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Trends in Social Protection
Finland 2002

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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SUMMARY

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Finnish social expenditure as a proportion of GDP near EU average

As a proportion of GDP, social spending was on the same level, at 25%, in 2000 as in 1990. Total social expenditure in 2001 is estimated to be € 34.4 billion. The increase compared with the preceding year is primarily due to an increase in pension and health care expenditure.

Unemployment is expected to increase somewhat in 2002. The rise in social expenditure due to changes in economic trends is expected to be very slight, in view of current forecasts. The increase of social spending to 26% as a proportion of GDP is a result of slow economic growth and the adjustments that have been made to benefits.

Almost one third of social expenditure is spent on old age. The second largest category of expenditure is that of illness and health. These two make up over half of all social spending. This share will continue to rise in the years to come. The share of unemployment expenditure will remain around 10% during the next few years. The proportion of families with children will remain at 12%, and expenditure on functional disabilities at 13%.

According to the Growth and Stability Pact, which complements the basic agreement of the European Union, public economy should in the long run be close to being in balance or showing a surplus. The state of the Finnish economy is very stable, despite the slow-down in production growth in 2001. The stability of the economical trend is increased by the unemployment insurance buffer fund, which makes it possible to lower unemployment insurance payments of wage earners.

The sum total of the 2002 state budget comes up to € 35.3 billion. The budget increased the government grants to municipalities for developing social and health care services. More resources were targeted at mental health work, services for an ageing population, the development of services aimed at children and young people, as well as social work and the improvement of out-patient care services. The 2002 state budget includes a so-called poverty package aimed at preventing poverty and exclusion. Its total impact comes up to € 157 million.

Statutory social security contributions by employers will decrease compared to 2001.

Majority of social protection expenditure are income transfers

The proportion of social costs that consists of income transfers increased during the past decade. An improvement in the economic situation and a decrease in unemployment led gradually to a diminished need for social security benefits. The slow-down of economic growth in 2001 makes it harder to improve the employment situation. If the economic slump is of short duration, the increase in income transfers due to a possible rise in unemployment will also remain small. This would be of great importance in order for social and health care services to have

sufficient resources. Social and health care spending as a proportion of GDP was about 3% lower in 2001 than in 1990.

Social and health care services

Social and health care services rely largely on municipal funding

Municipalities play a central role in the provision and funding of social and health care services. Municipalities provide funding covering 70% of the costs of social and health care services. 20% of the costs are covered by government grants to municipalities. The remaining 10% is financed by client fees.

The government's share of financing services fell clearly after the 1993 reform on government grants to municipalities. Municipalities were at the same time left with an increased responsibility for financing the services. To balance this off, the revenue generated by company taxation improved the financial capacity of a number of municipalities. Government grants to municipalities have been increased somewhat in recent years.

According to the estimation of the Ministry of the Interior, the financing status of municipalities seems to be developing in a positive direction in 2001-2003. The share of municipal taxes of total municipal tax revenue increases and that of company taxes decreases. This, together with the system of government grants to municipalities and the adjustments made in it evens out the revenue base of municipalities of different sizes.

Finnish health care spending remains low

The degree of satisfaction on the part of the public towards social and health care services remains high. According to a survey made in EU Member States, nearly 80% of Finns are either very satisfied or satisfied with the state of health care in the country. The figure is the highest among EU Member States (European Commission 2000).

Total health care expenditure in Finland in 1999 was still below the EU average, both as a proportion of GDP (6.8%) and in terms of per capita spending. The rise in salaries of health care staff will be seen in coming years as a rise in costs. Health care expenditure is generally the higher the wealthier the country is, but there seems to be no clear correlation between health care spending and the proportion of people over 75. An ageing population does not increase health care costs at the same pace as the population ages. The major part of health care expenditure concentrates on the last year of life.

Many municipalities have for years reserved unrealistically low sums in their budgets for health care costs. It is known even when the budgets are being approved that there will be a deficit, and that health care services will run out of funds during the budget period. This makes sensible long-term planning of activities difficult. Inadequate resources also lead to the formation of queues. As a rule, queues mean added costs to the municipalities in the long run.

The rise of medicine costs continues

Refunds on medicines paid by sickness insurance have risen in recent years. This is due to the use of expensive medicines and the extension of sickness insurance refunds to cover them, first as basic reimbursement and later as special reimbursement drugs. High medicine costs have also led to a situation where the number of people whose medicine costs exceed a personal annual limit has grown rapidly. Medicine reimbursement costs are expected to rise by over 10% annually.

The rapid growth of medicine costs is not an exclusively Finnish problem. Solutions for curbing the rise of medicine costs have been sought for in other EU countries as well.

Health situation generally good

The percentage of people who feel their health to be good has remained around 70% in recent years, while the percentage of those who perceive it as poor has diminished somewhat. In contrast, headache, insomnia and stress-related symptoms have become more prevalent.

Arteriosclerosis remains the most common circulatory disease, even though male mortality from arteriosclerosis has clearly decreased. Cancer morbidity has remained more or less unchanged in recent years, whereas the prevalence of asthma, allergies and diabetes has shown a rapid increase, as has the occurrence of mental health problems. Musculoskeletal disorders remain the primary cause of impaired working and functional capacity, while accidents remain the main cause of premature death and disability.

Providing performance information for consumers

Differences in the availability of treatment, treatment practices and outcomes of care have been receiving increasing attention. There are significant differences in the treatment frequency of even the most common illnesses. In the case of basic surgical procedures the per-capita differences can be as high as five-fold, or even ten-fold in the case of more uncommon procedures. There are also great differences between hospital districts in the length of time patients have to wait for medical procedures, and the quality and effectiveness rate of treatment stills show significant differences.

The entire population to be covered by public dental care

The scope of public dental care was extended in April 2001. Those born in 1956 or later have been admitted to municipal dental dare. As of the beginning of 2002 municipal dental care will cover also those born in 1946 or later. From the beginning of December 2002, age limits will no longer apply, and the entire population will be covered by dental care. The reform will mainly improve the situation of people in large municipalities. To be able to carry out the reform, municipalities have already taken on more dentists and made arrangements with private service providers. Municipal dental care has also been targeted more effectively than before at those in need of dental care services.

National health insurance refunds on dental treatment expenses were extended in April 2001 to those born in 1946 or later. All age limits will cease to apply as of the beginning of December 2002.

Increased problems from drug use

The use of drugs grew rapidly in the 1990s. It is estimated that there are 30,000 regular drug users in Finland, almost half of whom use so-called heavy drugs. The majority of the users are young people aged between 20-30. According to the latest data, drug use is no longer increasing. It seems that the increase of drug use has levelled off, particularly among young people of the most active experimentation age. As of 2001, there also seems to be a downward trend in drug-related deaths, which had been increasing since 1996. Drug-related crime is still growing, however, showing that drug-related problems are becoming worse.

An early onset of tobacco and alcohol use often predicts experimental drug use, while experimenting with drugs is a good predictor of moving on to regular drug use or more harmful drugs.

Costs of services for the disabled have gone up - problems in availability of services as well

The structure of services for the disabled has changed towards a community care. The numbers of clients of many out-patient services as well as housing services showed a steady increase throughout the 1990s. On the other hand, trends in the number of service recipients have varied with regard to different services and support measures. There are differences in how the Services and Assistance for the Disabled Act is applied, which gives rise to inequality between people with disabilities. There are challenges associated particularly with the availability of those services and support forms that depend on budgetary appropriation and are not included in subjective rights. The discharging of institutional care for the mentally handicapped also seems to have slowed down.

Funding will play an important role when the promotion of equal availability of services for the disabled is being considered. Key issues are the sufficiency of resources, particularly in smaller municipalities, as well as the division of funding responsibility between the central government and municipalities.

More resources, quality and innovation needed for care for older people

There is a need for taking on more staff in elderly care services. In order to guarantee the quality and quantity of services for older people, in addition to sufficient and trained staff, more effective utilisation of the new technological aids and technology in general as well as contious process of innovating is called for. The goal is for quality and customer-oriented services to become key issues in all municipalities, in addition to cost effectiveness.

The aim is that the national recommendations for high-quality care and services for older people issued by the Ministry of Social Affairs and Health will make services for older people more efficient.

The services aimed at elderly people living at home have not developed at the same pace as the cutbacks in institutional care. The most important challenge of services for the older people is the development of services for older people living in ordinary homes, as well as a rehabilitative approach in all services.

Need for adjustment of client fee policy

The regulations concerning social and health care client fees have been changed several times over the years. The client fee rules that have emerged as a result of the changes are very hard to decipher, both for the clients and other parties concerned. When changes have been made, in most cases only a single fee has been focused on. It has become increasingly unclear whether the changes in client fees promote the goals of social and health care policy. There seems to be an obvious need for finding out whether the current client fee policy promotes the objectives set for social and health care policy. Changes in the context of client fee policy also speak for a reconsideration of the objectives and principles behind fee policy.

Fertility rate remains unaltered, even though the number of children being born has declined

Last year, 56,000 children were born in Finland, which is about 9,000 less that ten

years ago. The low birth rate is primarily explained by the fact that the small cohorts born in the 1970s have now reached childbearing age. The number of babies born has declined particularly in the provinces of Kainuu and Lappi, which have continued to exhibit strong migration to centres of growth.

By European standards the Finnish fertility rate is still high at 1.74, the EU average being 1.53 (in 2000). The relatively stable fertility indices of recent years are the result of the relatively common phenomenon of women giving birth to a second or third child. Women are having their first child at a later age, however. The average age of women giving birth for the first time was 27.6 in the year 2000.

Family policy support can influence the timing of having children, but it does not have a decisive effect on the number of children a family decides to have.

Improved employment in regional centres

The number of employed persons continued to grow from 1994 to 2000, but the growth came to a halt in 2001. The employment rate is now 67%. Employment has improved in all age groups.

The growth of employment is concentrated in southern Finland and centres of growth. During a ten-year period of observation, the only region showing an increase in the number of employed was Uusimaa, where the number of people with a job rose by 34,000 from 1990. During that same period of time the number of employed persons diminished in both Lappi and Häme by 22,000.

The most significant changes in the position of women in the labour market can be summarised by three trends that began in the 1990s. Firstly, an increasing number of jobs in the public sector are fixed-term jobs, and secondly, unemployment among women has risen above that among men. Thirdly, the employment of mothers with young children, especially single mothers, has fallen more than that of other population groups. The negative effects of these changes are reflected particularly as weakened social protection for women and diminished possibilities for taking advantage of parenthood leave. The proportion of mothers receiving minimum parenthood allowance has risen from 6% to 27%.

Employment rate among the elderly has risen

The employment situation of those over the age of 55 has improved rapidly since 1998. Unemployment has diminished especially in the case of age group 55-57. The fact that part-time pensions have become more common has cut down the number of people leaving the job market.

Persons belonging to the large post-war cohorts do not seem to have the same tendency to choose the 'path' to unemployment pensions as the previous cohorts. However, it is still very hard for an elderly employee who has been made redundant to find a new job. Problems in finding employment underline the need for supporting elderly employees in their coping with work, workplace health promotion (WHP) and arranging rehabilitation at a sufficiently early stage.

The average age of people taking up a pension has risen somewhat in recent years.

The proportion of persons taking up disability pension has fallen

The average age of persons taking up disability pension has risen. The proportion

of persons under 55 on disability pensions has long been showing a downward trend. The proportion of pensions granted on grounds of mental health problems has risen, however.

The decline in taking up disability pensions is partly due to the utilisation of other forms of social protection as well as extensive unemployment. Some common diseases, such as hypertension, may also have a lower prevalence than before. This may indicate that the risk of unemployment may even continue to decline in the future.

Improved employment conditions for people with disabilities

The employment situation of persons with diminished working capacity has remained difficult, even though the general employment situation has improved. Only few persons receiving disability benefits are currently employed. The improvement of possibilities for finding job is a key issue when looking for solutions to diminish exclusion among the disabled and persons with diminished working capacity. Supporting employment is in many cases well motivated even from a financial point of view, when considering the costs of alternatives to employment.

As of September 1, 2000, all young people between 16 and 17 with severe disabilities are guaranteed the opportunity to receive vocational rehabilitation, during which time a rehabilitation allowance is paid to the young person on the basis of a tailored training and rehabilitation plan. The reform has significantly reduced the number of young persons going on to a pension. The training and educational possibilities of young disabled persons will be improved further as of April 1, 2002, by extension of the period of time during which the rehabilitation allowance is paid.

The support measures falling under social protection provided by municipalities promoting the employment of the disabled and people with diminished working capacity will be made clearer. Provisions on actions supporting employment and work activities will be added to the Social Welfare Act. Measures aimed at promoting employment denote setting up specific support activities or a job (previously known as sheltered work), if the person finds it difficult to find employment solely with the aid of employment services or employment policy measures.

Long-term dependency on social assistance a challange

The number of social assistance recipients has fallen somewhat in recent years, but costs have not gone down. The economical situation of households who have long relied on social assistance has deteriorated. The long-term unemployed must increasingly rely on social assistance, intended as a last resort. The social assistance reforms that have been carried out have been done so with the aim at encouraging the acceptance of work and taking the need of added support better into account, by increasing the amount of preventive social assistance.

The income-equalising effect of income transfers and taxation has weakened

Income differentials in income between households have grown since the mid-1990s. The reason behind this development is the strong growth in capital income; particularly households with the highest incomes have been able to increase their share of income. Real disposable income has grown in all income tenths, but the growth of income in the lowest tenth has remained modest, however.

The income-equalising effect of income transfers has weakened since the mid-1990s. This is partly due to an improved employment. As employment returns near the pre-recession level, the income formation of a growing number of households is once again based on their own earned income, which is a very desirable development. Improved employment only explains part of this development, though. The level of some social transfers has lagged behind the general income trend, even though the purchasing power of many benefits has been secured with index linkage.

Relative poverty, which measures the proportion of population on a low income, increased in the late 1990s. The number of low-income single parents rose in particular. The rise in poverty rate is partly a result of a general rise in household incomes, which has caused the relative poverty line to rise. Assessed with a fixed poverty line, adjusted only with regard to changes in prices, the growth in poverty levelled off by the end of the 1990s.

FOREWORD

When the previous report on the trends in social protection was published a little over year ago, the financial starting point looked excellent. Now we are experiencing a slight economical slowdown, and once again we must consider how much we must and can indeed afford to invest in social protection. According to a number of surveys, the opinion of the majority of people is clear: current social welfare and health care services must be maintained, even if this means higher tax rates. The experiences of the early 1990s and the fact that the challenge could be overcome with the aid of high-quality social protection are probably behind this opinion.

The economic integration of the European Union was completed by the introduction of the common currency euro on January 1, 2002. Citizens also want the European Union to have a stronger social identity. As a response to this, a new kind of cooperation has been carried out on EU level, with the aim of combating poverty and social exclusion, among other things. This report includes a short account of this cooperation.

Social protection is increasingly understood as a positive investment even for enterprises. Good social protection promotes sustainable economic growth, while a well-balanced economy is a prerequisite for high-quality social protection. According to several surveys, Finland is one of the most competitive countries in the world. One explanation for this is a well-functioning and effective system of social protection, which is one of the cornerstones of social capital. This is also the foundation of the strategy of the Ministry of Social Affairs and Health published in 2001, with the following four areas as main guidelines:

- promoting health and functional capacity
- increasing the appeal of working life
- prevention and treatment of exclusion
- well-functioning services and reasonable income security

The guidelines for social and health care policy stated above both promote economic growth and stabilise the economy. In established social protection systems social expenditure as a proportion of GDP generally rises during an economic recession, and then falls during times of economic growth. This means that changes by a few percentage points of social expenditure as a proportion of GDP do not generally mean a change in the level of social protection.

The employment rate in Finland is at present 7% lower than at the beginning of the 1990s. This has meant that index-linked benefits have retained their relative level, but non-index linked ones, such as child allowance, have lost some of their purchase power. Investing in services has also fallen, which is seen as a low percentage of health care costs as a proportion of GDP in international comparison. The low level of these costs is eating away at Finland's economic growth potential. It seems likely that in the coming few years we must allocate more resources particularly at developing primary social and health care services.

Due to an ageing population there is obvious pressure to increase spending on elderly care, but not as much as the mere increase in the number of elderly people would lead one to assume. Improved functional capacity among the elderly as well as more effective community care systems are helping to slow down the growth of costs. It is of particular

importance to solve the problems related to service financing, because differences in population age structure between different parts of the country will continue to increase. This means that we must secure the possibilities of tax-based financing and be able to develop client fee systems in an appropriate manner. This report gives some thought to the principles of developing client fee policy.

Trends in Social Protection is primarily the responsibility of the Finance and Planning department of the Ministry of Social Affairs and Health. The experts involved in production of the report are listed overleaf.

Helsinki, June 2002

Kari Välimäki, Director-General

TRENDS IN SOCIAL PROTECTION IN FINLAND 2002 EXPERTS

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The report was drawn up under the direction of Deputy Director-General Rolf Myhrman. Senior Research Officer Riitta Säntti was responsible for editing. Office secretary Päivi Ahtialansaari completed the figures. The cover and layout of the publication were designed and produced by Publications Secretary Heli Ulmanen.

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1 Financing and operating environment of social protection

The European Economic and Monetary Union (EMU) began its operation on January 1, 1999, and the integration of European economies was complemented with the introduction of the common currency euro on January 1, 2002. The economic and monetary union consists on eleven EU Member States in addition to Finland. Great Britain, Sweden and Denmark have stayed outside the monetary union. The core of EMU is the internal market with its four freedoms - the free movement of goods, services, labour and capital. Within EMU, competitiveness is vital, with emphasis on factors such as an appealing working life and maximum utilisation of human resources.

Monetary policy is managed on the level of the European Union, and its key goal is price stability. Decisions on financial policy are made on national level, but they are guided by the provisions of the Amsterdam Growth and Stabilisation Pact. They are related to the stability of state economy and the entire public sector economy. The validity of the Growth and Stability Pact is put to test in times of recession. It should be remembered in times of a possible economic slump that a healthy population with good functional capacity is a prerequisite for economic development.

1.1 The development of social expenditure

In 2000, social spending as a percentage of GDP was on the same level as in 1990, i.e. 25%. In 1993 at the height of the recession social spending rose to almost 35%, particularly due to the drop in GDP and the increase in unemployment benefit spending. Strong economic growth and more effective operation returned the percentage to the 1990 level after that (Figure 1).

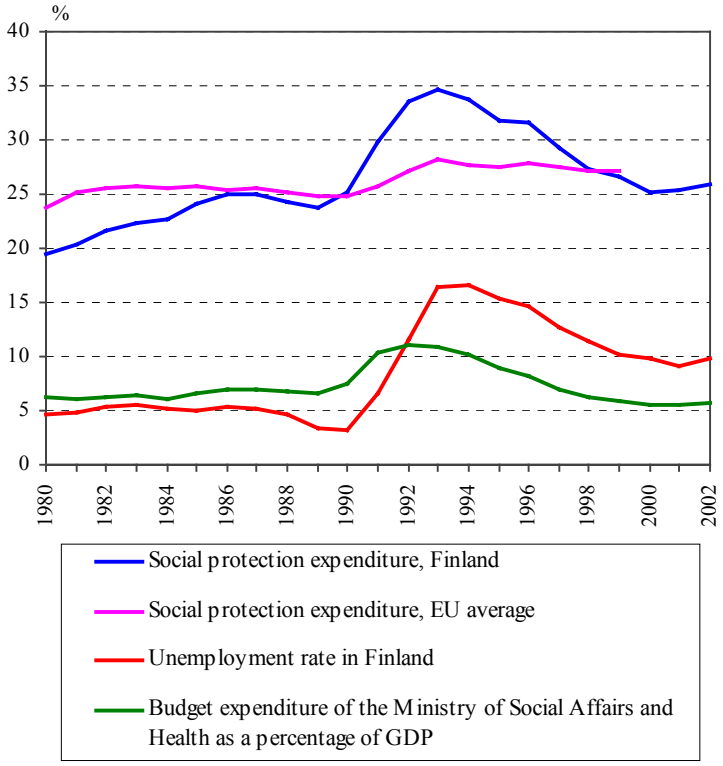
Production growth slowed down rapidly during 2001. As the economy slows down, social expenditure as a percentage of GDP begins to grow. Social protection acts as a stabiliser of economy. Its role is to promote the health and functional capacity of the population, to prevent and treat exclusion and to secure the availability of well-functioning services. Social protection also contributes to Finland maintaining its position as a viable, effective and dynamic society, even in times of economic slowdown.

Social expenditure in 2001 is estimated to be € 34.4 billion, or 25.4% of the GDP. Compared with the year 2000, social spending rose by € 1.4 billion. The rise is primarily due to an increase in pension and health expenditure. In real terms, social spending rose by only 1.5% in 2001. The slowdown in production was not yet reflected in the employment situation, for the employment rate rose by one percentage point from the previous year, i.e. to 67%.

