FINNISH SOCIAL PROTECTION IN 2003

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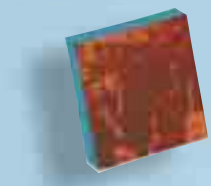



1. THE FINNISH SOCIAL PROTECTION SYSTEM – A SUMMARY

Basic elements in Finnish social protection

The basic elements in the Finnish social protection system are preventive social and health policy, social and health care services, and social insurance. The main aim of social protection is to safeguard people's income by providing a comprehensive system of basic security and income-related benefits which guarantee a reasonable level of consumption in different risk situations. An important element in the Finnish social protection system is the comprehensive social and health services it provides.

The social protection system has been built up over several decades. It is characterized by universality of benefits. As in other Nordic countries, it is primarily residence in the country that qualifies a person for social protection.

The social protection system has guaranteed social cohesion, fairness and equality. Almost all households get some kind of income transfer or use social and health services from time to time. The system of income transfers has effectively levelled out income distribution, which is fairly even in Finland, measured in terms of households' disposable income. The poverty rate is one of the lowest in the EU.

The principle of equality is firmly incorporated into the social protection system. The vigorous development of the day care system for small children has enabled women to participate widely in working life, and about 70% of mothers of young children do so. All children under school age (7 years) have the right to municipal day care.

Social expenditure near EU-average

The ratio of social expenditure to GDP is now under the EU average. In 2003, social protection expenditure accounted for 26.9% of GDP. Social expenditure is mainly financed by employers, central government and the municipalities. The direct contribution to social protection expenditure made by the insured is far lower in Finland than in other EU countries, and the financial contribution of central government and the municipalities is correspondingly higher. This is a typical feature in countries with benefits based on universality.

Close connection between preventive actions and social and health services

Preventive action is an integral part of social protection in Finland. Its aim is to forestall a range of risks and problems so that use of the more expensive services and forms of assistance can be minimized. People are encouraged to look after their own health and to cut their use of tobacco and alcohol. The main areas of preventive action are environmental health care, effective primary health care, occupational health care, maternity and child welfare services, and the prevention of poverty and social exclusion.

The municipalities are responsible for arranging basic services like schooling, social services and health services. Most municipalities have less than 10,000 inhabitants. Statutory services are provided by municipal institutions, either the municipality's own or joint bodies run together with other municipalities. The municipalities can also buy these obligatory services from the private sector.

Both central government and the municipalities have the right to levy taxes. The municipalities receive a central government grant to enable them to arrange the services they are obliged to

provide. Clients have to pay a fee for the services they use. The most important areas in the service sector are primary health care and specialized medical care, children's day care, care of older people, services for people with disabilities, social assistance and child welfare. Social assistance is a last-resort benefit. Private services supplement the public services.

Certain benefits, such as parental leave and child allowance, are universal. The level of child allowance depends on the number of children in a household, and is payable for children under 17. Child allowance is non-taxable. All parents have the right to take parental leave, and fathers resident in Finland have the right to a separate paternity allowance for 6–18 working days. In addition to this, fathers are entitled to paternity allowance for 1–12 weekdays immediately after the end of the parental allowance, if the father has had parental leave for at least the final 12 weekdays of the parental allowance period. When a baby is born, the family also receives a maternity pack that contains clothes and baby care requisites. All children under school age (7 years) have the right to municipal day care or, alternatively, their families can receive financial support for private day care or home care for their children. The municipalities are obliged to arrange preschool education to all children under the age of 7.

Comprehensive and statutory social insurance

In Finland, all residents are covered by social security schemes which govern basic pensions (national pensions), sickness and maternity benefits and unemployment benefits. In addition, all employed persons are entitled to benefits based on employment, such as earnings-related pensions and benefits for employment-related injuries. A distinctive characteristic of the social insurance system in Finland is that a large proportion of social insurance is managed by private insurance institutions, although the system is obligatory and statutory.

Finland has two pension systems: the national pension scheme and the earnings-related pension scheme. Both schemes pay old-age, disability and survivor's pensions. The national pension scheme provides pensions on the basis of residence to guarantee a minimum income, whereas the other scheme is based on employment and related to earnings. The national pension is coordinated with pension from the earnings-related pension schemes and paid to persons with a low or no earnings-related pension. When the earnings-related pension exceeds a certain amount, there is no entitlement to national pension. National pensions are administered by the Social Insurance Institution (Kela). The earnings-related pension schemes are managed by private insurance institutions. The Finnish Centre for Pensions (ETK) is the central body. The public sector has its own pension institutions.

Unemployment benefits consist of earnings-related allowance, basic allowance and labour market support. Most employees are covered by their own sector's unemployment fund, in which case they are entitled to an earnings-related allowance.

All employed persons and farmers are covered by mandatory insurance against occupational injuries and occupational diseases. Self-employed persons other than farmers can take out voluntary insurance. The occupational accident insurance scheme is administered by private insurance companies. Motor vehicle third-party liability insurance is obligatory in Finland.

National health insurance compensates for income lost due to temporary incapacity for work. The allowance is proportional to the applicant's earnings. A lengthy illness or period of disability can affect the everyday life of the person concerned in various ways. Rehabilitation

can help prevent and alleviate these effects. Rehabilitation benefits are provided in order to improve and maintain the capacity of persons with handicaps or severe disabilities to work and cope with their everyday lives as well as possible, despite their condition.

According to opinion polls, the Finnish social protection system enjoys widespread public support.

EU as an operational framework

Under the principle of subsidiarity, social policy belongs to the competence of Member States. Nevertheless, the European Union is more and more the environment in which social policy has to operate. The euro area now covers 12 countries, including Finland, and has generated further discussion about the financing of social protection. While the main impact of EMU is clearly positive, as interest rates have been falling and the economy expanding, the risk of asymmetrical shocks is nevertheless still real within the framework of the Stability and Growth Pact.

The entry into force of the Treaty of Amsterdam reinforced the social dimension at EU level. The Treaty of Nice will further strengthen the position of social policy, as it includes confirmation of the legal basis of the new Social Protection Committee (art. 144). Common challenges shared by the entire Union include raising the employment rate, combating poverty and social exclusion, an ageing population and sustainable financing of the pension systems and health care. These challenges are closely connected with the process of Union enlargement.

