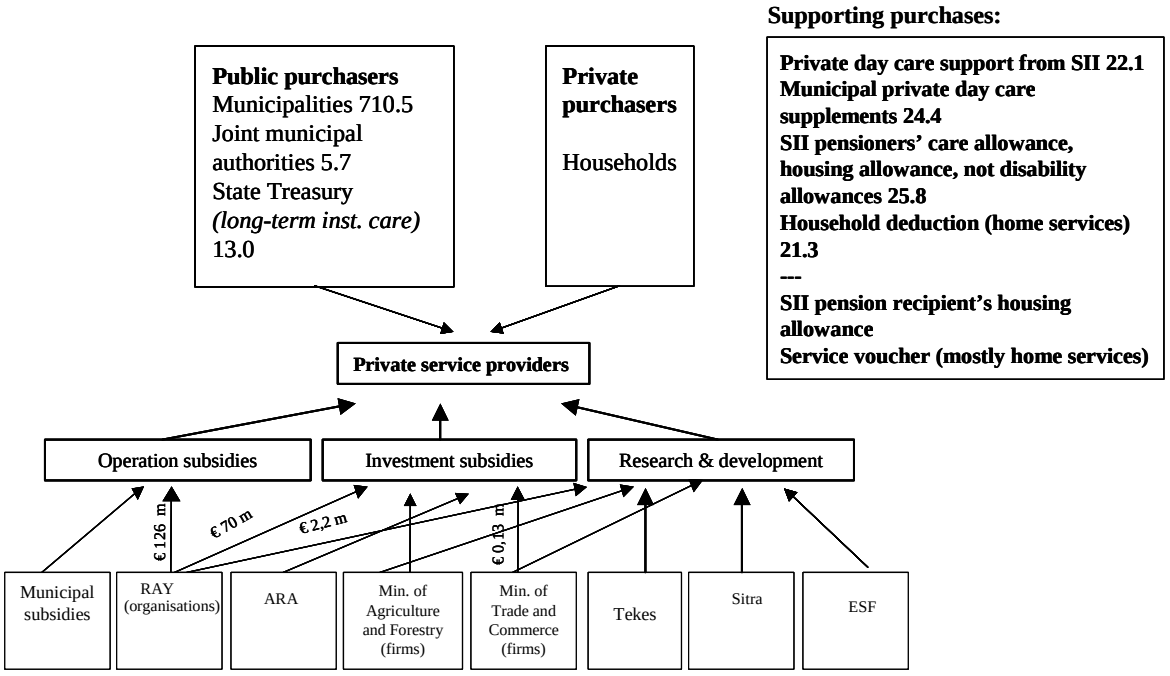
In a highly competitive market, services must be turned into products, which calls for development of cost accounting in municipalities. Through more effective cost accounting, municipalities are also able to compare the prices of services they produce themselves and those they purchase. In the case of hospitals, cost accounting has shown rapid progress in recent years. Service acquisition calls for special expertise. For small municipalities, sufficient resources for the acquisition of purchased services may be acquired e.g. through regional cooperation.

Figure 40. Money flows in private social and health care in 2002, € million

Money flows in private health care in 2002, € million



Money flows in private social services in 2002, € million



Source: National Research and Development Centre for Welfare and Health[xiii]

The purchaser-provider model in health care

The purchaser-provider model refers to organisation of public services in such a way that the roles of service purchaser and service provider are separated. The purchaser-provider model may also be used as an internal steering model in a public organisation. At the core of this model is a clear separation of the roles of purchaser and provider as well as consistent application of these roles in the organisation of roles and authority and the steering of operation and economy. A public sector-party acts as purchaser, while the provider may be either a public or private service provider or a third-sector actor.

The aim of the application of purchaser-provider models in service provision has been to achieve cost-effective, high-quality and flexible service provision and clearly defined roles of all parties involved. The adoption of the purchaser-provider model and gaining benefits from its use calls for productisation, highly developed cost calculation and competence in acquisitions, quality control as well as reforms in organisation structure, management and steering. In addition, an effective services market and competition requires several service provides, whose prices and quality of services can be compared.

International experiences of purchaser-providers models are varied. At their best, competent acquisitions have enabled more clearly defined planning and operation in health care. However, the belief in permanent economic advantages brought about by competitive tendering among services providers has dwindled; the results have often proved to be transient. Little by little, traditional purchasing, which emphasises prices and quantitative buying of services, seems to be losing ground in health care. In its stead, contractual arrangements based on strategic partnerships between service purchasers/organisers and providers are emphasised more clearly than before. Strategic agreements are used in an attempt to steer service providers' operation, encouraging it into a direction where population health needs are met better than before.

In Finland, the means of health care steering and intensification, which is the aim of the purchaser-provider model, has been promoted in different fields using current organisation and steering methods. The most important development phase has been the development of contractual steering in various ways. Compared with international purchaser-provider models, competition has not been a very marked goal within the Finnish system. In Finland, competitive tendering concerning emergency and non-elective operation is only possible in the 3-4 largest cities.

Responsibility for organising service provision will remain with the public sector in the future as well. Despite this, service provision can be arranged via private enterprises or non-profit organisations

The steering relationship between the central government, municipalities and service providers does not always work in the best possible manner. Information steering is as yet not well-established, its impact varies, and systematic development work is still called for. The economic incentives for providing care of different actors do not always work in the right direction. Furthermore, legislation partly dates back to a time when the significance of resource steering was decisively greater.

5.1.7 The impact of competition on service structure

According to a survey[1] conducted in May 2005 by the Trade Union for the Municipal sector (KTV), development of municipalities' own operation and municipal cooperation are most widely accepted among Finns as the best ways of making municipalities' service provision more effective. Compared to these, consolidation of municipalities gets a poor mark among citizens as a means of intensifying service production. Competitive tendering and externalisation of municipal services are even less popular alternatives. About 70 percent of respondents wanted to retain health care centre and hospital services as municipal services. More than half of the respondents believed that the quality, supply and even availability of services would remains at least on its current level. One in two also thought that this applied to the number of services as well. However, the majority did think that the employment security and status of staff would deteriorate.

Table 10. The best way to make municipal service provision more effective (percent)

Development of municipalities' own organisations	26
Increasing cooperation between municipalities and extending over municipal boundaries	23
Consolidation and merging of municipalities	8
More opportunities for service units to decide on their own operation	8
Improving the level of competence of municipal staff	7
Competitive tendering and externalisation of services	7
Improving the management skills of supervisors	6
Privatisation of services	2
Other means	1
Cannot say	13

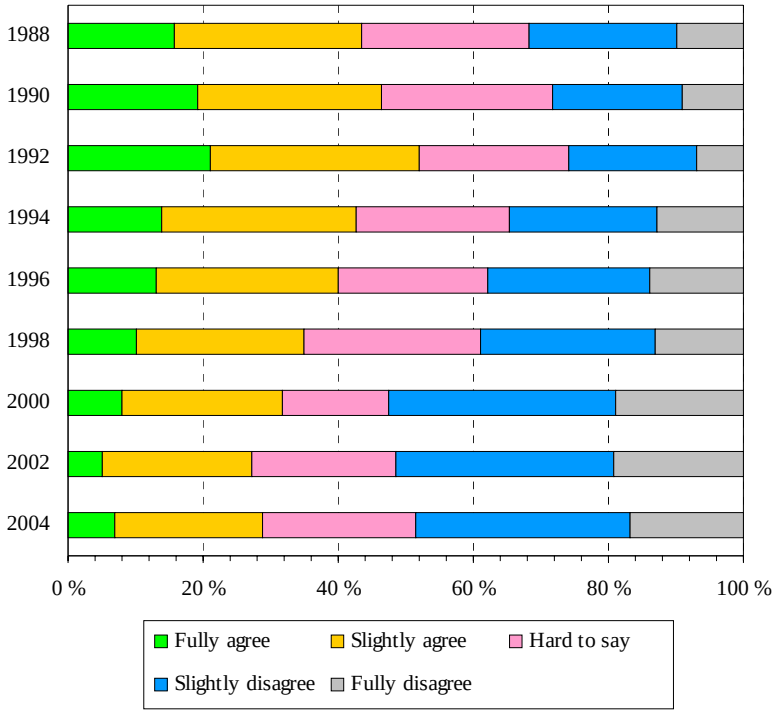
Source: Survey conducted in May 2005 by Suomen Gallup commissioned by the Trade Union for the Municipal Sector (KTV).

According to a national survey on values and attitudes conducted by the Finnish Business and Policy Forum EVA (2005), public services should also be primarily produced by the public sector. Nearly 50 percent are opposed to the privatisation of public services as a means of making them more effective; less than one third are willing to privatise them (Figure 41).

When externalising services, attention must be focused on the prerequisites of well-functioning competition. There must be a sufficient number of potential service providers in the market in order to achieve the rise in efficiency which is the goal of increased competition. In the social and health care services market, factors such as the asymmetrical nature of information, lack of autonomy on the part of the clients and the special competence required hinder the general functionality of the market mechanism. A situation where private service producers dominate the market and are thus able to freely determine the price level of services can be prohibited by efficient regulation. However, in health care services calling for special professional competence, the emergence of regional monopolies is likely.

The cost pressure of private services is hard to mitigate without efficient competition or direct regulation of the market. This is something that should be kept in mind when negotiating international agreements that have an impact on the way social and health care services are arranged.

Figure 41. ”The majority of public services in our country should be privatised in order to make service production more efficient”



Source: Onnellisuuden vaikea yhtälö (The difficult formula of happiness), national survey on values and attitudes by the Finnish Business and Policy Forum EVA 2005.

International comparisons have shown that according to the criteria used, the private services sector in Finland is less developed than in many other OECD countries. The share of publicly produced services is high in Finland, while the wage level in public services is low compared to the wage level in other fields. In order to increase the employment effect of the service sector, it has been suggested that the public sector should externalise more services to the private sector than is currently the case. At the same time, the wage level should be raised, particularly in social and health care, to make the sector more attractive to employees.

International trade in services

When looking at the employment effect of services, international competition and the rules of international trade must also be taken into account. Capital, goods, services and people can move freely within the European union. However, it has been observed that the free movement of services has not progressed at the expected rate within the internal EC market. In practice, numerous administrative and technical obstacles imposed by the member states have made the cross-border provision of services difficult.

The proposal for a Services Directive drafted by the commission would bring about uniform practices concerning cross-border trade in services within the EU. The aim is to make the different license systems, requirements concerning service providers, administrative regulations and monitoring practices in different member states more simple and uniform, and to abolish some of them altogether. It is believed that

economic competitiveness and domestic product will get a boost from a well-functioning internal services market.

There is also an ongoing attempt to abolish obstacles to trade in services between member states of the World Trade Organisation (WTO). Russia, an important trade partner for Finland, is currently engaged in negotiations on becoming a member of the WTO.

Finnish legislation does not include any regulations discriminating against foreign companies providing social and health care services. When operating in Finland, both Finnish and foreign companies must follow the same rules and regulations. As the public sector is increasingly externalising its services, international competition can also be expected to tighten. Service providers in EU member states in areas adjacent to Finland that have a lower cost level than Finland are able to provide services at a lower cost, either from the country of origin or through their staff operating in Finland. This may have significant effects on the employment impact of service companies operating in Finland and the wage level in the field.

In a situation characterised by an increasingly free trade in services, more attention than at present must be focused on the quality of services, ensuring their continuity, monitoring service providers and making sure that terms of employment are adhered to. The impact of free movement of people and services on the development of national service system is hard to predict. There has so far been little cross-border movement of service users in Finland, but the situation may change with internationalisation and the development of the internal market of the European union.

Issues related to trade in services and promoting competition are topical both within the European union and in terms of reforming Finnish legislation. On a national level, a new Act on Acquisitions is currently under preparation. The act includes provisions e.g. on competitive tendering of social and health care services and acquisitions. The rules on government grants are currently being reformed in the European union. The aim is to bring the Services Directive into effect within the next few years. Finland’s goal is that the providers of social and health care services, regardless of their country of origin, will still have to adhere to Finnish legislation in all respects when providing services in Finland.

The debate on the modernisation of social protection also involves the promotion of competition and the improvement of competitiveness. The role of the public sector in service provision is a constant subject for debate in a situation characterised by increasing international competition.

5.2. Reasonable income security

The primary purpose of income security is to secure recipients’ income in various life situations. The aim is both to ensure a reasonable income for households and to even out income differences between different types of families. An even distribution of income during a person’s life cycle is also a key objective of income security. In addition to these actual objectives, income security and the taxes and social insurance contributions levied to finance it affect households and other economic actors in other ways as well. Income security changes the economic incentives associated with different choices, and it can thus for its part direct households’ behaviour.

Recent changes in income security

In accordance with the Government Programme, the level of several income security benefits was raised in 2004 and 2005. Child allowances were raised at the beginning of 2004, while income testing with respect to spouse's income was eased in the case of labour market support. In 2005, the level of national pensions, child home care allowance and the minimum sickness, maternity, paternity and parenthood allowance was raised. In the Sickness Insurance Act reform, the income security of persons with short-term employment as well as the grounds on which parenthood allowance is calculated in the case of consecutive pregnancies were also improved. [xiv]

The reforms in legislation concerning so called change security entered into force on 1 July 2005. The aim of change security is to improve the status of employees who have been given notice. As part of change security, an employee who has been given notice can get unemployment security, the level of which is raised by a re-employment programme supplement. The re-employment programme supplement can be paid to a person for whom a personal employment programme has been drawn up, and who has been given notice due to economic or production reasons. In addition, the person who has been given notice must have worked for a minimum of three years in a position for which the employer has paid social protection payments and deducted tax at source. The job-seeker must also fulfil the normal criteria for unemployment security, such as wage earner's employment condition. The re-employment programme supplement is paid for the duration of measures included in the employment programme (training connected with job-seeking, work try-out, labour market training for adults) and when actively looking for a job independently after termination of employment contract, for a maximum of 20 days. In addition, the re-employment programme supplement can be paid for a period of time between measures, of no longer than seven days' duration, when the job-seeker is actively looking for new employment. The re-employment programme supplement is paid for a maximum of 185 days.

In 2005, the re-employment programme supplement for basic unemployment allowance recipients totalled € 4 per day, or € 86 per month. In the case of earnings-related unemployment allowance, the re-employment programme supplement entitles recipients to a higher compensation rate than normal earnings-related unemployment allowance. For example, the earnings-related unemployment allowance of a person with monthly earnings of € 1,500/month who gets the re-employment programme supplement is about one fifth higher than normal earnings-related unemployment allowance. Among those with a higher income, the increase is even bigger. The earnings-related unemployment allowance of a person who used to earn € 3,000/month who gets the re-employment programme supplement is nearly a third higher than normal earnings-related unemployment allowance. Persons taking part in labour training can also be paid a maintenance compensation in addition to an education allowance raised by the re-employment programme supplement. The raises to the level of benefits increase the economic incentives of taking part in active measures. However, the quality and impact of active measures must also be ensured.[xv]

As part of a one-off solution concerning the income security of long-term unemployed, a limited group of long-term unemployed were granted the right to pension support instead of labour market support as of 1 May 2005. Pension support provides better income security than labour market support. A law reform that entered into force on 1 July 2005 raised the basic unemployment allowance, education allowance and education

support of persons with a work history of at least 20 years. A corresponding increase had already been introduced earlier in the case of earnings-related income security.

The experiment where part of earnings are not taken into account when granting social assistance was extended until the end of 2006. Twenty percent of the earnings of a person or family seeking social assistance are not taken into account. In connection with the extension of the experiment, the maximum amount of earnings not taken into account was raised as of 1 April 2005 from € 100 to € 150 per month.

When preparing the budget for 2006, the government agreed on measures aimed at improving the status of those with the most limited means. The seven-percent housing cost co-payment of social assistance is abolished. This will increase the income of particularly those households receiving social assistance who have high housing costs. It is hoped that the reform will prevent the accumulation of unpaid rents and termination of leases. The reform is estimated to raise social assistance expenditure by some € 40 million on annual level. The reform is to enter into force on 1 September 2006. At the same time, the level of national pension will be increased by five euros per month. Both those who only receive the national pension and those who receive both national pension and employment pension will benefit from the adjustment. The adjustment of the level of national pension concerns some 660,000 pension recipients. The raise will also increase other benefits linked to the level of national pensions, such as survivors' pensions, farmers' early retirement aid and change of generation pensions, extra allowance for ex-servicemen, military allowance and the special allowance for immigrants. On annual level, the cost effect of the adjustment is estimated to total some € 40.5 million. The full amount of pension income deduction in municipal taxation is tied to the size of national pension. That is why the taxation of many pension recipients is also lightened by the increase of the level of national pension.[xvi] Return to work of the long-term unemployed is supported by a change in housing allowance. Housing allowance will continue to be paid unchanged for three months when a person who has been receiving labour market support or basic unemployment allowance for more than a year finds employment. The reform supports employment and prevents situations where benefits are claimed for recovery. The reform encourages employment, as getting a job no longer leads to an immediate reduction in housing allowance. The reform is estimated to concern some 5,000 housing allowance recipients, who benefit on average about € 200 per month. The housing allowance reform will enter into force on 1 March 2006.

Perhaps the most significant changes in income security during the current government period concern the employment pension system. The changes come gradually into effect from the beginning of 2005. The full impact of the reforms will only be felt in the distant future. In its government programme, the government pledged to complete the implementation of the reform concerning employment pension benefits in the private sector and to extend the reform to employment pensions in other sectors as well. New laws on state and municipal pensions came into effect at the beginning of 2005. In the state and municipal pension reforms, mainly the same changes in pension security were implemented as in the private-sector pension reform. However, an attempt was made in the reforms to take into account the special features of pension systems in the state and municipal sector. Compared to the private sector, the most significant difference is the integration of pensions earned by the end of 2004 within public-sector pension systems, and the norm for pension accrued prior to 1995 ("abate for early retirement"), if the employee wants to retire before his current pension age after having turned 63. The difference between these public-system reform proposals and changes in the private

sector is explained by the earlier accrual of supplementary pension and its protection in the public sector.

In spring 2005, the government introduced a bill to the Parliament with a proposal to Employee's Pension Act. The bill proposes that legislation concerning employment pension of employees in the private sector be made uniform. Regulations concerning employee's pension security in the Employee's Pension Act, the Temporary Employees' Pension Act and the Pensions Act for Performing Artists and Certain Groups of Employees are all included in the new Employee's Pension Act. The law reform continues the completion of the 2005 employment pension reform, and it does not include any actual pension-policy reforms.

5.2.1 Incentives to work and income security

Income security and labour-market participation

When looking at the incentives of income security, the emphasis is in most cases on how benefit recipient's labour-market participation is affected by income security. If reliance on benefits offers nearly the same level of income as employment, the threshold to accept work may rise and the original purpose of the benefits may be forgotten.

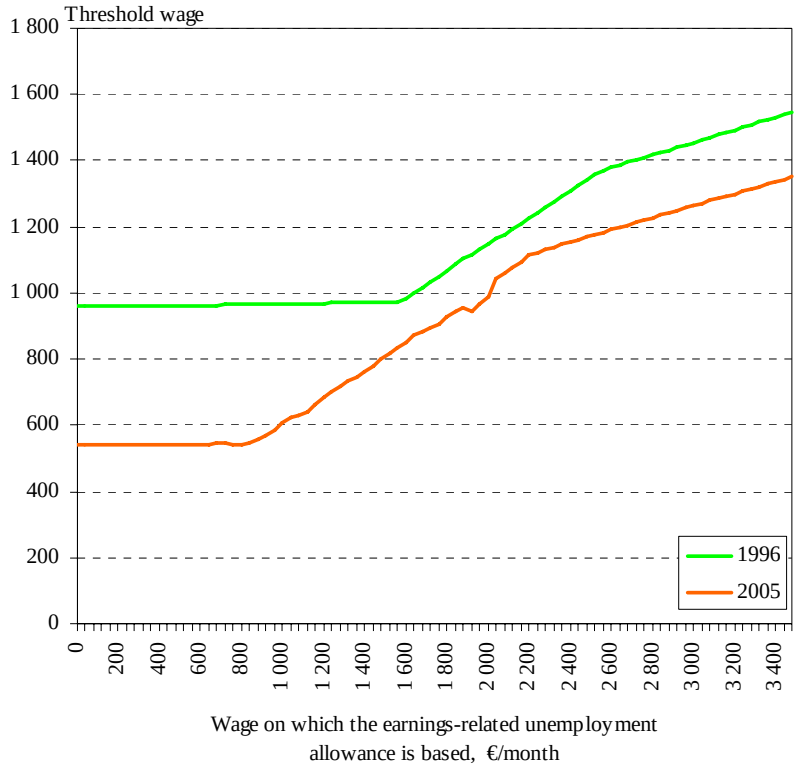
One way of illustrating the incentives to work of income security from this perspective is to consider the gross wage level at which disposable net income is the same as when relying solely on income security. The higher this threshold wage, the more likely it is that income security involves problems related to incentives to work. Figure 42 shows the threshold wage of a single unemployed person receiving earnings-related unemployment allowance living in a rented flat at different wage levels prior to unemployment using 1996 and 2005 tax-benefit rules. In addition to changes in tax-benefit rules, the change in earnings and rent level between 1996 and 2005 is taken into account in calculating the threshold wage. The figure shows that in the example, the threshold wage of a person receiving unemployment allowance has decreased, and incentives to work have improved at all levels of income.

The approach using threshold wage is a very simplified one. The results depend on the benefit being studied, family type, housing costs and other assumptions. In addition, threshold wage only describes the wage level that secures the same disposable income as income security. Since work may give rise to expenses, and free time has a value of its own, threshold wage should perhaps be defined as the wage level at which disposable income from earnings somewhat exceeds the level of income security. On the other hand, many people experience going to work and the human relations involved as an important part of life as such. These factors should also be taken into consideration when assessing the significance of threshold wages. [xvii]

The work incentives of income security can also be studied from the viewpoint of increase in income of employed persons. In that case, the focus is on the increase in income resulting from increased earnings. Part of the increase in gross income goes to taxes. The same household may also be receiving income-tested benefits (housing allowance, income-tested labour market support, care supplement for child home care allowance recipients), which are reduced as earnings rise. This may further diminish the increase in net income. In families with children, the increase in net income may be further diminished by a rise in municipal day care fees that are determined based on

gross income. In extreme cases, the combined effect of different systems may cause families to end up in a so-called income trap, where a household's net income does not grow much despite an increase in earnings. In studies, this is often referred to as high effective marginal tax rates.

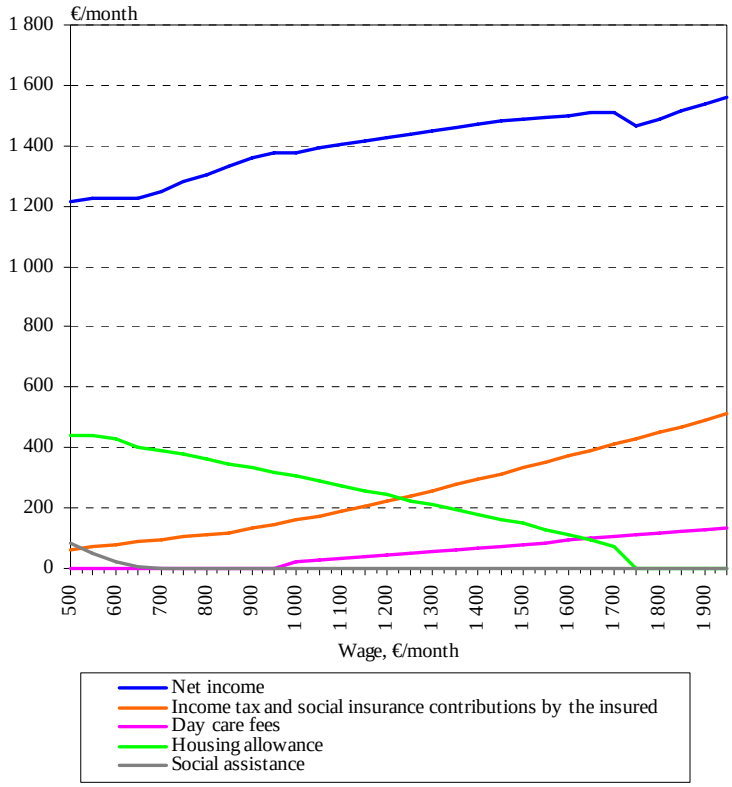
Figure 42. Threshold wages using 1996 and 2005 tax-benefit rules, euros per month at 2005 earnings level



Example with figures: a person earning € 1,600 euros per month who becomes unemployed should earn at least € 850 per month from a job in 2005 in order to attain the same disposable income as during unemployment on annual level. Earnings-related unemployment allowance, housing allowance and taxation, as well as possible social assistance during unemployment are taken into account in the calculation.

Figure 43 shows a hypothetical example of a situation approaching income trap. The figure shows the net income after deduction of child day care fees of a single-parent household with one child at different wage levels in 2005. In addition to net income, the figure shows housing allowance, taxes and social insurance contributions as well as day care fees, all of which depend on the size of wages. If the wage income is quite small, the household is also entitled to social assistance. In addition to the income categories presented in the figure, the size of net income is affected by child allowance and maintenance allowance. However, these are not income-tested, so their level does not change as the level of wage goes up. This is why they are not separately shown in the figure. The figure shows that the increase in net income as a result of an increase in wage income is particularly modest in the income bracket ranging from about € 1,000 to € 1,700 per month.[xviii]

Figure 43. Net income of single parent with one child at different wage levels in 2005



NB! The figure only shows income security benefits whose level depends on the level of other income. In addition to these benefits, the income of the household includes child allowance (€ 136.60 /month) and maintenance allowance (€ 118.15/month).

Incentive issues are generally assessed from the viewpoint of persons already receiving income security benefits and the increase in labour supply on the part of households. However, the attraction of part-time work is increased by high effective marginal tax rates, as in the example used in Figure 85. The reduction in net income when moving from full-time to part-time employment may be significantly smaller than the decrease in wage income.

It is quite easy to construct hypothetical examples such as those presented above, but it is more difficult to study their actual prevalence. Parpo (2004) studied the prevalence of income traps empirically using a sample representing the entire population. In the study, an income trap was defined as a situation where the increase in a household's net income remained below 20 percent of the household's increased earnings. Income traps defined in this manner were rare in wage earner households, and they seemed to be a more common problem among the unemployed. [xix]

The calculations used as examples may also be criticised for other weaknesses. In calculations, it is usually assumed that various benefits and payments change immediately after a change in earned income. However, e.g. the level of housing allowance is only adjusted between regular annual adjustments if the household's income increases by a minimum of € 300 per month compared to the income used as the basis of the previous decision. Correspondingly, municipalities allow a fairly substantial increase in income without adjustment of day care fees during a period of operation. In

practice, this means that income-tested benefits and payments do not change immediately as the level of income increases.

On the other hand, researchers referring to a "bureaucracy trap" emphasise the significance of interruptions or delays that occur in practice in granting benefits, leading to disincentives which the calculations do not recognise. Usually this refers to disincentives to accept short-term jobs on the part of the unemployed. For example, the unused vacation accrued at termination of a short-term employment contract is often paid in cash. The payment in lieu of holiday paid in this manner is averaged over a given period by dividing the payment in lieu of holiday by daily wage. No unemployment allowance or labour market support is paid for the averaging period.[xx] The system of averaging is as such a logical practice in comparison to those benefit receivers who take paid leave during their employment relationship, during which time they are not entitled to unemployment allowance. For an unemployed person, averaging may however cause an unpleasant surprise at the end of the employment contract. In addition to averaging, payment of unemployment benefit may be prevented by a new period of deductible. In the case of earnings-based and basic unemployment allowance, the period of deductible is set once per maximum payment period of 500 days, whereas the period of deductible for labour market support is only in force until the end of the calendar year during which it has been obtained. After this, a new period of deductible may be set. For example, a person who has received labour market support after the period of deductible at the last part of the year may again have to wait for labour market support after a short employment contract at the beginning of the next year. [xxi]

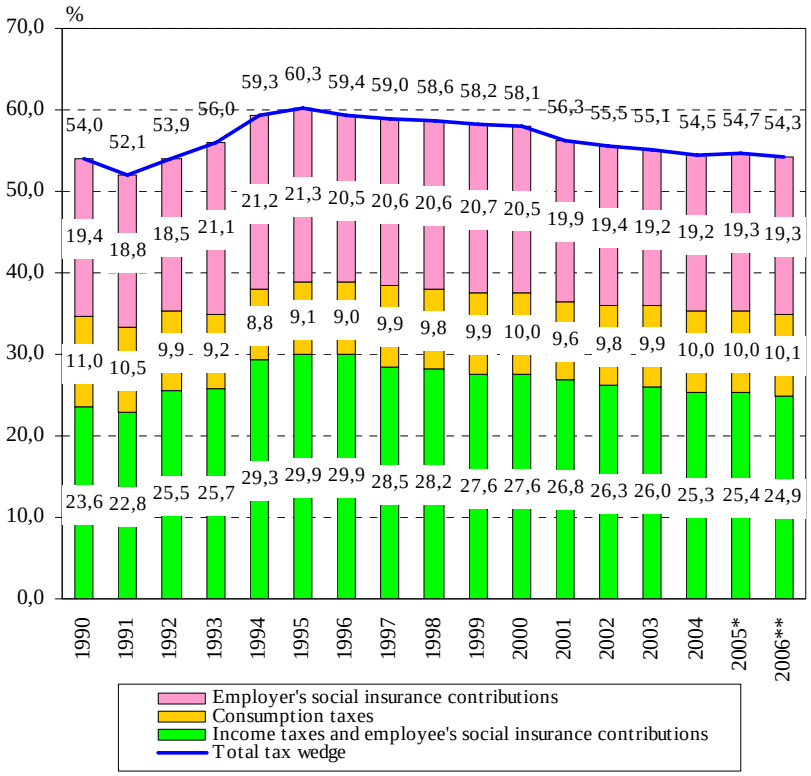
The fact that income transfer systems contain short-term economic incentives does not mean that households' choices are primarily influenced by them. Households may be planning their lives in a longer perspective than the duration of payment of current benefits. The number of days entitling to earnings-related unemployment ultimately comes to an end, and children move on from day care to school. Similar job offers may no longer be available at that time, so a job offer may be accepted even if the immediate short-term economic benefit remains minor. A job offered may also be seen as a first step towards better-paid positions. In addition, decisions are guided by other values besides economic motives. Households are also assumed to know the income transfer systems so well that they are able to predict their income in different situations. The recent discussion on the under-utilisation of social protection may indicate that there may be great differences between households' knowledge concerning income security. However, it is difficult to give any reliable estimates of the extent of possible under-utilisation, even in the case of individual income security benefits. [xxii]

Knowledge on the real effects of income security on households' behaviour is unfortunately considerably more limited than knowledge of the systems' incentive structures. The assessment of behavioural effects puts significantly greater demands on both research data and methods compared to study of incentive structures only. It is often very difficult to separate the effects of changes in the legislation from changes in other factors and in the operational environment. In addition to behavioural effects, the criticism towards income transfer systems and incentive traps may be based on notions of fairness. It is possible that the operation of income transfer systems is not seen as being particularly fair, e.g. if a person's net income does not increase appreciably when he moves from part-time work to full-time work.