The employment rate is expected to remain nearly unaltered in 2002. The unemployment rate will however increase somewhat. The growth of production is expected to speed up to 1.5% in 2002. In light of present forecast, the rise in social spending based on changes in economic trend will be very slight. The rise of social expenditure as a percentage of GDP is mainly due to slow growth of production. It will increase by half a percentage point in 2002, i.e. to 25.9%. If the Finnish economy recovers enough to show a 3% growth in 2003, social spending as a percentage of GDP will remain on the same level as before the recession. If

economic growth continues to be modest in 2003 and 2004 as well, social spending as a percentage of GDP will start to grow. The rise of social ependiture will be clearly slower than in the early 1990s even if economic growth remains slow.

Figure 1. Social protection expenditure in Finland and on average in EU Member States, plus the unemployment rate in Finland and budgeted expenditure in the main division of the Ministry of Social Affairs and Health in relation to GDP in 1980-2002

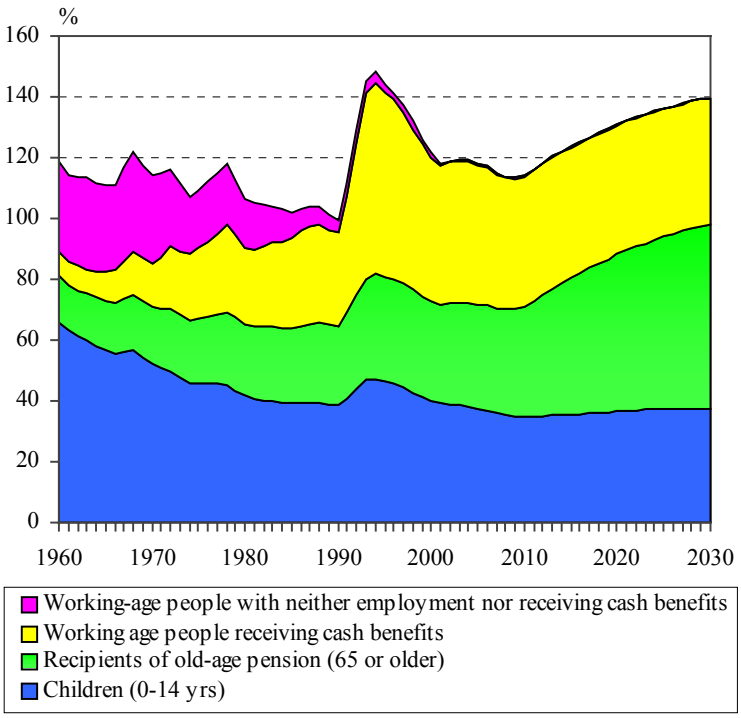


The increase of spending in the main division of the Ministry of Social Affairs and Health in the 2001 state budget and supplementary budgets was 5% compared to the year before. Social protection expenditure will increase by 5% in the 2002 state budget as well. The increase in spending is due to government grants to municipal social welfare and health care and health insurance. The rise in government grants to municipalities is primarily the result of statutory adjustments, transfers implemented to increase fiscal stability in municipalities and the proposed added resources to improve welfare services. The increase in health insurance costs is primarily due to a reduction in contributions as well as increased medicine costs.

1.2 Development of the economic dependency ratio

The economic dependency ratio indicates how many persons are supported by one employed person (Figure 2). The rapid fall in the employment rate weakened the economic dependency ratio in the first half of the 1990s. During the recession years, the employment and unemployment rates followed production trends with the same regularity as in the previous decades. A reduction of the unemployment rate seems to require a minimum economic growth of two percentage points.

Figure 2. The economic dependency ratio and its components: the trend from 1960 to 2001 and a projection until 2030, % of employed persons



The sharp decline in the employment rate in the early 1990s led to deep deficits in public economy, especially state economy, which necessitated cuts even in the social and health care sectors. These fortified the stabilisation of public economy in the latter part of the 1990s. Corporate economy rebounded, but poverty and exclusion grew. This has been seen e.g. as increasing social and mental problems in families and among children.

The cohort that entered the work force during the economic slump suffered particularly much of the effects of unemployment. There are also indications that the position of the cohort in question will remain weaker than that of those who were able to secure their position in the labour market before the recession, or of those who entered the work force after the recession without the burden of long-term or repeated unemployment.

The adjustment of social protection costs to unemployment

Despite the fact that the unemployment rate is nearly half of that in the year 1994, it is still over 9%. High unemployment together with early retirement increases social costs.

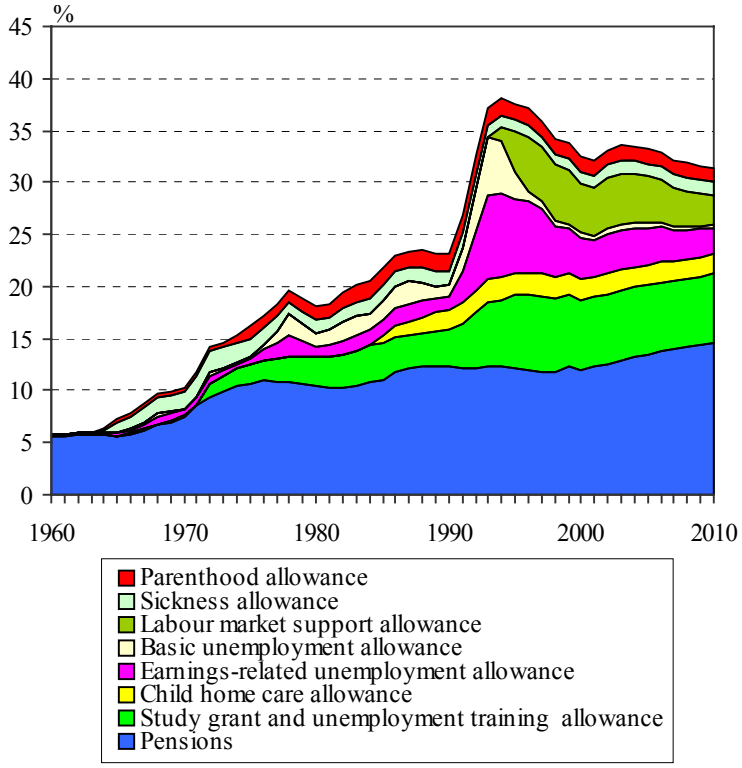
Finland is aiming to achieve the EU target of 70% employment rate of the age group 15-64, and especially the 50% employment rate for the age group 55-64.There are good chances of reaching this target, if the present downturn proves to be just a temporary slowdown.

According to the labour survey of Statistics Finland there were on average 238,000 (9.2%) persons without a job in 2001, which was almost 15,000 fewer than in the year before. Rapid economic growth increased the demand for labour especially among the over-50s and the under-25s. There has been no evening out in the regional development trend in

employment. Unemployment is very much a regional and structural phenomenon, which is why the usual economic and employment measures do not have a real effect on it.

Unemployment caused an increase in the need for and use of social protection benefits during the 1990s (Figure 3). The total social expenditure share of income transfers grew. Social protection benefits aimed at aiding individuals and families at times of risk have turned into long-term sources of income.

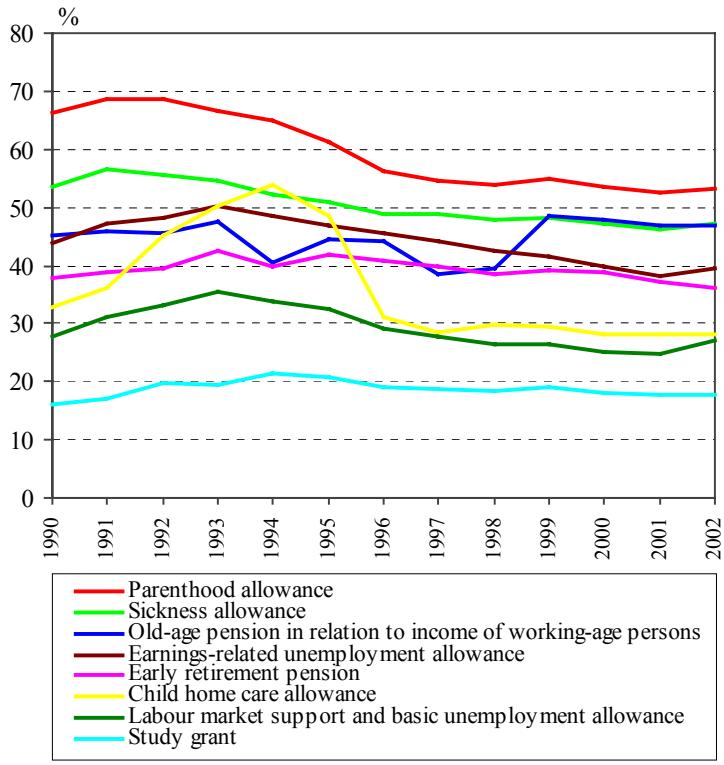
Figure 3. Working-age benefit recipients as a proportion of the working-age population in 1960-2001 and a projection for 2010, %



As the economy has picked up and unemployment fallen, the need for income security benefits has gradually decreased. The sudden onset of sluggishness of the economy in 2001 and 2002 following the previous growth trend slows down the improvement of employment and increases unemployment. If the economic slowdown is of short duration, the increase of the share of income transfers of total social expenditure will remain low. More resources are needed for social welfare and health care services. Benefits inkind expenditure as a proportion of GDP was about 3 percentage points lower in 2001 than in 1990.

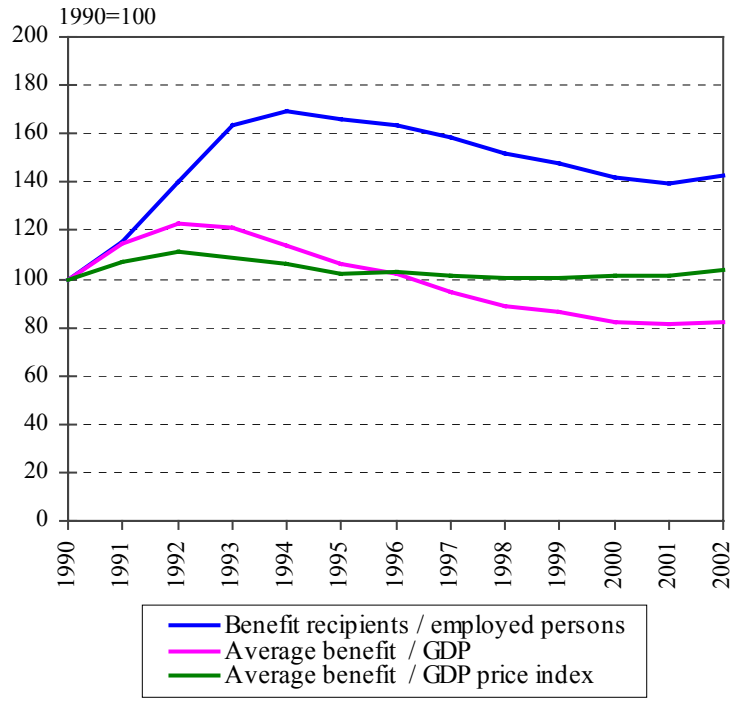
In the 1990s, social protection expenditure adapted to the call for stabilisation of public economy on benefit level as well. When the level of benefits is measured in relation to the average wage earned by people of the same age, recipients of parenthood allowance have the highest relative benefit level, the level of benefit being a little over half of the average wage of a person of the same age (Figure 4). Recipients of student allowance have the lowest relative benefit level. Most benefits decreased in relation to wages in the 1990s.

Figure 4. Trends in some pensions and allowances in relation to the average wages of employed persons of the same age in 1990-2002, %



The deterioration of the employment situation is seen in the fact that average benefits have grown at a clearly slower rate than the GDP, but at the same rate as prices (Figure 5). Income-related benefits, such as pensions, have best been able to retain their real level, whereas the level of benefits that are not linked to any index, such as minimum parenthood allowance, has been poorly retained.

Figure 5. Average income security benefits (pensions and allowances) in relation to development of GDP and the number of benefit recipients in relation to employed persons in 1990-2002

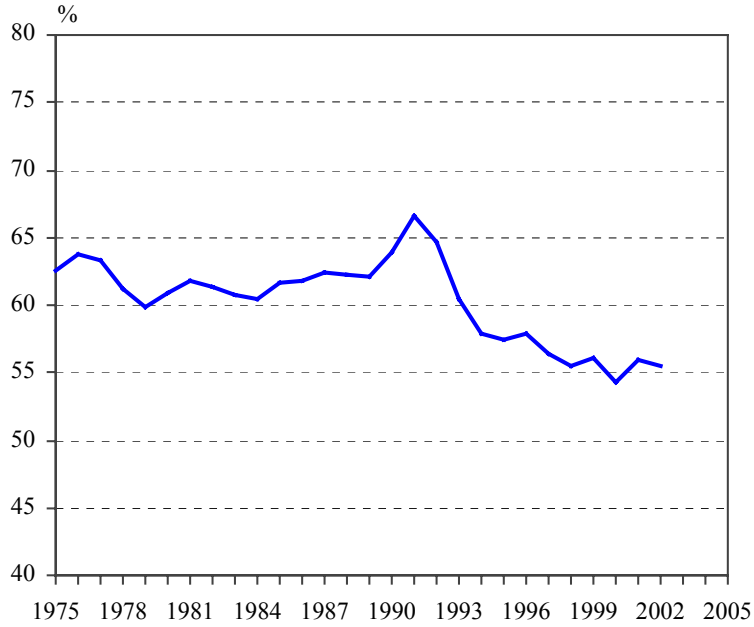


Capital income as a proportion of GDP has grown

Functional distribution of income changed markedly in the 1990s for the benefit of capital income. The value added share of wages and social security payments by employers has gone down 10 percentage points to 55% (Figure 6). The share of wage earner compensation was equally low in the 1950s. The changes in functional income distribution are explained by low employment and high work productivity. The growth of productivity has been particularly high in the IT sector, whose relative share of the domestic product grew very rapidly in the 1990s. The corporate tax reform of 1993 also brought with it a significant broadening of the corporate and capital tax base, at the same time as the corporate tax rate was lowered. Today companies show more profit in their profit and loss accounts than before the corporate tax reform.

Functional income distribution affects the funding of social protection expenditure. Many benefits are based on work income. The GDP share of tax revenue has slowly started to fall. This is partly a result of a lower tax rate of capital income compared to that of work income.

Figure 6. Salaries and employers' social security contributions as a proportion of gross value added in 1975-2002, %



1.3 The financing of social protection expenditure

The share of employers to financing social protection declined during the recession with cuts in employers' social security contributions. There was also a simultaneous drop in both the number of persons employed and the total payroll, which serves as the basis for calculating employers' contributions. The employers' share of financing social protection has grown somewhat with an improvement in the employment situation. There has also been a slight rise in the employers' contribution to the employment pension. The share of the insured has increased considerably since 1992 with the introduction of employer contributions to unemployment insurance and the employment pension. Central government contributes mainly to basic social security. During the recession in the 1990s, there was a rapid rise in the central government's share of financing as a result of unemployment. Central government expenditure is threatening to go up again in 2002 if unemployment increases.

Table 1. Financing of social protection expenditure 1990-2002, € billion

Year	1990	1994	1996	1998	1999	2000*	2001**	2002**
Central government	6.5	10.1	9.9	9.2	8.9	8.9	9.1	9.8
- budget expenditure minus government grants to municipalities and guarantee payments	6.2	6.7	6.3	6.3	6.1	5.9	5.8	6.2
- government grants to municipalities	0.0	3.1	3.1	2.2	2.2	2.2	2.4	2.5
- guarantee payments and items outside the budget	0.3	0.4	0.5	0.7	0.7	0.8	0.9	1.1
Municipalities	4.0	5.2	5.7	6,5	6.8	7.1	7.3	7.6
Employers	11.4	11.3	12.3	13.2	13.5	14.0	15,1	15.6
- insurance contributions	9.2	8.7	9.5	10.3	10.7	11.1	12.3	12.8
- tax payments	0.7	1.4	1.5	1.5	1.3	1.3	1.2	1.4
- contributions unconnected to work	1.5	1.1	1.3	1.4	1.5	1.6	1.6	1.4
The insured	2.1	4.7	4.6	4.6	4.6	4.5	4.8	4.8
- insurance contributions	0.7	2.1	2.5	2.9	3.1	3.2	3.3	3.4
- tax payments	1.4	2.7	2.1	1.7	1.6	1.3	1.4	1.4
Capital income	1.7	2.2	2.5	2.6	3.0	3.2	3.8	3.6
Total	25.7	33.6	34.9	36.1	36.9	37.8	40.0	41.3
Client fees	0.9	1.3	1.4	1.5	1.6	1.6	1.7	1.8

*preliminary data
** estimate

The financing structures of cash benefits, on the one hand, and of social welfare and health care services, on the other, are markedly different. The bulk of cash benefits are financed by employers, the insured and central government. The contribution of municipalities to financing cash benefits is minor. The only areas where the municipalities make a major contribution is in social assistance and the various forms of support for the care of very young children (Figure 7).

Municipalities play a major role both in the provision and the financing of social welfare and health care services, contributing about 69 % of total financing. Some 22% of social welfare and health care expenditure is financed by grants paid to the municipalities by central government, and the remaining 9% is financed by client fees. The relative contribution from central government has fallen clearly after the 1993 reform of the grant system, while the share covered by municipalities has increased (Figure 8).

Figure 7. Financing of cash benefits 1990-2002, %

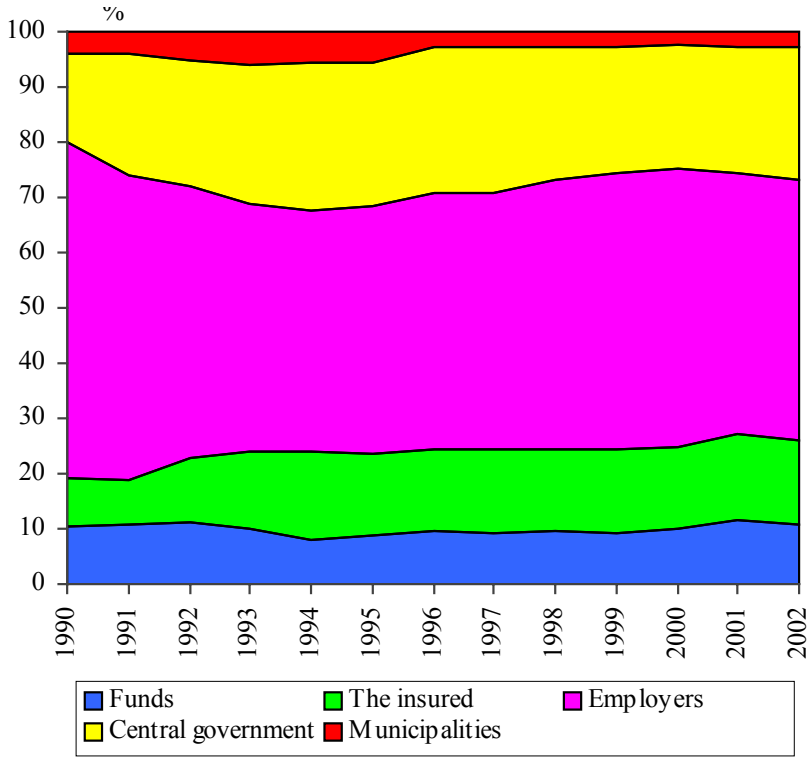
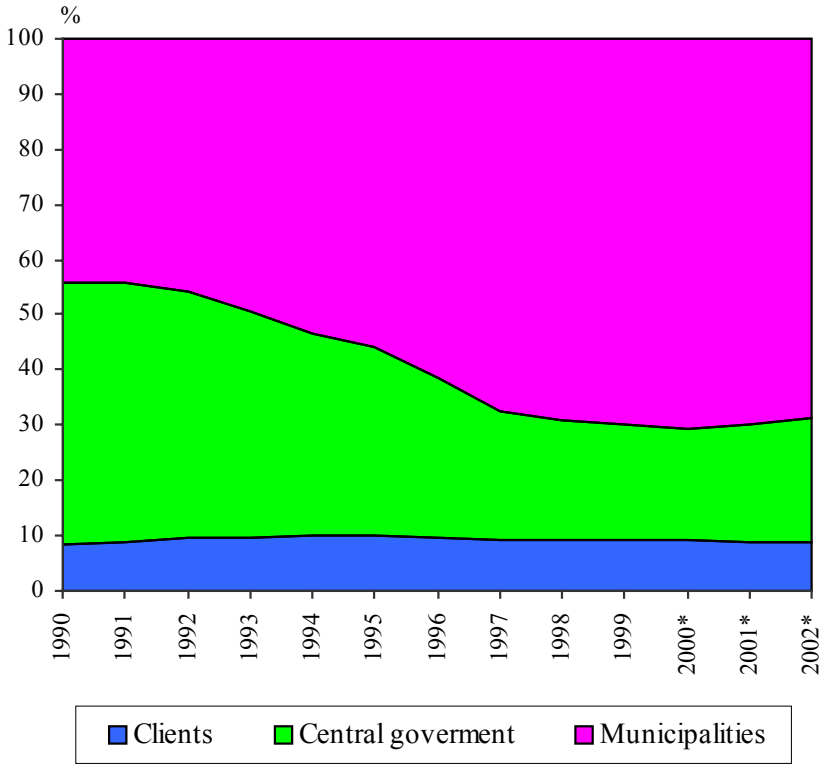


Figure 8. Financing of municipal social welfare and health care services 1990-2002, %



1.4 Social policy and public sector developments

According to the Growth and Stability Pact of the European Union, public economy should in a moderately long perspective be close to being in balance or showing a surplus. In its adjustment to the stability programme for the year 2000, the Finnish government announced that its goal was to maintain a minimum financing surplus in the public sector of 4.5% in relation to the GDP during its mandate. The minimum goal for central government finance would be a financial surplus of 1.5%. In the year 2000 the financial surplus in the public sector was 7% in relation to GDP.