The basic question is how to successfully combine macroeconomic policy, employment policy and social policy in order to improve the competitiveness of the European Union. Improving the social dimension of the EU means better coordination of national policies and strengthening the common framework for European social policy. The Open Method of Coordination (OMC) is a new form of cooperation at European level that integrates national diversity and European unity in a potentially fruitful way. It is a key element of the Lisbon Strategy accepted by the Lisbon European Council in 2000. Under the OMC, Member States can set common objectives and agree on follow-up indicators, reporting and benchmarking. So far, such common objectives have been agreed in the areas of poverty and social exclusion, pension policy and health care. They provide useful guidelines for further work in these areas at national level.

Strategic goals in the administrative sector

Shared strategic goals have been set for the entire administrative sector. The goals for 2003 were still largely based on the strategic goals set by the previous Government. The main challenges in the administrative sphere of the Ministry of Social Affairs and Health were linked with the ageing of the population and its functional capacity, economic trends, European integration, the employment rate and long-term unemployment, exclusion, regional development and sustainable funding for social protection.

The main outline of the strategic goals of the Ministry of Social Affairs and Health has been similar for many years now. The background documents for setting strategic goals in the sector are the report *Strategies for Social Protection 2010* , published in 2001, and the new Government Programme. During the year under review, the social welfare and health policy guidelines were grouped under four themes, which were

- promoting health and functional capacity,
- making work more attractive,
- preventing and alleviating social exclusion, and
- functional services and reasonable income security.

In accordance with the areas of emphasis in the new Government Programme, the welfare of families with children and gender equality were also emphasized.

2. SOCIAL PROTECTION IN 2003

SOCIAL PROTECTION EXPENDITURE AND USE

In 2003, social protection expenditure totalled EUR 38.5 billion. About one third of this was financed through the State budget. As social protection is financed through several main titles of expenditure in the budget, only 21.9% fell under the main division of the Ministry of Social Affairs and Health. As before, the bulk of this expenditure consisted of income transfers to households, municipalities and joint municipal boards. The percentage of off-budget financing was down on the previous year. (Figure 1)

Social protection expenditure has grown at a moderate rate in the past few years. In 2003, social protection expenditure in relation to GDP was 26.9 %. This was below the EU average. The only countries where the expenditure level adjusted according to purchasing power parity was lower than in Finland were Ireland and the three Member States in southern Europe (Table 1, Figure 2).

The Finnish social protection system is cost-effective: although social protection expenditure is lower than in the EU on average, the system is able to provide a reasonable level of social welfare and health services and income security to the whole population.

The annual change in the number of recipients of benefits was small. The number of pension recipients grew as the population aged. The total number of recipients of the various forms of unemployment benefits rose slightly. More people than before also received daily sickness allowance. The number of births rose slightly and caused a rise in the number of people receiving parental allowance. A fall in the total number of small children caused a fall in the need for support for child care. The number of recipients of social assistance fell slightly**.** (Table 2)

Figure 1.

Percentage of social protection expenditure financed through the State budget in relation to all social protection expenditure in 2003

Social protection expenditure € 36.5 billion

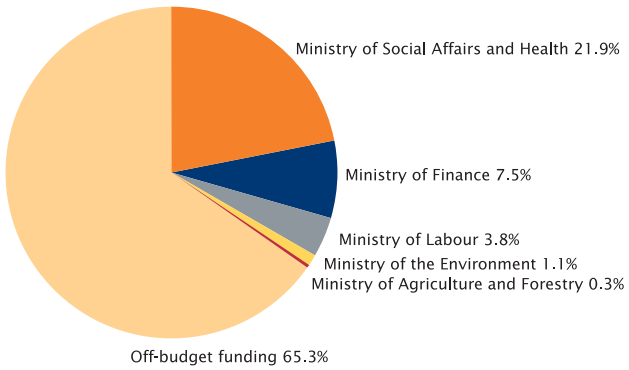


Table 1. *Trends in social protection expenditure*

	1995	2000	2001	2002	2003 *
Gross Domestic Product, billion €	95.3	130.1	135.5	139.8	143.4
Total social protection expenditure, billion €	30.2	33.1	34.8	36.9	38.6
Expenditure from the main title of the Ministry of Social Affairs and Health, billion €	8.2	7.3	7.6	8.1	8.5
Social protection expenditure/GDP, %	31.7	25.4	25.7	26.4	26.9

* estimate

Figure 2.

Social protection expenditure per capita in EU Member States in 2001 (in euros by purchasing power parity)

Source: Eurostat

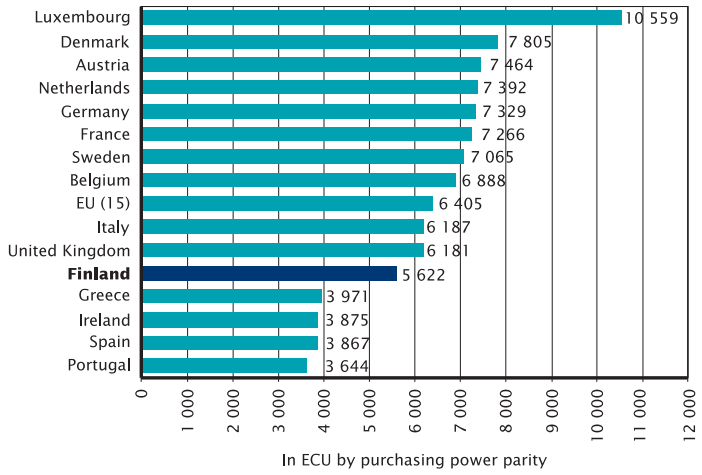


Table 2. *Recipients of social protection benefits 1995, 2000–2003 (1,000 people)*

	1995	2000	2001	2002	2003*
Pension recipients, total, Dec. 31**	1 157	1 224	1 233	1 255	1 276
Daily unemployment allowance	827	603	568	569	572
Daily sickness allowance	284	296	301	321	326
Parental allowance (mothers)	108	97	96	95	97
Child daycare allowances, Dec. 31 (children)	138	126	124	123	121
Social assistance	584	454	443	443	440

* estimate
** excluding recipients of survivor's pension only

FINANCING OF SOCIAL PROTECTION

Finnish social protection is financed through employer contributions and contributions by the insured, and through taxes and client/customer charges. The improved employment rate has increased the proportion of employer contributions. The government has stepped up its funding somewhat, particularly for municipalities' social welfare and health care expenditure (Table 3).