The financing of income security and the demand for labour

In public, the incentives related to income security are almost exclusively associated with the choices of individual persons or households. However, the incentive effects of income security and particularly those of its financing also concern other economic agents besides benefit recipients. The taxes and social insurance contributions levied to finance income security benefits contribute for their part towards widening the tax wedge between employer's labour costs and employee's net wage. [xxiii] There is fear that this may lead to weakened employment, if the cost of the tax wedge is primarily borne by the employer in the form of higher labour costs. On the other hand, if a considerable share of the tax wedge is over time transferred to employees through lower wage demands, the impact on employment is smaller. The link between taxation of labour and employment has been widely studied in different countries and using different types of statistical data. Despite this, researchers are by no means unanimous about the impact of the tax wedge on employment. [xxiv] In recent years, the tax wedge has been reduced, particularly by cuts of income taxes. (Figure 44.)

Figure 44. Total tax wedge of middle-income wage earner and factors contributing to it in 1990–2005. The share of different taxes of labour costs, %



The person is assumed to be under 53 years of age. The share of taxes has been calculated from labour costs, so the share of e.g. income taxes is not the same as the tax rate of a mid-income wage earner, which is clearly higher. Source: Taxpayers' Association of Finland/Kurjenoja (2005)

In the tax wedge calculation, the share of employer's social insurance contributions has been presented based on average payments. However, the disability and unemployment pensions of large employers include a deductible that increases with the company size.[xxv] The actual costs of large employers are thus dependent of the prevalence of disability and unemployment pensions within the company.

The disability and unemployment pension deductibles of large employers also change employers' incentives. It has been hoped that the disability pension deductible will encourage employers to look after the well-being at work. If fewer than average employees at a large company take up disability pensions, the company's contributions also remain smaller than average, thanks to the smaller deductible. On the other hand, disability may cause a large one-off expense to the company through the deductible. The recruitment threshold may thus be raised by the deductible, if a person's disability risk is assessed as being great. [xxvi]

The unemployment pension deductible may be used in an attempt to curb the use of the unemployment path to retirement in large companies. In the absence of deductible, the unemployment path to retirement would constitute quite an attractive means of adjusting employment, from the viewpoint of both the employer and the employees. From the perspective of an individual employer, the costs would be borne by others, while a reasonable income would be secured for terminated ageing workers. In the reform implemented in 2000, the unemployment pension deductibles of large employers were increased. According to a study assessing the impacts of the reform, the changes in incentives were seen in practice as well. The proportion of employees given notice with the aid of the unemployment path to retirement shrank most in the companies whose deductibles rose.[xxvii] As is the case with disability pension deductibles, there is also a downside to unemployment pension deductibles; raising the deductible may make employment of ageing workers increasingly difficult. The 2005 pension reform involves a gradual abolishment of unemployment pensions. Instead of unemployment pension older recipients of unemployment allowance may receive allowance for so-called additional days. In relation to this, the financing of unemployment benefits was changed so that employers were obligated to pay a deductible as part of the financing of additional days of unemployment allowance. In the case of unemployment security deductible, the principles of unemployment pension deductible are followed when applicable.

The incentive effects of income security also extend to public sector. The responsibility of income security financing varies, depending on the benefit. For example, labour market support and general housing allowance are financed by the state, whereas social assistance is financed by the municipality, and the calculatory government grant received for this purpose by an individual municipality is not dependent on the social assistance paid by the municipality (changes in labour market support and social assistance financing, see info box below). For benefit recipients, the most central issue is probably the income level guaranteed jointly by different benefits. What benefits this income package consists of is probably not particularly relevant. However, the composition of income coming from different income security benefits may have major impact for the economy of an individual municipality. In addition to financing responsibility, this is underlined even further by taxation. Unemployment allowance and labour market support are taxable income that raises the municipality's tax revenue as well.

Financing responsibilities also have an effect on how changes in employment affect the financial position of municipalities and the central government. The Government Institute for Economic Research has illustrated this with the aid of calculation examples, where the changes in public sector financial position are looked at when moving from labour market support to gainful employment. [xxviii] More than half of the improvement of the financial position of the public sector as a result of employment went to the central government. Municipalities' share of the total improvement of the financial position remained small. It was particularly small when the person being employed was a single low-income earner or a household with a child for whom day care had to be arranged at the same time. With the aid of calculation, the changes in the financing status of the public sector can be assessed in the opposite direction as well, i.e. when a person becomes unemployed and receives labour market support. This weakens the financial position of the central government in particular, while the direct economic losses to municipalities remain smaller. This is particularly evident in a situation where the municipality adjusts its operations by laying off its own employees.

The financing reform of labour market support and social assistance

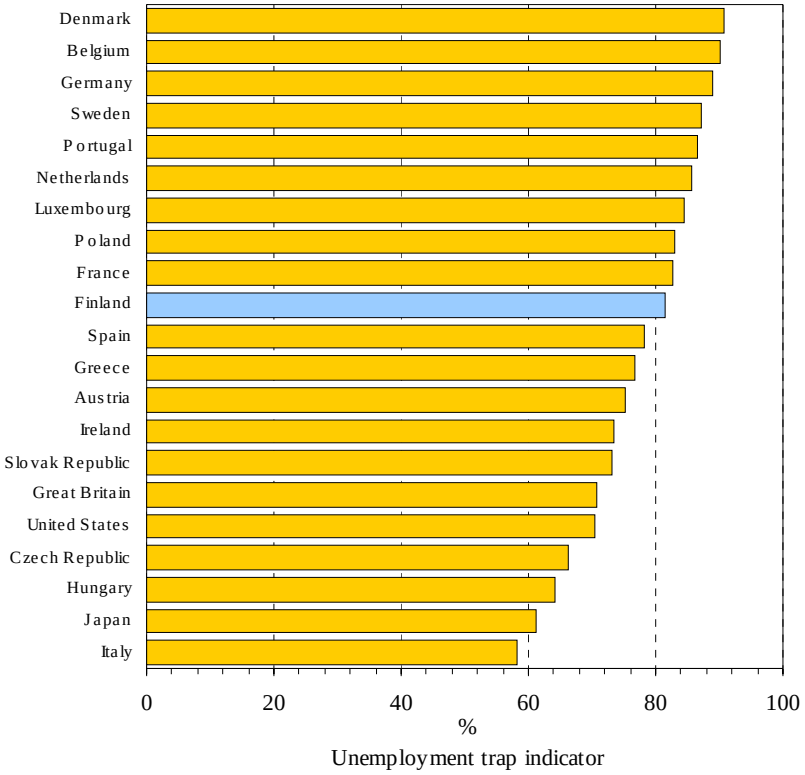
An unemployed person may lose his right to labour market support for a given period of time e.g. by refusing to participate in labour market training or practical training without a valid reason. From the viewpoint of municipal economy the situation is a difficult one, because in many cases the municipality pays out social assistance instead of labour market support, which is financed by the central government. There has been a fear that this will hinder efficient cooperation between municipalities and public employment services in dealing with employment issues. The differing financing responsibilities of different income security benefits may have affected operating practices. This is why the financing responsibility for long-term passive labour market support and social assistance will be re-distributed between the state and municipalities as of the beginning of 2006. The reform is part of a more extensive labour market support activation reform. Labour market support financing is reformed so that the state and municipalities finance the labour market support of persons who have received the support for 500 days with equal 50 percent shares. During active measures, the state stands for the financing even after the 500 days. The financing of social assistance is divided into basic social assistance and means-tested assistance. Basic social assistance consists of the basic amount of social assistance, housing costs, home insurance, household electricity and health care expenses. Basic social assistance is separated from the system of government grants, and it is financed jointly by the state and municipalities, each with a 50 percent share. [xxix] After this, the distribution of financing responsibility between the state and municipalities for the income security of persons who have received labour market support for more than 500 days is no longer substantially dependent on whether the person is entitled to labour market support or not. An exception to this is labour market support paid during various activation measures, which is financed by the state even after the 500 day limit. This will encourage municipalities to seek various activation alternatives together with the unemployed and public employment services even more actively than hitherto.

Income security incentive structures in international comparison

There is an increasing amount of international data for comparison on income security incentives. Most of the data are example calculations illustrating changes in income of different types of households in different life situations. In cooperation with its member states, the OECD maintains calculation models, with the aid of which the income security systems of nearly 30 countries can be compared. In addition to unemployment security and direct taxation, the models cover systems corresponding to the Finnish child allowance, general housing allowance and social assistance. At the same time as the calculation models enable comparison of compensation levels of different systems in the event of unemployment, they can also be used for assessing the economic incentives linked to employment. The same problems and limitations that were discussed above in connection with Figures 42 and 43 are encountered with these models and their use. However, in international comparisons the representativeness of the cases used as examples is even more difficult to achieve than in national comparisons.

Figure 45 looks at incentives related to employment with the aid of an unemployment trap indicator. The indicator illustrates that part of the increase in earnings resulting from employment that is lost as a result of increase in taxes or loss or reduction of benefits. The higher the indicator value, the smaller the person's economic incentives for employment. In the example used in the figure, a single person living in a rented flat has lost his job paying 67 percent of average wage. He is expected to find new employment at the same wage level. Re-employment is assumed to take place fairly soon, which means that e.g. in Finland, the person in question is entitled to earnings-related unemployment allowance. At least in the case used as an example here, the economic incentives for employment are even somewhat better in Finland than in other countries in northern and central Europe. Unemployment is of course affected by a number of other factors besides the economic incentives measured in a limited manner by the unemployment trap indicator. For example, Denmark is investing heavily in active labour policy emphasising job-seekers rights as well as responsibilities. Wage formation that occurs on local level and limited protection against dismissal are counterbalanced by good unemployment income security. This is why it has been possible to achieve a low unemployment rate and high employment in Denmark without compromising on the level of income security.

Figure 45. Unemployment trap indicator in some OECD countries, a person earning 67 percent of average wage in 2003. A single person living in a rented flat.



The higher the unemployment trap indicator value, the smaller the economic incentives for employment. Source: OECD

The availability of day care for children and the fees levied for it constitute a factor affecting parents' employment which has usually been ignored in international incentive comparisons. However, day care fees make up an expense category that is integrally linked to parents' working. Child day care is supported in different ways in different countries, and the size of the support varies. In Finland, public day care is available to all, and it is primarily financed through tax revenue. In other countries, the share of user fees may be higher, or parents may be obliged to purchase day care services from private service providers. [xxx] In Finland, the parents of children under three years of age are also supported through child home care allowance, which alters further the incentives to work of these families. In other countries, incentive elements corresponding to child home care allowance may be included in family taxation; however, they are not generally targeted quite as narrowly to parents with young children.

The OECD has presented preliminary calculations assessing the effects of income security benefits, taxation and day care fees on the economic incentives to work among parents with young children. In this connection as well, the incentives for employment have been assessed with the aid of the unemployment trap indicator described above. Because the parent who becomes employed is not assumed to have received unemployment allowance, the indicator can in this case be termed incentive trap indicator. The indicator is presented below both excluding day care fees (Figure 46 a) and including day care fees (Figure 46 b). The incentive trap indicator naturally gets a higher value

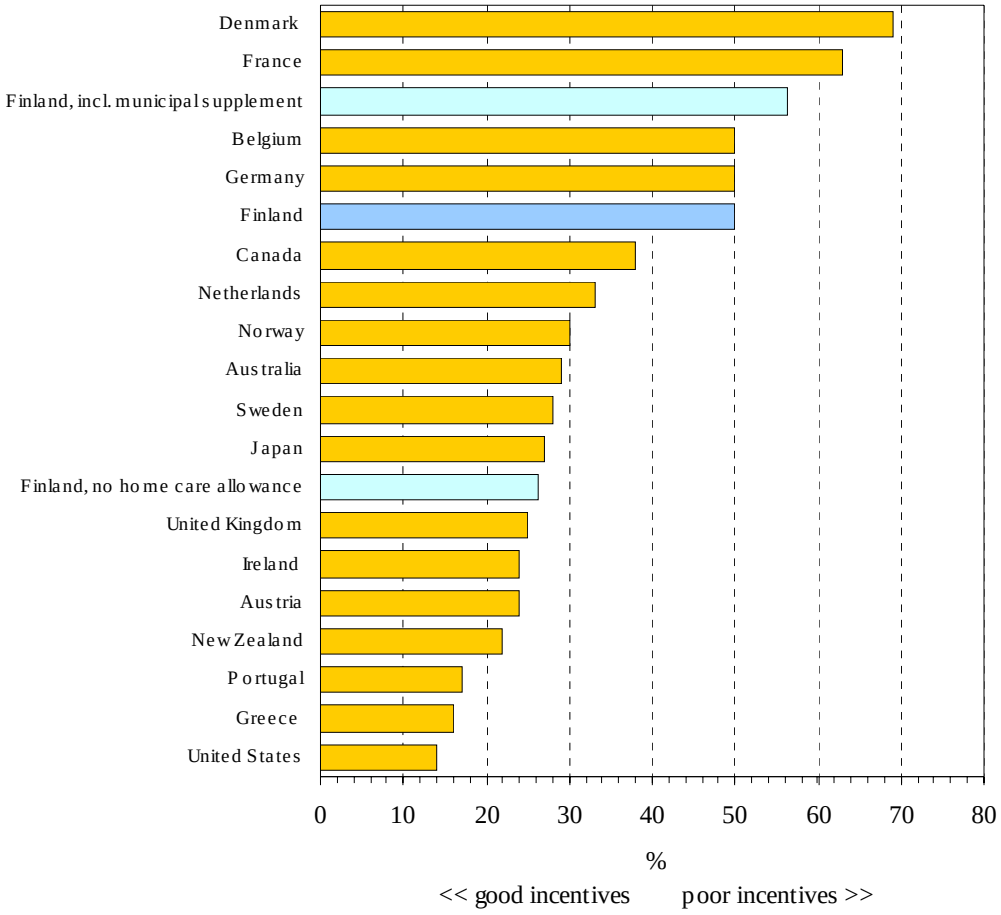
when day care fees are deducted from the net income following employment, in which case part of the income increase resulting from employment goes towards day care fees. In the case of Finland, the incentive trap indicator value and the employment threshold is raised in the calculations by child home care allowance. Some municipalities pay an additional supplement to child home care allowance. To illustrate the effect of municipal supplements, the Finnish indicator value is also shown taking into account the municipal supplement (Helsinki).[xxxi] Entitlement to child home care allowance stops when the family's youngest child turns three, at which time the economic incentives to work are also significantly improved. This is illustrated by also calculating the indicator value for Finland without child home care allowance. In that case, the assumption is, as in other countries, that the person caring for the children in the home is not entitled to any other "personal" income security benefits in lieu of child home care allowance. [xxxii]

When comparing Figures 46 a and b it can be seen that in some countries, the threshold to employment rises considerably if the effect of day care fees is taken into account. In these countries, high day care fees constitute a factor that restricts both parents' working. When comparing the incentive effects of our own system to other countries, day care services and the fees levied for them should also be taken into account, in addition to income security benefits and taxes paid. Changes in day care fees on the economic incentives to work of parents with children should also be kept in mind when amending the day care fee system.

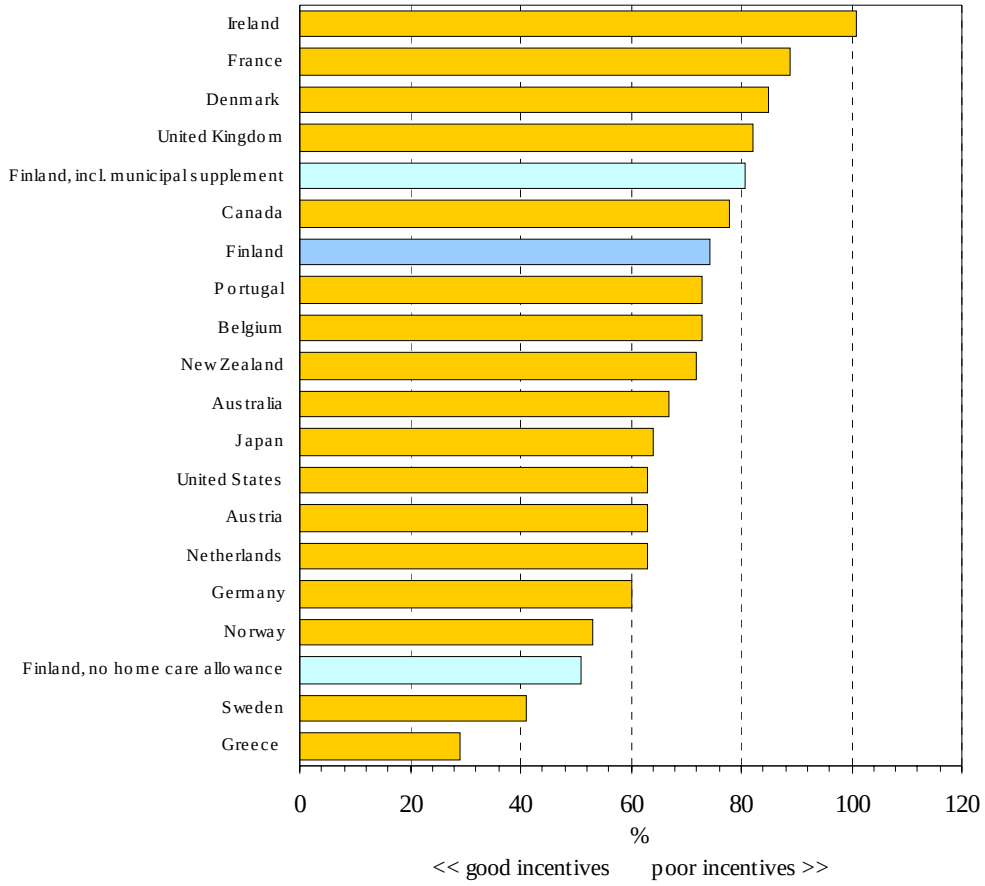
Child home care allowance reduces the economic incentives to work of parents with young children, in practice usually mothers. This was also remarked on in its recent report by the OECD, which recommended limitations to payment of this benefit. [xxxiii] Child home care allowance should naturally not be assessed merely from the viewpoint of incentives and employment. The aim of the allowance is to offer parents with young children the possibility to care for their children themselves. The allowance is a good example of the conflicts that can exist between high employment and other social policy objectives. A key issue in assessing child home care allowance is what are the long-term effects on labour-market outcomes for parents staying at home with the allowance.[xxxiv] Based on Figure 46 b, the economic incentives for both parents to work in the period after child home care allowance appear very good in an international comparison.

Figure 46. Incentives to low-paid work in families with children

a) Change in income security benefits and taxation in relation to income from the new job as the other parent becomes employed as well



b) Change in income security benefits, taxation and day care fees in relation to income from the new job as the other parent becomes employed as well



The higher the indicator value, the smaller the person's economic incentives to find employment. Data from 2001 or 2002. The parent becoming employed is assumed to earn 67 percent of average wage, and the parent who is already employed is assumed to earn an average wage. There are children aged 2 and 3 years in the family, who are in full-time day care after the other parent becomes employed. The parent becoming employed was not entitled to unemployment allowance prior to employment. Source: OECD (preliminary calculations), with the exception of Finland (calculations by the Ministry of Social Affairs and Health).

VI Well-being of families with children

Impact goals of well-being of families with children

- Supporting parenthood and family cohesion
- More equal division of costs due to children
- Improving safe environments for children to grow and develop in
- Promoting reconciliation of work and family life

In order to secure the well-being of children, the government programme of Prime Minister Vanhanen is committed to ensuring the stability and predictability of family and child policy. According to the government's strategy document, trust in the future on the part of families is improved by a long-term policy in which the well-being of children, young people and families with children is chosen as a clear social policy objective. The challenges include ageing of the population, a falling birth rate, the high average age of first-time mothers and postponement of the age of starting a family.

6.1 Starting a family and family formation

The aim of the family-policy lines of the Ministry of Social Affairs and Health is to encourage young people to start a family by providing more flexible housing arrangements, by improving income and services and by supporting work and study. The entry into the labour market of young people has been postponed especially due to longer study times. In the 1990s, employment contracts became irregular. Young women in particular have had difficulties in getting permanent positions; this applies to highly educated women as well. Family formation has been increasingly postponed. People get married at a later age than before, very often after cohabiting with the future spouse or another partner. Having children at an earlier age can be encouraged by intensifying studies and by reducing the number of fixed-term employment contracts.

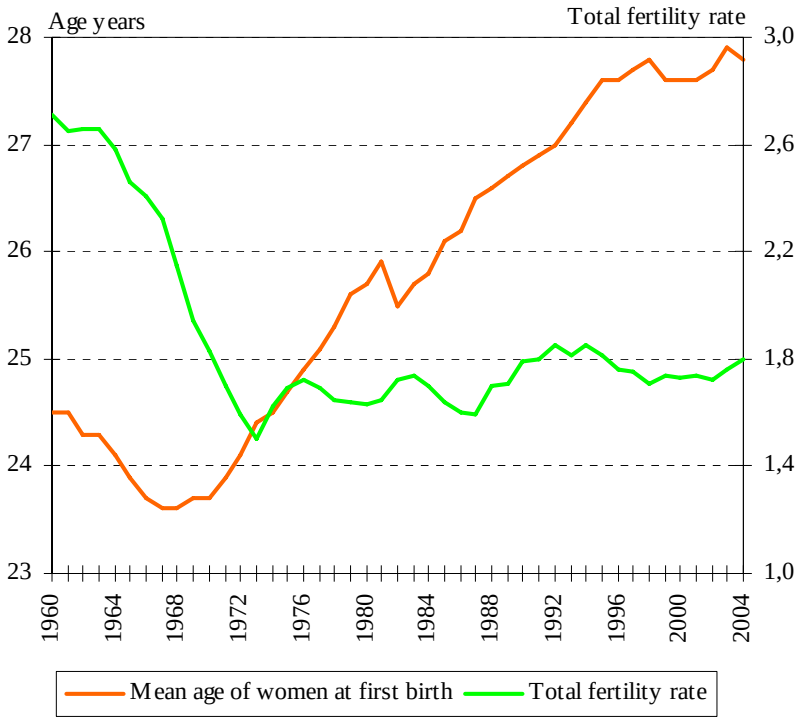
Birth rate

The birth rate has remained relatively stable in recent years. In 2004 a total of 57,758 children were born, which is 7,000 fewer than ten years ago. The decline in the number of children being born is a result of the fact that the small cohorts of the 1970s have now reached child-bearing age. Mean age of women at first birth primiparas has risen steadily, being nearly 28 years at the moment.

From a European point of view, total fertility rate is quite high in Finland. In 2004, total fertility rate in Finland was 1.80, while the EU average was 1.50. Total fertility rates that were higher than in Finland were seen in France, Ireland, Iceland and Norway. Birth rates in the new EU member states are very low.

There have been considerable changes in total fertility rates in different age groups. Fertility has decreased among women under 30, while it has increased among those over 30.

Figure 47. Mean age of women at first birth and total fertility rate in 1960–2004



Birth rates have been reduced by women's workforce participation and increased education level. However, in the Nordic countries, where women go out to work more commonly than in other European countries, the birth rate is also high. Significantly fewer babies are being born in countries in southern Europe, where women's employment has not been widespread. The level of family-policy support has been higher in the Nordic countries compared to southern Europe. It seems likely that family-policy support measures have prevented the birth rate from sinking to an even lower level. Surveys conducted have shown that the timing of having children can be influenced by family-policy support, whereas the number of children in the family cannot necessarily be influenced.

Family structure

The number of families with children has been steadily declining. At the end of 2004, the number of families with children was 592,800, which was nearly 20,000 fewer than in 2000. At the same time, changes have taken place in family structures. The number of cohabiting families is constantly rising. Seventeen percent of families with children are cohabiting families. More than half of first-born children are born outside of marriage; however, the parents often do get married later on.

Table 11. Types of families with children 1970–2004

	Married couple with children, %	Cohabiting couple with children, %	Mother with children, %	Father with children, %	Families
1970	88.9	0.9	9.0	1.2	677,035
1980	83.1	4.7	10.9	1.4	688,732
1990	76.6	9.4	12.3	1.7	659,052
1995	70.2	12.3	15.4	2.1	640,637
2000	65.1	15.5	17.0	2.4	612,627
2004	63.6	17.4	17.4	2.5	592,807

Source: Statistics Finland

Due to the increasing prevalence of divorce, the number of single-parent families grew rapidly in the 1990s. About 20 percent of families with children are single-parent families. At the end of 2004, there were 184,440 children under the age of 18 in single-parent families. The number of reconstituted families has also increased somewhat in recent years. About eight percent of families with children are reconstituted families.

Table 12. Number of children in families with children in 1990–2004, %

	Number of children in the family			
	1	2	3	4-
1990	44.7	39.1	12.7	3.5
1995	44.5	37.8	13.4	4.2
2000	43.8	37.7	13.9	4.6
2004	43.2	38.1	13.9	4.8

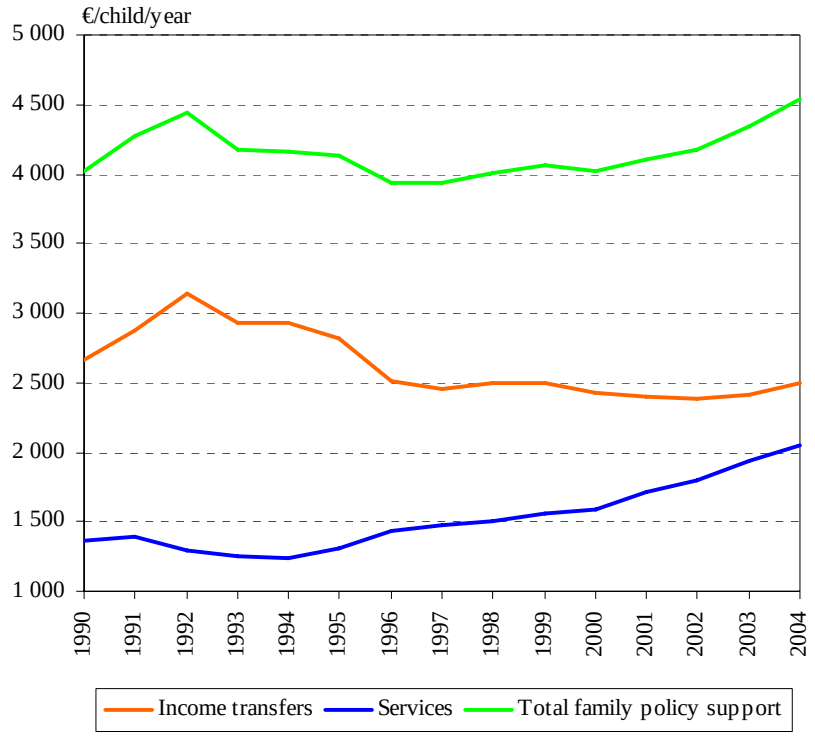
Source: Statistics Finland

There are two trends in evidence in family formation. The number of children in families with children is showing a slight upward trend, but at the same time, an increasing number of women remain childless. The OECD has also focused attention on the fact that an increasing number of women in Finland remain childless. At the moment, about 15 percent of middle-aged women are childless. This figure is expected to rise to 20 percent in the future. Childlessness is most common among highly educated women.

6.2 Evening out costs due to children

The starting premise of family policy has been to even out the costs to parents caused by children. The aim has been to prevent children from causing an undue consumption burden on families. Many benefits aimed at families have been raised in accordance with the Government Programme. The level of family policy support is nearly the same as in the beginning of the 1990s.

Figure 48. Family-policy support in 1990–2004, euros/child/year at 2004 prices

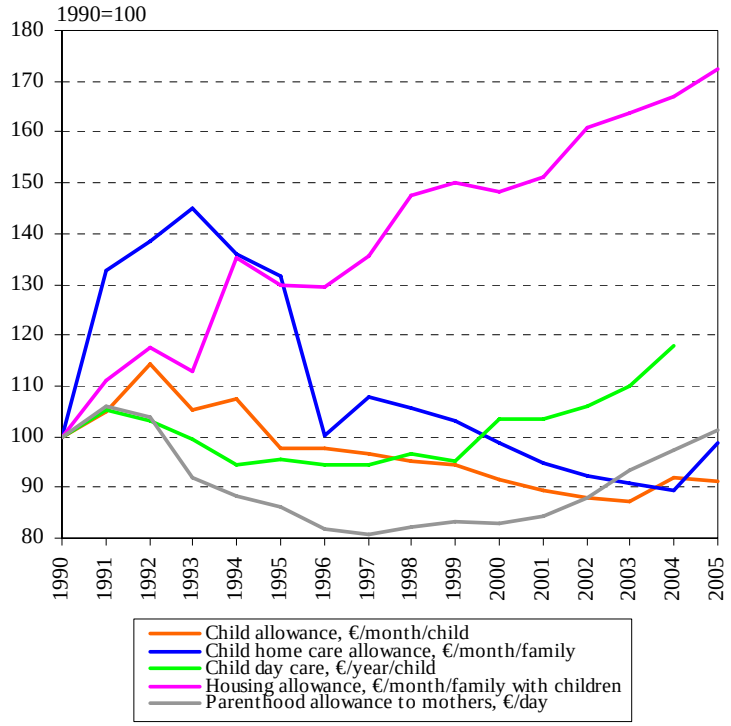


The income transfers aimed at families with children are not index-linked. This has been seen especially as weakened purchasing power of child allowance and child home care allowance. The child allowance for the family's first child and single-parent child allowance increment were both raised at the beginning of 2004. The increase raised the average child allowance per child by about six euros per month. Single-parent families benefited most from the raise. Despite the raise of the level of child allowance, it is still some 15 percent lower than in 1994, when the family support reform was implemented.

At the beginning of 2005, the minimum level of parenthood allowance was raised from € 11.45 to € 15.20 per weekday, or by some € 93 per month. The average parenthood allowance for mothers has increased by 4.8 percent since 2004. In 2004, 19.9 percent of mothers received minimum parenthood allowance.

A significant reform concerning mothers is that in the case of consecutive pregnancies within a short period of time, the level of parenthood allowance can be defined based on the earnings used to calculate the previous parenthood allowance. The reform came into effect at the beginning of October in 2005. When a corresponding reform was implemented in Sweden, the birth rate initially went up, but started to decline again after a few years. As a result of the reform, it is possible that the second and third child may be born within a shorter period of time than before in Finland as well, but the reform has only little impact on the total number of children in families. This reform may also improve the position of employees working as locums for parents on parenthood leave; fixed-term employment contracts may become longer. Earlier it was customary for many mothers to return to the labour market for a few months so that the parenthood allowance for the next pregnancy would be higher than the minimum.