The adjustment to the growth and stability programme for 2001 states that in 2001 the financial surplus of public corporations will remain at 4.5% of GDP, but will diminish thereafter for three years to about 2%. The government considers a smaller financial surplus acceptable, and sets a goal of strengthening public economy at a longer perspective.

Public debt is about 40% of GDP. Some of the public debt has been paid off during the past few years, which together with reorganisation of loans has cut down loan costs.

Economic stability is also increased by the unemployment buffer fund, which is now full. This has made it possible to lower unemployment payments. The income security of the unemployed was improved by an increase in the levels of daily unemployment allowance in the 2002 budget.

The Finnish economy is very stable by European comparison, despite the slowdown in production growth in 2001. The cornerstones of sustainable growth are the maintenance of working and functional capacity and independent initiative. The Ministry of Social Affairs and Health has laid out the trends in social protection in the coming decade in the form of four strategic guidelines[3]. They are

- the promotion of health and functional capacity
- increasing the appeal of the working life
- prevention and treatment of exclusion
- well-functioning services and adequate income security

Social policy and the budget proposal for 2002

The total sum of the 2002 budget comes to € 35.3 billion (FIM 209.9 billion). The main division of the Ministry of Social Affairs and Health accounts for € 8.1 billion (FIM 48.4 billion) of this total, which is around € 500 million (FIM 3.0 billion) more than in 2001. The Ministry of Social Affairs and Health's budgetary funding will cover a good fifth of all social protection expenditure in 2001. Social spending will also be partly financed from expenditure under other main divisions in the budget. Altogether around one third of social protection will be financed through the state budget.

The starting point for the budget from a social and health care policy viewpoint is the maintenance of a Scandinavian welfare state. The quality and accessibility of services is secured in the entire country for all groups of people. This calls for a balanced development of municipal economy, municipal cooperation and the introduction of new working models. The objective is to promote activities that prevent and diminish exclusion and the accumulation of social problems.

[3]Strategies for Social Protection 2010 - towards a socially and economically sustainable society. The Ministry of Social Affairs and Health, Helsinki 2001

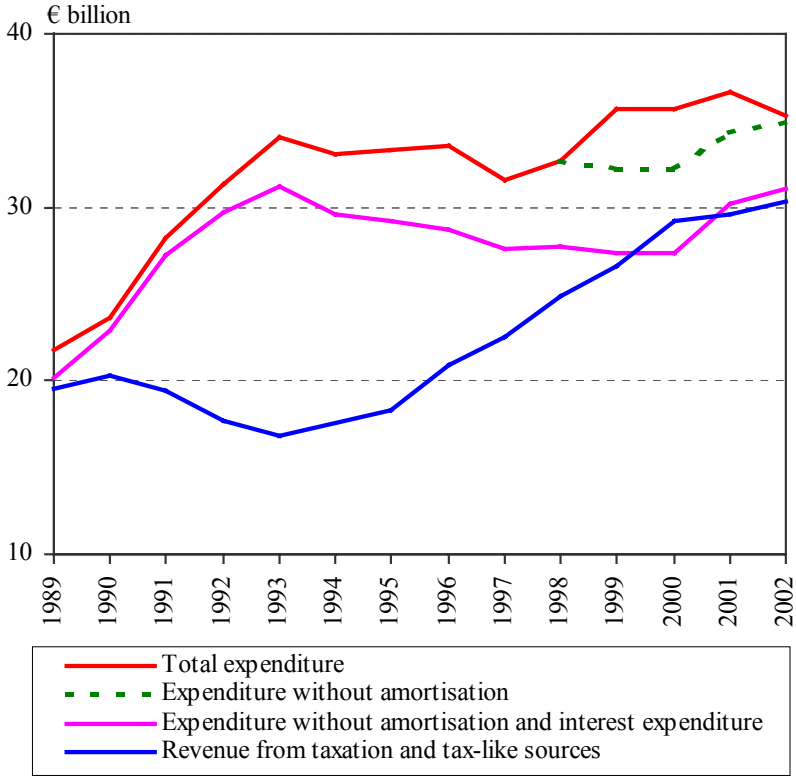
In order to increase the stability of municipal economy, the 2002 budget includes discontinuation of the claim for recovery of value added tax and its set-off mainly from company tax. The budget also includes an increment in government grants to remote areas and island municipalities and the removal of the 15% limit in the equalising of government grants based on tax revenue. The limit has been used for some municipalities receiving the highest amount of tax revenues. According to the limit, the equalising reduction calculated based on tax revenue has been at most 15% of the municipality's calculated tax revenue. The reform cuts back state expenditure by an estimated € 79.3 million in 2002. This is added to the government grants to cover the running costs of municipal social welfare and health care. Abandoning the set-off of value added tax also evens out the distribution of income between municipalities. The central government has recovered all value added taxes reimbursed to municipalities based on a calculation model of FIM/resident. The amounts reimbursed to and recovered from a municipality could differ from each other markedly.

Welfare services will be improved by increasing government grants to cover municipal social welfare and health care costs by € 74 million. A 1.5% cost level adjustment will be made to government grants, which equals half of the rise in the level of costs.

In organising municipal social welfare and health care services, special attention will be given to mental health work as well as services needed by the elderly, improving services for children and young people and developing social work and community care. The system of family caregivers as well as income security will be improved. Financing for these reforms will be channelled through the government grant system.

The statutory social protection payments by employers fell somewhat from the 2001 level. National pension payments fell by 0.45-0.65% in the private sector. The national pension payment paid by municipalities and church parishes fell by 0.75%. Employee payments remained unaltered, with the exception of the unemployment insurance payments, which fell by 0.2%. The payment load of pension recipients will be diminished, since the increased health insurance payment collected based on pensions fell by 0.8%. After the mid-1990s state taxes and tax-like revenues reached the nominal level of the late 1980s. In 1999, for the first time since the recession tax revenue exceeded the main division expenditure in the state budget. During the past few years, the amount of tax revenue has been around € 30 billion.

Figure 9. Government expenditure and central government revenue from taxation and tax-like sources 1989-2002



Municipal finances

According to the 2000 financial statements, there was a slight improvement in the financial position of municipalities and joint municipal boards in the country as a whole. The aggregate annual margin was € 1.7 billion. Municipalities need the annual margin to be able to fund their investments and to amortise their loans. Looking at types of municipalities and regions, differences in the financial position of municipalities grew. The differentiation in municipal economy is greatly influenced by the location of enterprises in different regions as well as regional differences in the employment situation, which is seen as uneven distribution of company tax revenue and municipal tax revenue. The differentiation in economic development has contributed to an increase in internal migration. The annual margin in 2000 was negative in 196 municipalities, while over 230 municipalities reported an accounting deficit. The number of municipalities with a negative annual margin was more than doubled from the year before[5].

[5]The figures are not fully comparable, because of changes in rendering of tax accounts and accounting practices.

Table 2. Key indicators of municipal economy, € billion

	1999	2000	2001	2002	2003	2004	2005
Operating margin	-13.0	-13.8	-14.5	-15.1	-15.7	-16.4	-17.1
Tax revenue	12.1	12.9	13.4	13.2	13.3	13.7	14.3
Central government grants for current expenditure*	3.2	3.4	3.7	3.9	4.0	4.0	4.1
- of which, administered by the Ministry of Social Affairs and Health	2.1	2.2	2.4	2.5	2.6	2.6	2.6
Other expenses, net	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	-0.1
Annual margin	1.6	1.7	1.7	2.0	1.6	1.3	1.2
Investments, net	1.3	1.6	1.9	1.9	1.9	1.9	1.9
Total outstanding loans	3.9	4.1	4.2	4.1	4.3	4.7	5.2
Cash assets	2.7	3.2	3.1	3.1	3.0	2.7	2.4
Net liabilities (total outstanding loans - cash assets)	1.2	0.9	1.1	1.0	1.4	2.0	2.8

The figures in the table are based from 2001 onwards on preliminary data or forecasts
*According to the municipalities' own account

Source: Advisory Board for Municipal Administration and Economy, August 29, 2001

Municipalities with a negative or weak annual margin were mainly ones with a smaller than average number of inhabitants. The economical situation was primarily improved in large municipalities with over 100,000 inhabitants. The fact that the number of investments is falling although the amount of total outstanding loans is growing is worrying in the case of small municipalities. This means that due to financial difficulties, current operating costs are also funded by loans. According to the financial statements from the year 2000 municipal expenditure has grown, offsetting the rise in municipal revenue. Operating costs rose around € 1 billion compared to the previous year.

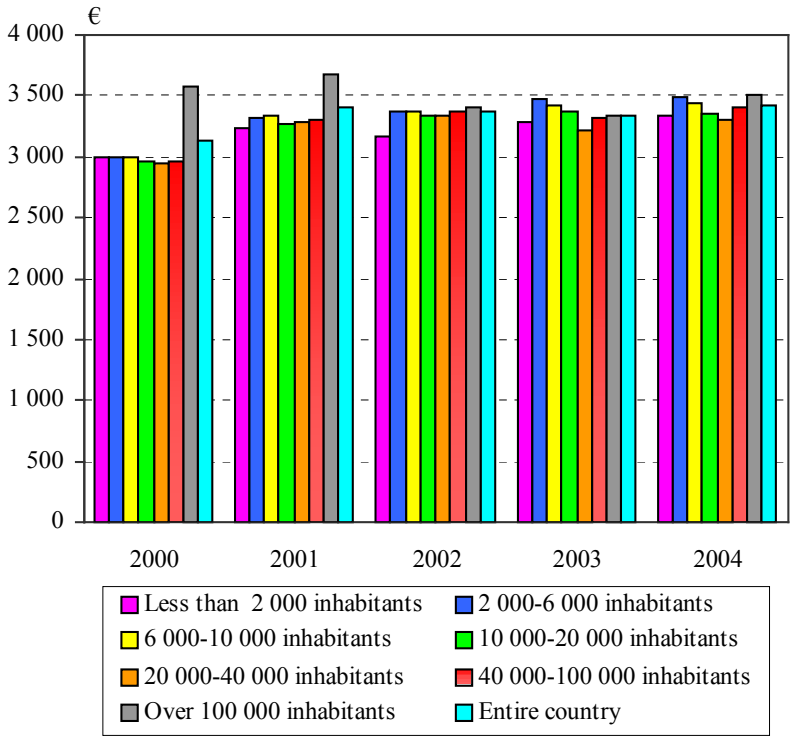
Migration is mainly directed to large growth centres. Smaller cities with universities/polytechnics as well as high-tech centres also attract newcomers. The people moving in are generally young and highly educated. As opposed to earlier, many unemployed are also moving, even though they have no security of finding a job in their new city of residence. In the short run, migrants mean overlapping costs for both the municipality of origin and the one they move into. The effects of a migrant's moving in are transferred from one municipality to another with a couple of years' delay.

In municipalities suffering from net population loss, the average age of the population rises and tax revenue falls. However, expenditure does not fall at the same pace as the population diminishes, which emphasises the importance of tax revenue equalisation and the role of government grants in the maintenance of regional welfare.

A significant change took place in the 1990s in the financing structure of social welfare and health care. There was a considerable reduction in government grants to municipalities, while the significance of tax revenue grew. This had a great impact of the economic situation of individual municipalities and the differentiation of municipal economies. Another factor that had a significant impact of municipal economy in the 1990s was the change in the structure of tax revenue. The share of municipal taxes of total tax revenue decreased, while that of company taxes increased. There were marked differences in company tax revenues between municipalities. Despite the rise in the number of municipalities with a negative annual margin it is not possible to discern a group of municipalities with a permanent negative annual margin. Municipalities with a negative annual margin are often very small municipalities with big economic problems.

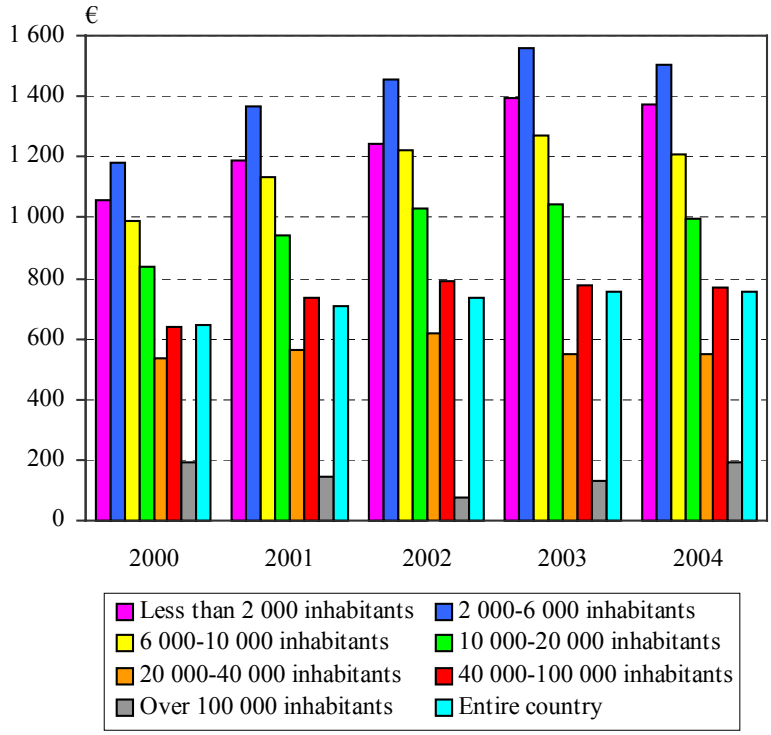
According to a Ministry of the Interior estimate, the financing situation of municipalities seems to be developing in a positive direction in 2001-2004 (Figure 10). The number of municipalities with a negative annual margin will fall. The emphasis in municipal tax revenue is increasingly shifting from company taxation to municipal taxation. This together with the government grant system and the changes made in it evens out the income base of municipalities of different sizes. By the year 2004 the tax revenues and government grants per capita of small and medium-sized municipalities are almost on the same level as those of large municipalities (Figure 11). Only in municipalities of less that 2,000 and in ones with 20,000-40,000 inhabitants will the revenue per capita remain smaller than in others. However, it must be taken into account that there may be great differences even between municipalities belonging to the same category. According to the calculation of the Advisory Board for Municipal Administration and Economy, the state of municipal economy will remain relatively good in the coming few years. Several measures aimed at increasing the stability and predictability of municipal economy will be launched in the year 2002: the claim for recovery of value added tax will be abandoned, the equalising system of government grants based on tax revenue will be reformed, and adjustments will be made in the government grant system. Even though these measures have a boosting effect on the economy of small municipalities in particular, what is crucial for the municipalities is that they must be prepared for any future problems.

Figure 10. Municipal tax revenue and government grants in 2000-2004, €/inhabitant



Source: Ministry of the Interior

Figure 11. Government grants in 2000-2004, €/inhabitant



Source: Ministry of the Interior

1.5 International pressures on social protection

The main effects of the European Union's treaty on Economic and Monetary Union are in the area of economic policy, particularly budgetary and monetary policy, but it also has implications for social protection and its funding, as economic decisions influence social policy and especially the financing of social protection.

The different national systems of social policy and financing models have emerged for historical reasons. Within the European Union, cooperation on social protection and powers to act in this area have been limited, cooperation being restricted mainly to issues relating to the supply of labour and the functioning of the labour market. In economic questions, decisions are taken which are binding on Member States and which also have an effect on their social policy, but there has been no wish for direct harmonisation of social protection. There is however growing pressure to coordinate the social policy in different Member States more closely as the integration process goes further. A sensible integration of economic, employment and social policy poses a great challenge for the decision-making of an expanding European Union.

New ground was broken in cooperation on social policy during the Finnish EU presidency. On November 29, 1999, the EU Council agreed to endorse the Conclusion on a joint strategy for reform and improvement of social protection. In accordance with the Conclusion, a group of high-level officials was appointed to prepare the strategy, beginning its work at the end of 1999. It was subsequently decided to set up a committee that a committee be set up to prepare the strategy, and this held its first meeting in December 2000.

Four broad objectives were adopted for cooperation:

- to make work pay and to provide secure income
- to make pensions safe and pension systems sustainable
- to promote social inclusion
- to ensure high quality and sustainable health care

The Committee on Social Protection initially concentrated on issues relating to the promotion of social inclusion. The efforts of Member States to combat exclusion have been charted, and the results have been used to draft guidelines for cooperation. The so-called open method of coordination, which was developed as a method of monitoring the realisation of the objectives approved by the Council of Europe in Lisbon, was adopted as the group's method of work. The method is based on the exchange of information on the systems used in different countries, defining joint guidelines and objectives, the improvement of comparability of results by developing quantitative and qualitative indicators, and the dissemination of good practices. A constant dialogue between EU Member States together with fixed-term follow-up and assessment of national operating policies is believed to promote learning and to bring the systems closer together, while yet respecting national differences in areas where the Union has no legislative power/competence.

During the year 2001 national action plans to combat poverty and exclusion were drawn up in all Member States for two years, following jointly approved guidelines. The European Commission prepared a summary a joint report of the action plans, which was approved at the Laeken summit in December 2001. Joint European social indicators have been developed in order to support the

development of social policy and to measure the various dimensions of exclusion. At the end of the year the indicator working group gave its joint report under the guidance of the Committee on Social Protection. The work relating to indicators will expand in 2002 to cover pensions and elderly care services.

The Committee has made progress in its work and is now looking at pension systems. The Committee on Social Protection and the Committee on Economic Policy have prepared a joint report on pensions. Worries that the Member States have in common are an ageing population, the sufficiency of pensions and the funding of social spending in the future. In the field of social protection the open method of coordination will next be applied in the study of the quality and sustainability of health care and how to increase incentives motivation for work. During the Belgian presidency the central theme in discussion was the promotion of corporate social responsibility of social enterprises, social community economy and social enterprises corporations. EU organs have emphasised networking of different actors and the role of social partners labour market organisations and NGOs in combating poverty and exclusion. The annual spring meeting of the Council of Europe will define the tasks related to the Lisbon strategy and confirm their follow-up. The relation of the open coordination method to economic policy has remained relatively unclear.

Many issues relating to social welfare and health care policy have also appeared on the agenda at trade negotiations at the WTO. Developing nations have expressed grave concern on the effects that the patent protection of intellectual property rights may have on the access to availability of reasonably priced medicines in poor countries. There was a wish to define more precisely the interpretations of the TRIPS treaty governing the trade on industrial rights and copyrights. The problem of drug availability became acute in combating communicable diseases, such as the HIV/AIDS epidemic in South Africa and Brazil. The drug industry was eventually forced to back down and allow the production of cheaper medicines in these countries. The ministerial conference meeting of ministers in Doha approved a declaration concerning the availability of medicines and industrial rights and copyrights, which among other things confirmed the right of every member state to produce drugs in emergency situations with ability to issue the aid of a compulsory licence. As the significance of the TRIPS agreement for the development of new drugs was recognised, an agreement was also reached to the effect that the accord on the protection of intellectual property must be interpreted so that it ensures the access to availability of existing drugs and does not prevent WTO members from working to promote public health.

In the pursuit of global free trade, there has also been a wish to extend activities to trade in services trading services. Services are understood in a broad sense in this connection, and they are supposed to include e.g. the provision of cultural, social welfare and health care services. Increased liberalisation of the trade on services will be part of the new WTO negotiation round. Requests concerning individual countries must be submitted by June 30, 2002, and offers by March 31, 2003 at the latest. The European Union has, with some exceptions, competence jurisdiction in matters of trade policy. This means that the Commission represents Finland as well, e.g. in negotiations at the WTO.

There has been a wish to secure continuing national jurisdiction in the provision of public services. The definition of public

services has been left to each country. The removal of obstacles to the free movement of labour is also related to social protection systems and the employment services of social welfare and health care. The enlargement of the European Union means added pressure to move over to majority decision-making even in areas requiring unanimity at present, such as services and intellectual property.