There is no uniform European model for financing social protection. In countries with universal social protection systems, the financing contribution of the public sector is higher than average. The annual changes are slight, the proportion of employer contributions has fallen somewhat and the proportion of the public sector contribution has risen slightly in recent years.

SOCIAL AND HEALTH CARE POLICY

Social protection expenditure is mainly made up of pensions, municipal social welfare and health care services, unemployment security and health insurance. The changes in the percentages of these different expenditure items compared with the previous year are slight. (Figure 3)

Household income and income distribution

The growth in income differentials between households which had continued since the mid-1990s levelled out in 2001. In 2002, the income differentials remained almost unchanged. The increase in income differentials in the second half of the 1990s was largely due to a rise in capital income. In 2001, the capital income received by households fell noticeably, and this resulted in an overall reduction in income differentials. Despite this slight fall in income differentials, the differentials were still much greater in 2002 than in the early 1990s. The equalizing effect of social income transfers and taxation was weaker than before.

Poverty risk, the indicator for the percentage of low-income population, has begun to rise in recent years. This increase was largely due to a rise in the general income level, which has raised the poverty risk line which is tied to the population's average income. Close to 70 per cent of the population below the poverty risk line are members of households where no member of the household has a job, and they depend to a great extent on various forms of income security.

The risk of poverty has grown in most family types. The biggest growth centres on single-parent families and families where the youngest child is under school age. Low incomes are most widespread among young people living alone. The risk of poverty in this group is increased by the high percentage of students it includes. Compared with other EU Member States, Finland has a very low poverty risk both among the population at large and among children, in particular. The risk of poverty among older people in Finland is at about the level of the EU average (Figure 4). However, it is more common for older people in Finland to own the flat or house where they live than in other EU Member States. This means that even a fairly low income may secure a reasonable standard of living.

Table 3. *Total financing of social protection in Finland from 1995, 2000- 2003, financing contributions as percentages*

Financing body	Contribution to financing of social protection, %				
	1995	2000	2001	2002	2003*
Central government	29.1	24.0	23.3	23.7	24.8
Municipalities	16.7	19.2	19.4	19.6	19.3
Employers	37.7	37.7	38.8	39.2	40.0
Insured	13.7	12.1	11.6	11.0	10.6
Other income	6.9	7.1	6.9	6.5	5.0
Central government	100.1	100.1	100.0	100.0	100.0

* estimate

Figure 3.

Social protection expenditure by category in 2003, percentages of total expenditure, € 38.5 billion

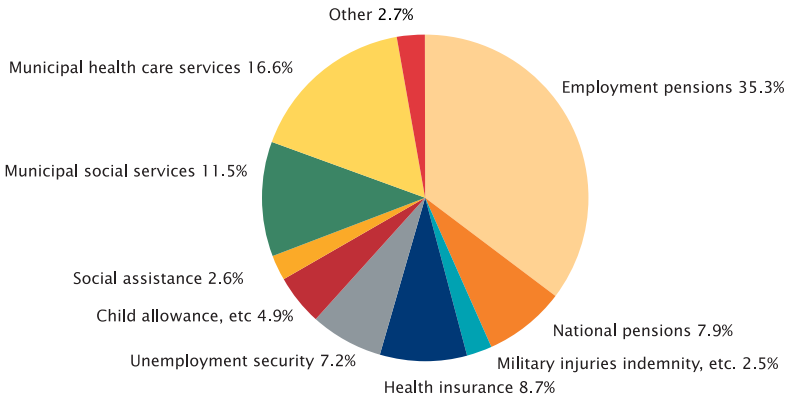
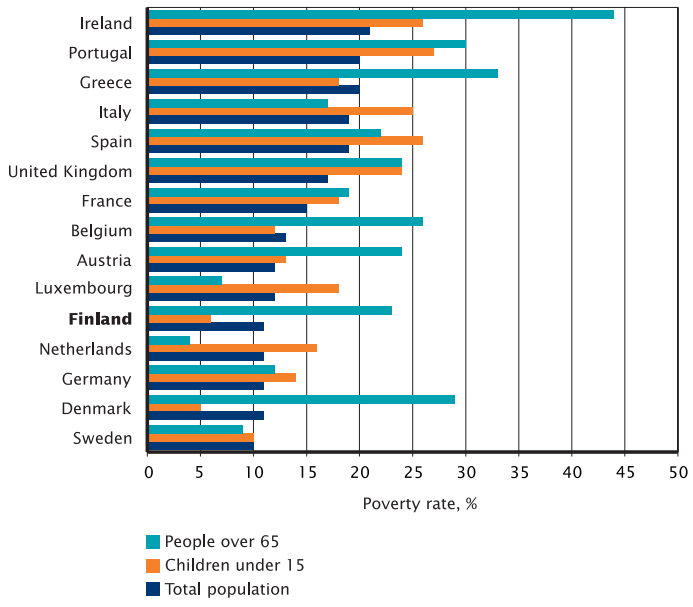


Figure 4.

Risk of poverty of total population, children and older people in the EU Member States in 2000

Poverty rate: 60% of disposable income. New OECD consumer units.

Source: Eurostat (ECHP)



CASH BENEFITS

Cash benefits accounted for about two thirds of social protection expenditure. The function of statutory social protection is to ensure all citizens against the loss of income or the expenses incurred from illness, disability, unemployment, accidents, old age, widowhood, or the birth of a child.

The aim has been to finance basic benefits out of tax revenue, while employment-related benefits are financed with contributions from employers and the insured.

Unemployment security

The purpose of unemployment security is to secure a reasonable income for unemployed people. Unemployment security is paid in the form of earnings-related daily allowance or basic daily allowance. Labour market support is paid to those who do not fulfil the conditions for receiving the daily allowances or who have already received the allowances for the maximum period. The unemployment security schemes are designed to take account of insurance principles and to retain incentives to return to work.

Both employment and unemployment fell somewhat as a consequence of a lower supply of labour. Long-term unemployment remained high. The number of recipients of earnings-related and basic daily unemployment allowance grew, but periods of unemployment became shorter. The number of recipients of labour market support continued to fall.