Figure 49. Real growth of some forms of family policy support in 1990–2005



The child home care allowance was raised by € 42 per month at the beginning of 2005. After the raise, the real value of child home care allowance is nearly the same as after the 1997 reform, but clearly below the early 1990s level. The majority of children (73 percent) are cared for with child home care allowance after termination of the parenthood allowance period. The recipients of child home care allowance usually return to work before the end of the child home care allowance period, or a new child is born in the family. Only one in four child home care allowance recipients is paid the allowance up to the point when the child turns three. The change of parenthood allowance in the case of consecutive pregnancies may lengthen the period for which child home care allowance is paid.

Municipalities attempt to reduce the demand for day care by paying municipal supplements to child home care allowance recipients. In some municipalities in the capital region, fairly high municipal supplements are paid out. In recent years, the number of municipalities paying a supplement to child home care allowance recipients has gone down. Only 19 municipalities paid a municipal child home care allowance supplement via the Sickness Insurance Institute in September 2005.

Economy of families with children

A positive employment trend and lighter taxation have improved the economic position of families with children. Income transfers to families with children have been raised as well. However, despite the positive trend, the development of the economy of families with children lags behind that of the rest of the population. The economy of single parents in particular has improved more slowly after the recession compared to the rest of the population. The primary reason for this is higher unemployment among single parents.

The number of families with children living below the poverty line has not decreased. Poverty has increased particularly among families with several children. In 2003, 24 percent of single-parent families and 9 percent of two-parent families lived below the poverty line. There were 132,000 children in low-income families in 2003. About 12 percent of all children below 18 belonged to families living below the poverty line.

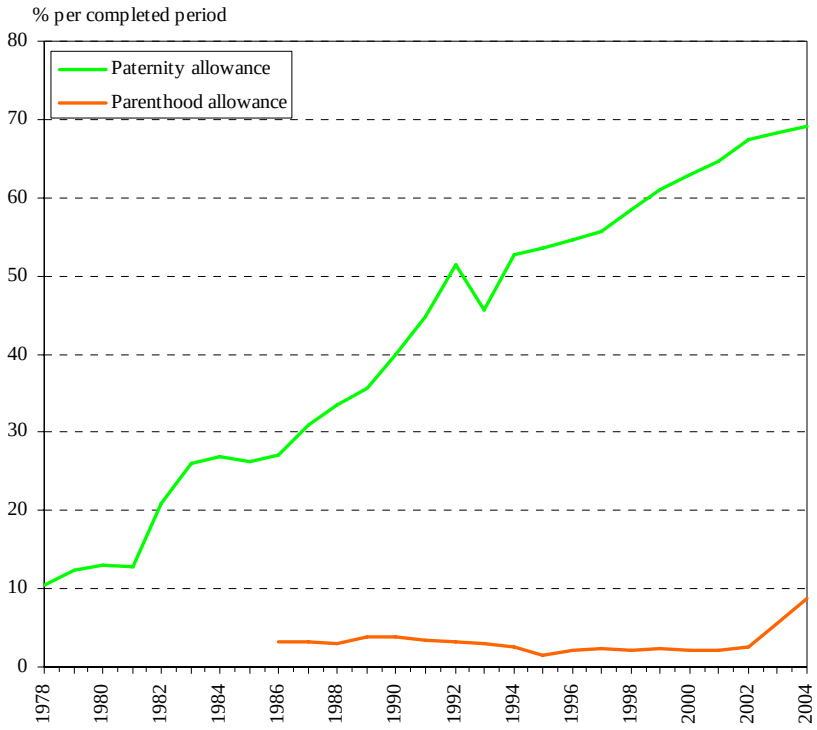
The majority of single parents living below the poverty line have young children. Unemployment is significantly more common among single mothers compared to other women with children in the same age group. Unemployment among single mothers has not been reduced as quickly as among others.

6.3 Supporting parenthood

Family leave

The aim of the development of the system of family leave has been to support families' possibilities of reconciling work and family life. Family leave is still prevalently used by women, even though the proportion of fathers making use of family leave has increased steadily. Sixty-nine percent of fathers took paternity leave in 2004, whereas the use of parenthood leave is still rare among fathers. The use of parenthood leave increased thanks to the new so-called bonus leave system. In 2004, 8.8 percent of fathers took parenthood leave. If the so-called bonus leave were not included, the share would be 3.6 percent.

Figure 50. Fathers receiving paternity and parenthood allowance in 1990–2004, percent per completed period



The popularity of the new bonus leave has remained considerably more modest than was expected, which is partly due to the timing of the leave at the end of the parenthood allowance period. If the father uses his leave at a time when the mother intends to take child care leave, it may cause problems in the family. The timing of the father's own family leave month should be more flexible so as to encourage more fathers to take advantage of it. It should be possible to take the "father's leave month" even after the termination of the parenthood allowance period.

Fathers are encouraged to make use of family leave by evening out family leave expenses

When developing family leave legislation, the aim has been for both parents to have equal possibilities to take part in caring for their child. In practice, however, fathers have taken relatively little advantage of family leave, even though taking short paternity leave is fairly common.

A more even distribution of family leave also calls for a change of attitudes. Child care has traditionally been seen as a woman's task. Attitudes towards fathers taking family leave have not always been without their problems in the workplace, either.

It has also been assumed that the use of long family leaves by women weakens their labour market status. The fact that fixed-term employment contracts are common among young women may also be partly due to the fact that employers fear that young women may take long family leaves.

According to the government programme of Prime Minister Matti Vanhanen, the costs to employers caused by family leave will be evened out more than at present. The compensation for holiday pay paid to employers was raised at the beginning of 2005. At present, the use of family leave and the costs caused by them are unevenly distributed among employers in different sectors. The use of family leave also gives rise to costs to employees, because not nearly all family leaves are paid. Family leaves are mostly used by mothers, which burdens employers in sectors mostly employing women. The costs caused by family leaves are currently partly compensated. The amount of compensation is not sufficient, and not all employers seek compensation. Employees' compensations for family leave vary according to industry.

> A rapporteur appointed by the Ministry of Social Affairs and Health has proposed a separate insurance for parents, which would be used to compensate employers' costs and to pay parenthood allowance to employees. The rapporteur also proposed raising the compensation level of parenthood allowance, abolishing the gradual levels of parenthood allowance, as well as compensation to the employer for wages paid during the time parents care for a sick child. In order to obtain a more even distribution of costs, the rapporteur suggested that the expenses caused by the reforms be shared jointly by all employers. This would be financed by a new parent insurance payment paid by employers, which would come to about 0.29 percent.

Raising the level of parenthood allowance would encourage fathers to make use of family leave. According to surveys, the most common reason why fathers do not take family leave is economy. Raising the level of parenthood allowance would make it easier to agree between employers on the fact that maternity and paternity leaves are

paid leave. If fathers took more advantage of family leave, it would also even out costs between sectors that mostly employ men and those mostly employing women.

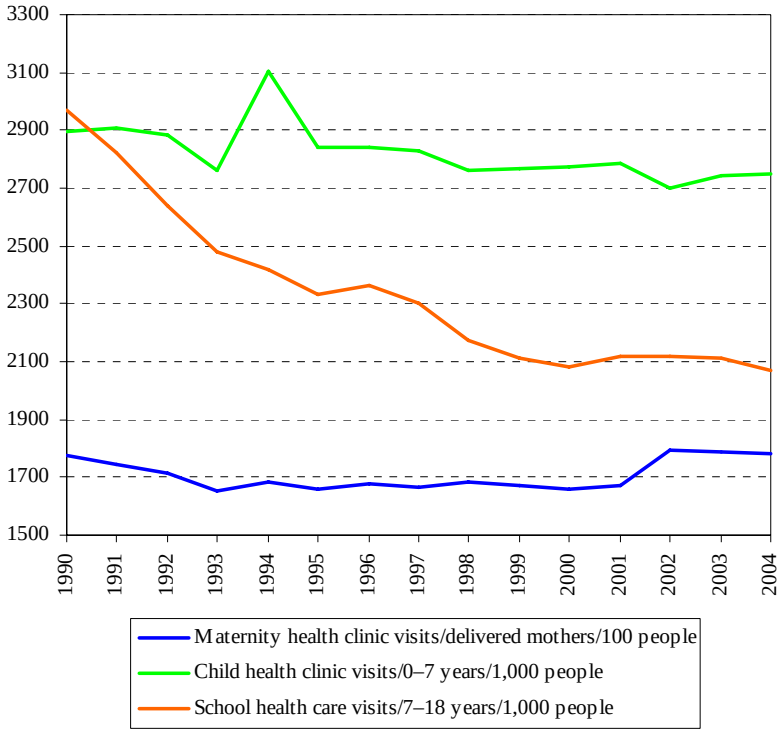
Many employers pay their employees wages for the time they care for a sick child. The rapporteur's propositions include paying compensation to employers for wages paid during the time the parents care for a sick child.

Supporting parenthood as part of the services provided by municipalities

The task of maternity and child health clinics is to promote the health and well-being of expectant mothers and families with children under school age. In the 1990s, the resources of maternity and child health clinics were cut. As a result, the number of visits was reduced, particularly in the case of periodic check-ups and home visits by clinic staff. In 2004, only one third of health care centres implemented periodic check-ups of infants in accordance with recommendations. The home of one in three families with a newborn baby is not visited by a health care worker.

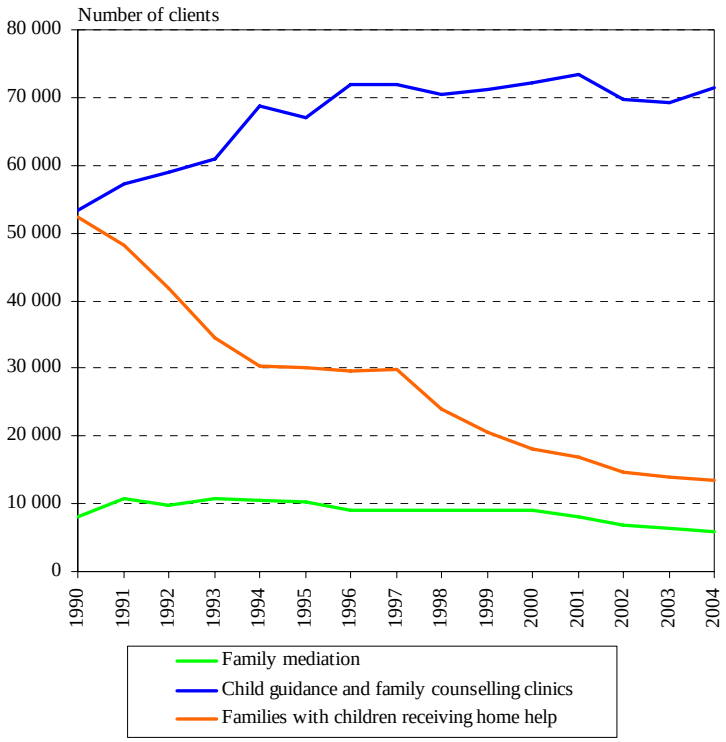
A new child health clinic guidebook was published in 2004 aimed at supporting preventive and health-promoting work in the municipalities. According to the guidebook, the emphasis in maternity and child health clinic work is increasingly on supporting parenthood, a lifestyle that promotes the family's health, and on promoting the psychosocial wellbeing of the child and the entire family. Early recognition and provision of help to families in need of special support is also important from the viewpoint of reducing health disparities.

Figure 51. Visits to maternity and child health clinics and school health care in 1990–2004



The number of visits has decreased, particularly in the case of school health care. There have been considerable differences between municipalities in the provision and operating practices of school health care services. At the moment, the number of public health nurses and doctors for school health care is not sufficient at all health care centres. The aim of school health care is to promote the well-being of the entire school community as well as students' health, and to support healthy growth and development in cooperation with students, their parents, teachers and student counsellors.

Figure 52. Special services for families with children in 1990–2004



In recent years, the possibilities of families with children to receive municipal home help have diminished considerably. The number of families with children receiving home help has decreased from 52,000 (1990) to 13,400 (2004). At the same time, the number of clients at child guidance and family counselling clinics has increased. In 2004, the number of client visits was 71,300. The number of staff at family counselling clinics has been increased in recent years, but the amount of staff is too small in relation to the clients' needs.

Child welfare

The number of children placed outside their own home has increased steadily. In 2004, the total number of children and young people placed outside their own home was 14,704, or 1.1 percent of the age group. Forty-six percent of these children were in institutional care, and 54 percent were placed in foster care. Professional foster homes are entered in statistics under foster care. Total number of children and young people taken into custody was 8,673. The majority of children are taken into custody with the consent of the parties involved; however, the number of urgent decisions to take children into care against the will of those involved has increased. The most common reasons for placing children outside the home include parents' substance abuse and

mental health problems, which often lead to child neglect and domestic violence. Today, an increasing number of decisions to place children outside the home are based on the fact that the child is displaying symptoms such as school difficulties, criminal behaviour or drug abuse.

In the last few years, the number of children receiving child protection services in community care has grown, and there are more and more long-term clients. In 2004, the clients of community care included 59,912 children and young people. This is an increase by more than 3,500 compared to the previous year.

The compensation system for large costs in child protection has been in force since March 1999. The aim of the system has been to even out municipalities' large child protection costs. A fixed appropriation is defined in the state budget for the financing of the evening-out system, amounting to 50 percent of the estimated total amount of large child protection expenses. In autumn 2005, the Parliament discussed a bill according to which the system of evening out large costs would be replaced by a new child protection coefficient depicting the need for child protection in the government grants for social and health care. The current system has proved to be hard to manage and its costs difficult to predict. The system has failed to support the operation of small municipalities in particular.

6.4 The environment in which children grow and develop

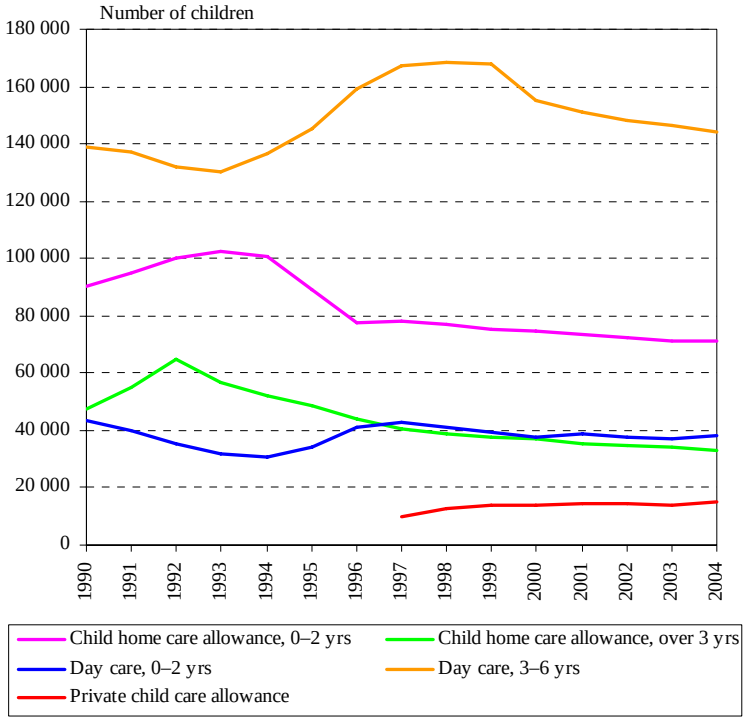
Creating a safe environment for children to live, grow and develop in has been one of the objectives of family policy in recent years. From the point of view of children, sufficient preconditions for early childhood education and comprehensive education play a key role.

Child day care

The number of children in day care has decreased in recent years, due to a falling birth rate and the pre-school reform. In 2004, there were 185,780 children in municipal day care. The number of children cared for with child home care allowance has diminished slightly. The number of children cared for with private child care allowance has remained fairly constant in recent years. Nearly 15,000 children were cared for with the aid of private child care allowance in 2004. The number of municipal supplements to private child care allowance has grown in recent years. In September 2005, 67 municipalities paid a municipal supplement to private child care allowance through the Sickness Insurance Institute.

The number of children under school age in need of day care will not change significantly in the next few years, whereas the need for afternoon care for school-age children will grow.

Figure 53. Children in municipal day care and children cared for with child home care allowance and private child care allowance in 1990–2004



Reforms proposed to day care fees

The committee charting the reform of social and health care payment policy and payment system proposed that the maximum day care fee be raised from € 200 to € 250 per month, and from € 180 to € 200 per month for the next child in age order. The committee proposed abolishment of the minimum fee, because municipalities are best able to assess the situations in which a fee should be charged. When municipalities can themselves decide when not to charge a fee, this may have an effect on day care use. It is possible that children who are in need of day care services due to pedagogical reasons are left outside their scope. Regional inequality may also increase as a result of the reform.

According to the proposal, the fees of part-time and shift day care would be reformed so that the fee would be determined on the basis of day care time used. It is assumed that this will encourage families to use day care in a flexible and appropriate manner, in accordance with the family's real needs and the child's interests. As a result of the reform, the time spent in day care by children may be reduced, as the time spent in day care is adjusted to the real need of care. If the service structure of municipalities is at the same time made more versatile, this may lead to a reduction of the total amount of day care services.

The concept of family used in determining day care fees has proved to be unclear and hard to decipher. The committee suggests that the concept of family be altered so that actual family size is taken into account when defining the fee. Changing the concept of family would lower considerably the fees of those single parents who have more than one child. Two-parent families with several children would also benefit from the reform.

6.5 Reconciling work and family life – OECD recommendations

In spring 2005, the OECD published a report entitled Babies and Bosses: Reconciling Work and Family Life, which looks at family policy in England, Canada, Sweden and Finland. The OECD gave recommendations for ensuring the well-being of parents and children, with high employment and high birth rate as their aim.

The OECD prompted Canada and England to set up more numerous as well as less expensive child care alternatives for working parents, so that parents are better able to reconcile their work- and family-related responsibilities. On the other hand, the report also states that Finland should limit the use of long family leaves. Compared to Finland, gender equality in connection with family leave has been more successfully realised in Sweden, particularly with reference to men.

Finland and Sweden started investing in family-friendly policy for more than 30 years ago, while extensive measures aiming at reconciling work and family are of much more recent date in Canada and England. In Finland and Sweden, parents are given support up to the point when their children are in their teens: flexible family leaves, inexpensive, high-quality child day care and possibilities for parents with young children to work shorter hours. Because these solutions are costly, Canada and England have generally opted for a lower tax rate instead of higher social service expenditure. However, these countries have in recent years started to expand the scope of subsidies aimed at parents. Surveys conducted in Finland and Sweden have shown that the tax base is widened by parents of young children going to work, so that it covers the expenses caused by child day care.

The labour market is favourable to women in all four countries: three out of four women aged 25 – 54 go out to work, even though there are significant differences in mothers' working hours. Working full time is normal practice in Canada, Finland and Sweden, whereas women in England often work part time. The weekly working time of mothers in Canada and Finland is 38 – 40 hours, while about half of mothers with children under school age in Sweden work less than 35 hours per week. Women's wages are lower than those of men in all four countries. Wage differences of women and men belonging to the upper income categories are greater in all four countries than the corresponding OECD average.

According to the OECD report, reconciling work and family is in many respects successful in Finland. Women's employment rate, 66 percent, clearly exceeds the corresponding OECD average, 55 percent. The OECD paid particular attention to the fact that the majority of women work full time. However, in contrast to other countries, mothers of children under three years of age work less often than elsewhere. In Finland, persons on child care leave who have an employment contract in force are entered into statistics as being outside the labour force.

The OECD observed that fixed-term employment contracts are common among young women, which is why attention should be focused on reconciling career and motherhood. In Finland, childlessness is more common among women with a second-stage tertiary-level degree than e.g. in Sweden. Many women may find reconciling career and motherhood difficult. If women stay away from work for too long, their

career opportunities may weaken. There are relatively less women in leading positions in Finland compared to Canada, for example.

The Finnish model of reconciling work and family life was seen as positive in international comparison, because it offers parents with young children the possibility to choose between different alternatives. All children under school age have access to municipal day care, which reduces obstacles to employment. The fees charged for day care are also quite reasonable. Child home care allowance provides economic support to families who do not use municipal day care. Because provision of municipal day care is relatively expensive, some large municipalities pay municipal child home care allowance supplements so that parents would not use municipal day care. As a result, as parents choose between working and caring for the children in the home, the choice is influenced by economic incentives, so that mothers stay at home to care for their children. In Finland, 44 percent of two-year-olds were in day care outside the home, while the corresponding figure in Sweden was as high as 85 percent.

The report points out that in view of the population trend in Finland, it would be extremely important to increase the supply of female labour in the near future. The goal of the government's policy is to raise the employment rate to 75 percent by the year 2010. According to the OECD's assessment, this calls for a reform of child home care allowance. In addition, the provision of afternoon care for school children should be expanded and the economic incentives of part-time work among parents with young children should be improved.

The OECD report includes the following recommendations for promoting reconciliation of work and family life in Finland:

- Day care guarantee and paying child home care allowance to parents who do not make use of municipal day care increase the possibilities of choice among parents with children under 3 years of age. Taking into account the level (some municipalities pay an additional supplement) and duration of child home care allowance, it is no wonder that many parents with very young children – usually mothers – are not gainfully employed. This weakens their future career opportunities and makes the goals of gender equality harder to attain. In addition, the child home care allowance system is a hindrance to an increase in labour supply, at a time when predictions indicate that concern for the supply of labour is warranted. This is why the possibility of reforms limiting the payment of benefits and/or the duration of payment should be considered.

- In order to secure the long-term financing of child day care, the system of family day care should be retained to the extent possible, as a less expensive alternative to service provided in day care centres.

- The possibility to extend afternoon care for schoolchildren to cover 9- and 10-year-olds should be charted.

- Part-time work should be promoted; payment of the current partial child home care allowance should be reformed so that parents with children under school age are entitled to part-time work for two years, and the benefits paid during this time are financed with current financing.

Assessment of the OECD recommendations

In the following, the OECD recommendations are assessed and relevant background information is sought for from the starting premises of national family policy.

Reduction of child home care allowance and/or shortening the duration of allowance payment

The use of child home care allowance to care for very young children right after the termination of parenthood leave has been popular. However, the period during which child home care allowance is paid has remained relatively short. One in four child home-care allowance recipients returns to work when the child is 18 months old at the latest. Only one in four child home care allowance recipients is paid the allowance up to the point when the child turns three. During child care leave, employees retain their employment contracts, and many return to their previous jobs after child care leave.

Some municipalities pay a municipal child home care allowance supplement, the size of which varies greatly between municipalities. Only one in four child home care allowance recipients lives in a municipality where a municipal supplement is paid. The level of child home care allowance is lower than many benefits, such as labour market support. In its calculations concerning child home care allowance, the OECD has used the highest municipal supplement paid, which has only been in use in two municipalities.

Extension of morning and afternoon activities to schoolchildren to cover 9- and 10-year-olds

In the autumn of 2004, morning and afternoon activities were launched for pupils in grades 1 and 2 of comprehensive schools. Thirty-eight percent of pupils in grades 1 and 2 have taken part in the activities provided. The aim of the activities is to support homes and the school in their educational task as part of early education. Participation in the activities has been voluntary. Extension of afternoon activities to cover children aged 9 and 10 would be an expensive solution.

Encouraging part-time work among parents of children under school age and partial child home care allowance paid during two years

Finnish women typically work full time. Part-time work is relatively uncommon compared to other countries in Western Europe. Unlike elsewhere in Europe, women's part-time work is not primarily linked to child care. In Finland, people work part time when full-time work is not available, or while they are studying. Even though the parents of young children have the possibility to work shorter hours due to caring for their children, few have taken advantage of this option. Reconciling work and family becomes easier if working part time becomes more common among both mothers and fathers. Part-time work is also a matter of economy for families.

At present, partial child home care allowance is paid to parents with children under three and to parents whose children are in grades 1 and 2 in comprehensive school. The partial child home care allowance comes to € 70 per month. It is likely that part-time

work would become more common among parents with children over three if they were entitled to economic support during that time.

Favouring family day care

In recent years, the share of family day care of all day care provided has diminished. At the moment, the problem is that family day care providers are getting older, and it has been difficult to attract young people to the field. However, family day care in the home of the day care provider is often the parents' primary choice, especially in the case of younger children. Increasing the availability of family day care and improving the status of family day care providers are included in the Government Programme.

VII Promoting gender equality

Impact goals of promoting gender equality

- Reducing differences in pay between women and men
- Reducing temporary employment contracts
- Increasing woman entrepreneurship
- Increasing the share of women in political and economic decision-making
- Reducing prostitution and violence against women
- Gender equality policy issues assessed from a male perspective as well
- Mainstreaming of gender equality adopted in central government administration

Measures aimed at promoting gender equality have long focused on the world of work and the public sector. During the past ten years, the following issues have emerged as new gender equality themes: reconciling work and family life, uneven distribution of costs due to family leave, violence against women, and the relation between men and gender equality.

7.1 Gender Mainstreaming in central government administration

Gender mainstreaming is a key objective in the government's gender equality policy. Mainstreaming is an administrative means of promoting gender equality. In all ministries, decisions are made which may have different effects on men and women. The aim of mainstreaming is to develop administrative methods and ways of operation that support the promotion of gender equality as part of the operation of ministries and authorities. Mainstreaming of the gender perspective is about officials assessing and taking into account the potentially different effects their decisions have on men and women, and aiming to promote gender equality by their own actions.

The government's gender equality objectives are implemented with the aid of the government's equality action plan. The government's gender equality action plan for 2004–2007 includes nearly 100 measures: some aimed jointly at all ministries, such as mainstreaming of gender equality, and some aimed at the ministries' own main divisions. The action plan comprises legislation, education and development projects.

The reformed Equality Act came into force in June 2005. The reformed Act strengthens the obligation to promote equality as well as elimination of discrimination stipulated by law. The Act defines the regulations concerning gender equality planning in the workplace. Drawing up a gender equality plan becomes obligatory in companies with more than 30 employees. It must include e.g. a charting of women's and men's wages and wage differences. In future, an employer who neglects gender equality planning may be subjected to sanctions.

The government promotes mainstreaming e.g. by providing training on the assessment of gender impacts to officials taking part in legislation drafting. In addition, training in assessment of mainstreaming and gender impacts is arranged for other officials working in central government administration. Ministries promote mainstreaming within their own administrative sectors. Projects and data provision promoting gender equality are included in performance agreements made with offices and institutions under different ministries.

It is the government's aim that the 2008 budget be prepared in accordance with new guidelines that take the gender perspective into account. In 2005, commissioned by the Ministry of Social Affairs and Health, the Government Institute for Economic Research conducted a survey on the gender impacts of the Ministry of Social Affairs and Health budget. This survey is being used as basis for work.

As of 2004, the guidelines for drawing up government bills include a reference to assessment of gender impacts as a separate impact assessment area. In law drafting, the question of whether gender has any significance in the area being prepared should be considered from the very beginning. If this is the case, the gender perspective should be included among others in the drafting process. Taking the gender perspective into account may have a major impact on the final contents of a government bill. A good example of this is the reform of the Occupational Safety and Health Act; during the drafting process, the concept of occupational safety assumed a wider scope, complying better with today's world of work.

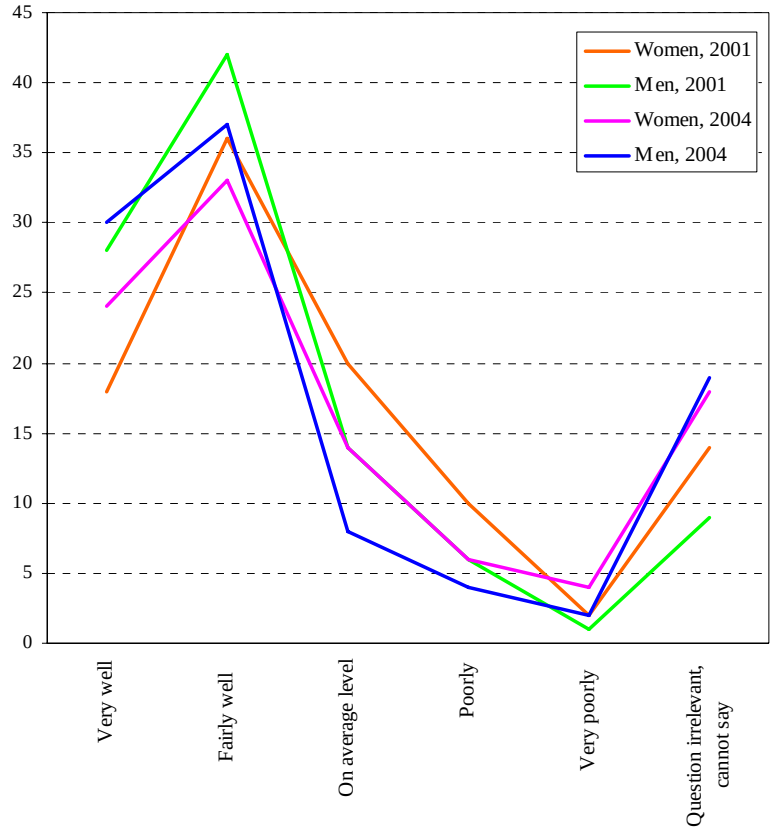
7.2 Women's status at work and temporary employment contracts

According to the results of the Gender Equality Barometer, gender equality was realised either fairly well or very well in the respondents' own workplace. Women's assessments did not vary significantly from those of men. However, compared to men, women did feel slightly more often that gender is a negative factor in terms of pay, appreciation of professional competence, career advancement and distribution of work burden.

Temporary employment contracts are more common in the public sector than in the private sector. The proportion of temporary employment contracts diminished somewhat among both women and men in 1997–2004. The proportion of temporary employment contracts decreased more rapidly among men, which led to a widening of the gap between men and women.

Besides women and the public sector, young people are particularly affected by temporary employment contracts. In 2004, half of all employees in temporary positions were under 30 years of age. Gender differences in the number of temporary employment contracts are greatest among young adults (25–34 years).