In connection with these negotiation rounds, the Ministry of Social Affairs and Health has considered it important that potential international agreements do not hinder or hamper in any way the implementation of broadly based long-term national social welfare and health care policies. For instance, Finland is opposed to attracting foreign companies into the country by lowering the level of social protection or by skimping on international norms on labour relations.

International Labour Organisation (ILO) conventions and recommendations present the so-called core norms relating to issues such as freedom of association, the use of child labour and equality. Many developing countries nations have vocally opposed the incorporation on these core norms into WTO conventions, fearing a deterioration of their own relative position.

The demand to follow basic labour-related norms must be seen as part of a more extensive objective to attain both economically, socially and environmentally sustainable development growth, in which the social dimension has a central role as a reducer of poverty and social injustice. As a result of globalisation and EU membership, an increasing number of trade policy trade-political choices will have to be made, where both social welfare and health care policy issues must also be taken into account.

2 Social protection expenditure by target group

Almost one third of social expenditure is spent on old age. The second largest category is sickness and health. Together these account for over half of all social protection expenditure, and their share will continue to rise in the years to come. Expenditure on unemployment will remain at around 10% in the next few years. Expenditure on families and children will remain at 12%, and expenditure on disability at 13%.

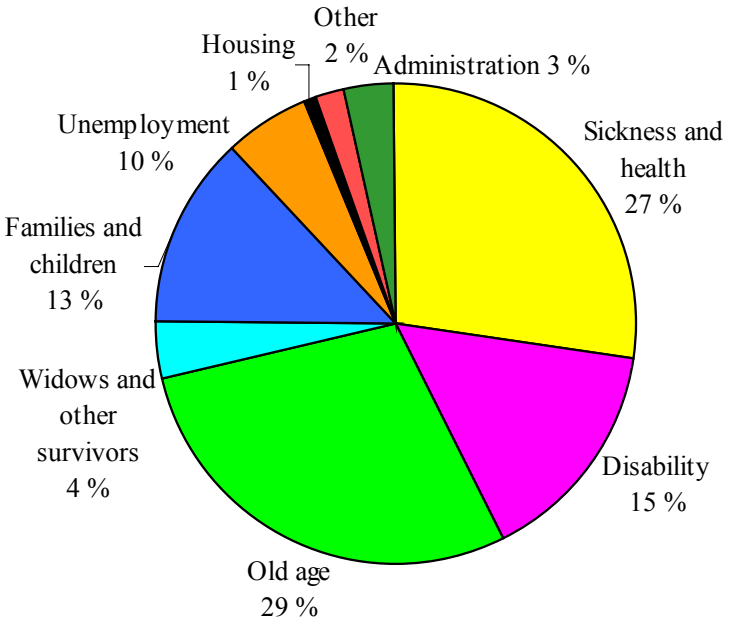
Compared with 1990, the share of sickness and health and of disability expenditure has clearly fallen, and that of unemployment and old age has grown (Figure 12).

Employers are the largest single source of financing for social protection expenditure, contributing to pensions, unemployment security and health insurance. The insured themselves contribute to these benefits as well. Central government contributes mainly to basic security, i.e. basic unemployment security, child allowance, housing allowance, as well as government grants to municipalities for social welfare and health care services. Municipalities bear the main responsibility for financing social and health care services.

There were major changes in the financing of social protection in the 1990s: the share paid by the insured grew, and that paid by the employers fell. There will be no major changes in the financing of social protection expenditure in 2001-2002. The accumulation of the social security funds will increase the proportion of social protection expenditure financed out of interest and dividend income from the funds (Appendix 1). The share contributed by the central government has fallen and that contributed by the municipalities has grown (Figure 13).

Figure 12. Distribution of social protection expenditure in 1990 and 2001

1990



2001

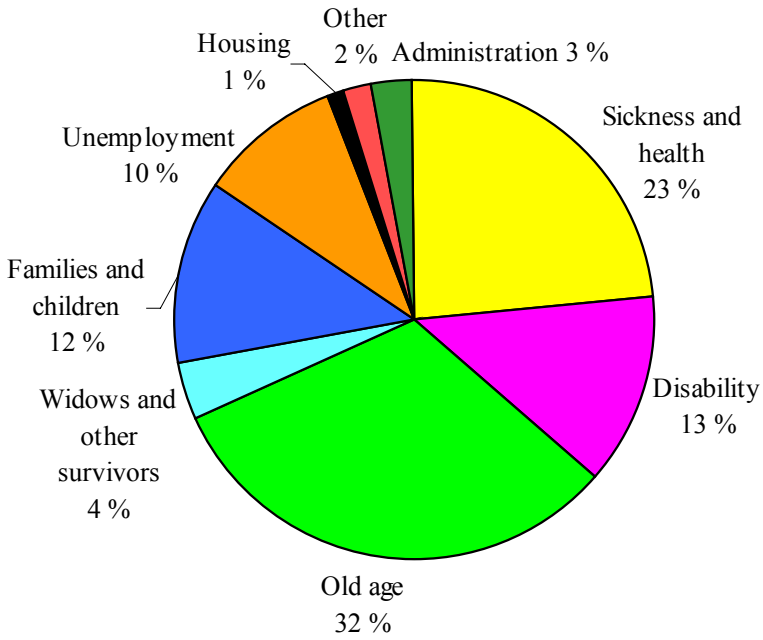
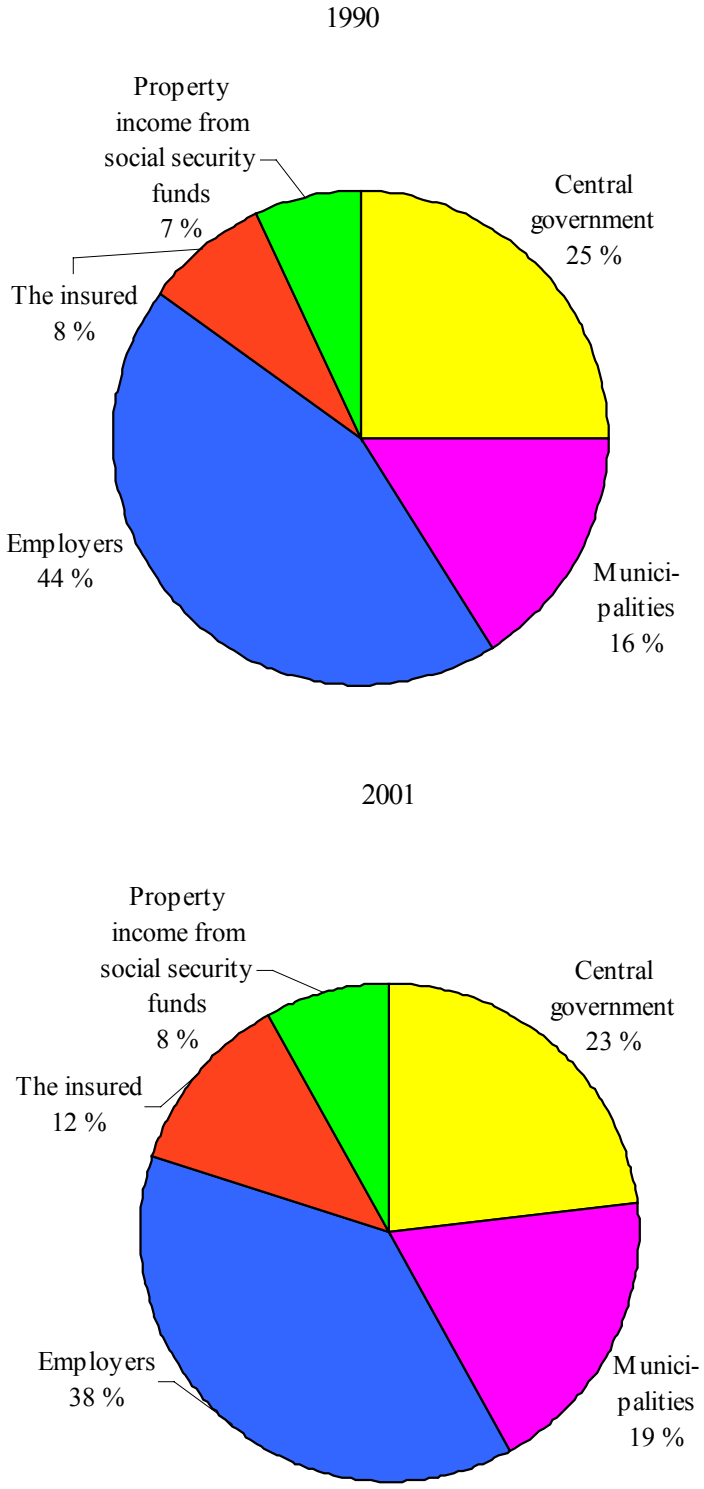


Figure 13. Financing of social protection expenditure in 1990 and 2001



2.1 Sickness and health

	1999	2000*	2001**	2002**
Expenditure on main category (€ million)	7 200	7 600	8 200	8 550
- of which, cash benefits (€ million)	1 420	1 520	1 580	1 630
% of social protection expenditure	22.4	23.1	23.9	23.6
% of GDP	6.0	5.8	6.1	6.1
Life expectancy				
- Men	73.7	74.1		
- Women	81.0	81.0		
Persons receiving sickness allowance during the year	286 900	296 300	297 800	299 300
Primary health care				
- medical and health care visits/1,000 inhabitants	4 898	4 927	4 920	4 950
- dental care visits/1,000 inhabitants	951	936	960	970
- bed days/1,000 inhabitants	1 578	1 594	1 600	1 630
Specialised medical care				
- outpatient visits/1,000 inhabitants	1 140	1 125	1 140	1 160
- bed days/1,000 inhabitants	1 051	1 015	1 000	1 020

* preliminary data
** estimate

Expenditure on sickness and health is estimated to total € 8.2 billion in 2001 and € 8.5 billion in 2002. This is almost a fifth of all social protection expenditure and about 6% of GDP. The share of social protection expenditure attributable to sickness and health has grown rapidly in recent years.

Finnish health care costs near EU average

Overall health care expenditure in Finland[5] in 1999 was still below the EU average, both as a proportion of GDP (6.8%) and per capita.

On the basis of time-based data from OECD countries it seems that themore affluent nations have become, the more they use on health care, both per capita and as a proportion of GDP (Figure 14). On the other hand, health care expenditure is not directly linked to the number of persons over the age of 75 (Figure 15). It would seem on the basis of the OECD data that changes in population structure have had very little effect on health care expenditure. New technological advances and strong incentives to provide health care services and the rise in the income and education level of the population have played a much greater role.

The ageing of the population does not increase health care costs at the same pace as the population ages. New methods for treating old ailments are constantly being developed. Many new methods of treatment can initially be expensive, but their price goes down with time. A major part of health care expenditure is focused on the last six months of life. In the coming few years the salaries of doctors will rise, and this will also be seen as an increase in health care costs.

[5] The OECD definition includes all private health care costs, but not salaries or daily allowances paid out during sick leave.

Figure 14. Total health care expenditure and GDP in some OECD countries in 1999

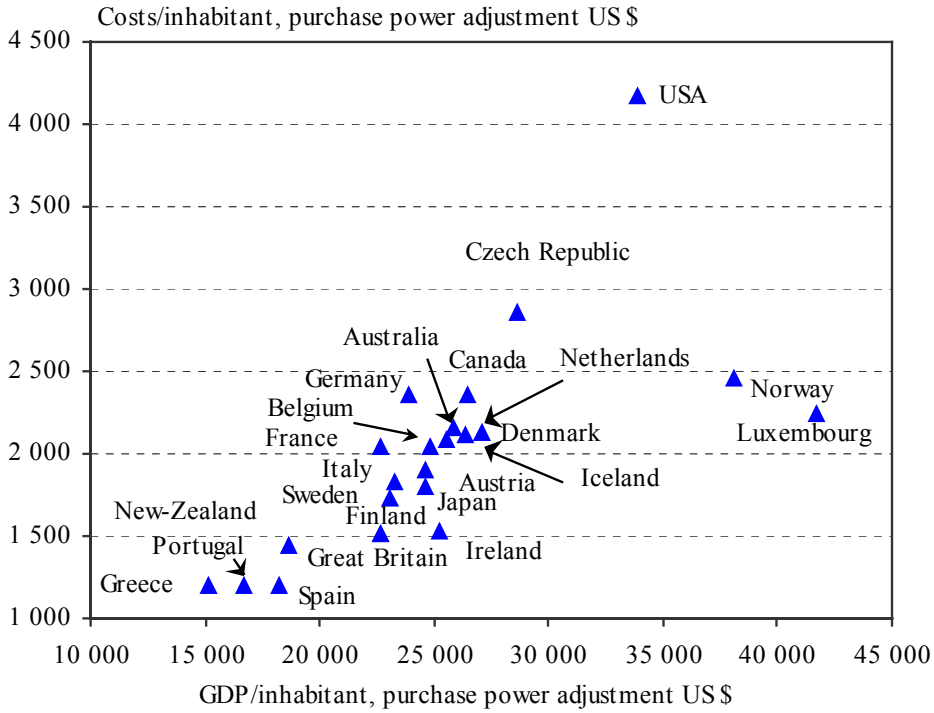
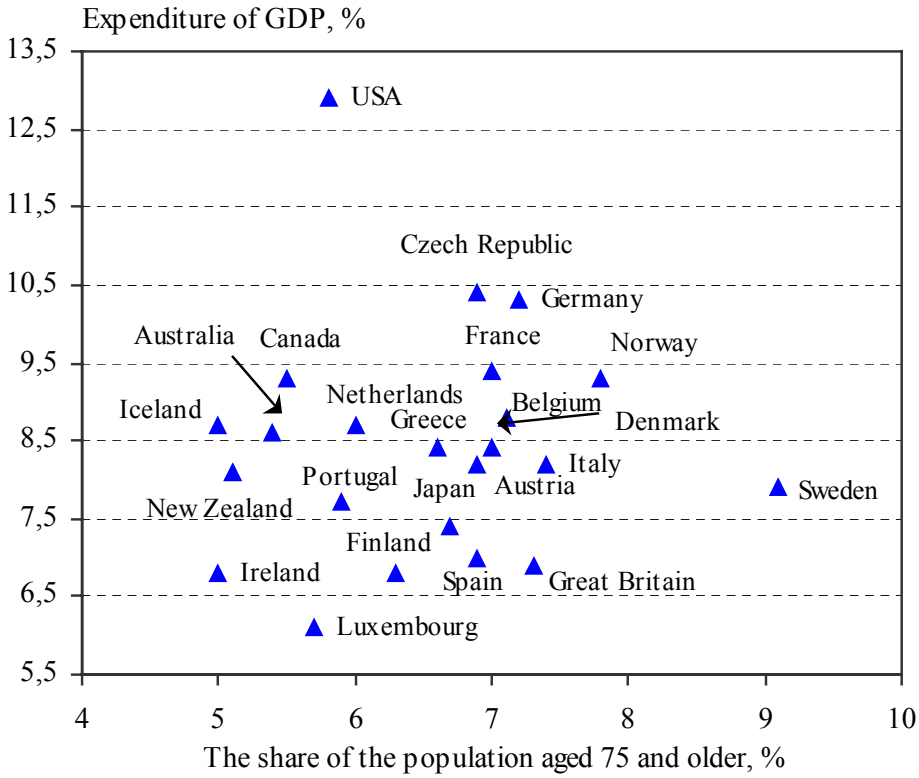


Figure 15. Total health care expenditure and the share of old-age population in some OECD countries in 1999



As a result of the doctors' strike, for the first time in years a reduction was seen in total production and the number of patients at hospitals in 2001. Treatment periods were shortened and the number of operations fell. The fall in the number of surgical procedures is also a result of a shortage of specialised physicians. Demand for services continues to rise, however. More emergency calls were made to hospitals than previously. This is also partly a result of a shortage of doctors - it prevented health care centres from providing services, forcing the ill to seek care at hospital emergency units.

Many municipalities have for years budgeted unrealistically low sums to cover their health care costs. It is known even when the budgets are being approved that there will be a deficit, and the services will run out of funds during the budget period. This makes sensible planning difficult in the long run. Inadequate resources also lead to the formation of queues. Having people wait for long periods of time to get treatment may increase total costs to the municipalities and other parties many times over, taking into account the costs due to waiting for treatment, loss of income, possible complications and recovery after treatment or operation. It is also a matter of improving the patient's quality of life.

Medicine costs continue to rise

Expenditure on medicine refunds grew by almost 11% in 2000, and by 13% in 2001. The growth is expected to continue at the same rate in the next few years. The costs of fully refunded medicines and additional refunds rose in particular. The increase in medicine costs is due to a switch to use more expensive drugs, the extension of health insurance refunds to cover significant and expensive drugs, and the acceptance of new drugs to be covered by special reimbursement. The wholesale prices of drugs have not gone up, however.

About one million people are entitled to special reimbursement on the costs of medicines on the basis of chronic or serious illness. Hypertension is the most common disease entitled to special reimbursement. Additional refunds were paid in 2000 to nearly 114,900 persons whose medical expenses had reached the personal annual limit (€ 558). This represents a 14% increase, and the number of recipients continues to grow.

The rise in the number of people whose medical expenses reached the personal annual limit is partly due to the rapid rise in medicine costs. After the personal annual is exceeded, all medicines are free of charge to the patient. There seems to be a rise in the number of medicines acquired by the patients after reaching the annual limit. About half of those who have exceeded their annual personal limit are 65 or older.

According to an OECD survey, there is a trend towards the use of increasingly expensive drugs as total health care expenditure rises. Rising medicine costs can however be curbed by favouring medicines that have been shown to be good and inexpensive. Doctors play a crucial role in this. Medicine costs are lower in countries with public health care than in countries where health care is based on a private system.

The rapid rise in medicine costs is not an exclusively Finnish problem. Other EU Member States have also looked for solutions to curb medicine costs. Nowadays reasonable pricing is expected of a reimbursable drug in all EU Member States with the exception of England and Germany. The prices of medicines are compared to those in other EU countries. This has led to a reduction in differences in

drug prices in countries in Western Europe. Many countries now require health economical assessments by drug manufacturers in order to be able to estimate the total benefits and costs of a drug, whereas regulating the share paid by patients is not seen a primary method for controlling reimbursement costs.

Measures outside the reimbursement system are also employed in an attempt to curb medicine costs: the gross margins of pharmacies and drug wholesalers have been adjusted and the prices of medicines have been cut in most EU Member States. Pharmaceutical companies are also increasingly involved in taking on the rise in costs and the instability related to the cost effectiveness of new drugs. It has been possible to reach an agreement in advance on an acceptable annual rise in prices. There has also been an attempt to influence the prescription practices of doctors with the aid of personal medicine budgets for physicians and information and education campaigns targeted at them.

In Finland, elderly people account for a major share of medicine costs. Around 39% of reimbursements are paid to those 65 or older. The ageing of the population only explains part of the rise in medicine refunds and costs - in 2000, only 1% of the rise was explained by this. In the future, the need of medicinal treatment will not grow at the same pace as the proportion of old people. The improved health and functional capacity of the elderly will postpone the need for health care services and medicines to a later age.

Health situation generally good

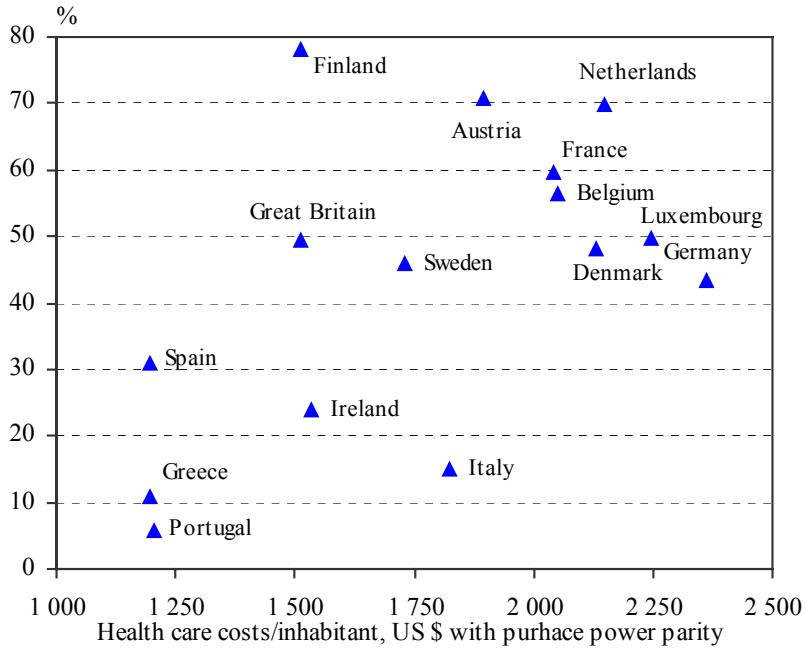
Taken as a whole, the Finnish population is in relatively good health. Life expectancy is continuing to rise for both men and women, but the difference between the sexes has not been significantly reduced. Differences between the sexes in accidental or violent deaths explain much of the differences in life expectancy between the sexes. A particularly significant factor is the prevalence of alcohol-related deaths among men, which substantially reduces their average life expectancy compared to women.