The full basic daily unemployment allowance was EUR 23.02 a day in 2003. The full labour market support is the same amount as the basic daily allowance. If an unemployed person has one, two or more than two children, there is a child supplement to the labour market support of EUR 4.36, 6.40 or 8.26. The average earnings-related daily unemployment allowance was EUR 43.75 a day in 2003.

On January 1, 2003, a number of amendments were made to the unemployment security system, in order to develop the system to support remaining at work and employment more than hitherto:

- Provisions concerning income security during periods of unemployment were collected within one Act.
- Entitlement to earnings-related daily unemployment allowance was made more accessible. The period of employment required for the daily allowance was reduced to eight months instead of ten. Where applicants for other forms of unemployment security are concerned, the period of employment required for the daily allowance remained unchanged at ten months.
- A person born in 1950 or later can receive daily unemployment allowance until the age of 65 as opposed to 60 as hitherto (in the form of 'entitlement to additional days'). At the same time, the unemployment pension as a form of pension will cease to exist in 2007. The 'entitlement to additional days' will be given to people over the age of 59 who have worked for at least five years out of the past twenty years.
- It became easier for entrepreneurs to transfer from one unemployment fund to another as a consequence of less stringent requirements concerning the period of employment required.

Central government funds labour market support and basic daily unemployment allowance. Income from employee unemployment insurance contributions for employees who are not members of unemployment funds is also channelled into the funding of the basic daily allowance.

The earnings-related benefits paid by the unemployment funds are financed by unemployment funds, employment funds, employer and employee contributions and by central government. Out of the earnings-related daily unemployment allowances paid by unemployment funds, the State funds a portion equal to the basic daily unemployment allowance. The unemployment funds pay 5.5% of earnings-related unemployment benefit; the rest is financed by the Unemployment Insurance Fund from employer and employee contributions. The Fund has set up an unemployment security buffer fund to ensure liquidity and even out fluctuations in unemployment insurance contributions. In the year under review, the assets of the buffer fund exceeded the maximum decreed, and as a consequence, unemployment insurance contributions were reduced.

National health insurance

The aim of health insurance is to compensate for loss of income due to short-term illness and to complement public health care by providing access to reasonably priced healthcare services from the private sector and medicines prescribed for out-patient care.

As of the beginning of 2003, the minimum level of maternity allowance, special maternity allowance, paternity allowance, parental allowance and special care allowance rose from EUR 10.90 to EUR 11.45 a day. A corresponding increase was also introduced for the minimum amounts of daily sickness allowance and rehabilitation allowance. When an unemployed person takes parental leave, the daily allowance is determined based on the unemployment security received by that person in the same way as daily sickness allowance. The improved employment rate and certain other factors have caused an increase in the number of sick days in recent years.

The reconciliation of work and family life became easier as of the beginning of 2003, when paternity leave was extended by 12 weekdays, on condition that the father has had parental leave for at least the final 12 weekdays of the parental allowance period and takes the additional 12 days immediately after that. This adds up to 24 weekdays of consecutive leave. The popularity of paternity leave has remained lower than expected, however.

As of the beginning of the year under review, it has been possible to take parental leave in the form of part-time leave, which allows the father and mother to take partial parental leave at the same time. Entrepreneurs also received the right to partial parental allowance.

The number of dentists' appointments reimbursed by health insurance has grown significantly since the entitlement to such reimbursement has been gradually expanded to all age groups. In December 2002, the right to reimbursement for dental care was expanded to cover the entire population.

In order to make the use of medicines more cost-effective and ensure appropriate use, Finnish pharmacies have been obliged as of April 2003 to substitute the cheapest corresponding medicine with the same pharmaceutical substance for a prescribed drug (generic substitution). A combination of generic substitution and a fall in pharmaceuticals prices led to savings for

customers and for the medicines reimbursement system of a total of EUR 63 million, and the growth in expenditure on reimbursement for medicines slowed down considerably. The savings were much higher than anticipated. The deductible in reimbursement for medicines rose in 2003. Preparations for reforming the entire system for reimbursement for medicines continued.

Health insurance is funded from employer and employee contributions. Central government is responsible for funding the basic daily allowance. In 2003 the health insurance contributions by the insured – both wage-earners and pensioners – was 1.5 per cent. The extra 0.4 percentage point contribution by pensioners was eliminated as of the beginning of 2003. The health insurance contributions on wages paid by employers rose by 0.014 percentage points as of the beginning of the year. This increase made a three-year experiment possible, in which the social insurance contributions by private employers and State-owned companies in most municipalities in Lapland and in certain municipalities in the archipelago were waived for 2003–2005. The experiment is designed to improve employers' ability to take on more staff.

However, the contributions by employers and the insured did not cover the sum required for financing the health insurance system. The guarantee payment by central government rose to EUR 677 million, or to one-fifth of all health insurance expenses. In addition, EUR 300 million of the revenues from value-added tax was paid into the sickness insurance fund.

Pension insurance

Recipients of pension on Dec. 31	1995	2000	2001	2002	2003*
Old age pension	804 100	869 700	875 600	889 600	906 900
- early old age pension	42 400	64 700	57 800	62 050	66 300
Part-time pension	5 450	24 500	29 100	39 500	41 400
Disability pension	309 500	276 300	267 900	267 200	271 300
- individual early retirement pension	63 350	34 800	24 500	20 400	19 000
Non-earnings-related pension	39 150	54 300	58 000	57 600	56 000
Survivor's pension	260 100	281 300	283 400	284 750	286 000

* estimate

Pension security is made up of earnings-related pension and national pension. The earnings-related pension is earned through a person's own work and is the primary form of pension security. The function of the national pension is to ensure that every resident of Finland receives a minimum pension. In 2003, the number of recipients of old age pensions grew and the popularity of part-time pensions continued to grow rapidly. The number of recipients of other types of early retirement pensions fell or remained unchanged. The tendency to disability pensions increased slightly.

An extensive reform of private-sector pensions was approved in autumn 2002. The main aims of this new solution are to ensure the solvency of the earnings-related pensions system as life expectancy grows, to encourage people to stay on at work for 2–3 years longer than at present, to secure the labour supply, to simplify the pensions system, and to make the grounds for receiving pensions fairer. The main part of the reform will enter into force as of the beginning of 2005.