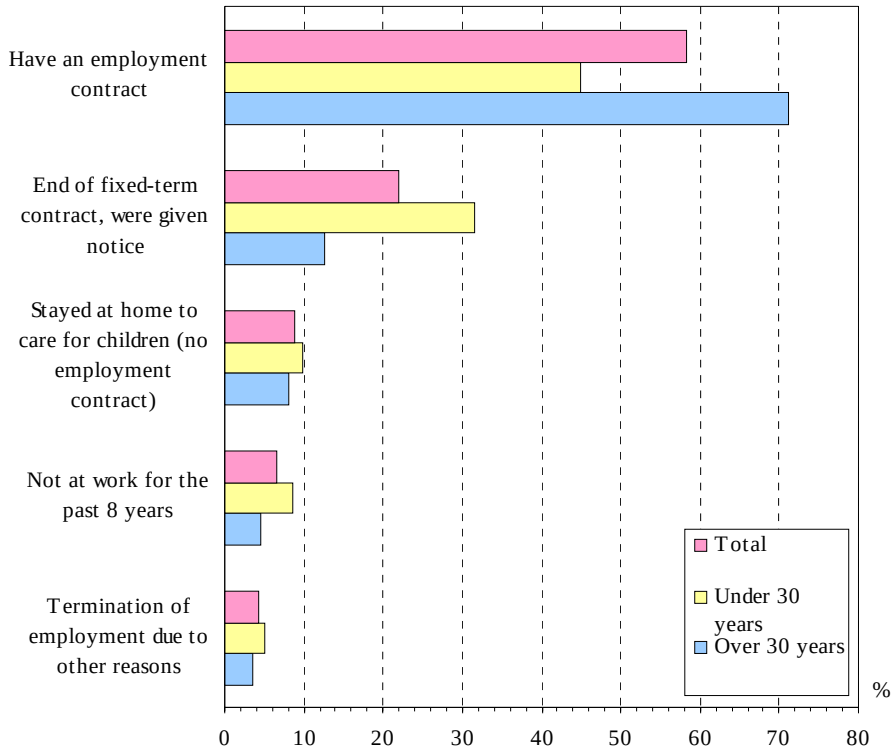
Figure 54. Is gender equality realised in the workplace?



Source: Gender Equality Barometer 2004.

In 2004, only some 60 percent of women on maternity or parenthood leave had an employment contract that was in force. Even fewer, i.e. less than half of those who were on child care leave, had a job to go back to after family leave. The employment contract of about one in five mothers on maternity, parenthood or child care leave had been terminated because it was temporary or because the employee had been given notice. Some aspects of the family leave system (e.g. entitlement to pay and accruement of leave during maternity leave, right to partial child care leave after returning to work) are best equipped to provide support to those with a continuing employment contract or who have a job to go back to.

Figure 55. Relation to work of women on maternity or parenthood leave according to age in 2004



Source: Statistics Finland, labour force statistics

In December 2005, the rapporteur appointed by the Ministry of Labour presented her report on the prevalence of fixed-term employment contracts, their distribution between women and men and the legality of the use of fixed-term employment contracts and the grounds used as the basis of the contracts.

It was observed in the report that the proportion of fixed-term employment contracts had stagnated, despite the fact that legislation concerning the use of fixed-term contracts had been tightened. The use of fixed-term employees was shown to pose the biggest problem in situations where the employer's operation is permanent, or when the employer has a need of permanent labour. Secondly, there is a gap in the legislation concerning hired labour, which increases the use of hired labour as a buffer against fluctuations in economic trends. The means of monitoring and legal safeguards have proved to be slow and inefficient, which has contributed towards the extensive use of fixed-term employees. The rapporteur proposes amending the Contracts of Employment Act and its motivations, as well as the adoption of new and efficient monitoring methods. The proposals concern both the private and the public sector. Launching of a triadic law-drafting project for regulation of the use of hired labour is proposed. In addition, co-operation procedures and negotiation rights related to the use of labour must be developed. The battery of proposals also includes recommendations concerning staff policy and local agreements, statements related to gender equality and recommendations for research and survey projects.

The Ministry of Finance has issued guidelines on fixed-term employment contracts to ministries, offices and public services. The grounds of the fixed-term employment contracts used are looked at, and action is taken to reduce the number of fixed-term contracts and to ensure that they are only used in cases in which they are well-motivated. The number of fixed-term employment contracts is monitored. The Commission for Local Authority Employers has also issued guidelines concerning the reduction of fixed-term employment contracts.

The government has improved the status of fixed-term employees in terms of determining the size of various allowances with a law amendment (Government Bill 164/2004) that came into effect in January 2005. Following the amendment, parenthood allowance is calculated on the basis of earnings used in determining the previous allowance in cases where the age difference between children is no more than three years and the recipient has had no earnings during this time. In addition, employees are entitled to earnings-related allowance after just one month of work in cases where they would have continued to work if it were not for the onset of disability or parenthood allowance period.

The differences in women's and men's wages are primarily based on structural labour market factors; the differences are minor in the case of similar type of work. The pay gap calculated based on average regular-hour earnings has long remained at about 80–82 percent. Since the beginning of the 1990s, the relative pay gap has narrowed in the private sector, while it has widened in the public sector.

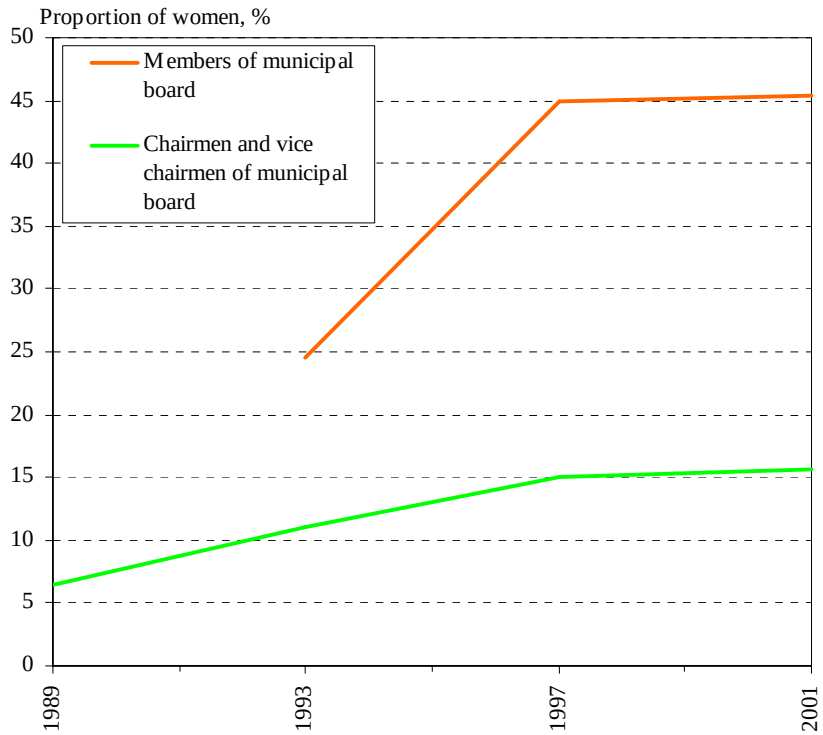
Narrowing the pay gap is one of the government's aims in promoting gender equality in the workplace. The reformed Equality Act is also used in an attempt to impact pay equality. Among others things, the Act requires that wage charting must be included as part of the gender equality plan in individual workplaces. One possible means of promoting equal pay between women and men is to adopt new, incentive wage systems.

7.3 The share of women in political and economic decision-making

Women and municipal decision-making

The Act on Equality between Women and Men was reformed in 1995 so that all municipal organs, with the exception of municipal councils, must have at least 40 percent of both women and men. The municipal board is one of the key forums of regional decision-making.

Figure 56. Proportion of women among municipal board members and chairmen



Source: Association of Finnish Local and Regional Authorities

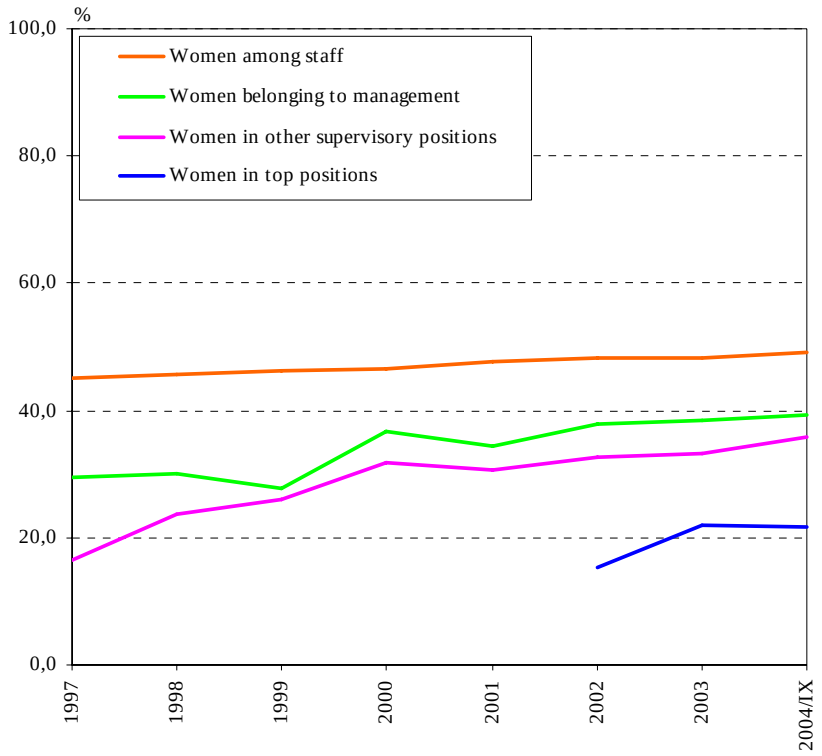
Today, the gender distribution in all municipal boards is in line with the quota regulation included in the Equality Act. In 1993, only 24.5 percent of municipal board members were women. The proportion of women as chairmen and vice chairmen of municipal boards has also grown clearly during the period under study.

The share of women among elected members of municipal councils also showed a slight but steady growth in the 1990s. When looking at individual municipalities, the share of women varies between five and sixty percent, and between 27 and 42 percent in different regions. In 2001, 23 percent of municipal councils were chaired by women. On national level, women's representation does not reflect gender distribution among the inhabitants in municipalities. During the current government period, the government is encouraging political groups and organs to increase the proportion of women candidates.

Women in top positions in central government administration

The gender distribution in the topmost central government administration has been followed since 2002, and that in upper and mid-level administration since 1997. The proportion of women among the highest positions, which depending on the time of study comprise nearly 200 persons, rose considerably in a year's time. The proportion of women has also increased in upper and mid-level central government administration, but it is still nowhere near the proportion of women among central government employees. It is estimated that by 2011, only 20 percent of the current directors are still at work. This may make it easier to increase the number of women in top positions.

Figure 57. Proportion of women among central government administration directors and staff in 1997–9/2004



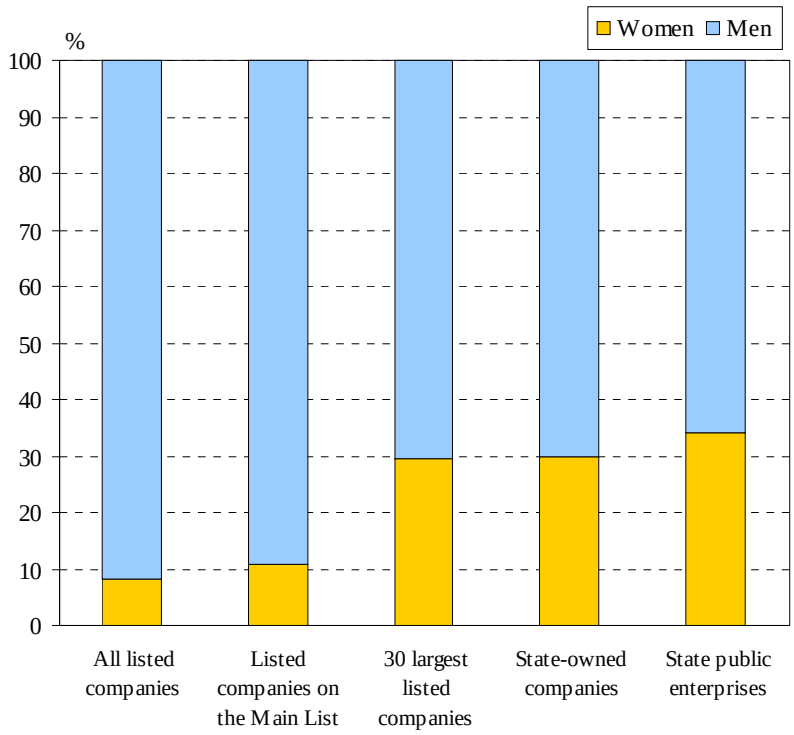
Top positions include State Secretaries, Permanent Secretaries, Under-Secretaries of State, Director-Generals and corresponding posts, as well as topmost management of government departments, i.e. departmental heads. Management includes upper- and mid-level managers of offices and departments, as well as directors of performance units and corresponding units. The category "other supervisory positions" includes positions where managerial and supervisory tasks take up over 50 percent of working time.
Source: Ministry of Finance.

In March 2004, a Ministry of Finance working group presented its memorandum on the placement of women in top positions in central government administration. Using recommendations and examples, the Ministry informs the administration of actions aimed at increasing the number of women applying for open positions.

Women and economic decision-making

The proportion of women as board members is highest in state public enterprises, somewhat lower in state-owned companies and clearly lower in listed companies. However, the proportion of women is clearly higher on the boards of large listed companies compared to small ones. The proportion of women on the boards of the thirty largest listed companies is nearly the same as in state-owned companies.

Figure 58. Gender distribution of the boards of state public enterprises, state-owned companies and listed companies. Situation in July 2004



Source: Corporate websites. The item “all listed companies” from Kauppalehti.

The gender distribution of board chairmen and vice-chairmen is more uneven. Only one company has a woman as chairman of the board. All vice chairmen of state public enterprises are men; 16 percent of the vice-chairmen at state-owned companies are women. Only three percent of the vice-chairmen of listed companies are women.

The government is committed to increasing the proportion of women on the boards of companies where the state holds shares. This aim is included in the government’s equality action plan. The action plan to increase the number of women on the boards of state-owned companies as well as firms in which the state holds shares was extended in 2005. Searching for suitable women candidates has been the responsibility of the ministry to which ownership steering of the company in question belongs. How well this objective has been reached could be assessed after shareholders’ meetings held in spring 2005.

1. The objective was reached on the boards of companies owned entirely by the state, where the proportion of women among members appointed by the state is 40 percent. However, the proportion varies between 20 and 50 percent when looking at different ministries.
2. The objective has also been attained in companies where the state owns the majority of shares, and which are not listed. The proportion of women members appointed by the state is 42 percent. However, when looking at different ministries, the proportion varies between 29 and 55 percent in these companies as well.

3. In companies where the state is minority shareholder and which are not listed, the proportion of women members appointed by the state is 35 percent (i.e. the goal is reached when one male member of the board is replaced by a woman). The proportions vary between ministries in this case as well, ranging from 25 to 100 percent.
4. In listed companies where the state is majority shareholder or wields actual power, the proportion of women among state-appointed members was 39 percent, meaning that the goal of coming close to 40 percent was reached (when looking at different ministries, the proportion varies between 33 and 39 percent).
5. In listed companies where the state does not wield actual power, the proportion of women among state-appointed members is 48 percent, meaning that the goal according to which the state aims at nominating its own candidates to the boards in a manner that implements the principles of gender equality was reached (when looking at different ministries, the proportion varies between 33 and 35 percent).

The government also pledged that it would encourage parliament groups to nominate both a female and a male candidate when appointing candidates for members of Boards of Directors. In spring 2005, the proportion of women among members of Boards of Directors was 29 percent. The proportion of women has been calculated from total numbers, because data on what proportion of members has been appointed based on proposal from the state are not available in all cases. However, it can be said that as a rule, fewer women have been appointed to Boards of Directors than to company boards, a programme concerning which has already been implemented for three years.

7.4 Assessment of the relation of men and gender equality policy

Looking at men and equality is a relatively recent theme in gender equality policy. So far, men and equality has been focused on as a separate issue within gender equality policy. The aim is to include the male perspective into all gender equality policy.

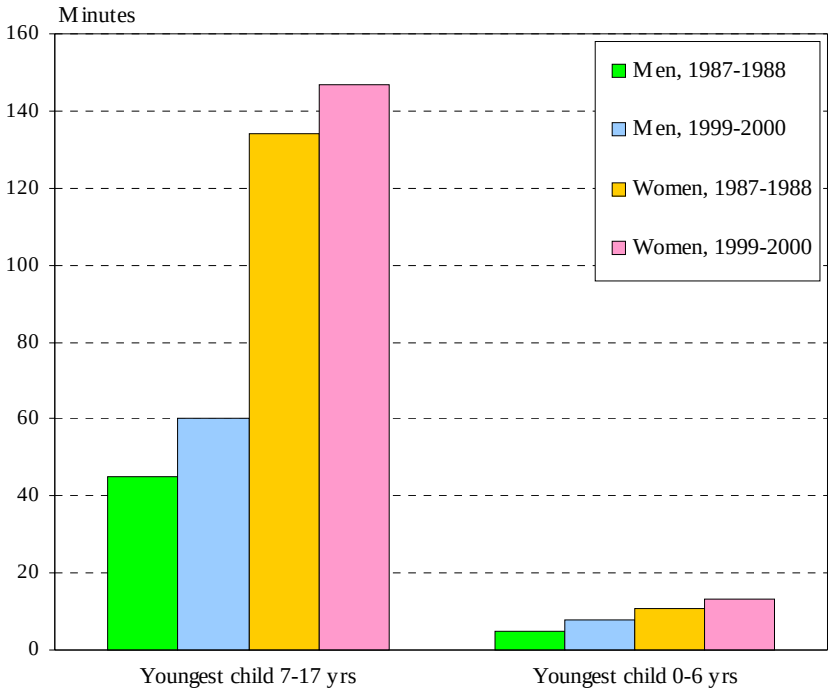
In gender equality policy, the male perspective has traditionally been linked to parenthood and reconciling work and family. The use of family leaves by fathers is a typical parameter related to men and gender equality. The use of family leave has been observed to be associated with active fatherhood. Participation in child rearing and household work is seen as improving fathers' quality of life by bringing them closer to their families. At the same time, it also improves the quality of life of their partners by making it easier to reconcile work and family life.

Participation in household work by men

Equal division of household work between the genders strengthens the position of men in families and improves women's equal opportunities for workforce participation. The time used by fathers to care for children increased in the 1990s. However, women still bear the main responsibility for caring for young children in particular (Figure 60).

Figure 59. Average time per day used on child care according to gender and the age of the youngest child in 1987–1988 and 1999–2000

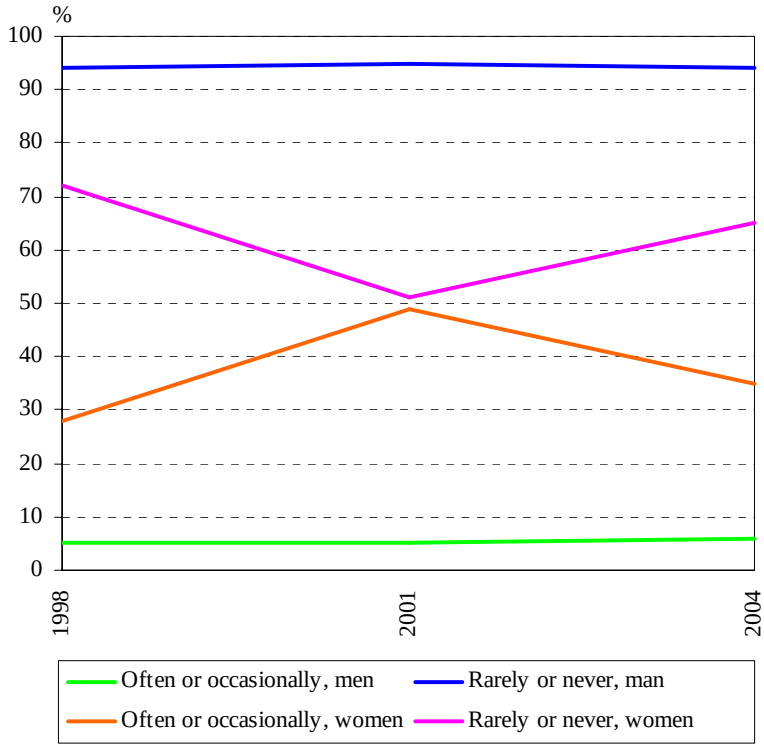
Two-parent families with children



Source: Statistics Finland, Niemi & Pääkkönen 2001.

Housework as a whole is also unevenly distributed between men and women. The division of housework is particularly uneven in families with children under school age. In these families, women used twice as much time on household chores compared to men (1999–2000). However, the time devoted by men to household work increased significantly in the 1990s. In families with children under school age, the time used by men on household chores increased by over one fifth. During the same period, the time devoted to household work by women remained nearly unchanged.

Figure 60. Experiences of excessive responsibility for housework among parents with children



Source: Gender Equality Barometer 2004

Uneven division of housework is also reflected in the experiences concerning the division of housework of parents in families with children. According to the Gender Equality Barometer, only a small minority of fathers feel that they bear too much responsibility for housework, whereas nearly one in five mothers felt this to be frequently the case. Half of all mothers in families with children felt at least occasionally that their responsibility for housework was too big. The division of housework may also reflect different values between genders; single women also devote more time to housework than single men.

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Appended figures

Chapter 1 Social protection and a changing operating environment

Figure 1. Women's employment rates by education level and age in 2003, %

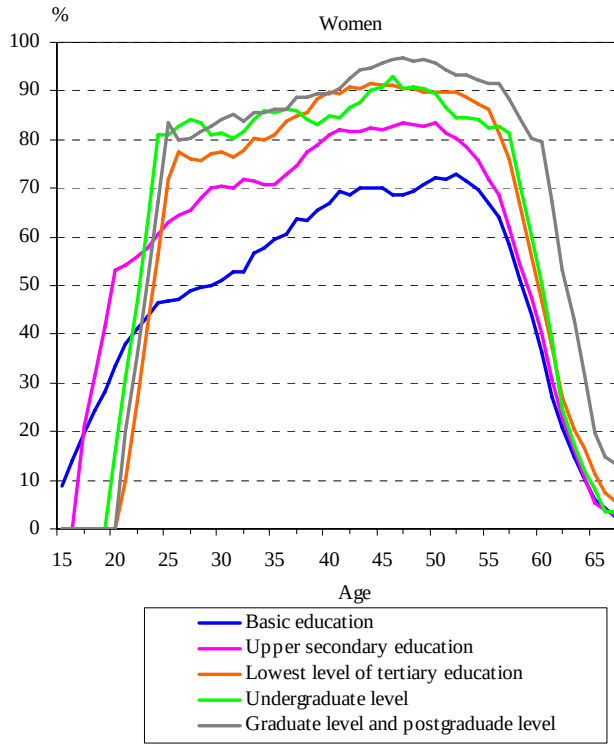
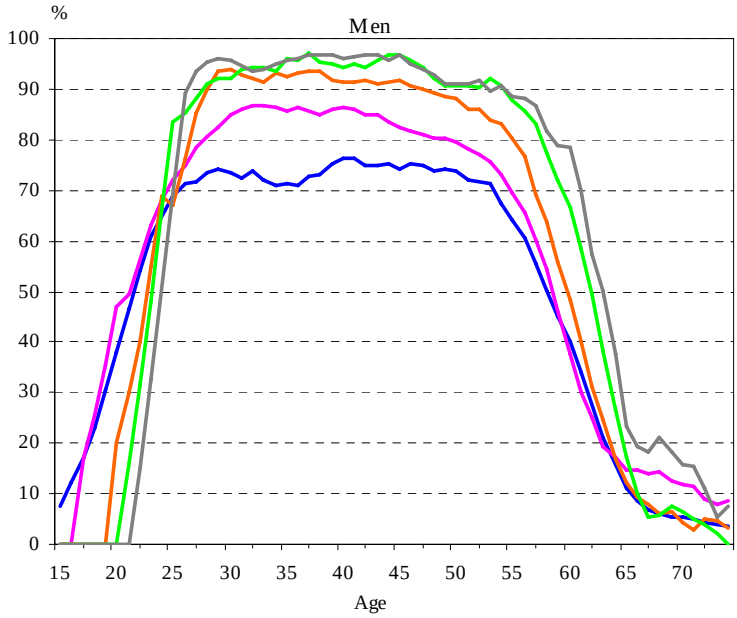
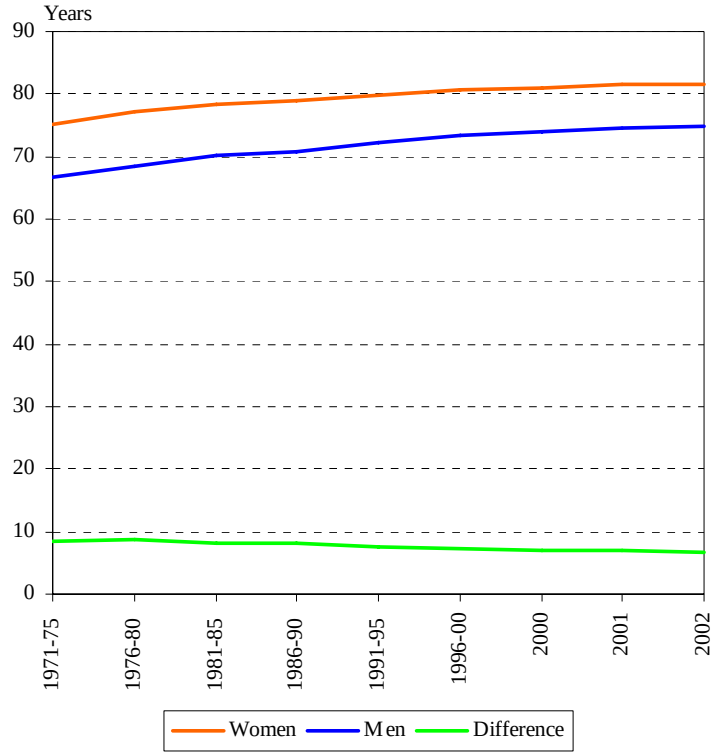


Figure 2. Men's employment rates by education level and age in 2003, %



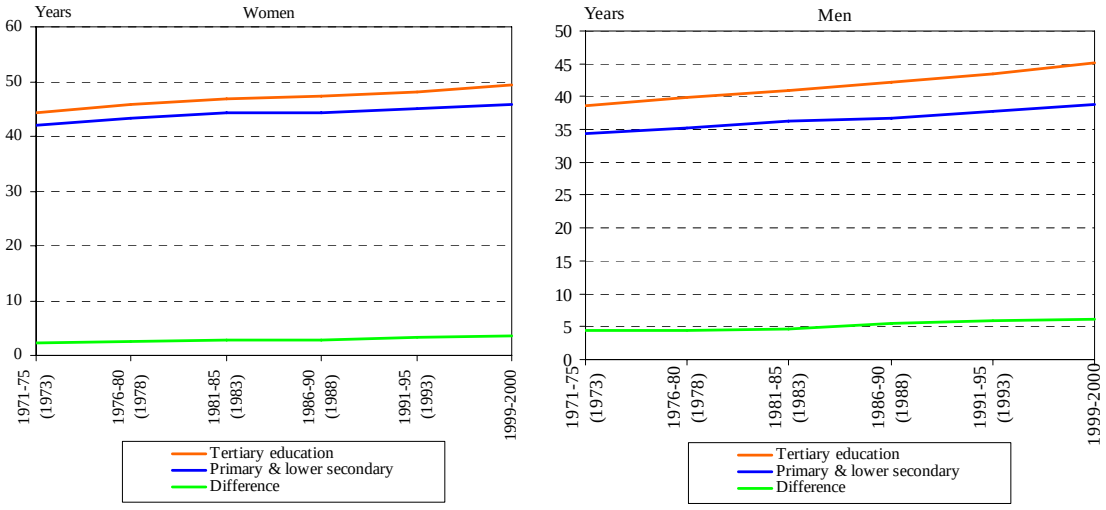
Chapter 2 Promoting health and functional capacity

Figure 3. Life expectancy in 1971–2003



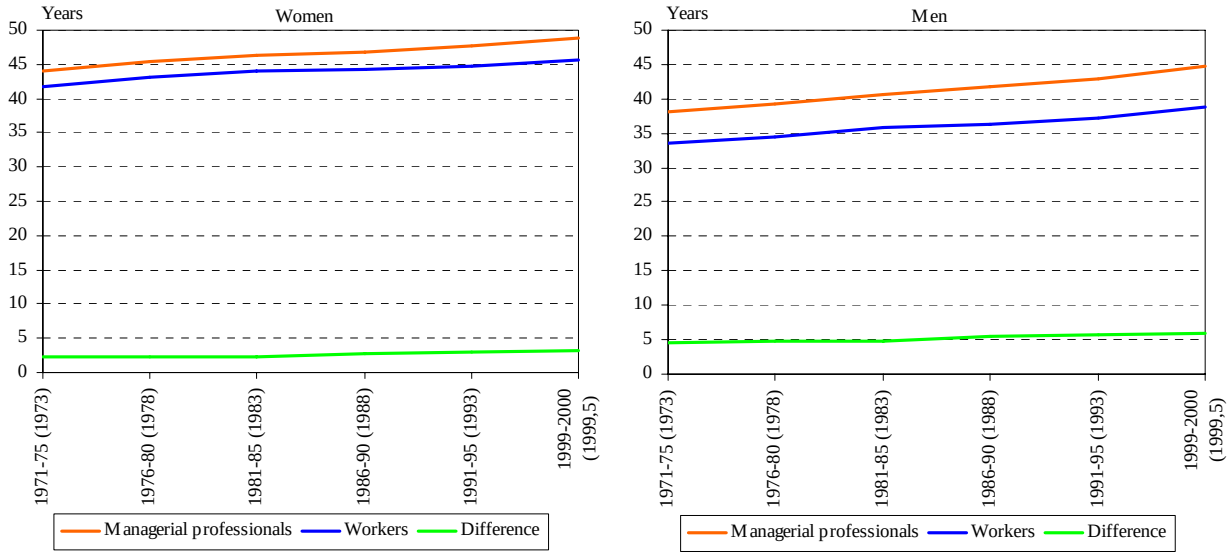
Source: Statistics Finland

Figure 4. Life expectancy of a 35-year-old according to level of education in 1971–2000



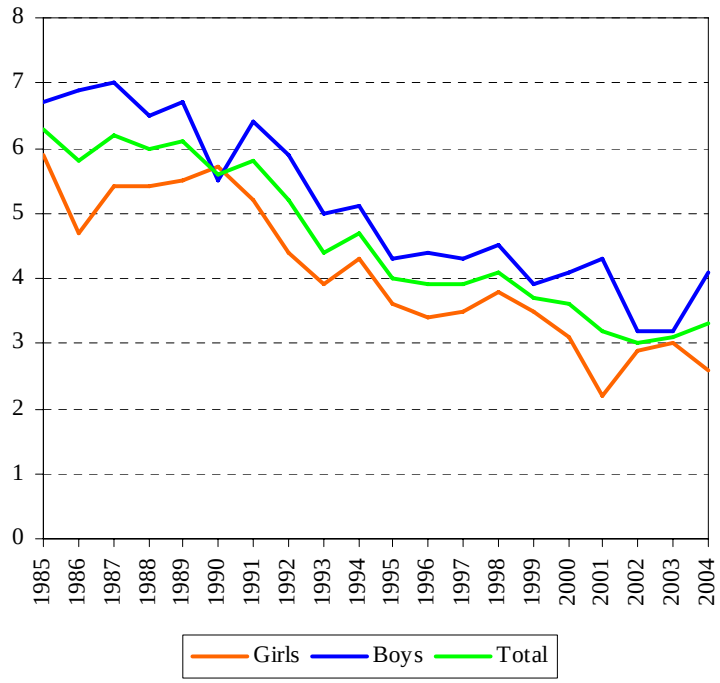
Source: National Public Health Institute and Statistics Finland