The percentage of the population who feel their health to be good or fairly good has stayed around 70% in recent years, whereas the percentage of those who would classify their health as poor has fallen somewhat. In contrast, headaches, insomnia and other stress-relates symptoms have become more common. Circulatory diseases account for the deaths of approximately half of all Finns. Arteriosclerosis remains the most common of these diseases, although male mortality from arteriosclerosis has fallen considerably. Cancer morbidity has remained more or less unchanged in recent years, whereas there has been a rapid rise in cases of asthma and allergy as well as mental health problems. Musculoskeletal disorders remain the most important causes of reduced working and functional capacity, and accidents the most important causes of premature death and disability.

Finns satisfied with health care services

Nearly 80% of Finns were satisfied with health care services in 1998 (Figure 16). The degree of satisfaction seems to be linked to health care costs. The higher the costs, the higher the degree of satisfaction among clients.

Figure 16. The share of population satisfied with health care services and health care costs per capita in EU Member States in 1998



Increased problems from alcohol and drug abuse

Alcohol and drug use causes annual costs to society totalling € 0.5-0.6 billion, and it is estimated that the indirect costs of alcohol and drug are € 2.5-5.0 billion. Most of the costs are due to alcohol use. Total costs are many times greater than tax revenue from alcohol production. In 2001 Finns consumed over nine litres of absolute alcohol per person. This is a clear increase from previous years. The number of problems caused by alcohol use has also continued to rise, and the need for drug and alcohol related services has grown. Alcohol problems are often accompanied by abuse of both medicines and illegal drugs.

Around 2,500 people die each year as a result of alcohol use, and 35,000 are hospitalised because of alcohol and drug related problems. The number of stays at hospitals and health care centres due to drug and alcohol has gone up, and there has also been an increase in the number of women treated for these problems. Substance abuse related problems are also treated in facilities for substance abusers, and persons suffering from substance use related problems are offered housing and community care. According to research, special services targeted at substance abusers have managed to decrease both substance dependency and morbidity due to substance abuse. The funds allocated to substance abuse treatment yield a manifold return as diminished health care costs.

Early intervention vital - treating drug problems among the young always pays off

The use of illegal drugs increased significantly in Finland in the 1990s. It is estimated that there are 30,000 regular drug users in Finland, 11,000-14,000 of whom use so called hard drugs. Most users are aged between 20 and 30. The share of Finns aged 15-16 who have sometimes experimented with drugs was doubled in four years in the 1990s. According to the latest data, the rise in drug use among the

young has stopped. The increase in drug use among young people of the most active experimentation age seems to have levelled off in particular. The trend in drug-related deaths, which had been increasing since 1996, seems to have been reversed in 2001. Drug-related crime is still rising, however, showing that the drug situation is getting worse.

Experimenting with drugs is influenced by many factors related to the individual, the family, youth group, social environment and the entire culture. The majority of young people in Finland still have a negative attitude towards drugs, and most of those who experiment with drugs only do so a few times. The fact that experimentation turns into regular use and particularly into drug-dependency is at least partly associated with the personal experiences of drug experimentation and biological differences between individuals.

Some children who are even otherwise experiencing a psychiatric crisis are at a particular risk with regard to drug use. The risk is greatest when both the individual's own predisposition and the environment reward drug use. Early onset of tobacco and alcohol use often predicts later experimentation with drugs, which for its part often predicts moving on to regular use of more dangerous drugs. The later the onset of drugs can be postponed, the less serious the consequences.

All substance-use prevention is also drug-prevention. Even occasional drug experimentation always calls for intervention. A young person in a situation predicting drug use and those already at risk should be helped as early as possible, even before they actually develop a drug problem.

The Finnish drug treatment system is only just being developed. Municipalities still have a limited capacity to offer drug treatment and there is a lack of places for treatment. The arrangement of treatment is hampered by contradicting attitudes and lack of competence, but treating the drug problem of a young person always pays off. Early intervention prevents the emergence of bigger and more serious problems that have consequences throughout the life of a young person. Preventive measures that help support the young person are much cheaper in the long run than the treatment of a serious drug problem with all its consequences.

A targeted subsidy for increased psychiatric services for children and young people

To correct the shortcomings observed in the psychiatric services aimed at children and young people, the Parliament granted the municipalities a targeted subsidy to the sum of € 11.8 million (FIM 70 million) in 2000, € 7.57 million (FIM 45 million) for the 2001 budget and € 3.16 million for the 2002 budget.

With the aid of the subsidy granted in 2000 a total of 385 posts were set up in hospital districts, 77 of them permanent posts and the rest fixed-term posts. 69% of the permanent posts were in specialised medical care and 19% in primary health care. The majority (90%) of the new posts were in community care. In addition to funding the new posts, the appropriation was used to set up five new wards in two hospital districts. The appropriation also helped establish several child and adolescent psychiatric units. In addition to this, the appropriation helped launch over 300 different projects for developing new operating and working methods in both prevention and treatment.

The situation of patients requiring immediate care waiting to get treatment has improved, and the waiting times in

child and adolescent psychiatric units and family counselling have been shortened. However, the situation of children and adolescents who are not in immediate need of treatment has not improved much. The operation is mainly targeted at children and young people in need of acute immediate care.

According to the hospital districts' estimate, the extra investment by the central government in child and adolescent psychiatry was needed, and it has been possible to improve these services with the help of the subsidy. According to a survey carried out, the fact that the subsidy is a one-off phenomenon poses a problem, since the operation funded by it tends to be lacking a long-term perspective, emphasising the non-recurring nature of activities.

In addition, government grants to social and health care expenditure were increased by € 4.20 million (FIM 25 million) in 2001 and by € 8.4 million in 2002 for the development of mental health work in municipalities.

Health inequality presents a challenge

Despite the generally positive trend in public health, health inequalities seem to be on the increase - there has been a rise in particular in health differences according to socio-economic status. Those who are better educated and have a better socio-economic status live longer and become ill less than those with a poorer status. Most of the difference can be attributed to differences in lifestyle. People with better education and more awareness are more eager to adopt a healthy lifestyle. As the level of education rises among the population people are more able to make use of information, which creates a favourable setting for activities aimed at promoting health. There is a lot of information available on health issues, but taking in the information and incorporating it in one's own activities is a slow process. This is also influenced by the practices adopted by the environment and one's family. Health equality can best be promoted by preventive measures, such as environmental health care, mother-child clinics and school health care. Increasing health equality is something that requires a determined long-term effort.

Regional differences in access to health care

A basic prerequisite of the Finnish health care system is efficient primary health care. Almost two-thirds of the population have been assigned their own personal physician responsible for their primary health care. The system of personal physicians has meant that more people have quicker access to treatment, but the target has not been met in all municipalities. Service provision has been hampered by a shortage of health centre doctors. In the autumn of 2001, 9% of health centre doctor's posts were unfilled, and 15% were filled by a stand-in.

In 2000 the Ministry of Social Affairs and Health commissioned an assessment on the availability of specialised medical care. A major part of the resources of specialised medical care is taken up by hospital care. Of the single diagnoses and groups of diagnoses the ones taking up the most ward resources are schizophrenia, arteriosclerosis, conditions related to coronary insufficiency and arrhythmia, conditions related to coronary occlusion, deliveries, femoral neck fractures, arthrosis of the hip and knee as well as gallstones. There are considerable regional differences in the number of treatment periods, patients and treatment days between these groups of diagnoses in an age and sex-matched population. There are also still

great differences in costs between municipalities.

In order for regional differences to be evened out a reassessment of treatment indication is required, together with increased cooperation between primary health care and specialised medical care. The survey mentioned above suggests that the development of national and regional treatment programmes be continued to improve the availability of specialised medical care. The rapporteur also suggests that if the hospital district is unable to provide care and assessment of the need of care within a set time, it must provide care for the patient in another hospital district. According to the suggestion, inhabitants within hospital districts should be informed of the waiting times regularly, e.g. via the Internet.

Investing in health equals investing in the future

The Council of State has made a decision in principle on the Health 2015 public health programme. It outlines the national health care policy in Finland for the next 15 years. The main emphasis is on health promoting activities, not so much on the development of health care services. The programme is extensive, covering several administrative sectors. The strategy outlines eight public health objectives. Investing in health equals investing in the future. A healthy population is a prerequisite for economic growth and competitiveness.

Public dental care to cover the entire population

Municipal dental care was extended in April 2001. That is when municipalities were to arrange dental care for those born in 1956 or later. As of the beginning of 2002, municipal dental care must be provided for those born in 1946 and later. From the beginning of December 2002, age limits will no longer apply. The reform will primarily improve the situation of people living in the larger municipalities. In order to carry out the reform, municipalities have taken on more dentists and made agreements with private dental care service providers. Municipal dental care services have also been more precisely targeted at those who are in need of the services. For example, annual inspections are no longer carried out routinely in cases where check-ups at longer intervals are sufficient, and some preventive measures are to be carried out by dental nurses.

National health insurance refunds of dental treatment expenses were extended in April 2001 to cover those born in 1946 or later. All age limits will cease to apply in December 2002.

New medicine refund models under consideration

The problem with the current system of refunds on medicine costs is that it is complicated and hard to understand for the patient, in addition to not being able to curb the rise in medicine costs to a sufficient degree. A memo by the working group on medicine refund issues was completed in March 2000, in which five different refund systems were looked at. The system developed on the basis of the current practice would include two reimbursement categories: a basic reimbursement category and one special reimbursement category. The new basic category would be more comprehensive than the present one, and its reimbursement level would be between the present basic reimbursement and the lower special reimbursement category. The number of medicines with special reimbursement status would be smaller than at present, including only medicines used in the treatment of serious and chronic diseases and ones that are necessary and vital for

treatment. Deductibles to be covered by patients could be calculated either separately at each time of purchase, for each medicine, or using a certain percentage.

Co-payment at time of purchase is used in the current reimbursement system. The patient pays the full deductible for medicines bought at the same time belonging to the same reimbursement category, and a refund is paid on the remaining sum using a given percentage. Within this system, it pays for the clients to concentrate the purchase of all medicines needed, but they might also buy medicines they do not necessarily need. In a system of medicine-specific co-payment the refund would be calculated separately for each medicine bought at the same time. The client's co-payment would consist of a fixed deductible, and a refund of a certain percentage would be paid on the amount exceeding that.

The patient's deductible would thus always be the same, regardless of whether all medicines are purchased simultaneously or separately. The system would be easier for the client to grasp, but the deductible of patients using several different medicines could easily become very high. A system where a certain percentage is used to calculate the size of the patient's co-payment means that there would be no fixed deductible, but the refund would be calculated as a certain percentage of the drug's production costs. This system would be readily understandable for clients.

In a system based on the degree of benefit of medicines, refunds would be staggered on the basis of how vital the treatment is as well as the benefits of the medicine. In assessing the usefulness of a pharmaceutical product the costs and economic benefits of the product would be taken into account in addition to its effectiveness. This system would encourage the use of medicines with the maximum health benefits, but keeping up the system might be difficult and cumbersome.

The third model is a cost-based system with a fixed medicine-specific deductible. This would be about € 10-17 (FIM 60-100). Costs exceeding that would the entitled to a bigger refund than at present, i.e. 80-90%. Cheaper medicines would thus be paid entirely by the patients and reimbursement would be targeted at expensive products.

The fourth model is a cost-based system with a personal annual limit. According to this system, a person with small annual medicine expenses would pay a greater share of them than a person with big annual medicine expenses. In this system the patients' initial deductible would be clearly higher than at present (€ 84-168, or FIM 500-1000), after which a certain percentage of the costs would be refunded, the refund percentage being higher, the bigger the annual medicine expenses. This would require an up-to-date register of patients' medicine purchases.

The last model is a municipal-based system, in which the aim is to make medicine treatment a more integral part of health care and to prevent inappropriate treatment choices due to different funding models in health care. In this system medicines and other treatment alternatives would be of equal value. Public health care would be responsible for all medication prescribed within the system, both in hospitals and in community care. The patient's co-payment for medicines prescribed in community care could be included in a fixed client fee, or a separate client fee could be charged for the medicine. Medicines prescribed in the private sector would be reimbursed and funded like at present. In this system, a

greater share of medicines would be prescribed within public health care.

According to the working group, reform could either be based on the present system or a cost-based system with medicine-specific patient co-payments. A rapporteur was appointed in February 2002 to continue the preparation of the reform on the basis of these two models.

Health care reform projects

The national programme Health Care for the 21st Century was carried out between 1998 and 2001. A national programme guidance and monitoring group was also appointed. The implementation of the programme relied on the cooperation of health care centres and hospital districts jointly with municipal social services departments, provincial governments, universities, polytechnics and regional councils.

The five regional cooperation groups based on the special areas of responsibility of university hospitals chose their spearhead projects on the basis of local needs. The spearhead projects included the following: securing the status of the patient, accessibility of services and treatment, division of work between hospital districts, wellness strategies, quality assurance, broadening the scope of the personal doctor system, availability of physicians, utilisation of information technology and guiding drug users to seek treatment.

In the autumn of 2001 the Council of State launched a national project to ensure the future of health care in Finland. The aim of the project is to assess the present and possible future threats to the service system. Issues that have emerged during the initial phase of the project have included e.g. securing access to treatment within a reasonable period of time, securing predictable, stable and sufficient funding and the maintenance of staff competence. The project management group will be giving its report in the spring of 2002.

Nearly 70,000 people exceeded the personal annual limit

Client fees of social and health care services were raised as of the beginning of 2000. The cost of day surgery rose in particular. A personal annual limit was also set for health care service costs. After € 588 (FIM 3,500) in 12 months, the use of out-patient care was free of charge and the fees charged for institutional care were significantly reduced. The purpose of the personal annual limit is to prevent unreasonably high costs for frequent users of health care services. In 2000, free cards were issued to nearly 70,000 people who had exceeded the personal annual limit. The majority of the cards were issued within health care. The free cards reduced the client fee revenues of municipalities and hospital districts by a total of € 20.6 million (FIM 122.5 million).

The system of personal annual limit was perceived as being complicated and causing a lot of work. In order to simplify the system, the time of monitoring was changed as of the beginning of 2001 from 12 months to calendar year. From the beginning of 2002 the personal annual limit is € 590.

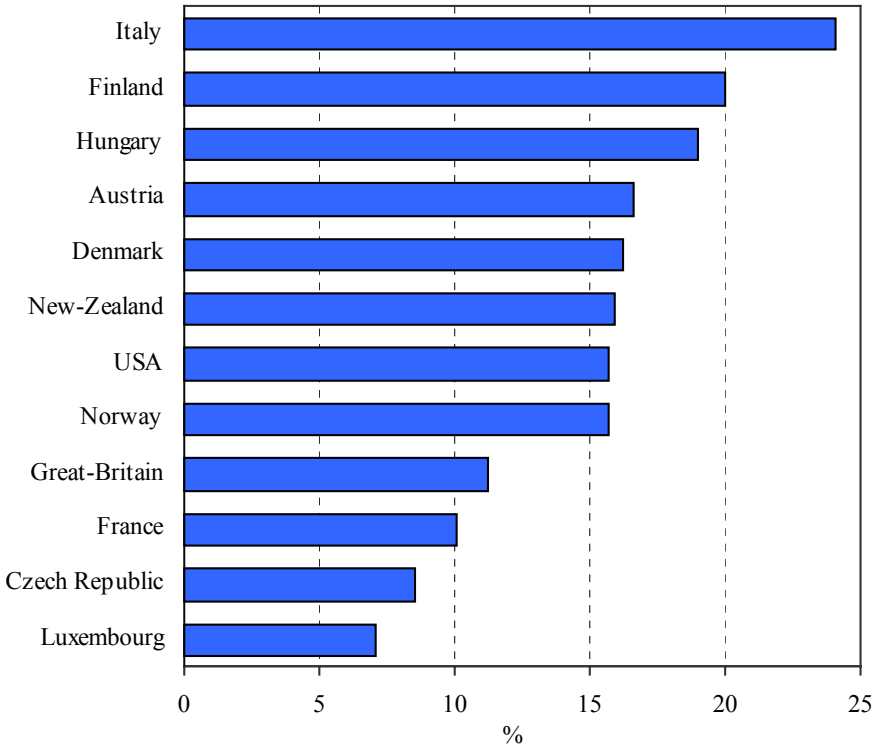
Health care expenditure funding

Between 1970-1999 the share of total financing of health care spending covered by public funding, i.e. tax revenue and statutory social insurance, rose in the OECD member states in which this share had been low 30 years ago. This was particularly true in the case of the United States, where the share of public funding rose by 8%, being 44.5% in 1999. In countries with a high public financing

share in 1970 the share has in most cases fallen by a few percentage points. The share of total health care spending financed by public funding in different countries has come closer together.

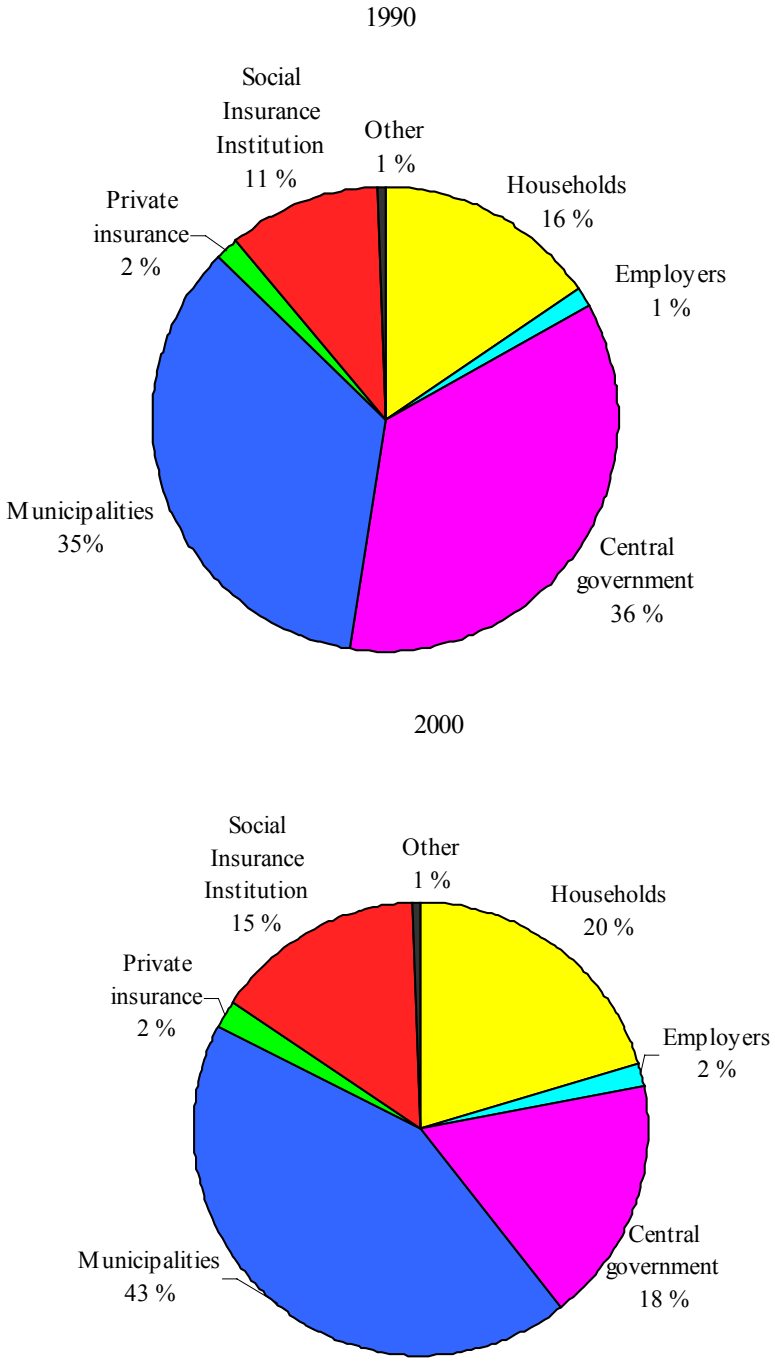
The share of total health care expenditure in Finland covered by public funding remained at 79-81% from 1975 to the early part of the 1990s. As a result of the recession, the share of public funding fell by a few percentage points, being 75.5% in 1999. This is close to EU average. The share of public funding as a proportion of GDP was 5.1% in Finland, compared to 5.7% in the US. In an international comparison, the share of health care costs covered by client fees is high in Finland (Figure 17). The recent raises in client fees increase this share even further. Raising client fees should be avoided in the future, since they present a burden particularly to low-income households. The Finnish client fee policy is looked at in more detail in Chapter 3.