In the reform, the options for early retirement will be restricted in that those born after 1943 will no longer be entitled to individual early retirement pensions, the age limit for part-time pension will be raised and conditions for entitlement will be made stricter. The age limit for old-age pension will become flexible; in future, people may choose to retire between the ages of 62 and 68. The pension agreement also comprised reform of the unemployment security system and improvement of earnings-related pension rehabilitation, and pension is now accrued for periods of child care leave and study. The new pension system also prepares for growing life expectancy by introducing a 'life expectancy coefficient' which will be applied to adjust new pensions for the first time in 2010.

To simplify the situation of pensioners all pensions are from 2004 paid from the last pension institution of a retiree. Thus a person retiring has to fill in only one pension application. This has so far applied to private sector schemes but will be enlarged to include also public sector pensions.

Earnings-related pensions are funded chiefly from employer and employee pension contributions. The average earnings-related pension contribution increased slightly, to 21.4% of wages. The contribution is divided so that the employer pension contribution is an average of 16.8% while that of employees is 4.6%.

National pensions are funded from employers' national pension insurance contributions, central government contributions and revenue from value-added tax. Central government contributions to national pension expenditure came to 29 % and the government also funds child care allowances, disability allowances and pensioners' housing allowances in full. In 2003, the total sum came to EUR 1,135 million. In addition, EUR 700 million in revenue from value-added tax was paid into the national pension fund. Employers' national pension contribution for private employers and state-owned companies was 1.35/3.55/4.45% of wages depending on the ratio between payroll and depreciations.

SOCIAL AND HEALTH CARE SERVICES

The strategic focus of social welfare and health care services was to improve the effectiveness, availability and comprehensiveness of social welfare and health care services which are the responsibility of the authorities, and to ensure access to basic income security throughout the country.

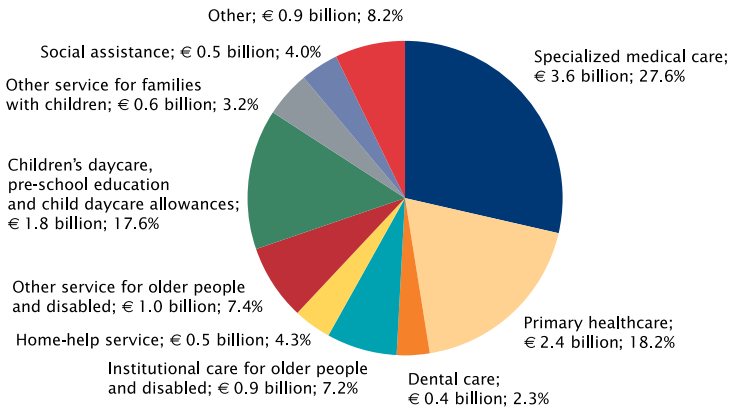
In 2003, municipal social welfare and healthcare expenditure came to an estimated EUR 12.7 billion. Out of this, EUR 3.1 billion was funded from the State budget, EUR 2.9 of it being paid to municipalities in the form of government transfers towards operating costs on computational grounds. The government transfer received by a municipality is based on the number of inhabitants and on the individual municipality's particular factors of need and condition. In 2003, the government transfer for operating costs for social welfare and health care was raised to 28.06%.

Nearly half of all social welfare and healthcare expenses are incurred by the municipalities from health care, and almost one-fifth from children's daycare and child care allowances (Figure 5). Advance estimates suggest that expenditure for health care and dental care grew in 2003. Meanwhile, expenditure on child care accounted for a lower percentage of municipal

Figure 5.

Municipal social welfare and healthcare expenditure in 2003[1)]

[1)] estimate



health care and social welfare expenditure than previously. The same changes are evident in staff numbers.

In December 2003, the Government approved the Target and Action Plan for Social Welfare and Health Care 2004–2007. During the year under review, a project on service legislation also started with the aim of preparing a long-term plan for the implementation of legislative amendments needed.

Social work

Social welfare comprises social services, social assistance, social benefits and functions related to them which exist in order to promote and maintain the social security and functional capacity of individuals, families and society at large. The main principles of social work in Finland are to prevent social problems, to improve the social security of the population and to promote people's initiative and independence.

Social assistance

Preliminary estimates suggest that a total of 260,000 households received social assistance in 2003; this is a slight increase on the previous year. The gross expenditure for social assistance grew by about two per cent on the previous year, which was due in part to the increase in social assistance payments which entered into force as of the beginning of 2003.

The provisions concerning social assistance were temporarily amended as of April 1, 2002. The amendments marked the beginning of a three-year test period to investigate incentives to work. Under this experimental system, a minimum of 20% of the earned income of recipients of social assistance up to a maximum sum of EUR 100 a month will be disregarded when calculating the person's entitlement to benefits. The experiment is scheduled for 2002–2005.

Services for older people

The aim is to care for as many of older people as possible in non-institutional care, and to support older people in living at home for as long as possible. Development of informal care

has been one of the focus areas this year. The majority of those being cared for in this way are over 65 years old. Three out of four of those being cared for needed help either all the time or at least continuously. Three out of four informal carers are women, and just over half of them are retired. Informal care has not developed in the desired direction. Support for informal care still has a rather uncertain position in the service system of the municipalities. There are not enough suitable temporary services available.

	1995	2000	2001	2002	2003*
Services for the elderly					
% of the over-75s					
- regular home care	13.8	..	12.1	..	12.5
- service housing	3.4	5.1	5.1	5.3	5.5
- old people's homes	6.5	5.3	5.1	5.0	4.9
- support for informal care	2.7	3.0	3.2	3.4	3.6

Legislation on the use of service vouchers in social welfare home help services was passed in 2003 and the amendments entered into force on January 1, 2004. The service voucher is a new system for the municipalities in arranging services. The value of the service voucher is determined according to the number of people in the household and their income. The municipality makes the decisions on the value of service vouchers for temporary home help and support services. The municipality must approve the service providers whose services can be purchased using municipal service vouchers.

Services for people with disabilities

The demand for services for people with disabilities continued to grow, as in previous years. The proportion of older people among the users of these services has grown. The need for transportation services, in particular, grows with age. Housing services continued to grow as institutional care continued to decrease. Quality recommendations for housing services for people with disabilities and assistive technology services were published during the year under review.