Figure 5. Life expectancy of a 35-year-old according to social group, 1971–2000



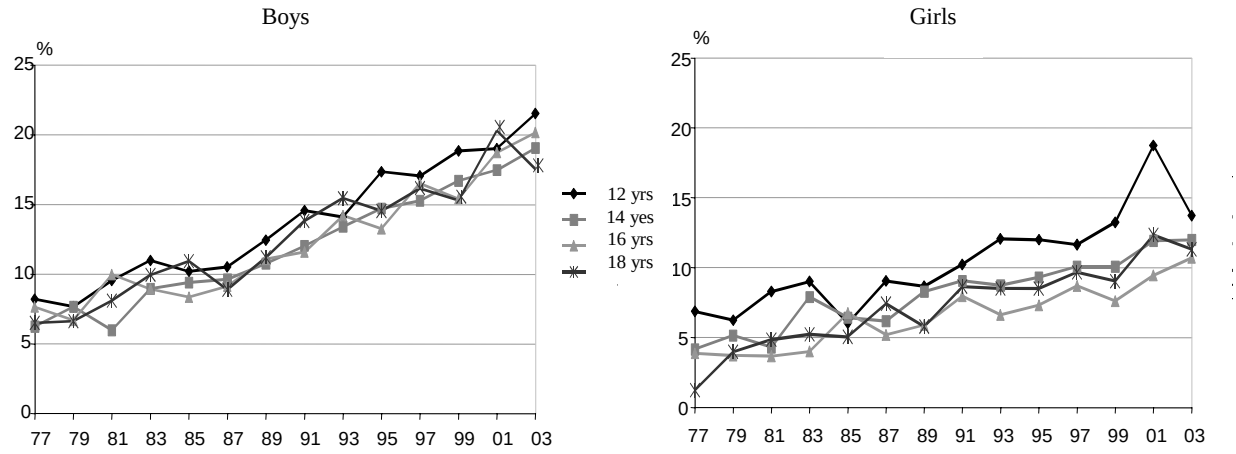
Source: National Public Health Institute and Statistics Finland

Figure 6. Infant mortality in 1990–2004



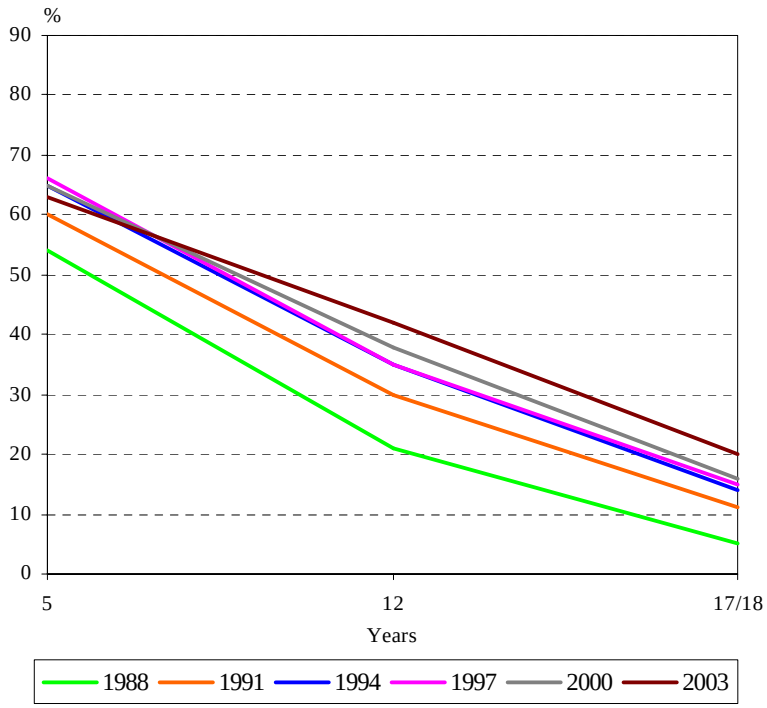
Source: Statistics Finland

Figure 7. The proportion of overweight persons among young people in 1977–2003



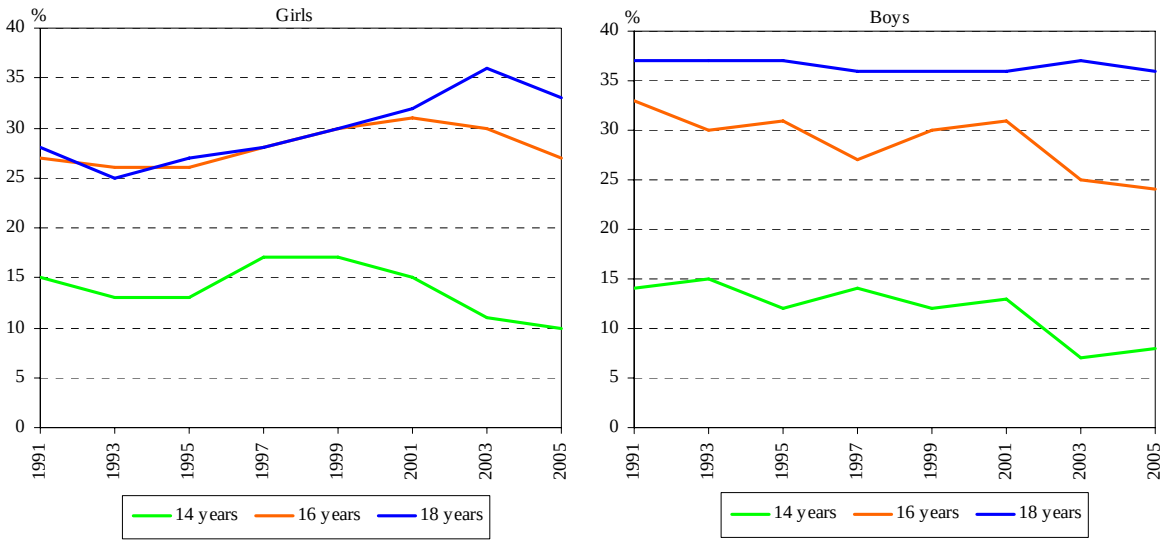
Source: Adolescent health and lifestyle survey (Kautiainen et al. 2002, 2004)

Figure 8. Proportion of children aged 5, 12 and 17/18 years with healthy teeth in 1988, 1991, 1994, 1997 and 2003



Source: Stakes

Figure 9. Proportion of daily smokers among adolescents in 1991–2005

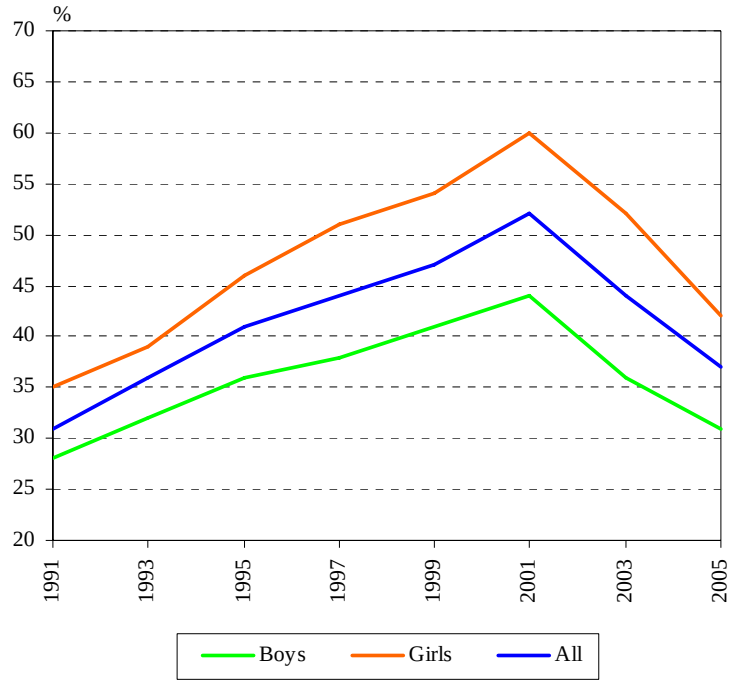


Source: Adolescent health and lifestyle survey

Figure 10. Proportion of adolescents getting seriously drunk at least one a month in 1991–2005

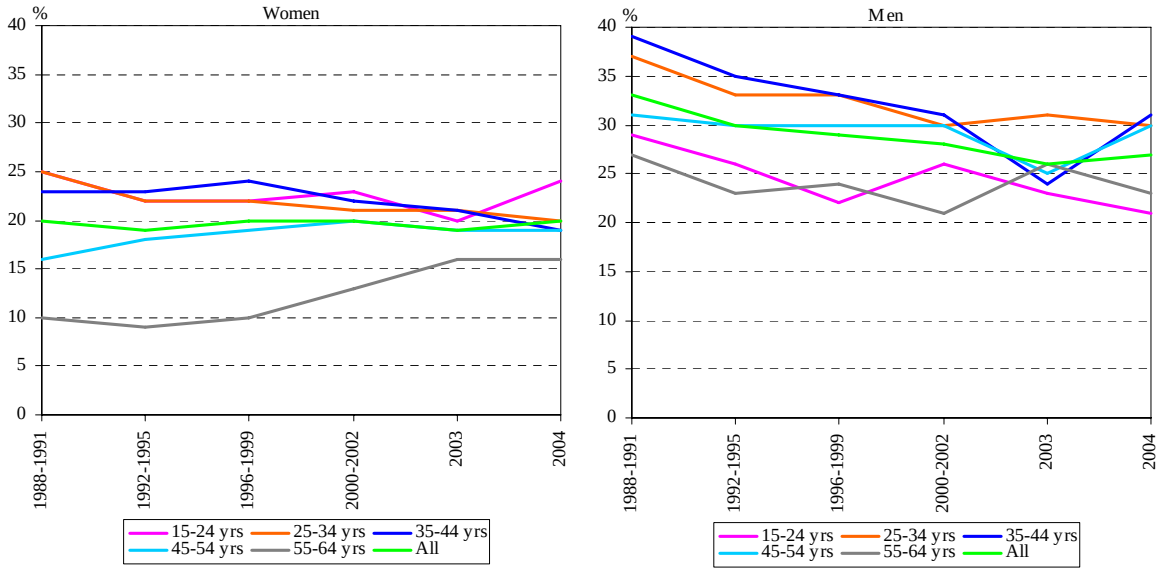
Source: Adolescent health and lifestyle survey

Figure 11. Proportion of 14- to 18-year-olds who know at least one person who has tried drugs during the past year (%) in 1991–2005



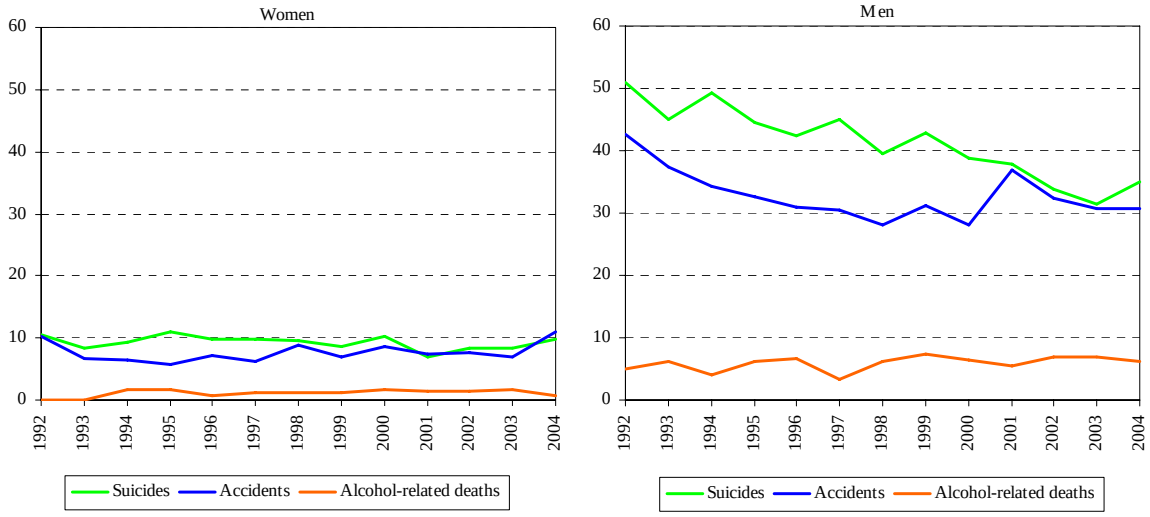
Source: Adolescent health and lifestyle survey

Figure 12. Proportion of daily smokers among adults in 1988–2004



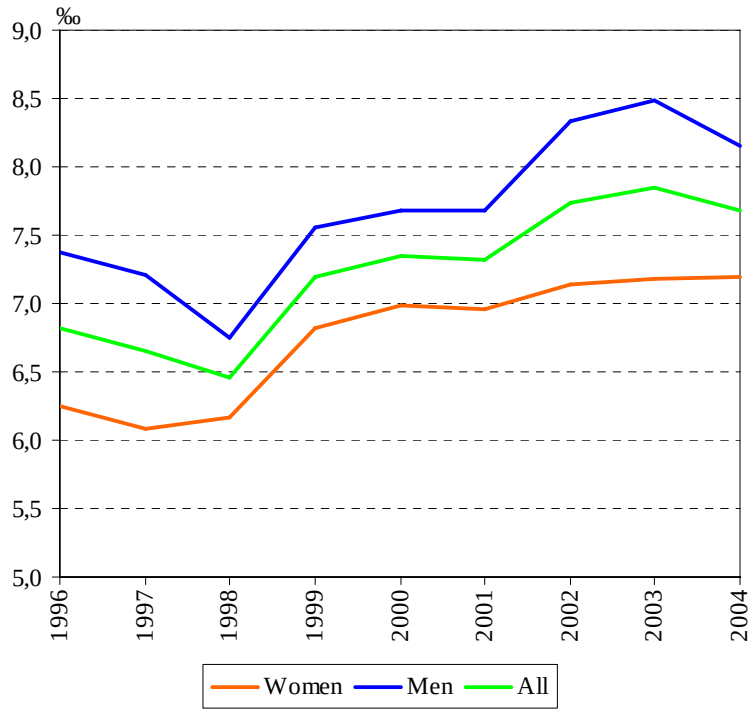
Source: National Public Health Institute

Figure 13. Age-standardised suicide, accident and alcohol mortality among men and women aged 15–34 in 1992–2004, per thousand



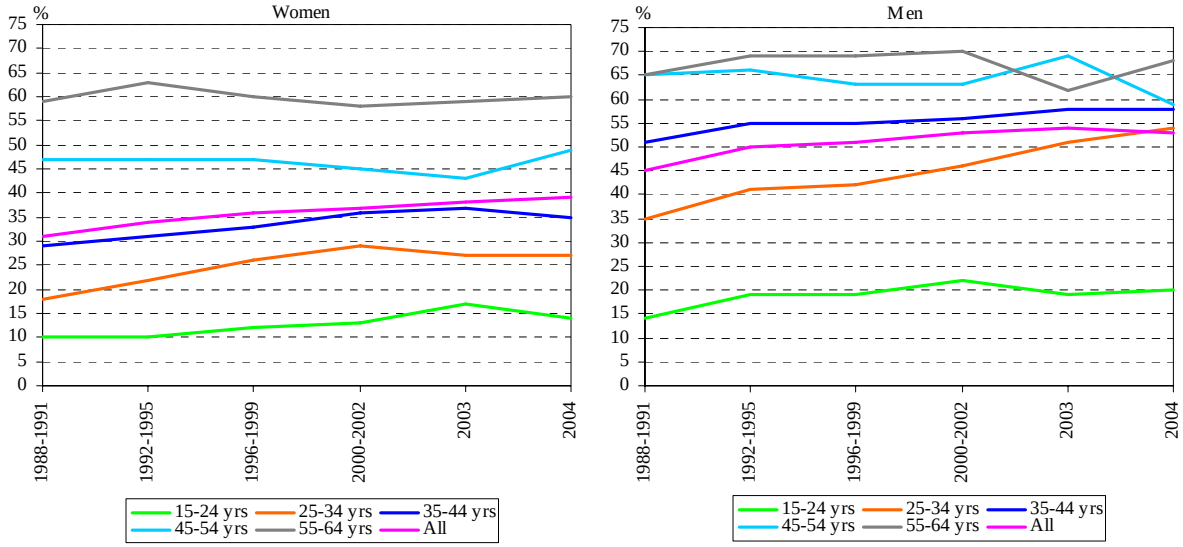
Source: Statistics Finland

Figure 14. New age-standardised disability pensions granted to persons aged 35–54 in 1996–2004, per thousand



Source: Finnish Centre for Pensions

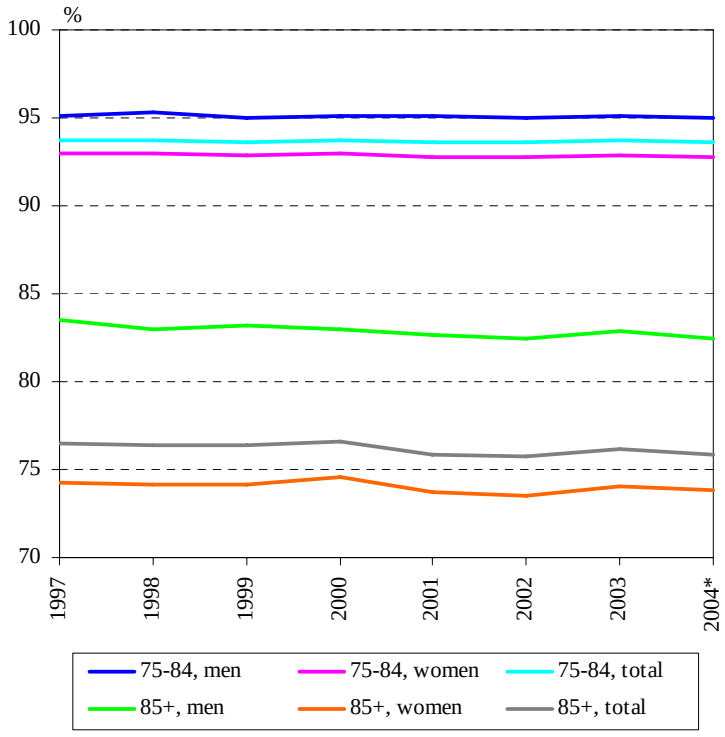
Figure 15. The proportion of overweight[1)] persons among adults in 1988–2004



[1)] Body mass index 25 or more

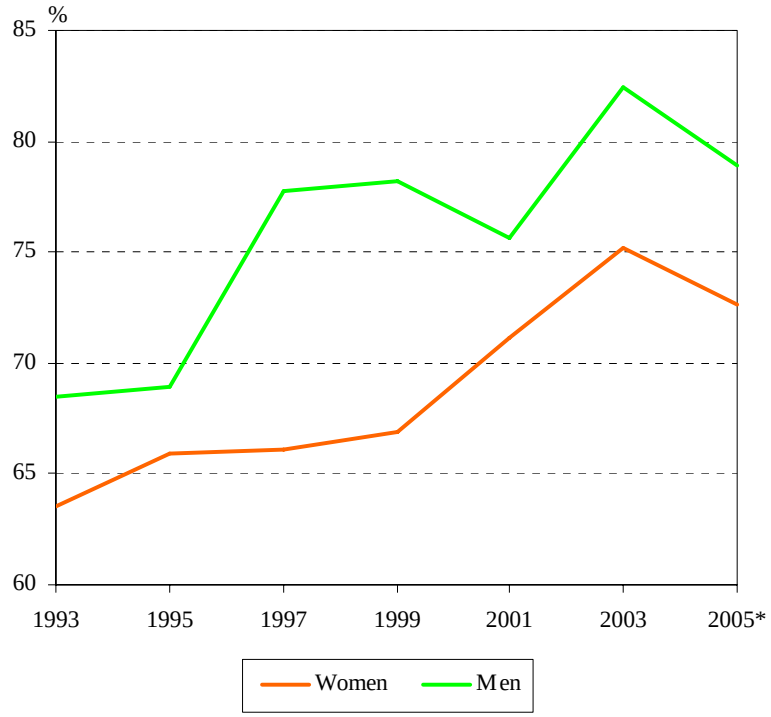
Source: National Public Health Institute

Figure 16. Proportion of persons aged 75–84 and those over 85 living at home in 1997–2004, %



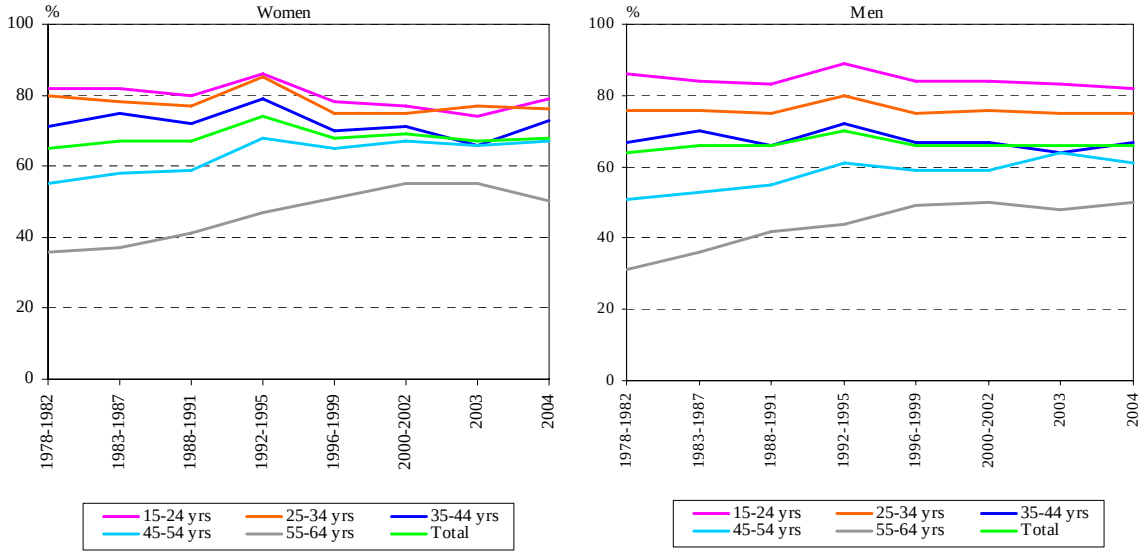
*preliminary data
Source: Stakes

Figure 17. Proportion of persons aged 75–84 able to move outside unaided in 1993–2005



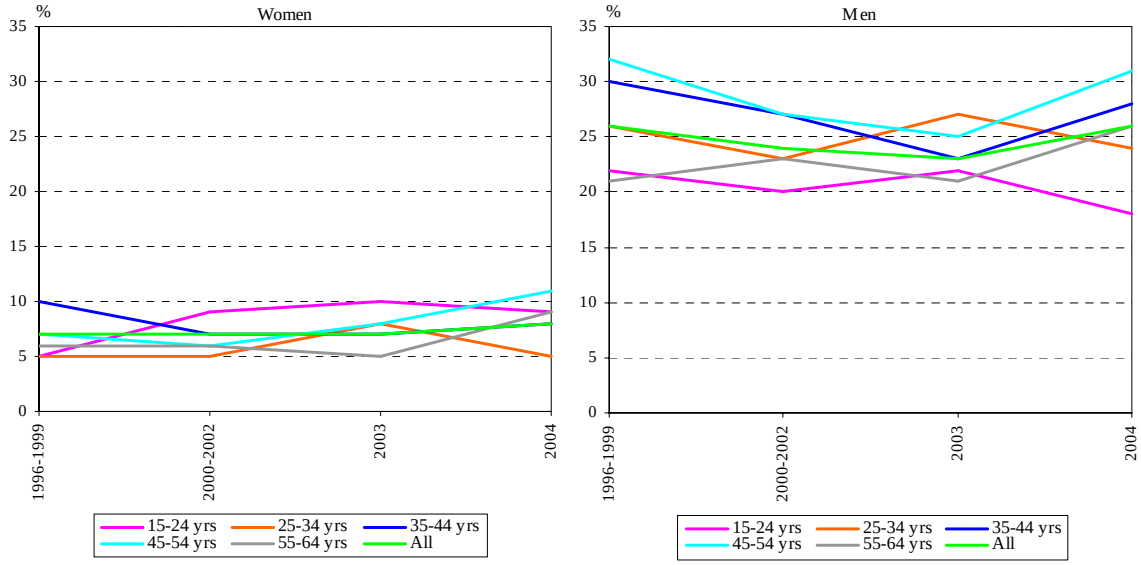
Source: National Public Health Institute

Figure 18. Proportion of those who feel their state of health to be good or fairly good by age groups in 1978–2004



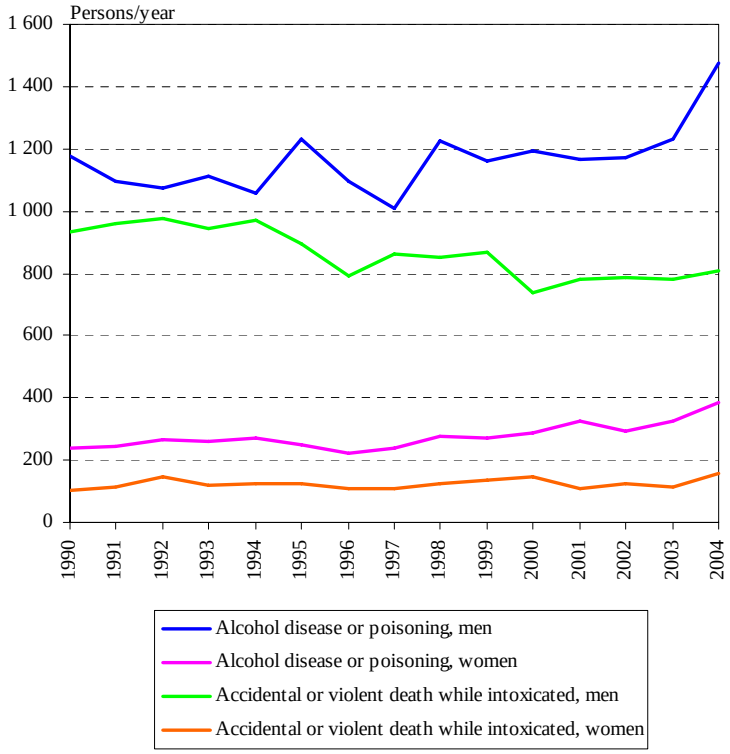
Source: National Public Health Institute

Figure 19. Proportion of those who drink six or more servings of alcohol at a time at least once a week, 1996–2004



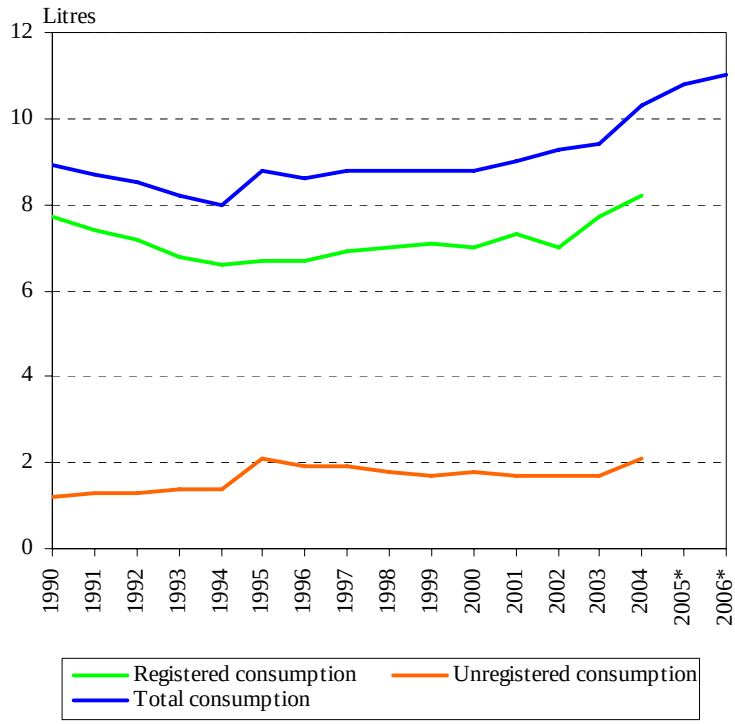
Source: National Public Health Institute

Figure 20. Deaths caused by alcohol in 1990–2004



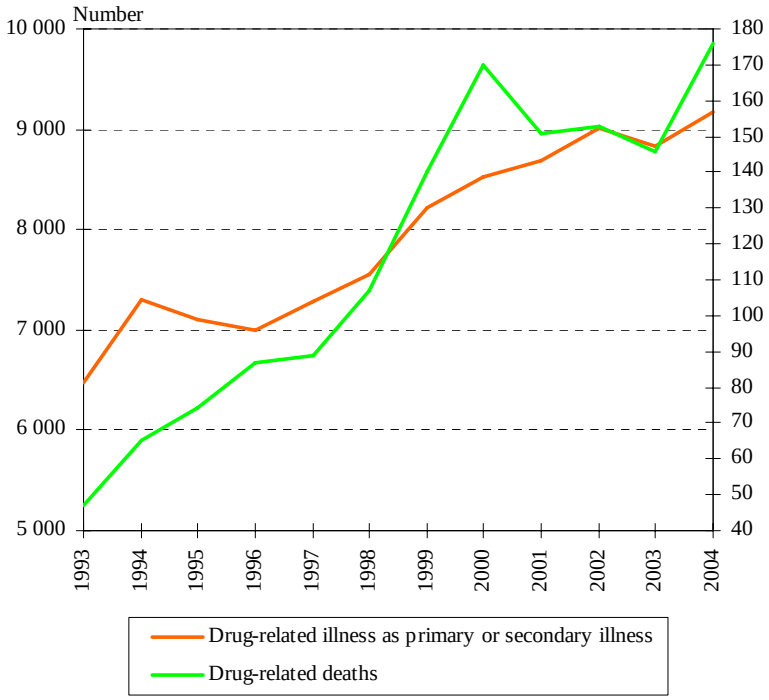
Source: Statistics Finland

Figure 21. Total consumption of alcohol per capita as 100 percent alcohol in 1990–2006