Figure 17. The share of client fees and co-payments in total health care expenditure in some OECD countries in 1999



The financing of total health care expenditure has been shifting increasingly to municipalities and households, while the share of central government has fallen (Figure 18).

Figure 18. Sources of funding for total health care expenditure in 1990 and 2000



* estimate

Municipalities receive a grant from the central government for the provision of social and health care services. In 2000, the grant covered approximately one fifth of the expenditure. In straight cash terms, there was a clear drop in the size of the grant until 1999, but it rose slightly in 2000. Municipalities are able to cover about 12% of primary health care costs and about 6% of the costs of specialised medical care by client fees.

Health insurance is funded primarily by contributions from employers and the insured themselves. Since 1998, the central government has made a special payment to guarantee the liquidity of the health insurance fund, and since 1999 part of the revenue from value added tax has been channelled into financing health insurance.

Statutory accident insurance is financed entirely from premiums paid by employers, and third party liability insurance from premiums paid by the insured.

Table 3. Sources of finance for expenditure on sickness and health in 2000

	Expenditure,	Financing contribution (%)				
	€ million	Central government	Municipalities	Employers	The insured	Clients
Health insurance [1)]	1 440	11	0	37	52	0
Statutory accident insurance[2)]	175	0	0	100	0	0
Third party liability motor insurance [2)]	60	0	0	0	100	0
Primary health care [3)]	2 130	21	67	0	0	12
Specialised medical care [3)]	3 000	23	71	0	0	6

[1)] Includes sickness allowance, but not parental allowance
[2)] Excludes pensions and continuous payments
[3)] Includes client fees

2.2 Disability

	1999	2000*	2001**	2002**
Expenditure on main category (€ million)	4 450	4 410	4 520	4 640
- of which, cash benefits (€ million)	3 530	3 390	3 470	3 540
% of social protection expenditure	13.8	13.3	13.1	12.8
% of GDP	3.7	3.4	3.3	3.3
Recipients of disability pension on Dec 31	282 050	276 300	275 900	276 700
Recipients of disability allowance on Dec 31	11 700	12 000	12 500	12 600
Recipients of transport services during the year	61 700	66 500	67 000	64 000
Disabled households receiving home help during the year	6 580	6 370	6 500	6 600
Disabled recipients of informal care allowance during the year	7 700	7 700	8 000	8 200

* preliminary data
** estimate

Social protection expenditure on various categories of disability is estimated to rise by € 120 million (FIM 713 million) in 2002. The share of expenditure on disability has been declining for a long time. The bulk of expenditure on disability (60%) is on disability pensions.

Pensions or other disability allowances are paid to approximately every tenth Finn aged between 16-64. The proportion of persons on disability pension reached a peak in the early 1990s, but it has fallen in recent years, particularly among those over 50, but among younger age groups as well. The share of those on disability pension has fallen to 8% of the 16-64-year-olds.

A fifth of the total expenditure on disability consists of service costs. The structure of services for the disabled has changed towards community care. The rights of the disabled guaranteeing them social services compensating for the disability as well as rehabilitation have been improved by legislation, especially in the late 1980s and early 1990s. This led to an increase in the number of clients in some service forms throughout the economic difficulties of the 1990s.

Objective to raise the level of employment among the ageing and the disabled

The policy related to working and functional capacity of the population has three main objectives. On the one hand emphasis is on the maintenance of the working capacity of ageing (45+) employees, raising the degree of employment and postponing retirement. Another key objective is to rehabilitate young disabled persons for the labour market (integration, activation). The third main objective is to promote the everyday coping and equal participation of disabled persons of different ages.

The number of employed persons in relation to the dependent is influenced by several other things besides population age structure. The most important factors include the real age of retirement and the participation of women in the working life. The greatest margin is seen the labour force shares of elderly men and women (see Figure 57). If they rise slowly, the availability of labour will start to shrink in a few years' time, but if they rise fast, the fall in the availability of labour will be postponed to around 2010. There is also a lot of potential for improvement in the

level of employment of young disabled persons and those with reduced working capacity.

When a person is ill or disabled, or when the health and working capacity of an employee are reduced, there are alternative types of action. 1. ”The working approach” emphasises rehabilitation, education and other measures aimed at removing the obstacles caused by illness or disability and keeping the person at work, or rehabilitating him for the working life. The preferability of this approach is emphasised nowadays both in the case of ageing employees and young disabled persons. (2) Various types of early retirement pensions have also remained a commonly used method of leaving the working life before old-age pension. (3) Sickness allowance and subsequent disability pension is a traditional exit route for leaving working life. It came to be less commonly used in the 1990s, partly due to the high unemployment, whereas leaving working life following unemployment (4) with the aid of unemployment allowance and unemployment pension became common. The ultimate alternative is arranging basic income (5) with need-based benefits such as labour-market support, social assistance and housing subsidies.

The mainstreaming of disability policy means that all administrative sectors assume responsibility for disability issues within their respective policies and respond to the needs of the disabled primarily with the general systems used within each administrative sector. Besides social protection that encourages inclusion, prevention of the exclusion of the disabled includes improving the employment situation as well as other issues related to the working life. The equal participation of people with disabilities is also influenced by the advances in accessibility in housing and other living environments as well as in traffic and communications.

Providing a work and living environment that takes the needs of the disabled into account does not necessarily cost more to society than leaving the disabled outside normal social activities and making various special arrangements. A more effective utilisation of new information and communication technologies and the latest technical aids as well as the application of new methods of employment can for their part promote equal opportunities for the disabled.

Measures aimed at promoting staying on at work

Legislation on pensions and other forms of social protection has been changed in recent years so as to encourage staying on at work. Attempts have been made to improve the status in the labour market of ageing employees and people with disabilities by increasing and improving vocational training and different measures aimed at maintaining working capacity. New employment methods have also been tried out in connection with various projects.

Many of the measures aimed at keeping ageing employees at work have involved pension policy decisions. In the 1990s the age limits of pensions were raised by increasing the age limit of unemployment pension to 60, by raising the old-age pension age of central government and municipal posts from 63 to 65 years, and by raising the lower limit of individual early retirement, first from 55 to 58 in 1996 and then again to 60 years as of the beginning of 2000. Some other deteriorations to the conditions of unemployment pension were made in 2000. These measures led to a drop in the number of people taking up unemployment pension and raised the number of people available for work, but this also led initially to an increase in unemployment among elderly employees. The

employment situation of elderly workers has only improved in recent years. Pension policy related measures have also included lowering the age limit of part-time pensions and the improvement of other conditions as well (see chapter 2.3).

Pension policy measures can reduce the number of people seeking retirement, but they do not necessarily have any effect on coping in the workplace. There has been an attempt to promote this aspect with rehabilitation and various programmes aimed at keeping up and raising the working capacity. Today, possibilities for rehabilitation must always be investigated before decisions on pensions are made. In 1996, the fixed-term unemployment pension was replaced by a rehabilitation allowance. Labour market organisations and work pension institutions have agreed that the right of those in work to early charting of rehabilitation paid for by the employment pension system is developed further. The system was launched in 2000 to cover those aged 58 and 59, and the aim is to extend the system to cover all employees in 2002.

When arranging rehabilitation, whether the recipient goes back to work or seeks part-time or complete retirement is significantly affected by his background. Timing plays a crucial role - rehabilitation that is arranged at a sufficiently early stage is a key factor to the effectiveness of rehabilitation.

Working capacity maintaining measures became increasingly common towards the end of the 1990s. It has been estimated that these measures are both economically and commercially profitable. They reduce sickness, accidents and pension costs and increases productivity. As far as results are concerned, it has proved to be important to extend the scope of activities to cover entire workplaces in addition to targeting individuals. At present, continuing these activities and developing them further, regardless of changes in economic trends, presents a key challenge.

The principal objective of the national programme on ageing (1998-2002) has been to achieve changes in the attitude climate in working life towards a more appreciative approach with regard to the resources represented by ageing employees. In addition to this, in 2000 a programme of action for promoting coping at work and an extensive programme aimed at developing working life were launched. According to some surveys, age discrimination against ageing workers in the job market is already showing signs of having been reduced. On the other hand, it is still common to be labelled as old, especially when new employees are recruited, from as early on as from age 40.

Increasing the number of years spent at work calls for changes in social protection, working life and attitudes in the future as well. All systems that entice people to seek early retirement instead of a realistic education or rehabilitation alternative must be reconsidered. On the other hand, raising the age limits of early retirement and other ways of tightening conditions can only have the desired effect if trends in the employment rate as well as other trends in working life support staying on at work. If that is not the case, the result may be an increase in the number of long-term and repeated unemployment of elderly and disabled persons, and a rise in the number of actual unemployment pensions.

Labour market parties agree on development of pension systems

In November 2001 the labour market parties reached an agreement in principle regarding the development of work pensions in the private sector. The objective is to alter the work pension system so that the average retirement age would be 2 or 3 years later than at present.

The goal is also to prepare for the increase in lifespan and secure the target level of income-based pensions so that it is sufficient and encourages people to stay on at work. If these objectives are achieved, there will be less pressure to increase employment pension premiums, and the long-term financing of the system is on a more secure basis than before.

The labour market parties propose among other things that vocational rehabilitation included in the work pension system be made statutory by legislation, which would entail a right to vocational rehabilitation on the basis of determination of threat of disability. According to the terms of the agreement, systems of individual early retirement and unemployment pension would be discontinued after a transition period, and the terms on disability pension would be altered. Changes in part-time and old-age pensions have also been suggested (see 2.3).

The majority of the changes are to enter into force as of the beginning of 2005. It is proposed that the reforms relating to rehabilitation and the abolition of individual early retirement pension for persons born in or after 1944 be implemented from the beginning of 2003.

There is an attempt to postpone the taking up of pensions with the aid of accelerated accural incentive system. This would involve a bonus accural rate of 4.5% instead of the usual 1.5% at the age of 63-67, when the present accelerated accural rate is 2.5% of wage income between ages 60-64. Employees could continue to work until the age of 68 if they wish. When postponing retirement to later than 68 years, pension would be increased by 0.4%, or 4.8% per each year of postponement.

According to the proposal, employees could take up early retirement pensions from the age of 62. Up to the age of 63 the reduction in pension resulting from earlier retirement would be 0.6% per month, i.e. 7.2% per year.

It is proposed that a system be adopted in disability pensions where the amount accrued during the so-called ”future period” would be taken into account in all disability pensions. The ”future period” would be calculated up to the age of 63. It is further proposed that the percentage of accruement is 1.2% from the age of 50. In the estimation of the eligibility for disability pensions in persons 60 or older, the vocational nature of disability would be emphasised.

Legislative drafting has been launched on the basis of the agreement in principle. In the initial phase this involves going through the many details of the proposals and assessing the effects of the proposed measures. In conjunction with this, the application of the proposed changes in employment pensions in the private sector is also considered in the public sector pension systems.

According to assessments carried out by the Central Pension Security Institute, the implementation of the new agreement on employment pensions would raise the average retirement age by almost a year. Taking into account the pension reforms that came into force at the beginning of 2000, the combined effect on the expected age of retirement in long-term perspective would be around two years.

Disability pension and unemployment pensions as exit routes from working life

In the 1990s, only about one in ten of all Finns aged 65 or more was gainfully employed until old-age pension age. This figure is estimated to rise in 2002 to one out of seven of all those turning 65.

In addition to issues related to demand of labour, the staying on at work of employees is also influenced by the alternative channels available for leaving working life. Employers can also influence, encourage or pressure employees to make decisions. Employees are most likely to choose the alternative that is possible or best suited for their own situation in life. It is easiest to pick an alternative you can influence with your own decisions. Unemployment in addition to fulfilling the age requirement is sufficient for unemployment pension, whereas around 25% of individual early retirement pension applications are turned down. About 10-20% of ordinary disability pension applications are turned down.

The employment situation of ageing workers is significantly affected by unemployment pension and the channel leading to it, i.e. the right to earnings-related unemployment allowance, which is currently restricted to those 55 or older. There has for a long time been an increased tendency for people to become unemployed after reaching the age of 55. There are no significant differences between the sexes in the frequency of unemployment, whereas limited education is clearly a risk factor for becoming unemployed and totally excluded from working life. It is rare for those on the path to unemployment pension to find a job. The use of the channel to unemployment pension is frequent in fields that have been affected by international competition and structural change.

The employment situation of ageing workers was improved later than that of younger age groups. This is partly due to the fact that many over-50s who are finding it difficult to find a job due to a low level of education or disabilities have become long-term unemployed or are suffering from recurring unemployment. Some of the unemployed belonging to this group of people might have taken the channel to unemployment pension, if they had managed to hold on to a job during the recession years. A project launched by the Ministry of Labour is currently looking at the pension preconditions of the elderly long-term unemployed.

The employment situation of the over 55s has improved rapidly since 1998 (Table 4). In 2000, the employment situation of ageing workers improved most of all age groups. Those aged 55-59 are the only age group participating in working life more extensively than in the late 1980s, as many as 65% of them being currently at work. Those aged 60-64 are also more commonly at work than was earlier the case, but on the other hand, there seems to be an increase in unemployment in that age group as well.

The positive development trend is most of all due to the fact that ageing workers have increasingly been able to keep their jobs. The improved employment situation of the young has meant that young, cheaper and better-educated labour has not been as readily available as during the recession years. The increasing popularity of part-time pension has also cut down the number of full-time employees leaving working life.

The share made up of the unemployed of all 55-59-year-olds had shrunk to 14% towards the end of 2001. Unemployment had fallen particularly among those aged 55-57. It seems fully possible that those belonging to the large cohorts born between 1945 and 1949 will not use the channel to unemployment pension to the same extent as the cohorts before them.

An early exit from working life depends to a large extent on the low demand for ageing workers. Ageing workers who are made redundant still find it very hard to find a new job. The difficulties in finding a

job highlight the need to help them cope at work, maintain their vocational competence and ensure that rehabilitation is offered at a sufficiently early stage.

When the over-55s leave working life, they are much more likely to take up a pension than become unemployed. Pension is at present the primary exit route from working life from age 58 onwards. The stream of people leaving work to take up early retirement pension was however diminished in the 1990s. The proportion of elderly recipients of disability pension fell both among the 55-59 and the 60-64 age groups. Unemployment pension and part-time pension have increasingly replaced disability pension and individual early retirement pension.

In 2000, half of those in the age group 55-64 (50% of women, 49% of men) were on pension (Figure 19). There are no significant differences in type of pension between the sexes among retired 50-64-year-olds. The biggest difference can be seen in the incidence of disability pension, which has always been more common among men than women, but the differences between the sexes have been reduced, which is partly due to the increased participation of women in working life. In 2000, 19% of women aged 55-64 and 22% of the men in that age group were on disability pension, while a slightly larger number of women than men have received individual early retirement pension since 1991.

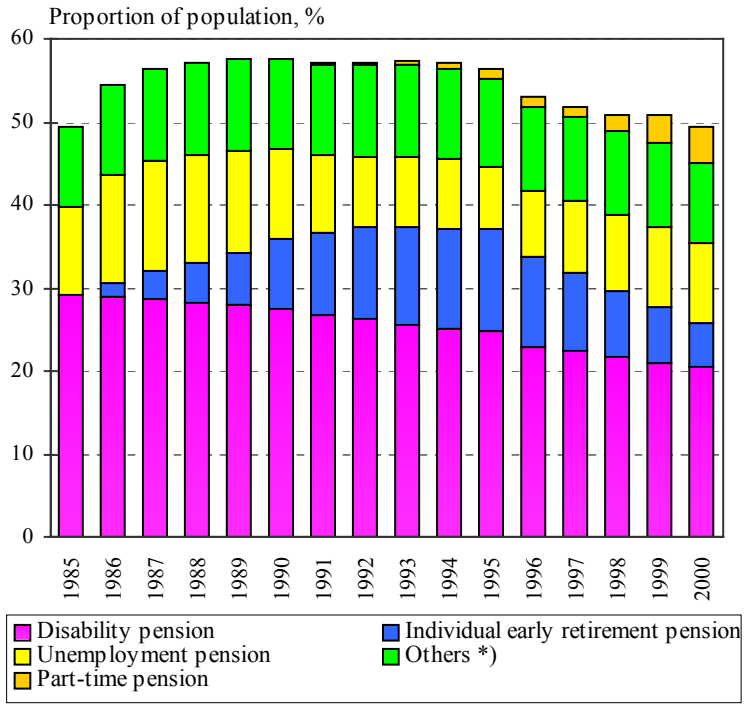
Table 4. Figures describing the labour market status and retirement status of ageing workers at the end of 1997-2001[1]

	1997	1998	1999	2000	2001
The employed, % of age group [2]					
55-59-year-olds	49.3	52.5	56.5	61.3	64.5
- Part-time	5.7	6.2	7.5	10.3	10.4
- Full-time	43.6	46.2	49.0	50.8	53.9
60-64-year-olds	19.5	19.3	21.8	24.8	25.8
- Part-time	5.0	5.2	6.9	8.1	7.5
- Full-time	14.5	14.1	14.9	16.6	18.3
Pension recipients, % of age group [3]					
55-59-year-olds	27.4	26.3	26.6	26.5	…
- Part-time	0.8	1.9	3.7	4.8	5.0
- Full-time	26.7	24.4	22.9	21.7	…
60-64-year-olds	79.3	78.1	77.0	76.5	…
- Part-time	1.9	2.2	2.9	3.7	4.6
- Full-time	77.4	75.9	74.1	72.8	…
The unemployed, % of age group[4]					
55-59-year-olds	21.1	20.0	18.9	16.2	14.1
60-64-year-olds	4.1	4.1	4.7	4.5	4.7
Expected years of future employment at age 50 v [5]	7.2	7.4	7.8	8.1	8.5*

[1] Fourth quarter 1997 - 2000, October-November 2001.
[2] Statistics Finland, study on labour.
[3] Central Pension Security Institute/Social Insurance Institution, joint statistics
[4] Ministry of Labour.
[5] Statistics Finland, study on labour and life-time tables.
* Estimate.

Source: Hytti 2002

Figure 19. Pension recipients aged 55-64 by type of pension as a proportion of population 1985 - 2000



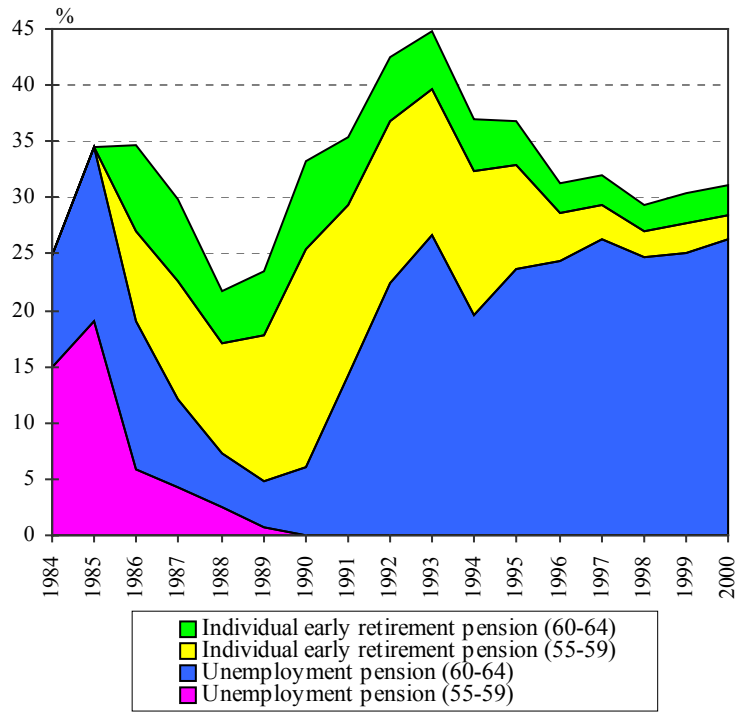
*) Old-age pension, special farmers' pensions, ex-servicemen's and veterans' pension

Pension recipients include all those receiving employment and/or national pension. As of 1996 only pension recipients residing in Finland are included, before that pension recipients living abroad are also included in the figures.

Source: Central Pension Security Institute

Among the age group 60-64 unemployment pension is almost as important as pension type as disability pension. Economic incentives also encourage people to seek unemployment pension. Compared to unemployment allowance, pension is a very competitive alternative, even though the level of unemployment pension was weakened in 2000. The attraction of pension as an alternative is increased by the fact that following a period of unemployment starting salaries are clearly lower than the average salaries of people of the same age. The eagerness of low-income workers to take up a pension is partly explained by the fact that their net income is likely to fall less than that of those with larger salaries. A low level of education, living in eastern or northern Finland, spouse's unemployment and working in the private sector also increase the likelihood of taking up unemployment pension.

Figure 20. New unemployment pensions and individual early retirement pensions as a proportion of the 55-64 age group in 1984-2000, %



The average age of people taking up a pension continued to rise in 2000, being little over 59 that year. The real age of leaving working life also rose, among other things because people spent a shorter time in the channel leading to unemployment pension. Even though the target of continuing rise in the age of retirement were met, ageing workers' need of special protection in case of unemployment will not go away in the next few years.