Preventing exclusion

There were still problems with over-indebtedness. The debt restructuring programme which was created by the state and the banks in 2002 in order to alleviate the position of the over-indebted continued. The purpose of the programme is to help debtors who are insolvent permanently or in the long-term. Social lending has also proved to be a way of preventing low-income groups from economic exclusion and from falling into a vicious circle of escalating debts. Work continued to establish social lending as a permanent practice throughout the country.

The situation in regard to homelessness improved during the year under review. Work to achieve the aims for reducing homelessness set down in the Government Programme included stepping up the provision of supported or sheltered housing offered by the social services to homeless people in need of particular support and care. Slot Machine Association revenues to

a total of EUR 11.2 million were allocated to the implementation of a homelessness programme for the Helsinki metropolitan area. These funds made it possible to start building or acquisition of nearly 600 housing units.

Alcohol and drug policy

In 2003, the consumption of alcohol in Finland was higher than ever before. By contrast, experimentation with drugs appeared to have levelled out for the present. Alcohol-related illnesses and deaths continued to rise. The demand for social welfare and health care services due to alcohol and drug abuse also continued to rise. (Figure 6)

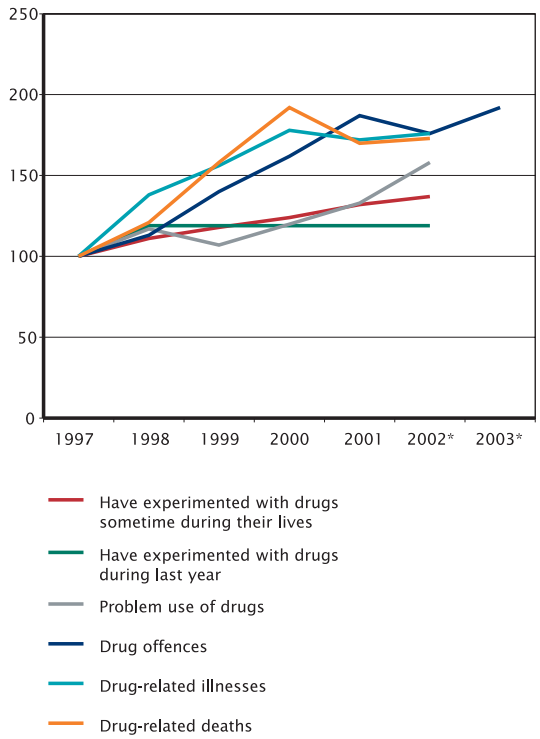
In October 2003, the Government made a Resolution on alcohol policy. The main aims are to reduce the harm from alcohol abuse considerably and to achieve a fall in alcohol consumption. Implementation of the programme is scheduled for 2004–2007.

Work on improving the effectiveness of treatment for drug addicts continued in 2003, as in the previous year, by including a budget allocation of EUR 7.5 million for that purpose in the State budget. The authorities intensified their cooperation on information provision on drug abuse. Young people are a particular target group for awareness campaigns. A special Drug Policy Action Programme will be implemented in 2004–2007 in order to reduce the harm from drug abuse and make treatment more effective.

Figure 6.
Development of the drug situation in Finland 1997–2003 (1997=100)

** = preliminary data*

Source:
National Research and Development Centre for Welfare and Health, Stakes



HEALTH CARE SERVICES

The aim of health care services is to help people stay healthy and retain their functional capacity for longer, reduce premature deaths, ensure the best possible quality of life for everyone, and reduce the differences in health between different demographic groups. The focus is on comprehensive preventive health policy. Every resident of Finland has the right to good health care and hospital care. The municipalities are required to provide health care services for their residents, either by producing the services themselves or procuring them elsewhere.

Total health care expenditure came to almost EUR 10.9 billion in 2003. This was 7.6% of GDP, which was still below the average for OECD countries. A majority of Finns (73%) are satisfied with their health care services, compared with an average of 44% in the EU Member States.

Health situation

Over the long term, the general state of health of the Finnish population has improved. Less than one in five working-age people have an illness or disability that impairs their work ability or functional capacity. The percentage of overweight people is growing, however. Smoking has fallen somewhat among both men and women while people now do more exercise in their leisure time (Figures 6–8). There are, however, still considerable differences in health between different demographic groups.

Figure 7.

Proportion of people who regard their health as good or fairly good, by age group

Source: National Public Health Institute

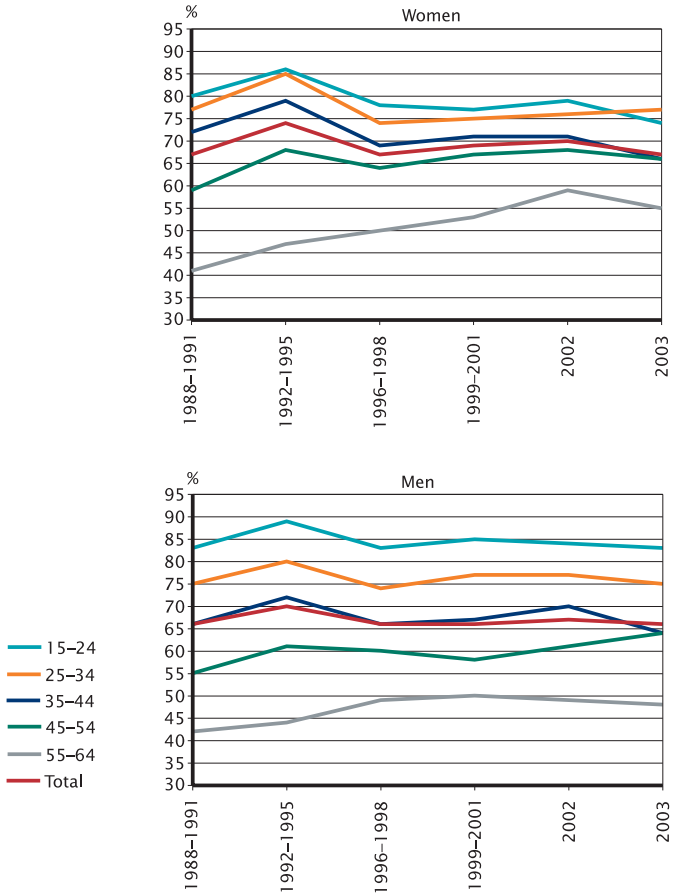


Figure 8.