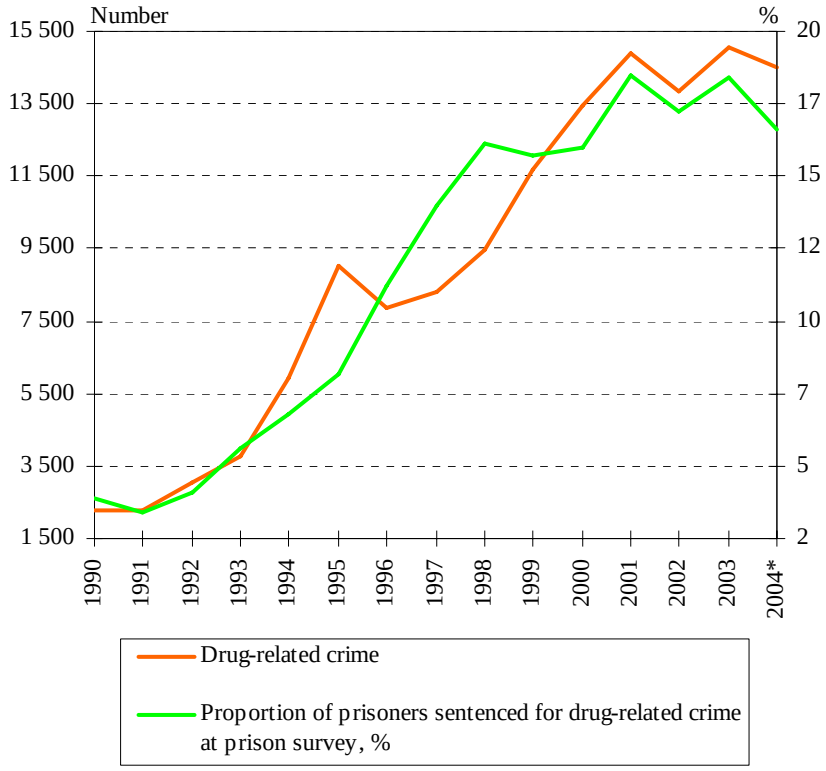
*estimate
Source: Stakes

Figure 22. Periods of care at hospital due to drug-related illness and drug-related deaths in 1993–2004



Source: Stakes and Statistics Finland

Figure 23. Drug-related crime and proportion of those sentenced for drug-related offences among all prisoners in 1990–2004



Chapter 3 Making work more attractive

Figure 24. Trends in the number of people receiving rehabilitation in 1990–2004

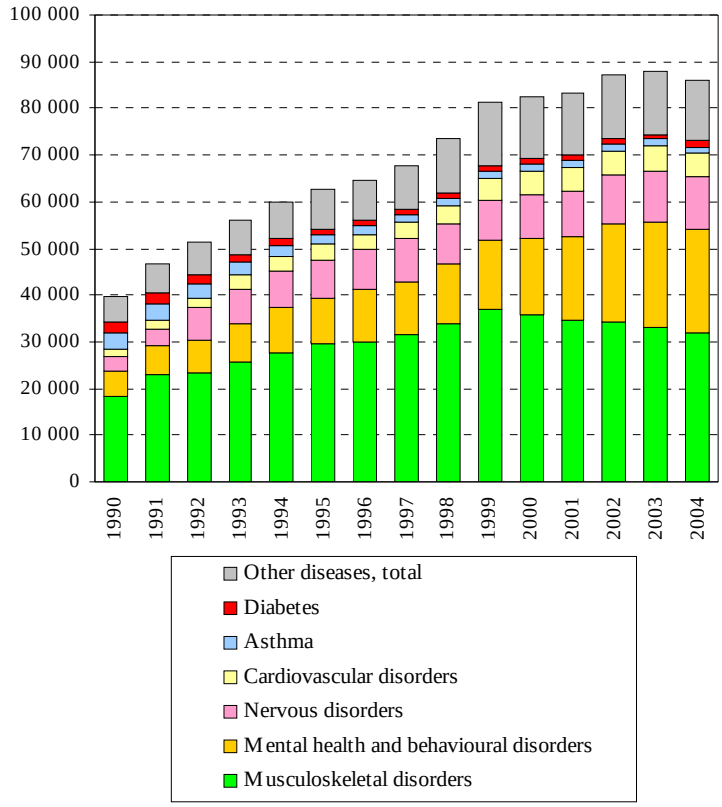


Figure 25. Trends in occupational diseases, accidents occurring in the workplace and on the way to/from work in 1993–2004

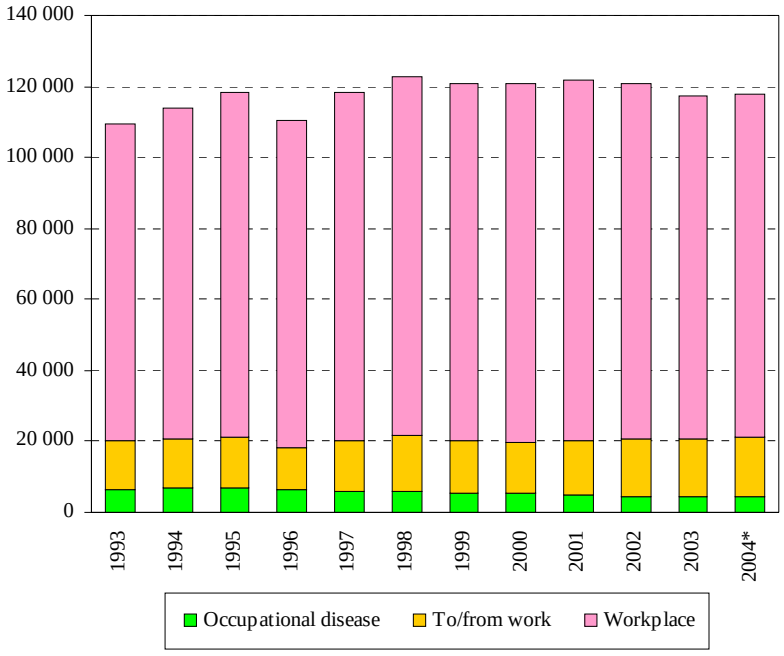


Figure 26. Disruptive effects of work-related stress in 1977–2003

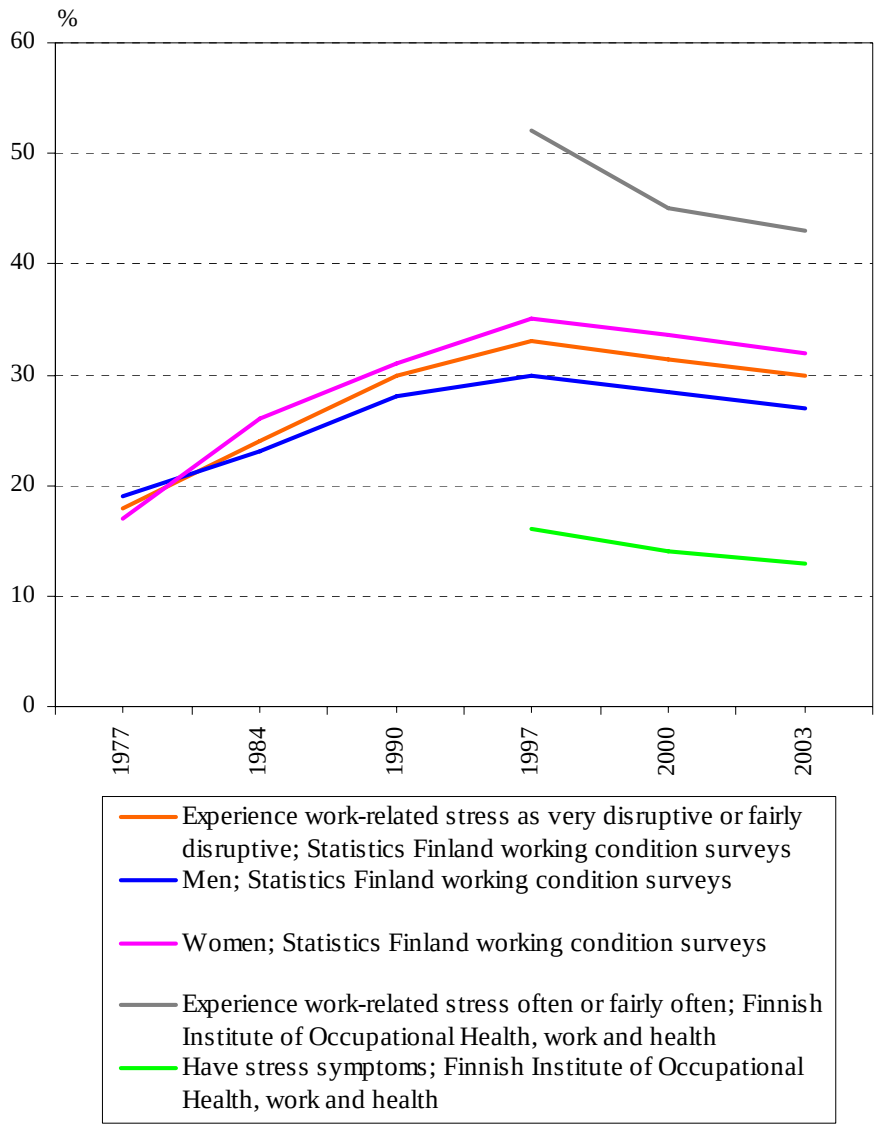


Figure 27. Working overtime with no pay in 1984–2003

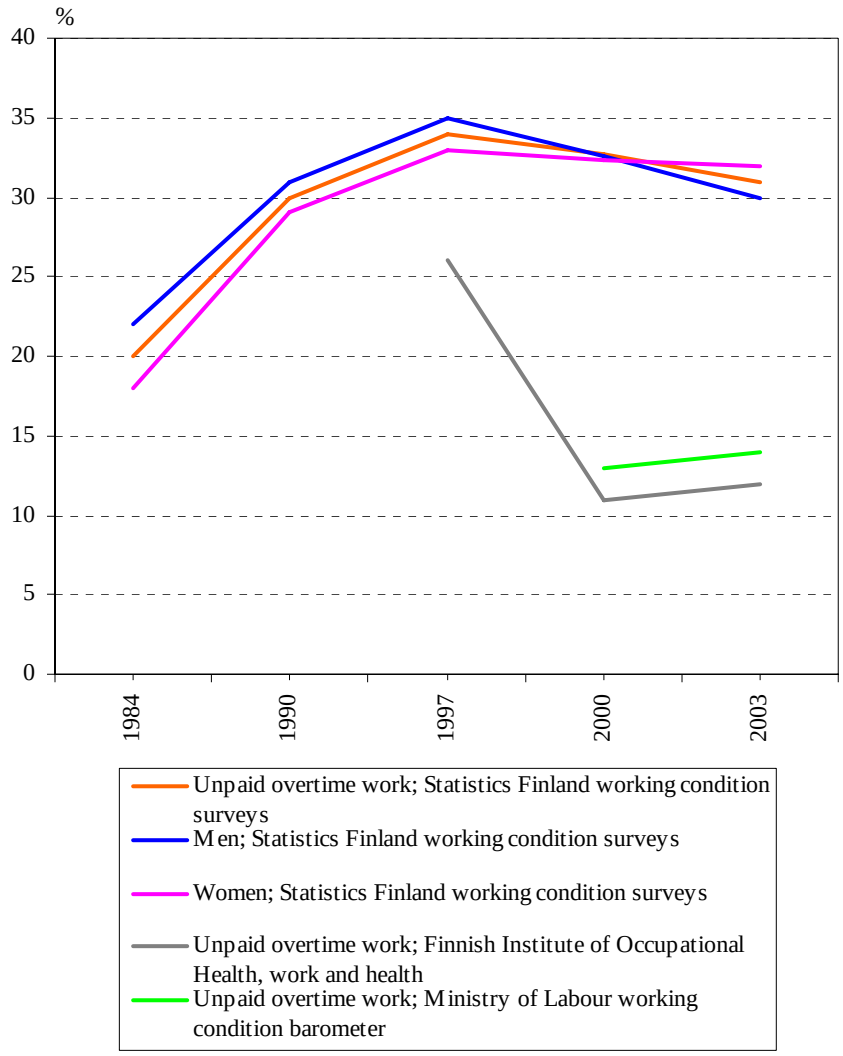


Figure 28. Development possibilities at work in 1977–2003

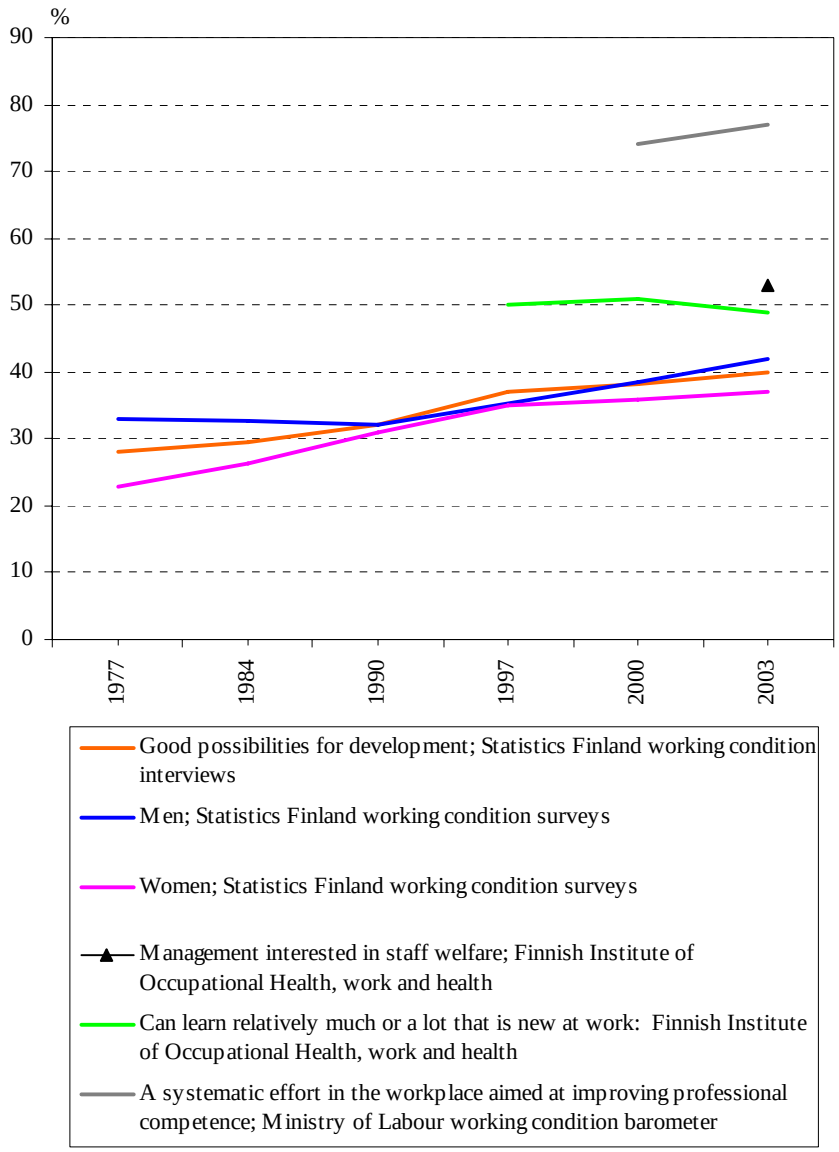
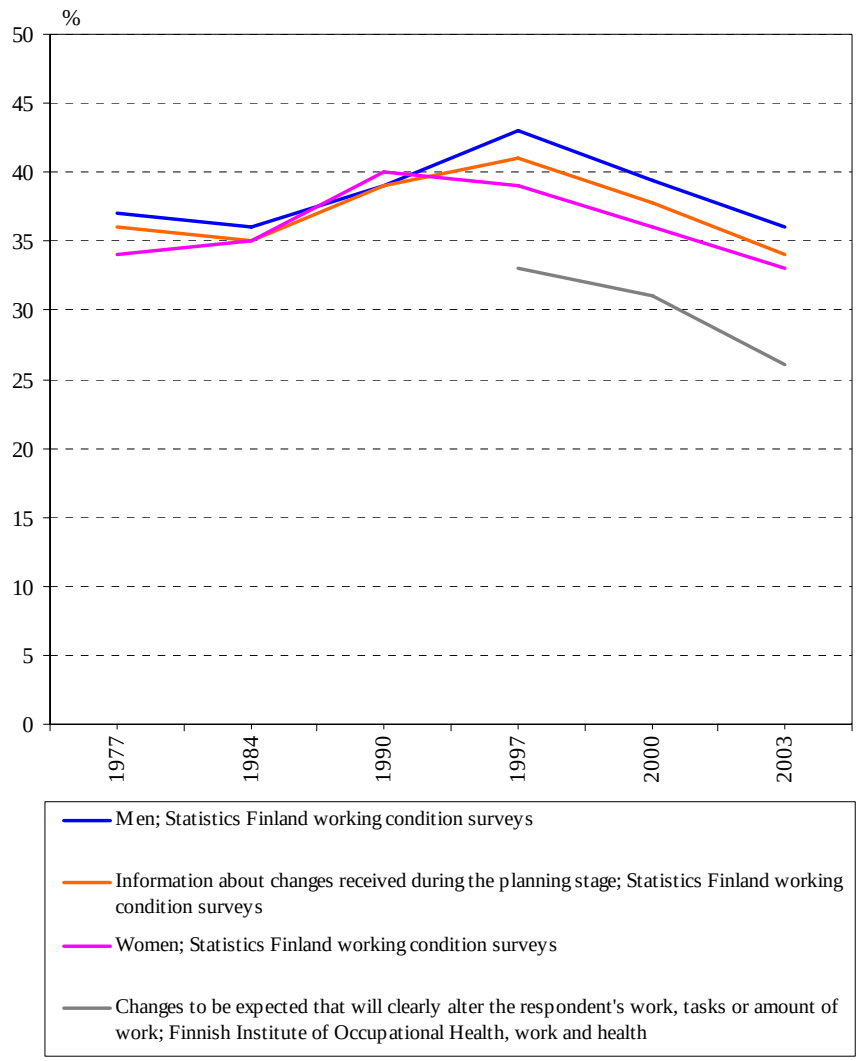


Figure 29. Receiving information about work-related changes in 1977–2003



Chapter 4 Preventing and combating social exclusion

Figure 30. Extended poverty in 1998–2003 (proportion of those below the 60-percent poverty line for several consecutive years)

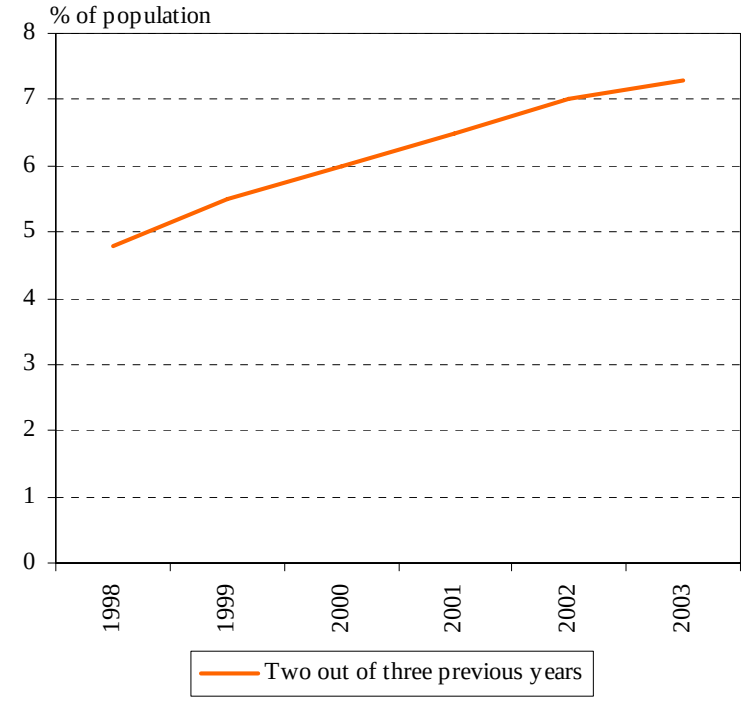


Figure 31. Proportion of households receiving social assistance for 10–12 months per year among all households receiving assistance in 1990–2003, %

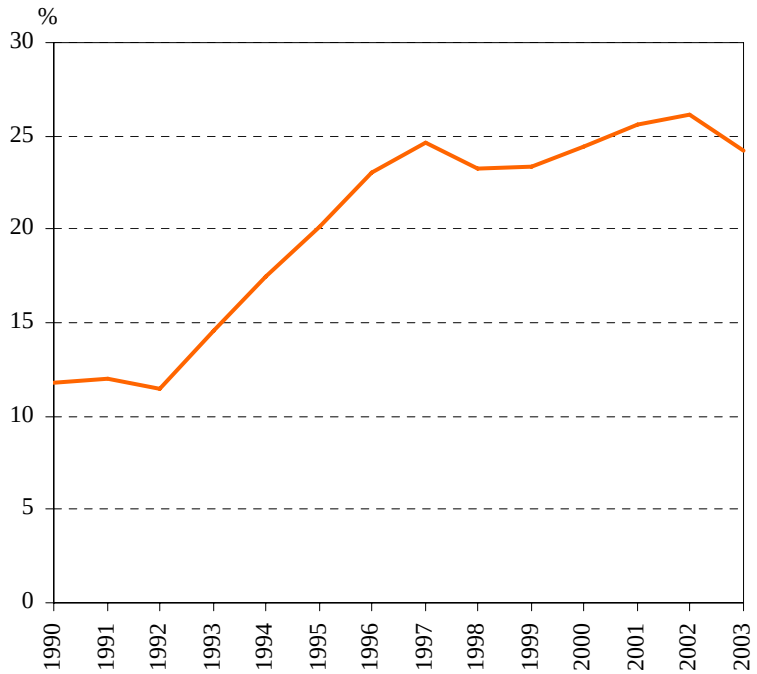


Figure 32. Long-term unemployment rate in 1993–2004

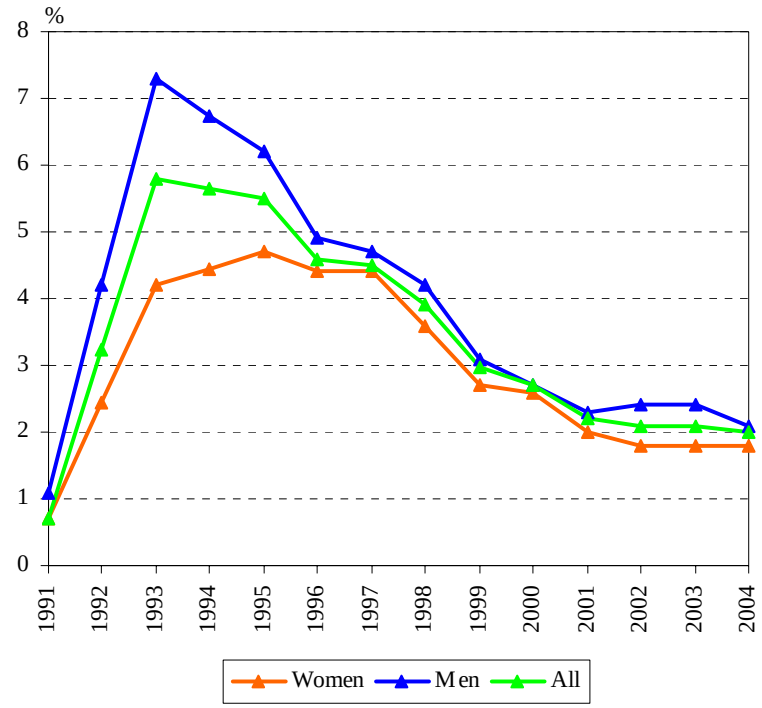


Figure 33. Trends in the number of homeless in 1990–2004

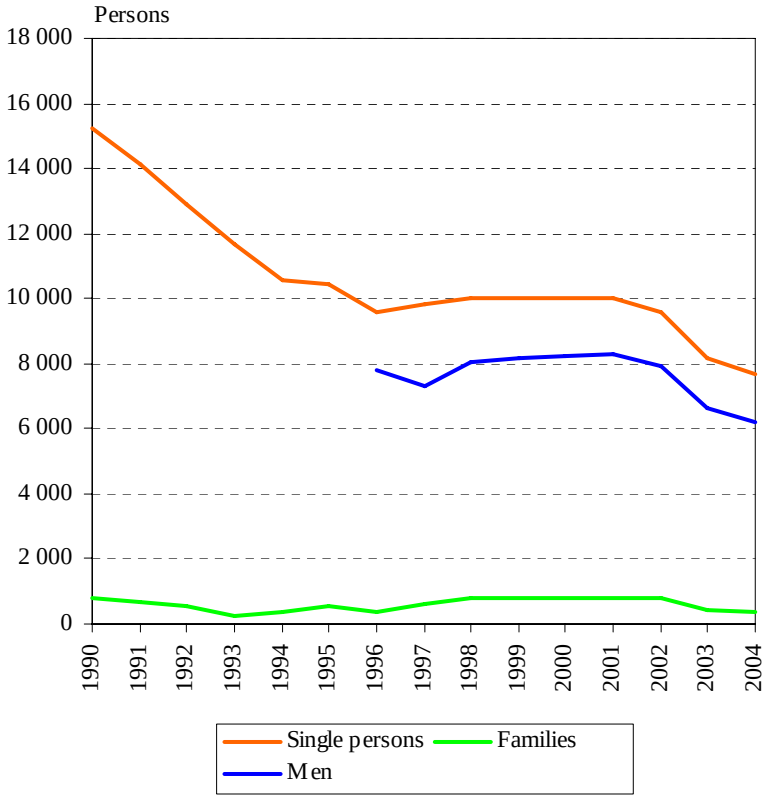


Figure 34. Number of children and young people placed in care outside the home in 1991–2004

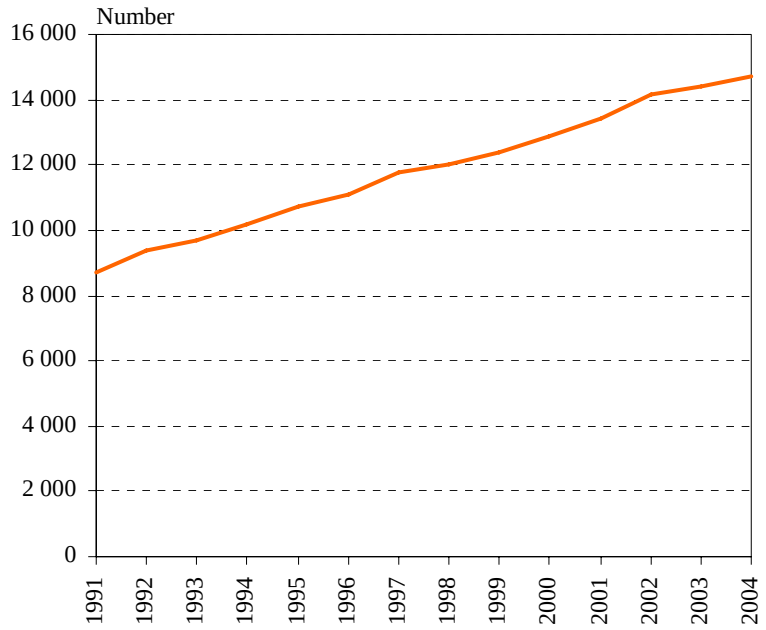


Figure 35. Young people with low education* as a proportion of age group 18–24 in 1995–2004, %

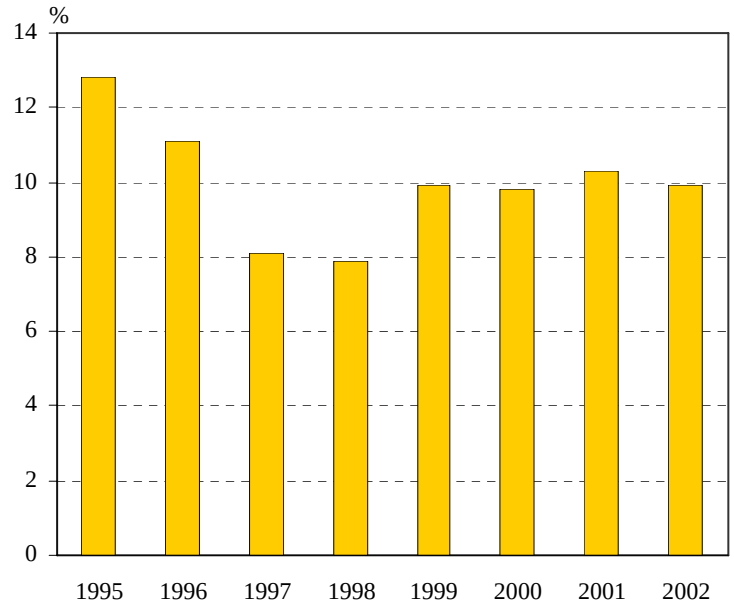


Figure 36. Average number of prisoners per year 1990–2004

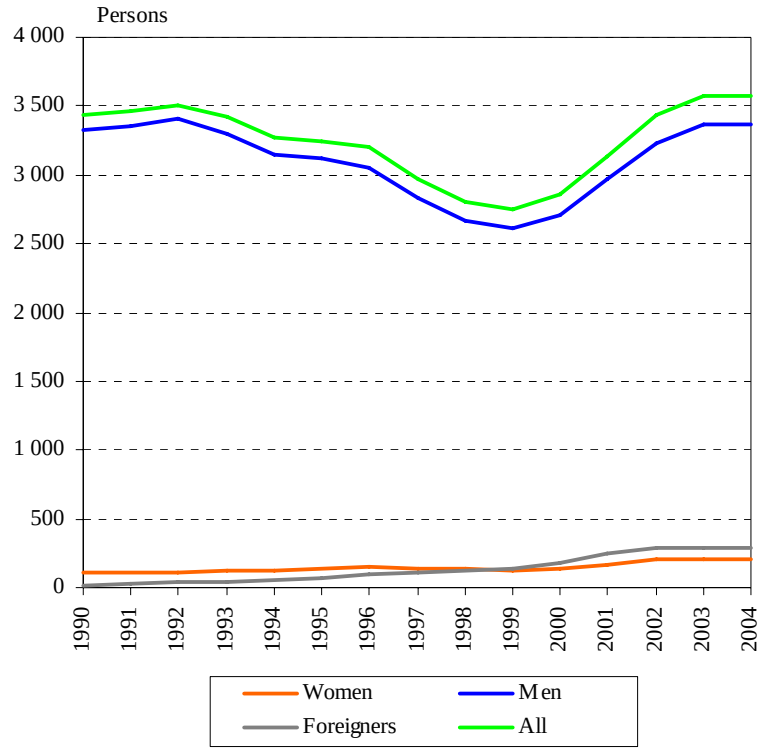


Figure 37. Persons treated in hospitals for alcohol and drug diseases and persons in outpatient treatment in 1990–2004