When older employees continue to stay on at work longer, it means that people at work are older than before. There is less pressure to leave work to take up a pension if the demands of the working life can be adapted to meet the needs of ageing workers and their physical and mental functional capacity.

Disability pension taken up by a smaller proportion of people

At present, about 30,000 people take up disability pension each year. The average age of those taking up the pension has gone up. The number of under-55s on disability pension has been declining for a long time. The disability pensions of the disabled and young persons with reduced working capacity have partly been replaced by study and rehabilitation allowance. The fact that the age limit has been raised from 55 to 60 has reduced the number of new individual early retirement pensions (Figure 20).

The fall in new disability pensions applies to other pensions than those granted on the basis of mental health problems.

According to Kela's register on prescription drug use, the health status of the large post-war cohorts is at least not poorer than that of previous cohorts. On the contrary, some common diseases like hypertension are less prevalent among baby-boomers. This may indicate that the risk for disability of those 50 or older may even continue to fall in the future.

The number of disability pension recipients is not an accurate indicator of health and working capacity. The number of disability pensions is influenced by the contents and scope of other types of social protection, the definition of disability required for pension, as well as changes in the employment situation and in working life.

The number of disability pensions in the 1990s was affected by widespread unemployment and the use of unemployment pension. Employees in hard lines of work, such as construction and industry, are most likely to seek disability pensions, and many were left without a job during the years of recession. This reduced the number of persons seeking disability pension. Other factors affecting the number of disability pension applications include a low level of education, place of residence, whether the spouse is working or not, as well as a previous negative pension decision.

The abolition of unemployment pension might increase the use of other early retirement pensions, such as individual early retirement, unless their conditions were changed. The extent of these effects would depend on how ageing workers are able to cope at work and how their status evolves in the job market.

Mental problems an increasingly common reason for disability pensions

The past two years have seen a considerable reduction in the number of disability pension granted on the basis of circulatory diseases. The proportion granted for musculoskeletal disorders rose steeply until the early 1990s, but it has remained relatively constant in recent years. Mental health problems have become increasingly common as a reason for disability pension. Figures 21 and 22 show the trend in the private sector, as no combined statistics on the public and private sectors are available before 1996. The trend in the public sector has been similar to that in the private sector.

Figure 21. Reasons for granting new disability pensions in the private sector in 1986 – 2000

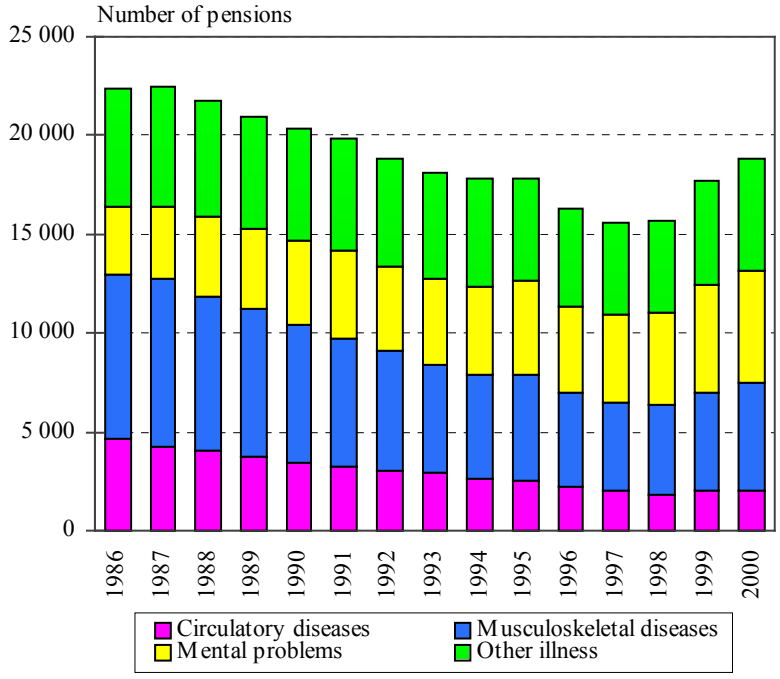
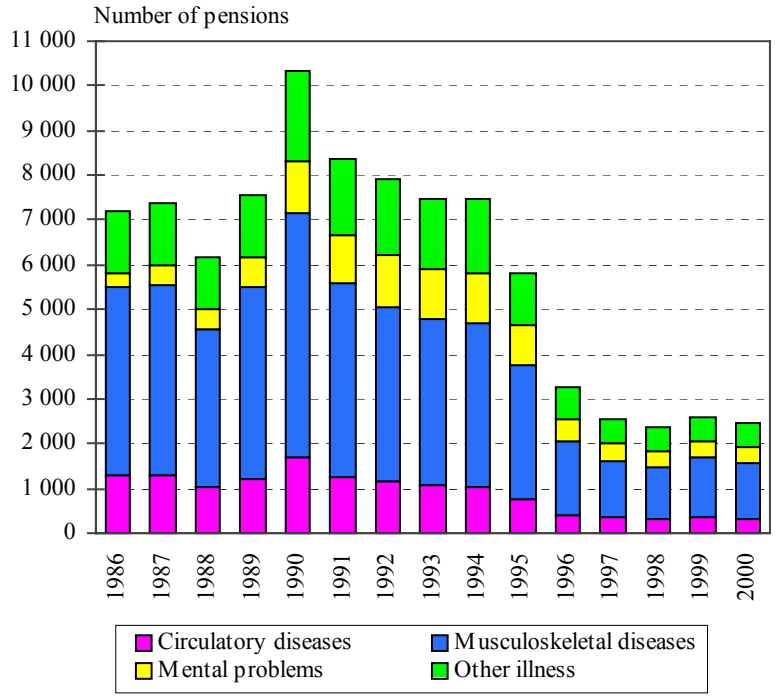


Figure 22. Reasons for granting new individual early retirement pensions in the private sector in 1986 – 2000



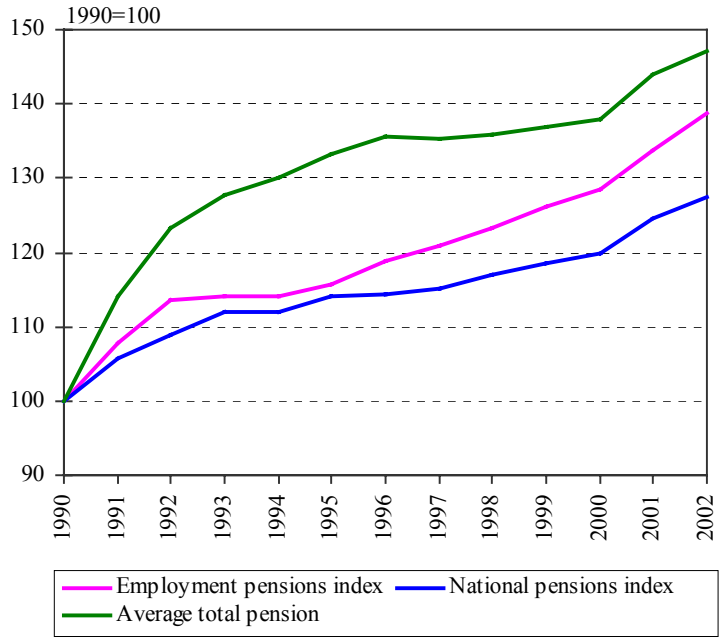
Source: Central Pension Security Institut

The level of disability pensions slowly rising

The remaining basic amount of the national pension was withdrawn from the beginning of 2001. The level of new disability pensions has been undermined by the full deductibility of the national pension since the 1996 pension reform came into force. When the level of work pension exceeds a certain limit, no national pension is paid out at all. Otherwise pensions follow pension index trends (Figure 23). Tax relief for pensioners has partly compensated for the cuts in pensions.

There are no significant differences between the sexes in the average total level of disability pension. At the end of 2000, the average total disability pension was € 902 (FIM 5,361) per month. The corresponding sum was € 872 (FIM 5,182) for women and € 1,072 (FIM 6,373) for men.

Figure 23. Trends in disability pensions in 1990 - 2002



Between 1996 and 2001 no new child increments were made to national pension, and no index adjustments were made to the increments granted earlier. The total amount of child increment was decreased by 20% per annum between 1998 and 2000. As of the beginning of 2000, a child increment of € 17.7 (FIM 105) began to be paid each month per every dependent child. A change in legislation came into force at the beginning of 2002 allowing new child increments to pension recipients. The child increment is granted to national pension or work pension recipients for every child, either his or her own or that of the spouse, under the age of 16 living in the same household. The increment can also be granted when the pension recipient is financially responsible for a child living elsewhere. The child increment is € 18.08 (FIM 107.50) a month for each child, and it is tax-free income.

There are an estimated 18,000 recipients of the new child increment, the majority of whom are on disability pension. In addition, there are some 7,000 persons who have been receiving the child increment for a longer period of time. The additional costs due to the child increment for 2002 are estimated to total about € 3.5 million (FIM 21 million). Taken as a whole, child increments to pension recipients are paid to an estimated total sum of € 5.4 million (FIM 32 million).

Number of new disability allowances on the rise

Disability allowance is a form of financial support provided by the central government intended to help working-age (16-64) people with disabilities not receiving a pension to manage in their daily lives, at work and in their studies. It is paid at three levels, depending on the degree of disability, need for support and any special costs due to the disability. In 2002, the three levels of support are € 75.96, € 177.16 and € 329.16 per month. The number of recipients of disability allowance has remained relatively constant for many years; in 2000 it was paid out to 6,415 women and 5,605 men. However, the number of new disability allowances started to increase in 1999. This was partly

a result of the reform targeting young persons with severe disabilities, which made rehabilitation allowance the primary alternative instead of a pension. The majority of the young disabled persons receiving rehabilitation allowance are entitled to a raised or special disability allowance.

Low level of employment among the disabled increases dependency on social protection

The equal right to work on the part of the disabled has been recognised in resolutions of international organisations and the Finnish constitution. According to constitutional provision regarding basic rights, central government must promote employment and strive to secure the right to work of all citizens. No one must without an acceptable reason be placed in a different position e.g. on the grounds of health or disability.

In addition to a poor employment situation, the structures and attitudes in social protection, particularly during the recession, constituted an obstacle to the employment of people with disabilities, and they are continuing to do so. Social protection is still often seen as the primary source to secure the income of the disabled. On the other hand, social protection is strongly attached to gainful employment: the amount of work pension and sickness allowance is dependent on wages earned.

Gainful employment, as opposed to social protection, is a primary alternative as a source of income for the disabled as well. The level of employment among the disabled has however remained considerably below that of the general population. The majority of disabled persons of working age are pension recipients, which means that they are not included in unemployment statistics. Pensions are the primary source of income for the majority, an estimated 70%, of persons receiving disability-related benefits, but there seems to be a slight increase since 1996 in the number of the disabled whose major source of income is from work or entrepreneurship. In 1999, income from work or entrepreneurial activities was the main source of income for an estimated one fifth of all recipients of disability allowance, rehabilitation supplement, accident and military injury compensation and rehabilitation allowance.

The employment situation of the disabled has remained difficult, even though the general employment situation has improved. The number of disabled job seekers has increased each year. In 2000, there were on average 40,000 job seekers with some degree of disability, the corresponding figure for the previous year being 38,800.

People with disabilities are generally unemployed for much longer than others. In 2000, 43% of the unemployed with disabilities were long-term unemployed. The proportion of older people among disabled job seekers is rising, which serves to lengthen the average duration of unemployment among the disabled. The fall in the uptake of new disability pensions also increases the number of disabled job seekers. The ageing of the population and various factors in working life give rise to physical and mental disabilities.

Finding a job with the aid of central government employment support has clearly become the most important form of special employment for the disabled (Table 5.). Between 1995 and 2000 a total of about 10,000 to 12,000 job seekers with disabilities were able to find a job in the public or the private sector with the help of the support.

Table 5. Job-seekers with disabilities and the vocational rehabilitation and employment activities arranged for them by employment administration in 2000 [1]

A total of 83,015 job-seekers with disabilities, of whom	**%**		**Number of persons**
- unemployed	83	- participated in work-capacity assessment and work and education experiments	8 328
- long-term unemployed	36		
- women	58	- took part in vocational guidance	5 660
- with no vocational training	53	- started employment education	8 248
- with no vocation	14	- started other type of education	1 329
- under 25	4	- placed in shelter work	43
- 45 or older	57	- found employment in the open job market	36 341
- with musculoskeletal disorders	39	- found a job with the aid of salary-based support measures	12 386
- with respiratory diseases	14		
- with mental health problems	14	- practical training with labour market support	1 809
		Sum total	**74 144**

[1] The table also includes measures carried out with European Social Fund (ESF) support

Source: Ministry of Labour

Promoting equal opportunities in getting employment and improving the possibilities for finding a job are key factors when looking for solutions that lessen the risk for exclusion of the disabled. In order for work to be the most economically profitable alternative in all cases, social income transfers, income taxation, services and fees should make up a whole that encourages activity. People with disabilities often need a combination of personal guidance and counselling, education, rehabilitation, benefits and other measures. An improving employment situation increases the possibilities of employment authorities to come up with tailored solutions for finding employment.

Supporting the employment of people with disabilities is well motivated not only from a human perspective, but often from an economic one as well, taking into account the costs of alternatives to employment. The alternative costs include various costs related to income security and services, which are often reduced when the person finds a job. In addition, when more people are employed, the tax revenue of municipalities and the central government increases.

In various employment, unemployment and pension alternatives the benefits and costs are divided in a different manner between the central government, municipalities and other actors, giving rise to transferring the costs from one party to another, which does not promote activities that are sensible from an overall perspective. On the other hand, a certain proportion of people with disabilities will always be able to generate a given added value with their own work, but not enough to be able to cover all the costs the job entails. These are issues that the disability policy should resolve.

New routes for finding employment in the open job market

The objective is for people with disabilities to find employment primarily in the open job market. Finland and other countries

have positive experiences of experimenting with a system where persons with mental handicaps and mental health problems have been assigned a personal job coach. The task of the job coach is to support people, and to make it easier for them to enter working life with the aid of a coach offering personal support, who can help them respond to the needs of the employers. The job coach can also provide help in looking for a job and applying for one, in career planning, and assist in learning new assignments in the workplace. A more extensive application of the method involving supported employment within the Finnish service system is a vital question in the future.

Social entrepreneurship is one possible alternative for promoting employment and finding jobs for the disabled. Many municipal work centres and workshops are considering a change to become social enterprises. In order to create clear guidelines, the Ministry of Trade and Industry is about to set up a development programme regarding social enterprise as a joint project with several other ministries.

The role of sheltered work and municipal work centres has long been considered to be somewhat unclear (Figure 24). This is why the support measures related to the employment of persons with disabilities is to be clarified by a change in legislation coming into force on April 1, 2002. The reform involves amending the Social Welfare Act to include new provisions concerning work activities and action to help people find jobs. Persons who have special difficulties in coping with everyday life because of disability, illness or a similar reason have been defined as the target group of action aimed at helping them find employment. The central government will continue to finance these activities in the future as well through the system of state grants to fund social welfare and health care in municipalities.

The activities aimed at helping the disabled to find employment includes arranging special support measures or a job (previously so-called sheltered work), if the person finds it difficult to find a job with the aid of employment services or employment policy measures. Like previously," work activities" means activities aimed at maintaining and promoting functional capacity carried out in a context other than an employment relationship. Those taking part in these activities are paid a tax-free work allowance.

The starting point of the reform is that social welfare will continue, as a natural part of its activities, to promote the employment of persons who can benefit from the services, work methods and expert help of social and health care. It is hoped that municipalities will be able to provide regional and provincial multidisciplinary services that can help people find ways of getting a job in a manner suited for their individual needs, maintain employment processes combining rehabilitation, education and work, as well as help people find jobs in the open market. The possibilities of the present work centres suited for this purpose could be made use of by developing and diversifying their operation.

Employment authorities will continue to have the main responsibility for the employment of the disabled. The Employment Act will be amended as of April 1, 2002, so that persons with reduced working capacity gain the same status as users of services and as recipients of support measures of employment administration as the young and the long-term unemployed. These groups are prioritised when central government employment financing is used to find jobs for the unemployed.

Figure 24. Persons in sheltered work and participating in work activities in 1994-2000

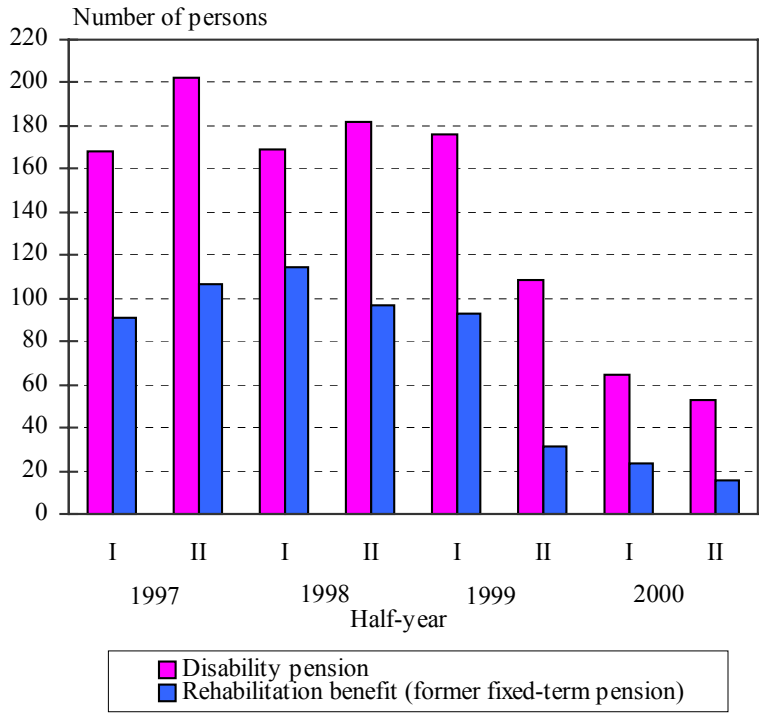
Rehabilitation instead of pension for the young

In August 1999, guiding all disabled young people aged 16-17 to vocational rehabilitation became the primary alternative instead of disability pension, which is no longer granted to persons under 18 until the possibilities for vocational rehabilitation have been assessed and the rehabilitation allowance period has terminated. The reform was targeted at those severely disabled young people who would previously have gone directly on to a pension at 16 without the benefit of intensified assessment of working capacity and rehabilitation.

To support vocational rehabilitation, a rehabilitation allowance is paid to the young disabled person on the basis of a personal study and rehabilitation plan. A condition for granting the rehabilitation allowance is that the working capacity and possibilities for gainful employment of the young person in question are significantly reduced because of illness, disability or injury. In 2002 the rehabilitation allowance for a disabled young person is € 388 (FIM 2,308) per month. If the person is still in rehabilitation upon turning 18, the allowance will be continued to the end of the rehabilitation period under way. According to the experiences so far, the rehabilitation allowance period continues after the age of 18 in most cases, meaning that education or other active rehabilitation measures continue after the age of 18.

After the reform came into effect, the number of new disability pensions and rehabilitation benefits has fallen significantly (Figure 25). Between January and October 2001 there were a total of 1,170 recipients of rehabilitation allowance for the young disabled.

Figure 25. New disability pensions and rehabilitation benefits granted to persons aged 16-17 in 1997-2000



In 2000, about half of the recipients of the rehabilitation allowance for the young disabled had a mental or behavioural problem, in most cases mental handicap. One in five had congenital deformities or chromosomal aberrations, and almost 20% had neurological disorders (e.g. cerebral palsy).

The majority (70%) of those receiving rehabilitation allowance for the young also receive disability allowance, nearly all of them receiving either increased or special disability allowance. The rehabilitation allowance for the young has been targeted at people with very severe disabilities. About half of the recipients have also been receiving vocational or medical rehabilitation arranged by Kela.

In 2000, a total of € 3.2 million (FIM 19 million) was paid out as disability pensions to young people aged 16-17, which was only half of the sum in 1998. The amount of disability benefits paid to young people almost tripled. The new benefit, rehabilitation allowance for the young, was paid to a total of € 2 million (FIM 12 million). In 2000, a total of € 7.1 million (FIM 42 million) was used to finance these three benefits, which was the same sum that was used for disability pensions and disability benefits in 1998. The objective of reducing the number of young people taking up a pension has been fulfilled without an increase in income security costs.

The rehabilitation and education possibilities of young disabled persons will be improved further as of April 1, 2002 by extending the period of rehabilitation allowance by two years, to age 20. The age limit for disability pension will be raised correspondingly. The reform will mean very little increase in costs, since current legislation already covers those aged 18 and 19 whose rehabilitation continues after they have turned 18. The number of rehabilitation allowance recipients is estimated to increase by 100.