Proportion of over-weight adults, by age group

Source: National Public Health Institute

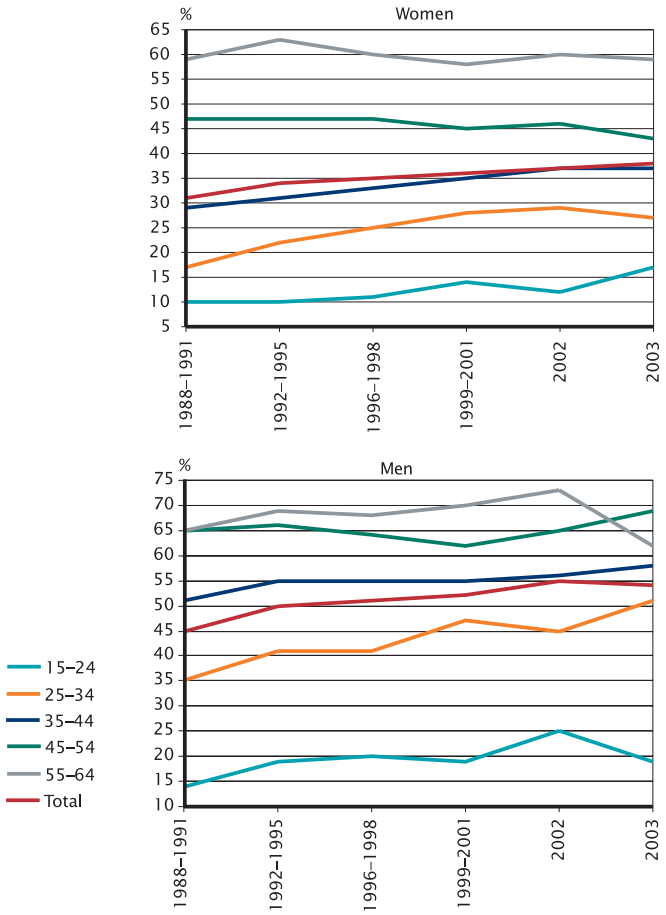
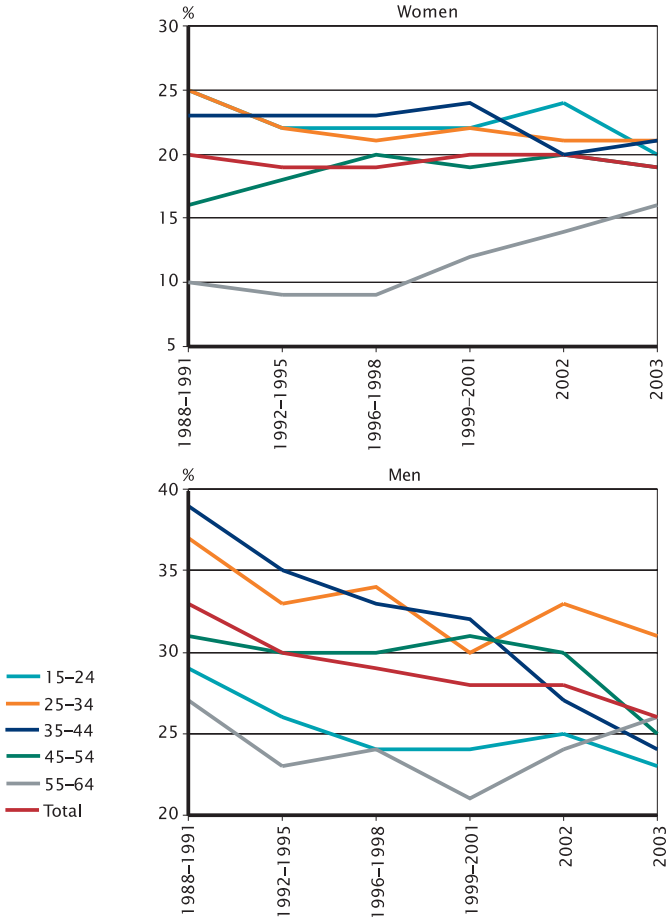


Figure 9.

Daily smokers, by age group

Source: National Public Health Institute



During the year under review, work continued on the National Health Care Project which started in 2002. The project progressed during 2003 according to the targets and timetable. The project is divided into 40 sub-projects, with the aim of ensuring functional primary health care and preventive work, ensuring access to services, securing access to labour and adequate staff skills, renewal of operations and structures and reinforcing the funding base for health care. Implementation of the Health 2015 public health programme continued during the year under review.

Amendments to the Communicable Diseases Act and Decree created improved capacity for combating communicable diseases. This was particularly the case concerning the hospital districts' ability to prevent outbreaks of hospital infections, as they now have new registration rights in this respect.

Primary health care and specialized medical care

Per 1,000 inhabitants	1995	2000	2001	2002	2003*
Primary health care					
- outpatient visits	4 651	4 855	4 835	4 791	4 800
- visits to prenatal clinics	..	915	922	980	980
- visits to mother-child clinics [1)]	2 841	2 771	2 788	2 702	2 700
- school health care visits [2)]	2 331	2 081	2 117	2 121	2 125
- dentists' visits	821	935	948	952	965
- discharges	44	54	48	48	50
- bed days	1402	1 495	1 463	1 421	1 400
Specialized medical care					
- outpatient visits	1 146	1 197	1 230	1 263	1 290
- discharges	194	181	171	170	170
- bed days	1 547	1 227	1 098	1 085	1 050

* estimate [1)] Per 1,000 0–7 year old [2)] Per 1,000 7–18 year old

In 2003, there was an average of 4.8 health centre visits per inhabitant, of which 1.8 were doctor's appointments. Municipalities were required to arrange dental care for everyone regardless of age as of December 1, 2002. In 2003, most of the health centres provided dental care services for the entire population.

In the supplementary budget for 2002, the Parliament approved a state grant of EUR 25 million to end queues for examinations and treatment. The funding in question was used for 80,000 out-patient visits and 29,000 examination and treatment appointments.

In 2003, the expenditure for specialized medical care grew by close to 6%, which was less than the previous year. Out-patient visits remained on the previous year's level, while surgical procedures fell somewhat. The number of patients awaiting surgery fell somewhat.

For the fourth year running, the State budget for 2003 included an appropriation for developing psychiatric care for children and young people and improving related services. The municipalities are receiving subsidies of a total of EUR 4.6 million, and continued the development projects started with the aid of the funding in previous years.