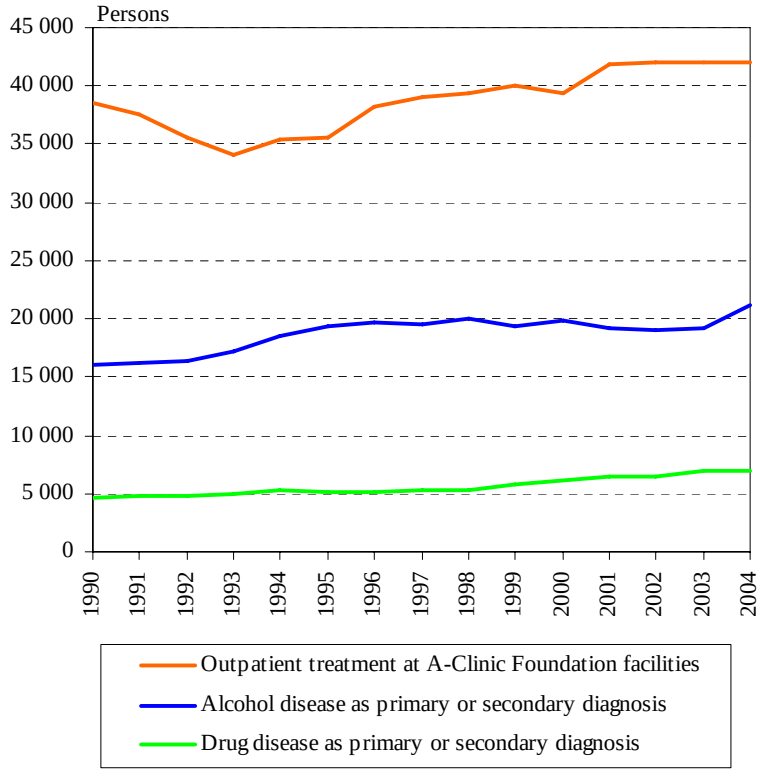
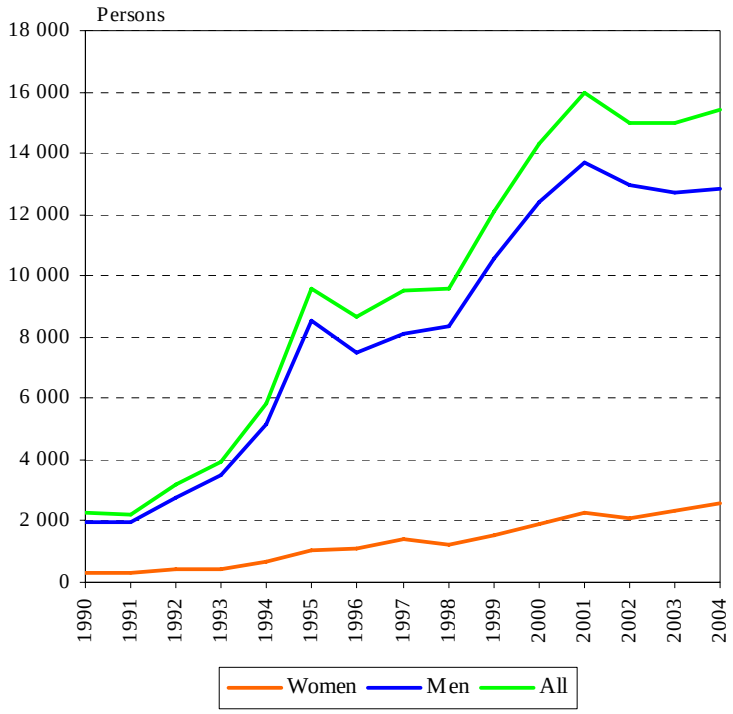
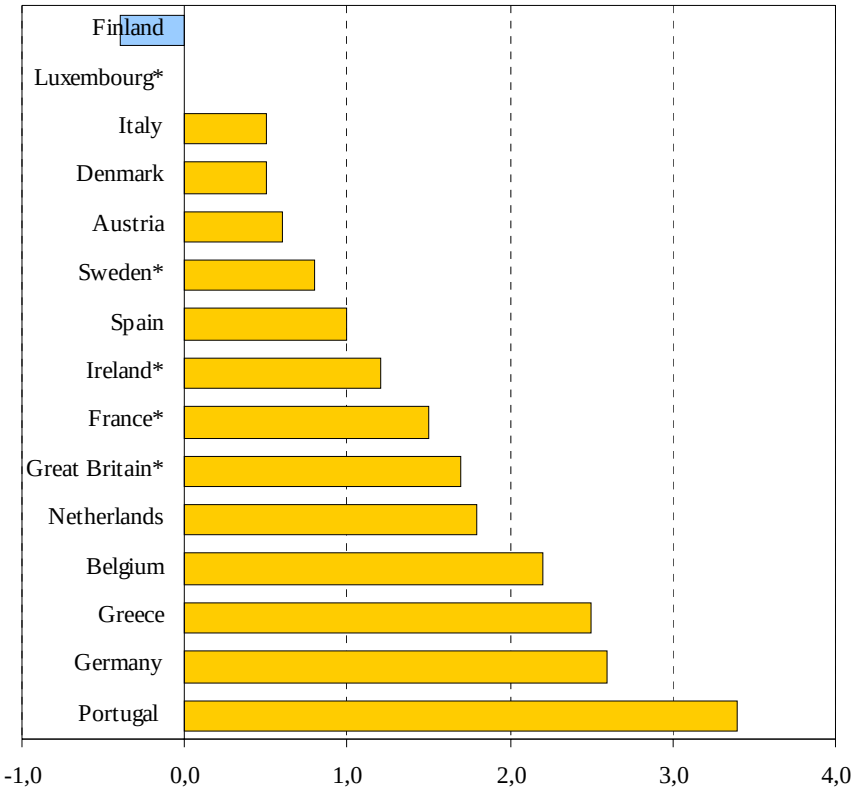


Figure 38. Trends in the number of persons suspected for drug crimes in 1990–2004



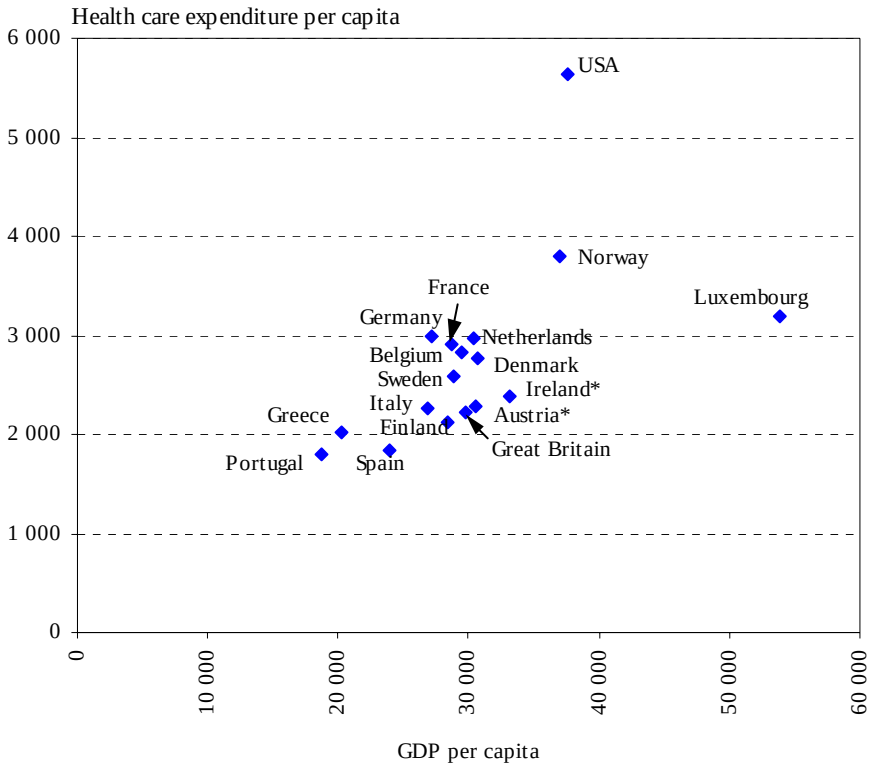
Chapter 5 Well-functioning services and reasonable income security

Figure 39. Change in health care expenditure to GDP ratio in 1990–2003, percentage points



*1990–2003 estimate or 1990–2002 data
Source: OECD Health Data 2005

Figure 40. Health care expenditure and GDP per capita in EU member states and the US in 2005 (US$, adjusted for purchasing power)



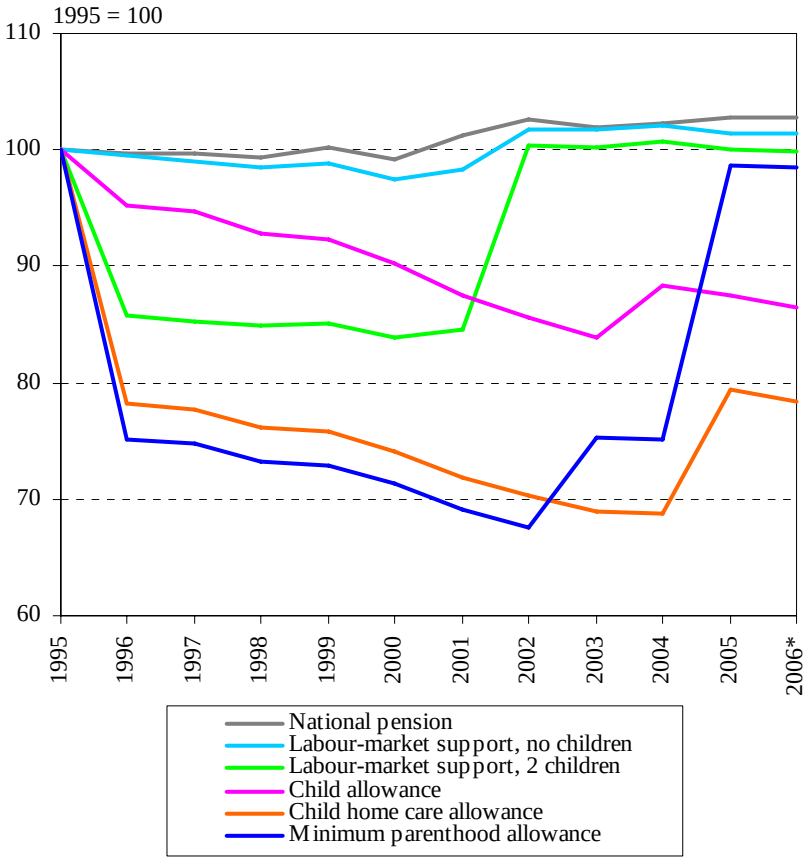
Source: OECD Health Data 2005

Table 1. Medicine and pharmaceutical product expenditure, change compared to previous year in 1990–2003 at 2003 constant prices, € million.

Year	Million euros	Change %
1990	954.4	
1991	1,015.2	6.4 %
1992	1,058.6	4.3 %
1993	1,100.9	4.0 %
1994	1,156.1	5.0 %
1995	1,232.5	6.6 %
1996	1,298.1	5.3 %
1997	1,355.4	4.4 %
1998	1,340.8	-1.1 %
1999	1,397.8	4.3 %
2000	1,463.0	4.7 %
2001	1,562.9	6.8 %
2002	1,660.5	6.2 %
2003	1,706.8	2.8 %

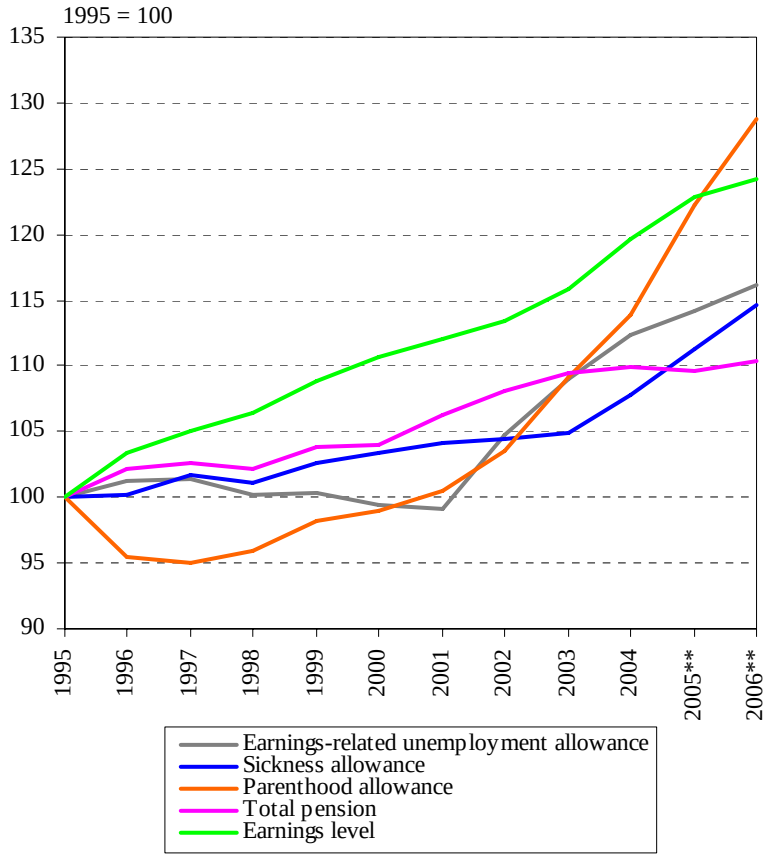
Source: Stakes, Health-care costs and financing in 2003. Statistical report 4/2005.

Figure 41. Real growth of selected income security benefits in 1995–2006



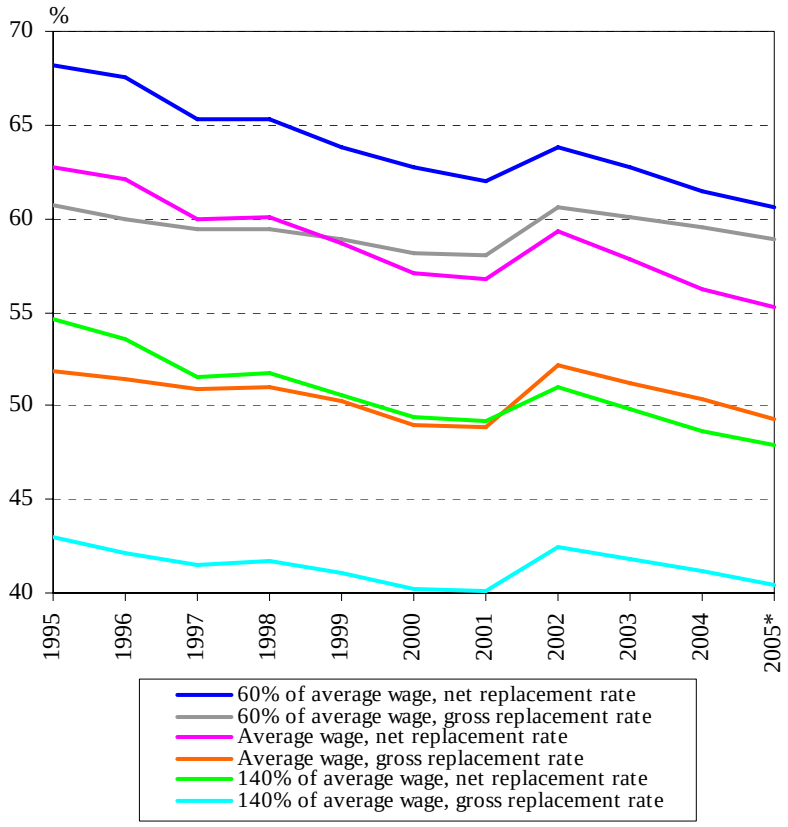
Child allowance: average per child weighted by family structure at the end of 2004.
Labour market support: full labour market support + possible child increment.
National pension: full national pension, single person living in first category municipality.
Child home care allowance: excluding income-tested supplement and possible increments based on the number of siblings, basic allowance until 1996. Weighted annual average, if the level of benefit was raised during the year.

Figure 42. Real growth of average total pension, average daily allowances and wage-level index in 1995–2006



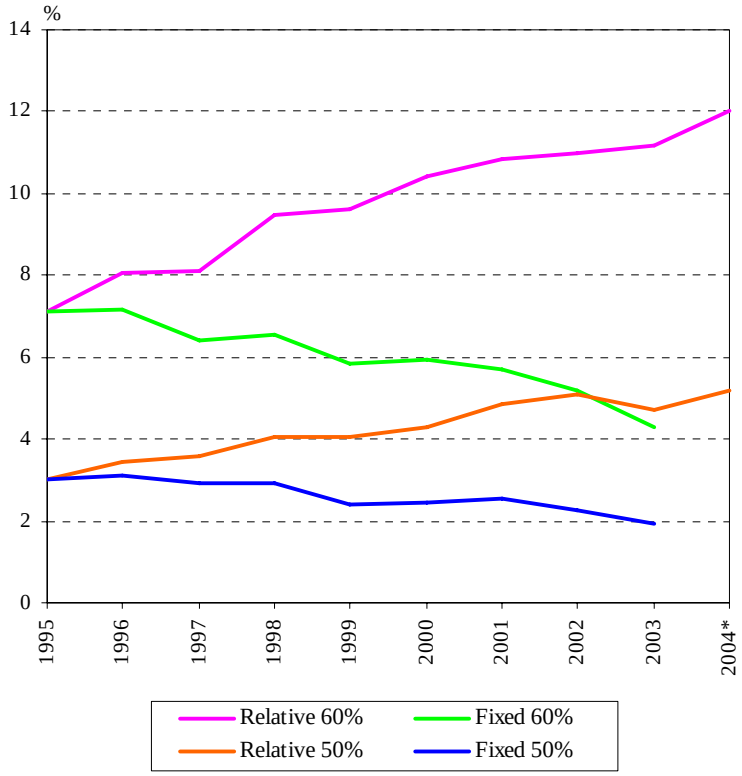
NB! Sickness and parenthood allowances also include allowances paid to the employer (with the exception of compensation paid to employers for payment in lieu of holiday pay during the parenthood allowance period).

Figure 43. Gross and net replacement rate of earnings-related unemployment allowance at different income levels in 1995–2006, %



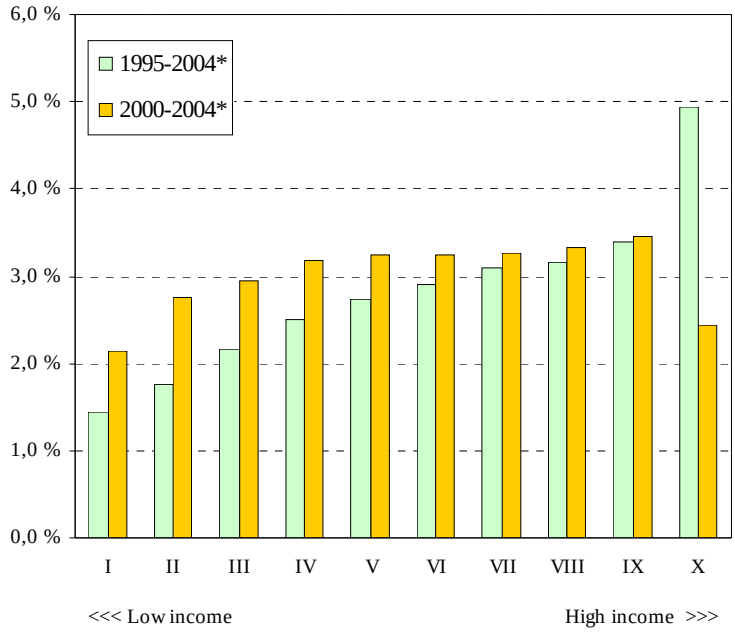
Average income: OECD's average production worker wage level. The figure also includes holiday bonus, which is not taken into account when the earnings-related unemployment allowance is calculated. This lowers the replacement rate somewhat compared to calculations where holiday bonus is not included in earnings during employment. Unemployment fund membership fee has not been taken into account in the calculation.

Figure 44. Proportion of population below poverty line, calculated using relative and fixed 1995 poverty line in 1995–2004, %. Poverty line 50 or 60% of households' median income



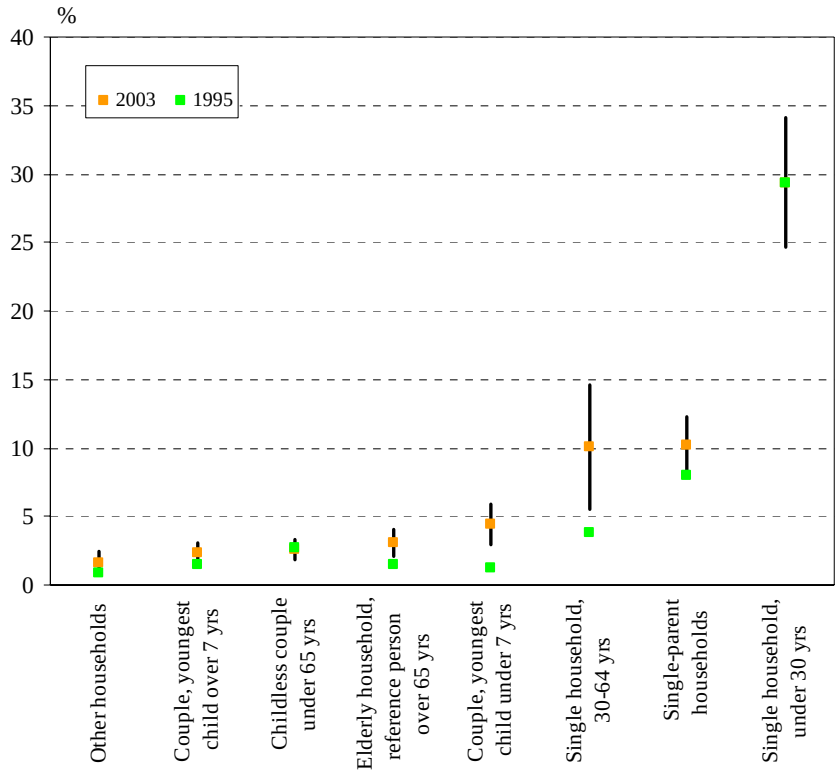
Income concept used: Households' equivalent disposable income (i.e. disposable income per consumption unit).
Modified OECD equivalence scale. Households weighted according to number of persons. Relative poverty line: relative poverty line is defined in relation to households' median disposable income each year. As the general income level increases, the relative poverty line rises correspondingly. Fixed poverty line: relative poverty line is defined in relation to households' median income at the beginning of period under study. Thereafter it has only been adjusted in relation to price changes. The real value of poverty line remains unaltered. Source: Ministry of Social Affairs and Health, Income Distribution Statistics micro data

Figure 45. Average annual change in households' real income per consumption unit in different income deciles in 1995–2004 and 2000–2004



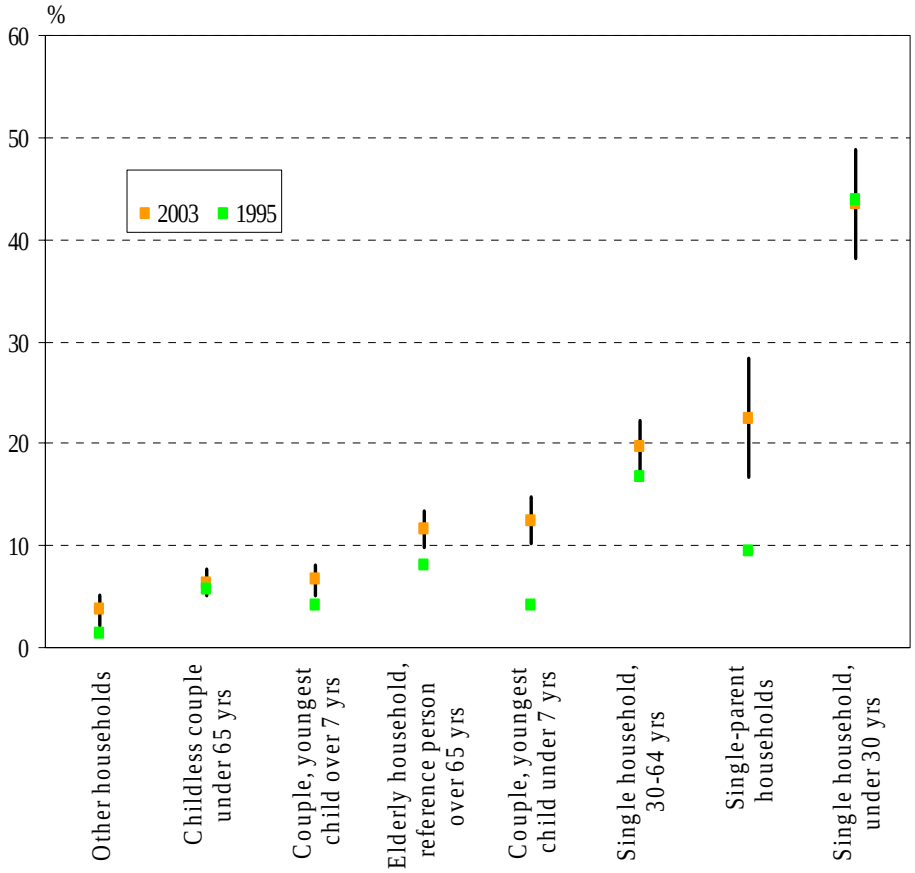
Source: Statistics Finland, Income Distribution Statistics

Figure 46. Proportion of population below poverty line by family type in 1995 and 2003, %. Poverty line: 50 percent of households' median income



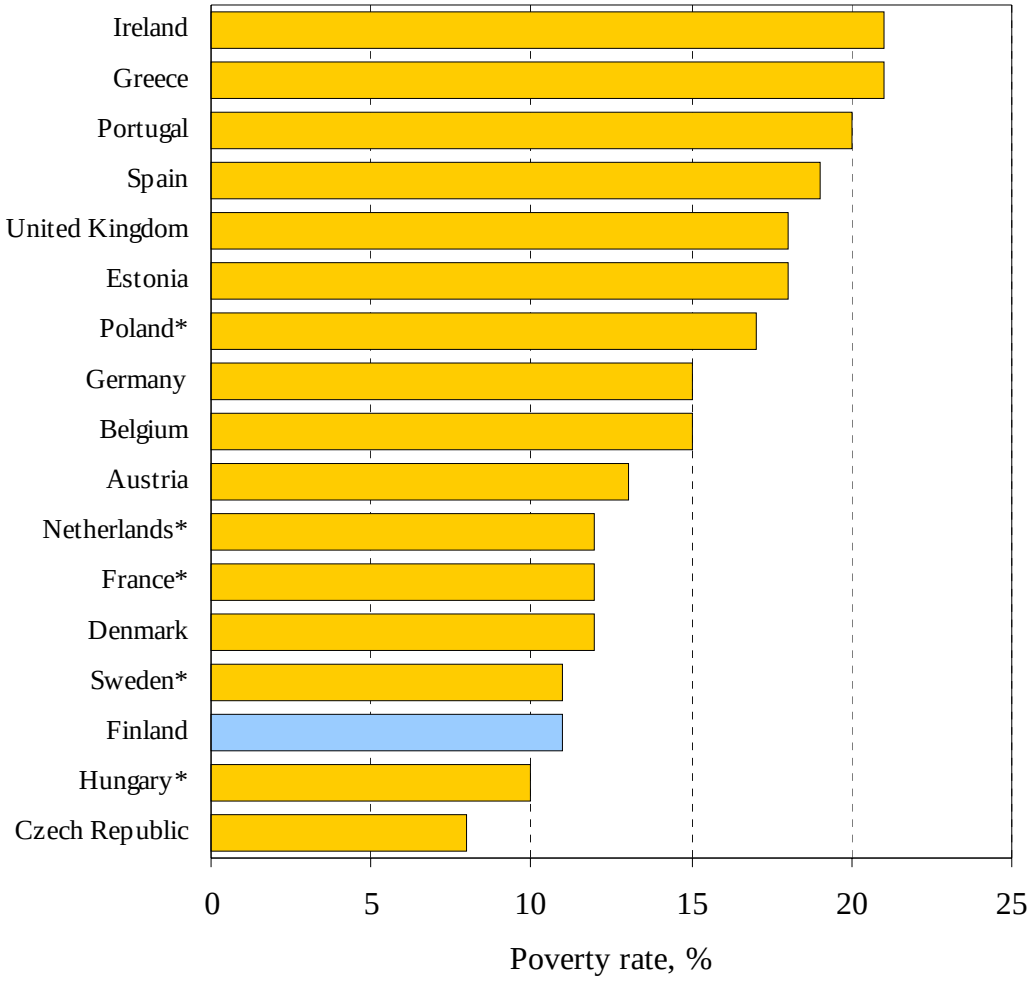
Vertical line: 95 percent confidence interval for proportion below poverty line in 2003
Source: Ministry of Social Affairs and Health, Income Distribution Statistics micro data

Figure 47. Proportion of population below poverty line by family type in 1995 and 2003, %. Poverty line: 60 percent of households' disposable median income



Vertical line: 95 percent confidence interval for proportion below poverty line in 2003
Source: Ministry of Social Affairs and Health, Income Distribution Statistics micro data

Figure 48. Poverty rate in selected current EU member states in 2002, %. Poverty line: 60 percent of households' median disposable income per consumption unit in each country



*Data from 2001. NB! Eurostat reports the data by interview year, even though the data concern the previous year, i.e. Eurostat reports the 2002 (2001) data in the figure as 2003 (2002) data. Source: Eurostat