During the year under review, the Advisory Board on Occupational Health Care prepared development guidelines for the Government Resolution on Occupational Health Care 2015. The 10 guidelines included in it support application of the renewed occupational health care legislation.

In 2003, a Decree was issued on testing electronic drug prescriptions. The experiment will continue until the end of 2004, and preparations will then be made for introducing electronic prescriptions permanently.

FAMILY POLICY

In 2003, an amendment to the Family Allowance Act was prepared in accordance with the Government Programme, raising child allowances as of the beginning of 2004. The child allowance for the first child was raised by EUR 10, and the supplement per child for children of single parents was raised by EUR 3 per month.

Parents' right to work shorter hours due to child-care responsibilities was extended to the end of the child's second year of school. At the same time, amendments to the legislation on children's home care allowance and private child-care allowance were prepared in accordance with the Government Programme. The amendments include raising the part-time care allowance to EUR 70 a month. The allowance will be raised as of the beginning of 2004 and entitlement will be extended as of August 2004.

The extensive information campaign on the reconciliation of family life and work ended in 2003. It was estimated that the campaign had encouraged fathers, in particular, to use their rights to participate in child care more.

WORKING CONDITIONS AND OCCUPATIONAL SAFETY AND HEALTH

Preliminary figures for 2003 indicate that compensation was paid for about 119,000 occupational injuries and diseases, which was less than the previous year. Estimates indicate that the incidence of occupational injuries (the number of occupational injuries per million working hours) has fallen even in accident-prone sectors such as industry and construction. The total number of occupational diseases for which compensation was paid has fallen considerably in recent years. However, the number of fatal accidents in the workplace grew in 2003.

Over the past five years, the mental stress caused by work has decreased. The amount of overtime has also fallen slightly. Workplace health promotion has developed favourably, especially in the public sector, and focuses on improving employees' occupational skills and occupational safety and health.

The number of sick days per employee began to rise in 1998. Sick leave was most common in industries which expose people to risk of musculo-skeletal disorders: industry, construction, agriculture and the social welfare and health care sector. The number of new disability pensions rose slightly, the main reasons were still musculo-skeletal disorders and mental problems. The average retirement age remained unchanged.

PROMOTING EQUALITY BETWEEN WOMEN AND MEN

In 2003 preparations for reforming the Act on Equality Between Women and Men continued. The work to mainstream gender equality also continued and was expanded to include the entire State administration.

Preparation of a national action programme for equality in accordance with the Government Programme started in cooperation with the other ministries. In December, a rapporteur was appointed to investigate the problems in relation to implementing equal pay for women and men and to study the requirements for starting an equal pay programme as set down in the Government Programme.

INTERNATIONAL ACTIVITIES

During the year under review, EU matters focused on preparations for the Intergovernmental Conference (IGC) and the European Convention which preceded it. The Ministry of Social Affairs and Health was actively involved in preparing Finland's statements and two of its aims were included in Finland's priorities for negotiations: one concerning the clarification of the relationship between health services and common market regulations and the other concerning a requirement for unanimity in trade policy agreements on social welfare and health care services.

Political agreement was achieved on the reform of the legislation on coordination of social protection systems. One of the immediate tangible applications of the reform is the European health insurance card for receiving care during temporary stays in another Member State. Finland's National Action Plan Against Poverty and Social Exclusion for 2003–2005 for the EU was also completed during the year.

Cooperation in the health sector was dominated by political discussions on patient mobility, linked with the IGC preparations. The December Council decided to found a European Centre for Disease Prevention and Control, whose task will be to coordinate surveillance, early warning and response networks for communicable diseases. Finland was particularly active in preparations for founding the Centre. The Ministry of Social Affairs and Health also took part in the operations of the European Agency for Safety and Health at Work (based in Bilbao).

Negotiations on an international Framework Convention on Tobacco Control were concluded at the WHO. Finland ratified the Convention. Finland took part in an OECD Health Project.

The Northern Dimension Partnership in Public Health and Social Wellbeing was ratified in Oslo in October 2003. The programme involves 15 countries and six international organizations active in the area. The focus areas of the programme are combating communicable diseases, prevention of widespread chronic illnesses and promoting healthy lifestyles.

Finland's action plan for cooperation with neighbouring areas (mainly North-West Russia) for 2003–2005 was published and a welfare development project for children and young people in Vyborg was started. The Barents Council approved a new cooperation programme in social welfare and health care for 2004–2007. Finland will be chairing the working group that implements the programme for the next two years. The focus areas of cooperation are combating communicable diseases, promoting healthy lifestyles and promoting integration of social welfare and health care services.

The meeting of Nordic Ministers for social welfare and health signed a new mutual social security agreement. During the year, a Nordic framework agreement for health care was also signed, with the aim of intensifying cooperation between health care authorities in the event of a crisis or catastrophe.

During the year under review, Finland participated actively in the work of the Council of Europe's programme and expert committees. In June 2003, Finland took over the chairmanship of both the Health Committee and the Public Health Committee for the next two years.

OTHER ACTIVITIES IN THE SOCIAL WELFARE AND HEALTH SECTOR

The institutions and agencies under the Ministry of Social Affairs and Health can be divided into research and development institutions and permit and supervision authorities dealing with administrative matters. At the end of 2003, about 3,680 people worked in these units, including the Ministry itself. Ministry personnel totalled 467. Performance targets were set for each administrative unit in the sector, and these were laid out in the performance agreement between the Ministry and the units. The performance targets for the various agencies and institutions within the administrative sector are based on the strategy guidelines of the Ministry.

Slot Machine Association

The administrative sector of the Ministry of Social Affairs and Health includes the Slot Machine Association. This is the only body in Finland licensed to engage in slot machine and gaming operations. The Association's profits are distributed through the State budget to promote health and social welfare.

In 2003, the turnover of the Slot Machine Association went up to EUR 581 million, an increase of 3.3 % on the previous year. Profit for the financial year came to EUR 396 million. In 2003, grants amounting a total of EUR 302.8 million were distributed out of the profits of the association to 1,193 NGOs promoting health and social welfare. In addition, EUR 97.75 million was allocated to the Finnish State Treasury for the rehabilitation of disabled war invalids and other ear veterans.