Chapter 6 Well-being of families with children

Figure 49. The number of children born and total fertility rate in 1970–2004

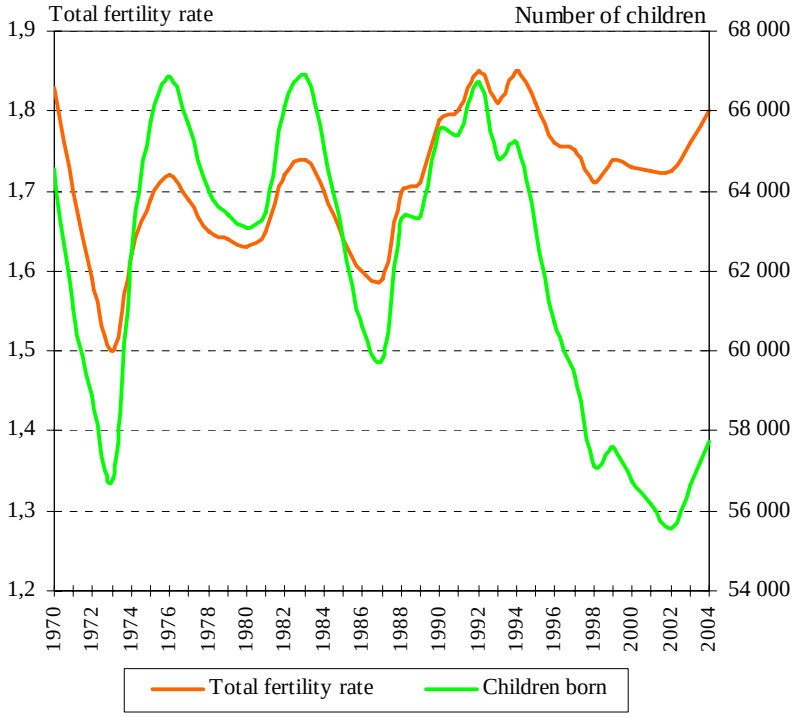
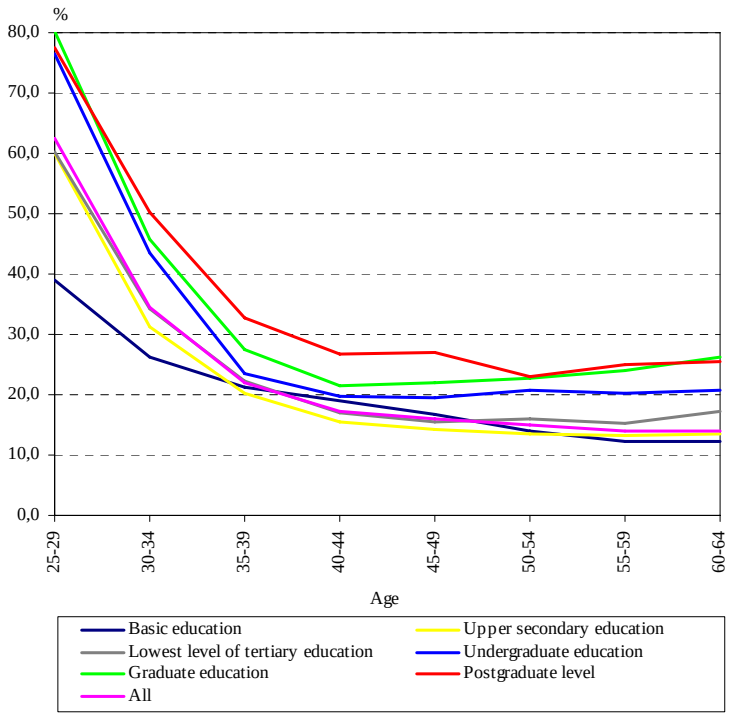
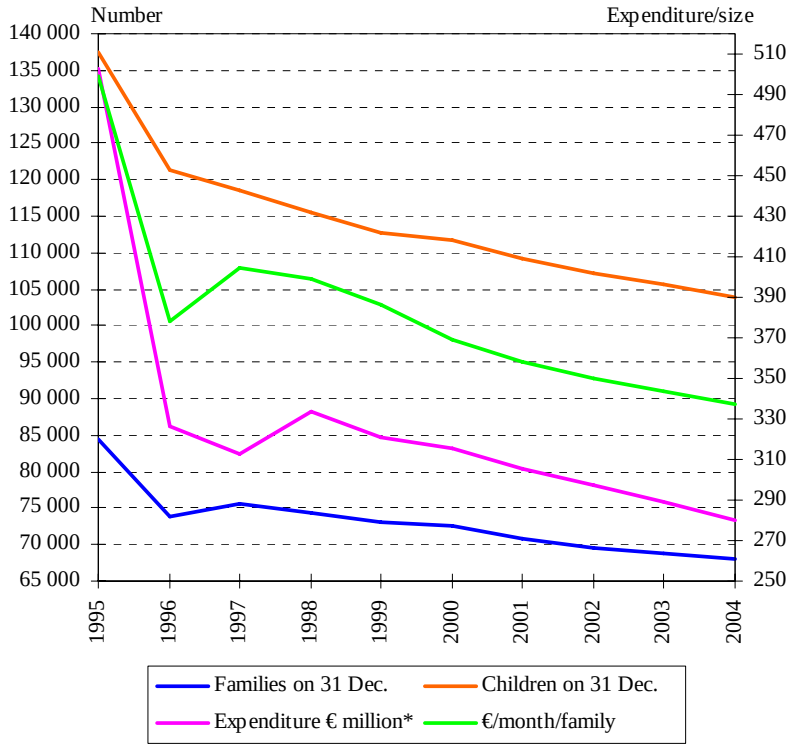


Figure 50. Proportion of childless women by education and age in 2002



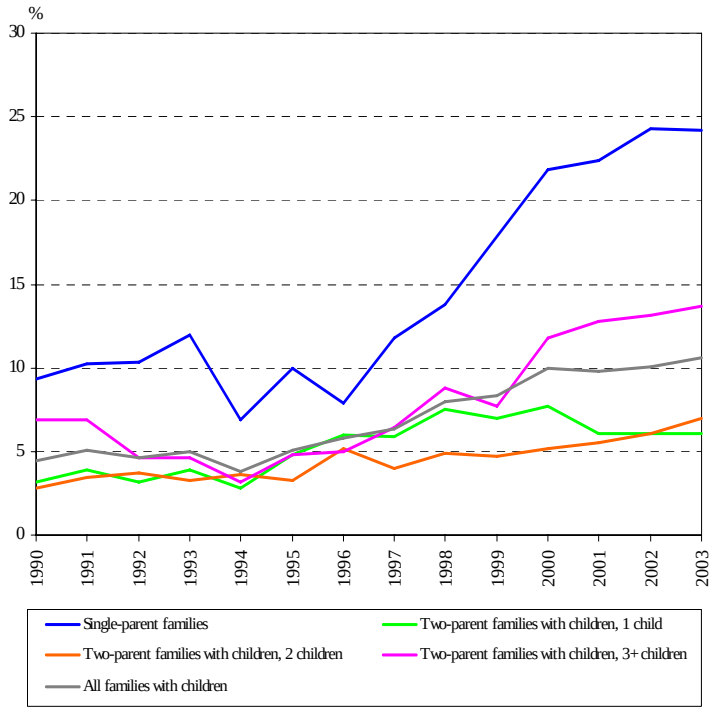
Source: Statistics Finland

Figure 51. Child home care allowance in 1995–2004



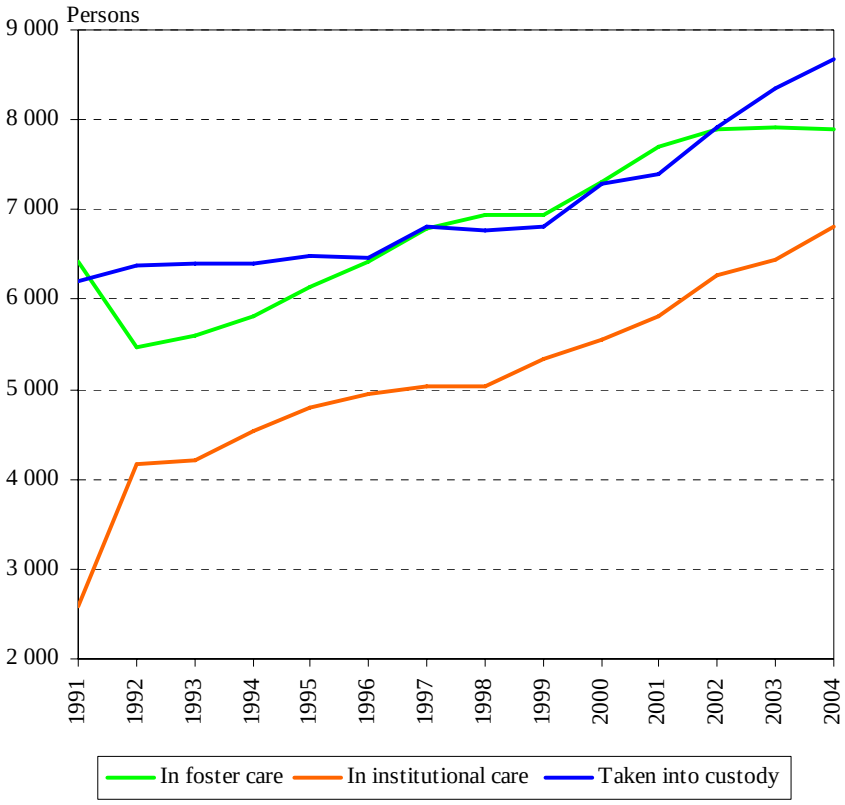
*in 2004 money terms

Figure 52. Families with children below low-income line in 1990–2003. Low-income line: 60 percent of median income.



Source: Statistics Finland

Figure 53. Children and young people placed outside own home and those taken into custody in 1991–2003



Source: Stakes

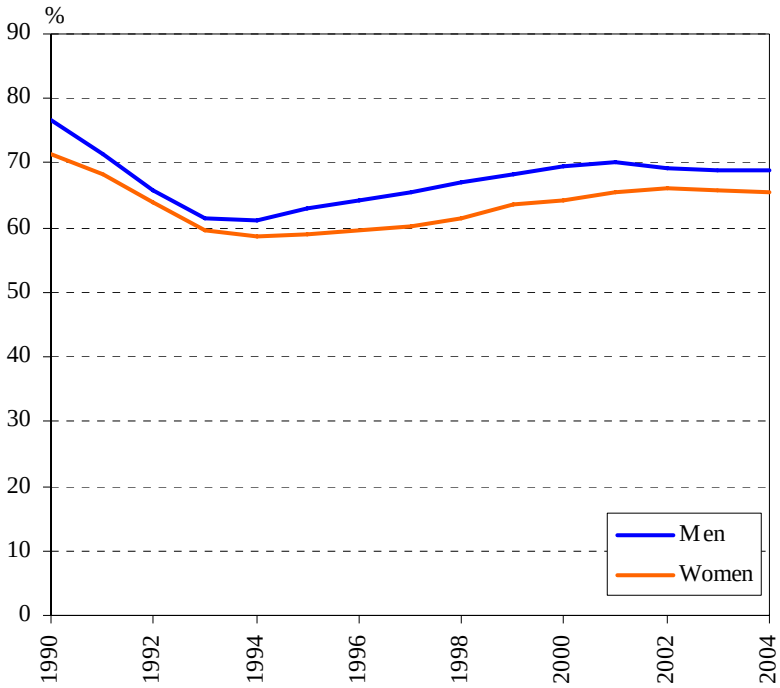
Table 2. Number of children under school age in municipal day care in 1998–2004, proportion of cohort, %

	Child's age, years							
	0	1	2	3	4	5	6	Total
1998	1.6	27.0	39.7	55.2	61.0	65.8	76.5	48.0
1999	1.4	26.1	40.1	55.8	62.7	66.9	77.7	48.4
2000	1.4	25.6	39.3	55.8	62.5	66.8	63.8	45.9
2001	1.5	26.0	40.3	56.1	62.8	67.5	64.1	46.2
2002	1.2	25.2	40.7	56.5	63.1	67.3	64.4	46.0
2003	1.3	24.9	40.3	57.4	63.6	68.0	64.1	46.0
2004	1.0	25.5	41.3	57.0	63.4	67.9	63.3	45.6

Source: SOTKA database

Chapter 7 Promoting gender equality

Figure 54. Employment rate by gender in 1990–2004, %



Employment rate: Employed persons as a proportion of population aged 15-64 yrs. Source: Statistics Finland, labour force survey

Figure 55. Unemployment rate by gender in 1990–2004, %

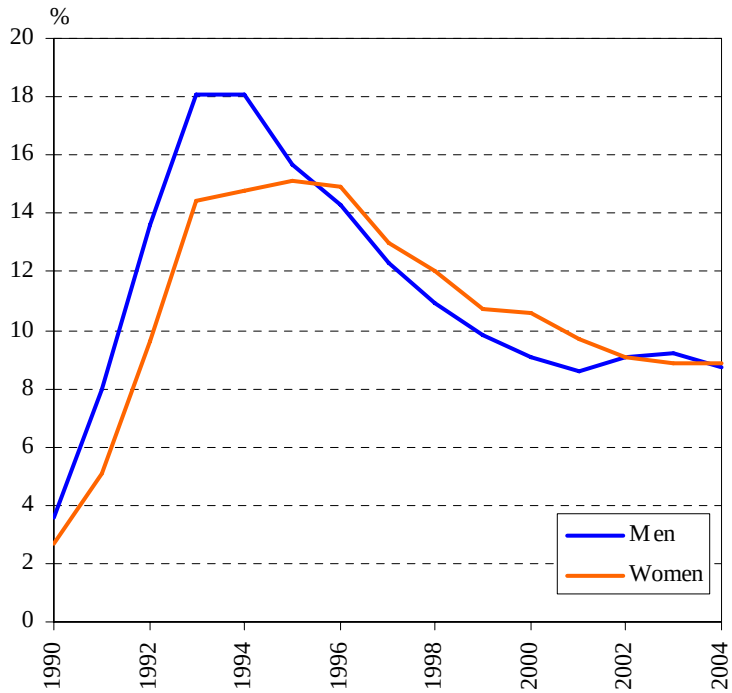
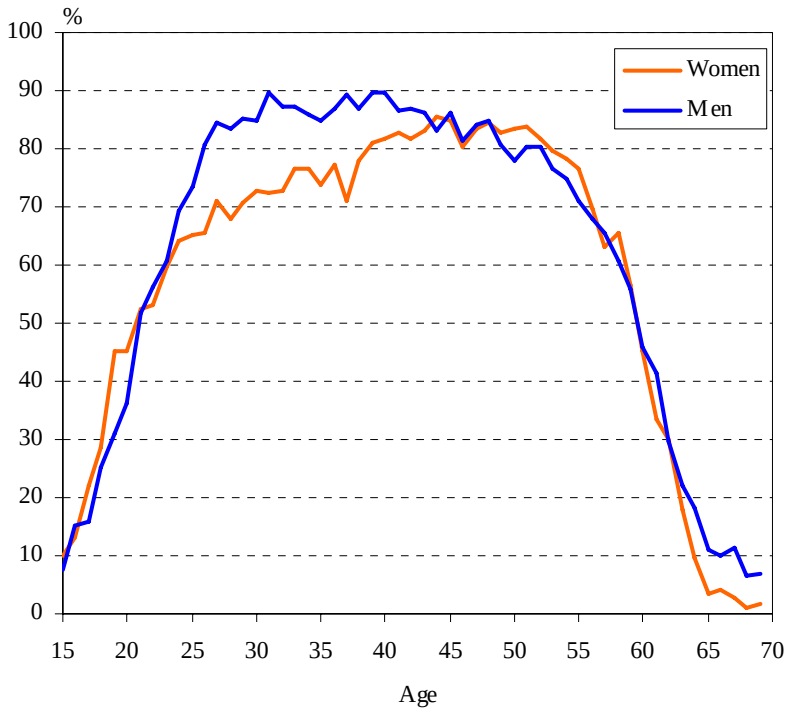
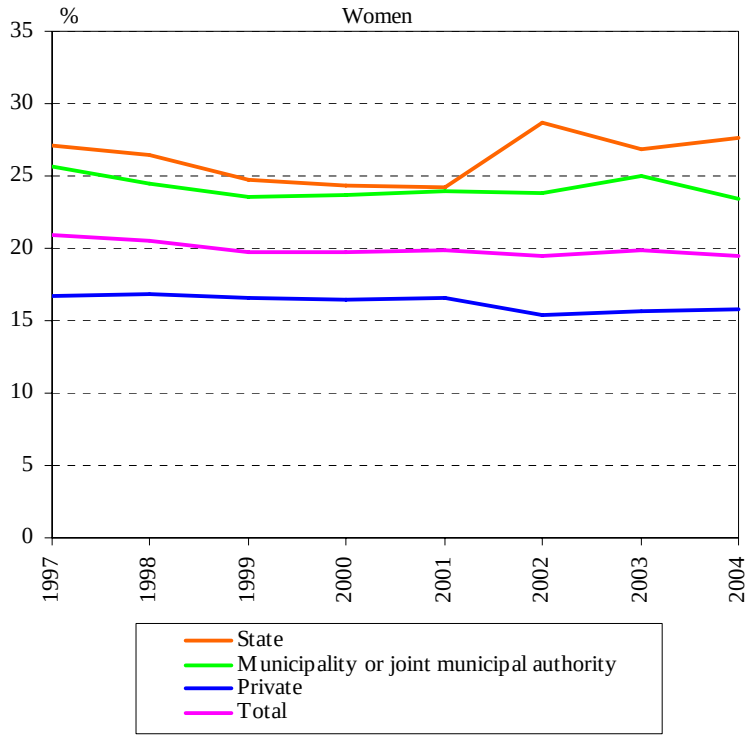


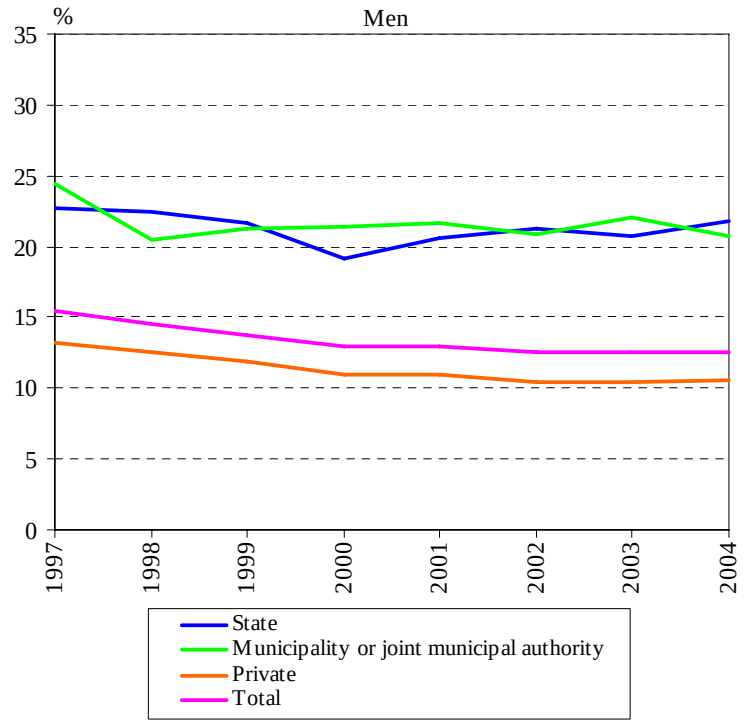
Figure 56. Age-group specific employment rates among women and men in 2004, %



Source: Statistics Finland, labour force survey

Figure 57. Proportion of fixed-term employment contracts in different sectors according to gender in 1997–2004, %





Source: Statistics Finland, labour force survey

Figure 58. Wage earners' average earnings for regular working time by sector in 1995–2003. Women's earnings as a percentage of men's earnings.

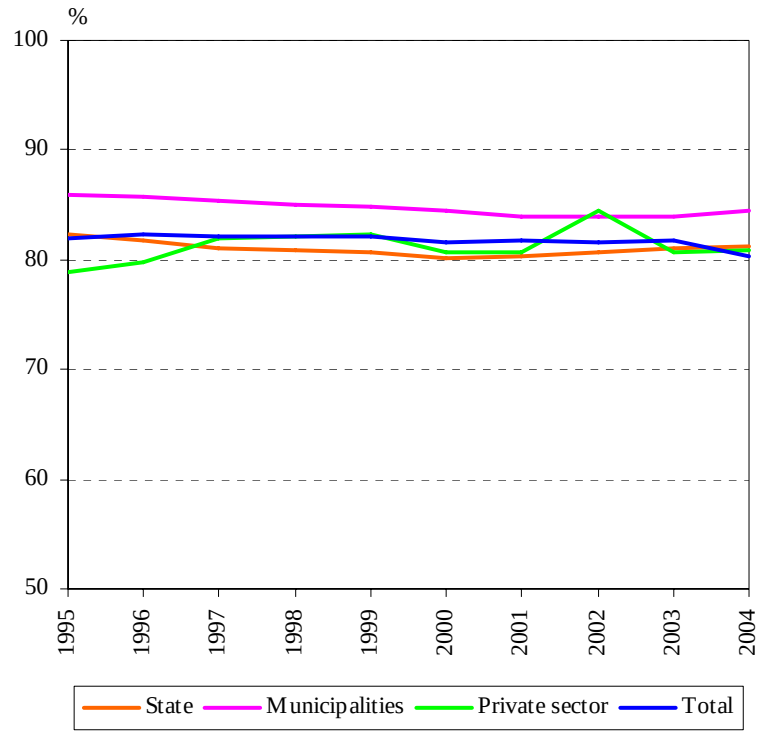
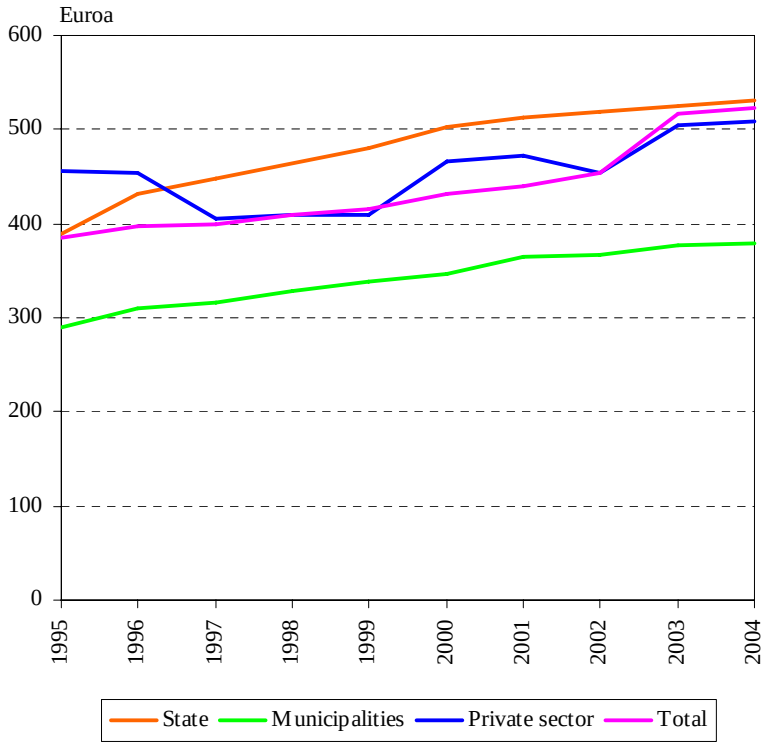
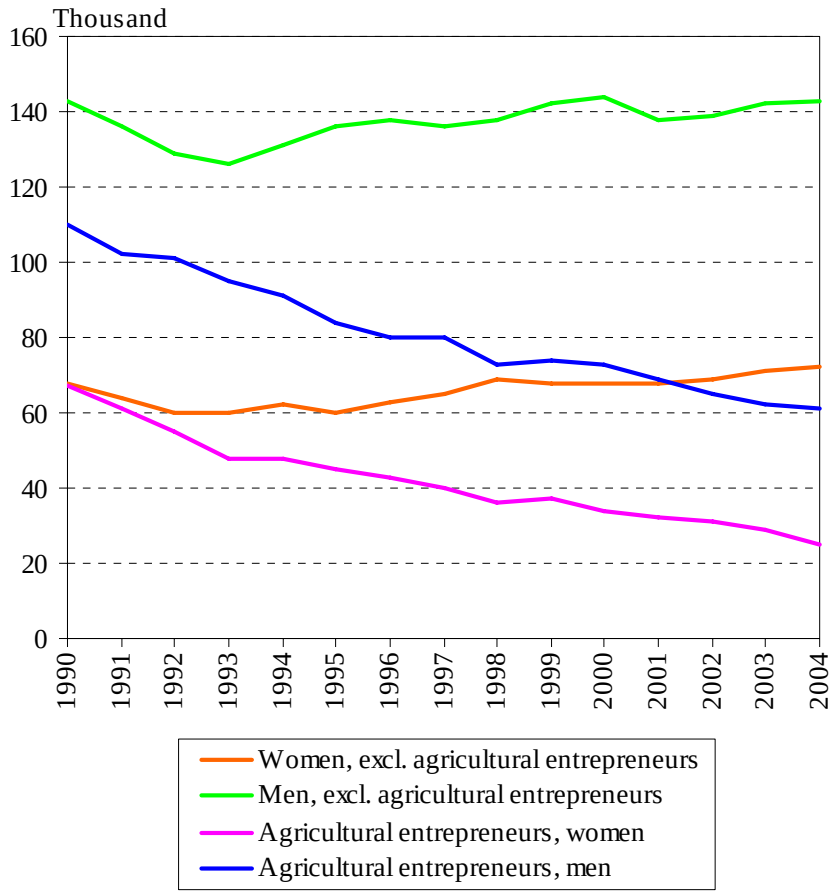


Figure 59. Differences in pay between women and men in euros in 1995–2003, at 2003 prices



Sources: Statistics Finland, Wage earners' monthly earnings according to earnings level index and consumer price index.

Figure 60. Entrepreneurs and members of entrepreneur families according to gender in 1990–2004



Source: Statistics Finland

Figure 61. Men and women as victims of violent crime in 1980–2003, 15- to 74-year-olds, during one year

Source: Heiskanen Markku, Sirén Reino, Aromaa Kauko (2004). Suomalaisten turvallisuus 2003. Research report 58 of the National Research Institute of Legal Policy.

Endnotes

[i] In its report on Finland, the OECD has used the same assumption of productivity growth. The approach is naturally very simplified; for example, changes in productivity growth and employment rate are assumed to be independent of each other.
[ii] Factors affecting social expenditure and its financing have been extensively looked at in the reports of the SOMERA committee.
[iii] Body mass index 25 or more
[iv] Alcohol disease as primary disease
[v]Theoretical distribution of medicine expenses between prescription drugs and hospital drugs on the basis of wholesale selling is 80-20 percent. This result is arrived at if the discounts given to hospitals for their drug purchases are not taken into account. Exact figures are not available. It is generally assumed that hospitals get on average a 15 percent discount.
[vi] The way services are arranged, their extent or content is not defined in legislation; assessment and implementation is left to the municipalities.
[vii] The financing streams are considerably more complex than presented here, especially in the case of services for the elderly, including e.g. various investment and operation subsidies.
[viii] The OECD discussed factors related to the multi-channel structure of our health care system in its report assessing Finnish health care.
[ix] The figures under different headings are not necessarily addable, because data have been gathered from several statistical sources.
[x] Part of subsidies given to other domains is directed to health care as well.
[xi]The sales of prescription drugs in outpatient care at taxable retail prices in 2003 totalled € 1,565 million, and those of self-medication drugs € 270 million, i.e. € 1,836 million in all. Of this sum, € 918 million was refunded by health insurance during 2003.
[xii] Income level has been observed to correlate positively with state of health. A larger proportion of the payments thus target people with lower incomes.
[xiii] The data are partly insufficient or lacking; however, the aim is to develop the compilation of statistics and develop permanent practices.
[xiv] Some of the increases and reforms were implemented in mid-year. National pensions were raised on 1 March 2005, and the grounds for determining the allowance in the case of consecutive pregnancies came into force as of 1 October 2005.
[xv] In addition to direct promotion of employment, e.g. labour training may naturally have other aims, such as more general maintenance of the work ability of the employed.
[xvi] The pension income deduction in municipal taxation is reduced as income increases, so not all pension recipients are entitled to it. In 2003, about two thirds of pension income recipients were also entitled to pension income deduction. Part of those entitled to the deduction do not currently pay income tax due to their small income and the pension income deduction, so they will not benefit from the deduction increase. On the other hand, as a result of the increase, the income bracket affected by the pension income deduction is widened somewhat, which will increase the number of persons benefiting from it.
[xvii] In addition to wages, employees are often entitled to other benefits as well, such as occupational health care, which are not taken into account in the calculations.
[xviii] The example assumes that the child is in full-time day care. Within a certain income bracket, the increase in earnings may also be considered to be related to a switch from part-time work to full-time work. This could also involve the use of full-time child day care instead of part-time care, which would mean an increase in fees as a result of a rise in earnings and longer duration of care. This could exacerbate the income trap problem in certain income brackets.
[xix] Primarily this involved adjusted daily unemployment allowance (combination of part-time work and unemployment allowance) or the reducing effect of spouse's income on labour market support. Other income-tested benefits and taxation play a role in these situations as well.
[xx] Payment in lieu of holiday paid at the end of an employment contract lasting no longer than 14 days does not pose a hindrance to allowance payment, but the income is taken into account as income during the so-called last adjustment period.
[xxi] A new deductible period is not required if the employment contract lasts no longer than 14 days. In the case of labour market support, the deductible period is five days.

[xxii] Virjo (2000) has presented estimates concerning the under-use of social assistance on the basis of income data reported by households in interviews. In such cases, the under-reporting of income data in interviews, and in the case of social assistance, of wealth data as well, constitutes a source of error that should be taken seriously.
[xxiii] In addition to income taxes and social insurance contributions, an estimate on the indirect taxes included in the household's consumption is included in the tax wedge.
[xxiv] For a more detailed account, see Koskela, Pirttilä and Uusitalo (2004), which is a recent Finnish review of research on the link between employment and taxation, and e.g. Nickell (2004) and Nickell, Nunziata and Ochet (2005).
[xxv] As of 2007, the firm's wage sum will be looked at instead of the number of employees.
[xxvi] The unemployment pension deductible payment system is replaced by a payment category system as of 1 January 2006. The payment category is defined on the basis of development of disability expenses in the company in previous years. The deductibles of large companies will thus remain in force, even though the calculation of deductibles is replaced by the payment category model. The cost calculated on the basis of unemployment pension is no longer charged directly from the employer; instead, it is taken into account when determining the level of payment in the years to come. The payment category model has mostly been implemented so as to comply with the international IFRS bookkeeping standard.
[xxvii] Hakola and Uusitalo (2005)
[xxviii]Mustonen and Viitamäki (2004)
[xxix] The added burden to municipalities caused by the new share in labour market support financing (the share for the "passive days" after the 500-day limit) would exceed the reduction of municipalities' financing responsibility for social assistance. However, this would be fully compensated by increasing the government grants towards social and health care and by raising the equalisation limit based on municipalities' tax revenue by one percentage point.
[xxx] See Färkkilä (2005)
[xxxi] In the example, the youngest child is assumed to be two years old. In 2001, the supplement paid by the City of Helsinki was FIM 800 per month and per household if the youngest child was two years old, and FIM 1,300, if the youngest child was under two years of age. The corresponding amounts in euros are currently € 134.55 and € 218.64 per month.
[xxxii] Based on material from income distribution statistics from 2000 – 2003, it seems that a relatively significant proportion of parents, mainly mothers, who have received child home care allowance are initially unemployed as the child turns three. On annual level, the proportion of mothers categorised as unemployed rises from 5 percent to as high as 15 percent as the age of the youngest child increases from one to four years (full years at the end of calendar year). After this, the proportion of unemployed mothers starts to fall fairly rapidly. The proportion is calculated from the entire cohort according to main activity during the year, so the figure must not be compared with unemployment rates from Labour Force Survey.
[xxxiii] OECD (2005)
[xxxiv] In the estimates, the selection bias of those receiving child home care allowance in terms of education level and other factors should also be taken into account. It may be difficult to discern all factors affecting selection directly from the research data. Parents with a particularly strong career orientation may not necessarily choose child home care allowance.