Improving conditions for suspending a pension

From the beginning of August 1999, persons receiving a full disability pension in accordance with the National Pensions Act have had the possibility to suspend their pensions for a minimum of six months and a maximum of two years, if they want to engage in gainful employment. The possibility of suspending pensions was intended as a measure that encourages and promotes gainful employment among people on disability pension. To ensure that work is always more economically profitable than pension, a disability allowance equalling the special disability allowance of € 329.16 (FIM 1,958.10) per month is paid in 2002.

The reform has not increased the number of people going out to work as much as was estimated, for only a few dozen pensions have been suspended. A legislative reform coming into effect on April 1, 2002 is intended to clarify the conditions of suspending a pension so that pension recipients would feel that seeking employment and putting the pensions temporarily on hold is a safe alternative. Putting a pension on hold will be based on the wage income of the pension recipient, so that a precise income limit is defined (€ 588.66, or FIM 3,500 per month), the exceeding of which suspends the pension. If the person stops working, or the income falls below the limit, the payment of disability pension will be resumed. The possible time for suspending the pension will also be extended to five years. While the pension is suspended the person entitled to it will receive a special disability allowance for a period of two years, as is the case at present.

The changes in legislation will mean estimated annual savings of € 2.6 million in central government pension expenditure. Disability benefit spending is estimated to increase by € 1.5 million and labour market support expenditure by € 2.1 million. The cost estimates have been drawn up with the assumption that about 500 pensions will be suspended each year.

Scope of sickness allowance is extended

The National Pensions Act has a provision that guarantees disability pension for the blind, those with severe mobility impairments and other corresponding groups of people with disabilities, regardless of their income from work. They have however not been entitled to sickness allowance during the time they are entitled to a pension. This has put disabled workers receiving disability pension in a less favourable position than other workers in cases of illness.

According to the law amendment coming into effect on April 1, 2002, the protection during sickness of workers receiving disability pension will be made the same as that of other workers. An employee receiving disability pension will be entitled to income-based sickness allowance. The sickness allowance is paid to the employer during the period that the employer pays sick leave wages. The aim of the reform is to improve for its part the possibilities for disabled persons to find employment. The reform will increase the number of people entitled to sickness allowance by about 1,000.

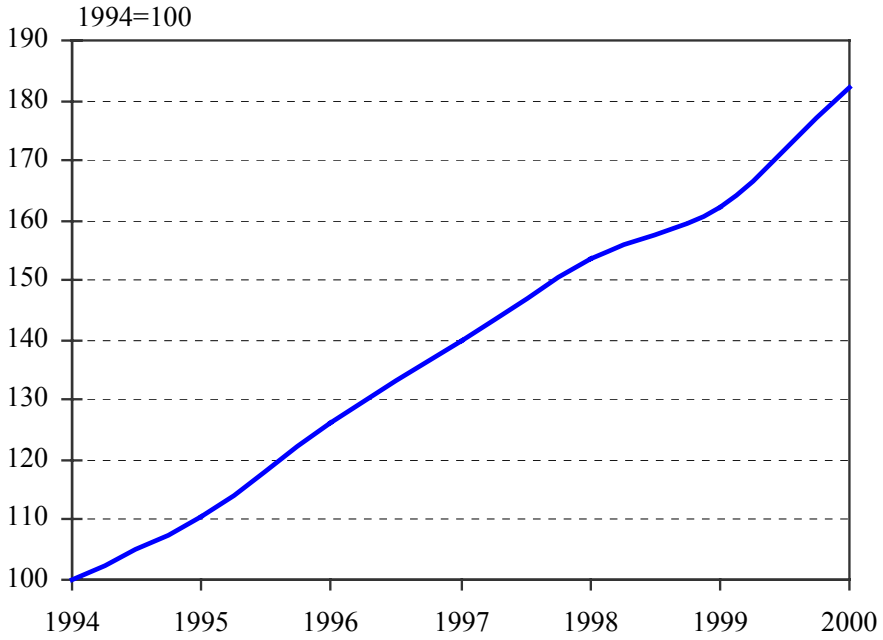
Costs of services for the disabled have gone up - difficulties in access to services

The objective of the Services and Assistance for the Disabled Act is to promote the preconditions of a disabled person to live and function equally with others as a member of society, and to prevent and remove the difficulties and obstacles caused by the disability. Severely

disabled persons have a subjective right to transportation and interpreter services, assisted housing, alterations in the home as well as equipment and technical aids in the home. Other services for the disabled, such as personal assistants, are provided at the discretion of the municipalities. The Services and Assistance for the Disabled Act came gradually into effect between 1988 and 1994.

The Services and Assistance for the Disabled Act is applied to an estimated 2% of the Finnish population. In the five largest towns this proportion was on average 2.2% in 1999 (1.1 - 2.9%). The costs of services and support measures provided in accordance with the Services and Assistance for the Disabled Act have risen rapidly (Figure 26).

Figure 26. The real trend in Services and Assistance for the Disabled Act service and forms of assistance costs in 1994-2000



The number of users of services for the disabled has also gone up (Figures 27 and 28). The trend in the number of service users has however varied in the case of different types of service and support. An estimated four fifths of disability expenditure is spent on services and forms of assistance included in the subjective rights of the severely disabled.

The services and economic forms of assistance based on the Services and Assistance for the Disabled Act are only arranged if the disabled person is not receiving sufficient or appropriate services on the basis of some other Act. The responsibility given to the municipalities to provide services for the disabled presupposes that the content and scope of the services needed are charted in each municipality.

Key factors contributing to the rise in the number of clients and total costs of services for the disabled include the ageing of the population, increased awareness of services for the disabled and the fact that more disabled persons live in their own homes. Technical aids and equipment that support independent living have evolved and become more versatile, and at the same time more expensive, due to the utilisation

of IT, among other things. It is difficult to assess how well the provision of services for the disabled answers clients' needs in different municipalities. The provision and structure of other municipal social, health and transportations services as well as geographical location have indirect effects on the need and costs of services for the disabled. Municipalities can also influence the trend in the number of clients and costs by actions related to service provision. It does however seem that there are significant local differences in how the Services and Assistance for the Disabled Act is applied, leading to inequalities between the disabled living in different areas. The availability of services and forms of assistance tied to budgetary appropriations causes problems, as many municipalities have not set aside sufficient funds to cover them.

There are no age limit provisions related to the granting of services and forms of economic assistance in accordance with the Services and Assistance for the Disabled Act, and the services have not been limited to apply to certain groups with disabilities only.

Transportation services have increasingly become a service form for elderly people with disabilities. Interpreter services are mostly used by young and working-age people with hearing disabilities as well as by persons with impaired sight and hearing. The aim is to extend the scope of the services to cover persons with speech impairments. A personal assistant is usually not given to a person under 18 or to senior citizens. People suffering from mental health problems are seldom granted disability services. More resources would be needed especially to provide supported housing to mental health rehabilitees.

Spending on rehabilitation of the disabled and other community care service forms than those related to the Services and Assistance for the Disabled Act also increased in real terms in the 1990s. The largest extension of services was seen in service and supported housing for the mentally handicapped. Municipalities often provide the services as purchased services. The number of inhabitants in institutions for the mentally handicapped and their costs have decreased as a result of the change in the structure of services provided.

The Ministry of Social Affairs and Health has launched a project in connection with the Target and Action Programme on social welfare and health care, in which quality recommendations for housing for the disabled are defined by the end of 2002.

Figure 27. Number of disabled people receiving home help, informal care allowance and other services for the disabled in 1992-2000

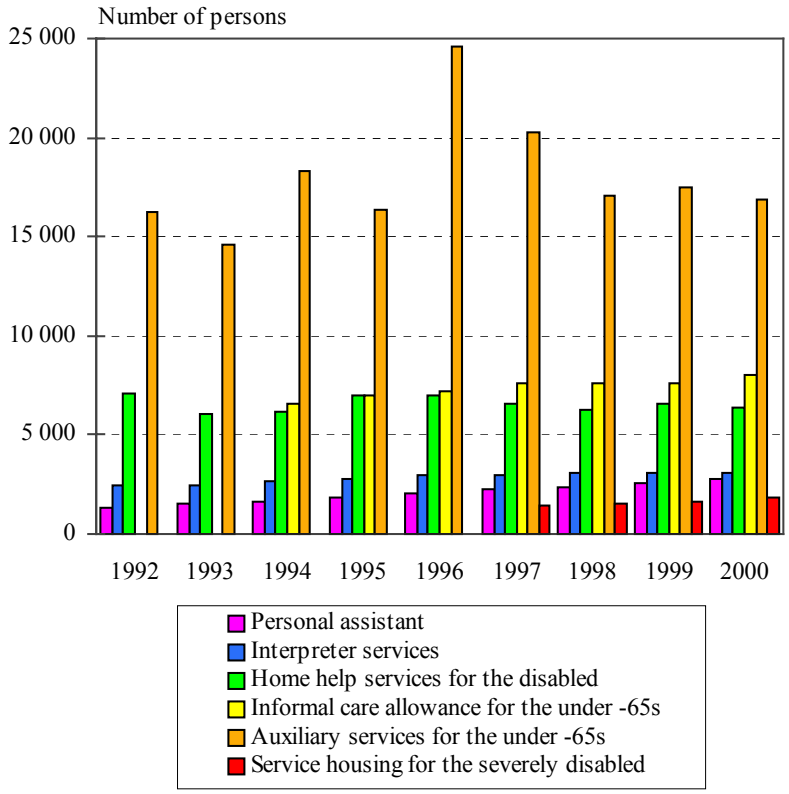
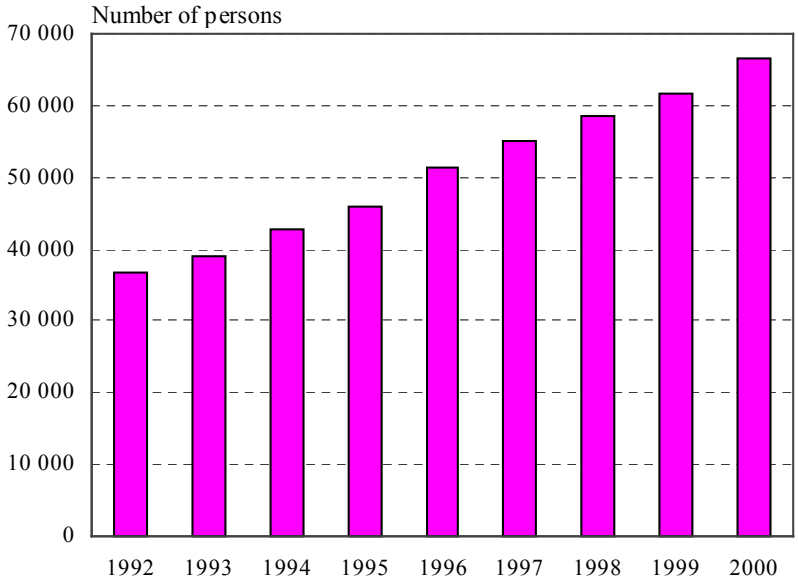


Figure 28. Number of persons receiving transportation services in 1992-2000



Transportation services under development

The rise of disability service costs can be predicted to continue. This is due to priorisation of community care in disability and elderly care policy and the need of development of services for the disabled. In addition to providing services for the disabled it is important to increase the

provision of obstacle-free living and working environments that reduce the need for special services. About 10% of the population, or 500,000 people, have permanent mobility impairment or functional disabilities. An obstacle-free living environment is also important to nearly everyone at some point in life. If the majority of service needs due to functional disability could be met by the provision of an obstacle-free environment, general services and other solutions serving the entire population, the Services and Assistance for the Disabled Act would fill its original purpose of securing special services for the most severely disabled.

Transportation is a basic right citizens are entitled to. In order to guarantee this right for everyone, a provision was included in the Services and Assistance for the Disabled Act obligating municipalities to provide transportation services for the severely disabled. The Services and Assistance for the Disabled Act was enacted at a time when public transportation was rarely suitable for use by people with severe disabilities.

Of all services under the Services and Assistance for the Disabled Act, transportation is by far the most widely used and the one that has expanded the most (Figure 28.) The use of transportation services was clearly more frequent in the Helsinki metropolitan area and other large towns than in sparsely populated or rural municipalities. In 1999 about 60% (€ 31 million) of the costs of services and forms of assistance related to the Services and Assistance for the Disabled Act in the five largest towns in Finland were transportation costs. Only 3% of transportation service clients made work or study related trips, which means that 97% of the trips were made either to run errands or for recreational purposes. Almost three out of four transportation service users were 65 or older.

The rapid rise in costs as well as the number of clients has prompted authorities to look for new solutions in order to be able to secure the future access to transportation of the elderly and the disabled. Providing obstacle-free public transportation is a primary alternative for the needs of the general public, and advances have been made in obstacle-free public transportation. New and more flexible public transportation solutions have been developed for transportation within municipalities, such as service lines, which play an important role particularly in reducing the need of transportation for the elderly. Projects aimed at developing service line traffic have been under way in some 100 municipalities. Various systems of booking and arranging transportation (e.g. transportation coordination centres) have been tested in different parts of the country and transportation services have been subjected to price competition. The municipalities are still bound by the provisions of the Services and Assistance for the Disabled Act, which is why even the new ways of providing transportation services must comply with current legislation.

Clear need to extend the scope of the system of personal assistants

The provision of personal assistants is a form of assistance tied to budgetary appropriation (i.e. not a subjective right). Severely disabled people are also able to live in assisted housing with the aid of personal assistants. The provision of personal assistants has risen somewhat; in 2000 a personal assistant was provided for some 2,800 persons with disabilities (Figure 27), but no personal assistants were provided in nearly one out of four municipalities.

Developing the system of personal assistants is one of the most central areas of development of services for the

disabled. There is a need to increase both the number of reimbursable assistance hours to current recipients of assistance, and to provide assistants to more people. Issues that need to be looked at in particular are the right to personal assistance and financing of the system. The education, wage level and employment security of the assistants are also key issues in developing the system of personal assistants.

In 1999, one in four recipients of personal assistance lived in the five largest towns in Finland, which used around € 6.7 million (FIM 40 million) to fund the system. Personal assistants were generally paid € 925 - 1,180 (FIM 5,500-7,000) per month.

In 2001, tax relief from the disability deduction in state and municipal taxation was € 42.0 million (FIM 250 million) in state taxation and € 25.2 million (€ 150 million) in municipal taxation. Due to a low income level, most persons with severe disabilities receive no benefits from the tax deductions. Disability deduction is an outdated method for promoting the functional and working capacity of disabled persons. For targeting forms of assistance of disability policy more clearly and equally, the provision of services and direct cash benefits are more useful. One alternative is to remove the disability deductions either entirely or partly, and to direct the resources available to the development of services for the disabled.

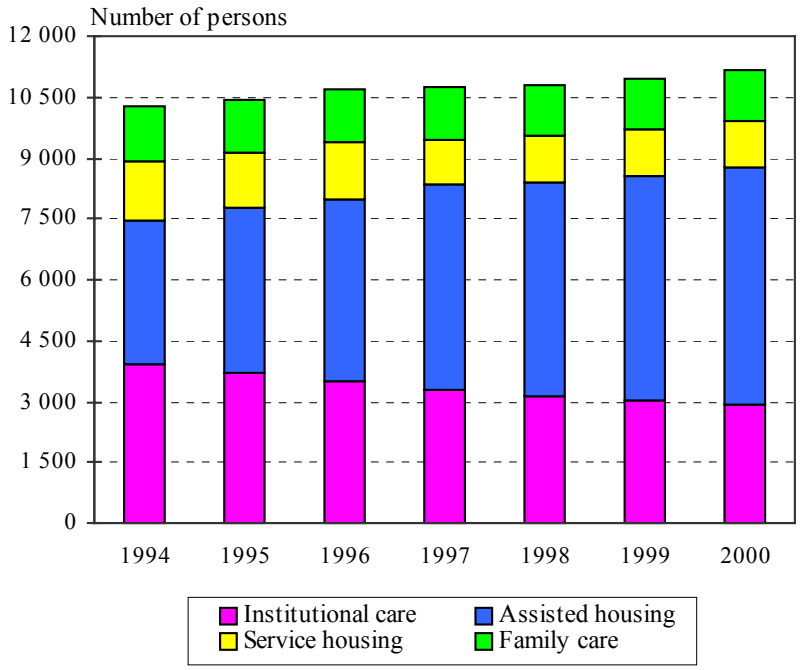
The mentally handicapped and their caregivers are getting older

There are a total of 30,000-40,000 people with mental handicaps, depending on definition. About 0,5% of the adult population have a mental handicap. The proportion of elderly persons with mental handicaps is on the rise, thanks to a rise in the average lifespan. There are an estimated 12,000 people over the age of 40 in Finland with a mental handicap. A mild mental handicap does not entail a shorter life expectancy, whereas the life expectancy of people with severe mental handicaps is 30% lower than that of the general population.

In addition to the Services and Assistance for the Disabled Act, the Act on Special Care of the Mentally Handicapped is the law that has special relevance to people with disabilities. It includes provisions with special reference to services for the mentally handicapped. It is estimated that some 20,000 people use special services targeted at the mentally handicapped, 6,000 of whom have severe mental handicaps.

The key objective of services for the mentally handicapped is to reduce the share of institutional care. Progress was made in this field in the 1990s, but it seems to have slowed down in recent years. Institutional care has primarily been replaced by assisted housing services, their number having grown faster than the number of patients in institutional care has gone down (Figure 29). A successful continuation of structural changes in service provision for the mentally handicapped requires that a sufficient quantity of assisted housing and its quality level is guaranteed, and that various types of temporary care function properly to help family caregivers and other forms of community care. It is estimated that around 4,000 persons of pension age work as family caregivers to the mentally handicapped. In addition to providing institutional care, the role of the special care districts lies in setting up centres of expertise to support basic service provision by the municipalities.

Figure 29. Clients of institutional care, housing services and family care for the mentally handicapped in 1994-2000



Case management helps families with disabled children

A disabled child means added challenges and problems for the family. The public system providing services for families with disabled children has often criticised for being fragmentary and poorly coordinated. The service network of a single family may include dozens of actors. Many families feel that applying for forms of assistance and services is cumbersome, and that information on disability benefits and technical aids is insufficient. Families with disabled children also wish for more flexibility, so that the needs of individual families are taken better into account.

Case management has often been suggested as a solution for the problems of families with disabled children. The Ministry of Social Affairs and Health has launched a project to be carried out in 2001-2003 aimed at children and young people with long-term illnesses and disabilities as well as their families. The aim is to try out various systems of case management in the municipalities and to find solutions that can help integrate services and other forms of assistance into functional entities to suit the needs of the families.

The financing of costs due to reduced functional capacity

National pensions are financed primarily by employer insurance payments and central government funds. The central government also makes a special payment when necessary to guarantee the liquidity of the national pension fund. In addition, in 2000 € 404 million (FIM 2,500 million) of the revenue from value added tax was channelled into financing the national pensions.

Employment pensions are funded from contributions by both the employers and the employees. Employees have contributed to financing of their own employment pensions since 1993.

The central government is solely responsible for the funding of disability allowance, and it also pays a state grant to

municipalities towards financing municipal social welfare and health care services. However, the primary responsibility for financing services for the disabled and other social welfare and health care services used by people with disabilities lies with the municipalities.

In 2000, five per cent of the costs of institutional care of the disabled was covered by client fees. This proportion has remained at the same level for several years. By law, community care service provided in accordance with the Services and Assistance for the Disabled Act and Act on Special Care for the Mentally Handicapped is partly free of charge, which is why the share of client fees towards financing these services is very minor.

Rehabilitation arranged by Kela is financed through health insurance. The rehabilitation arranged by employment insurance institutions is financed in the same manner as employment pensions.

Table 6. Financing of expenditure on the disabled in 2000 (preliminary data)

	Expenditure, € million	Financing share (%) Central government	Municipalities	Employers	The insured	Clients
Disability pensions						
- national pension	651	49	0	51	2	0
- employment pension	2 096	3	0	71	25	0
Disability allowance	28	100	0	0	0	0
Institutional care for the disabled [1)]	496	22	73	0	0	5
Services for the disabled [1)]	142	23	75	0	0	1
Rehabilitation services	306	41	0	29	29	0
Sheltered work and vocational rehabilitation	106	24	76	0	0	0

[1)] Includes client fees

Employers may see taking on a disabled employee as a considerable economic risk, even though there may be no factual basis for this on the grounds of the type of disability. This makes it more difficult for the disabled to find a job, and may partly explain why so few people take advantage of the possibility of suspending their pensions. In order to amend the situation changes are being made in how pension responsibilities are divided in the case of employees who are entitled to full disability pension as well as suspending their pension by the provisions of the National Pensions Act. The pensions of such persons will begin to be financed jointly by employers according to the principle of shared responsibility.

In order for the chances of the disabled to find jobs to improve further, it should also be considered how the division of employment and unemployment costs between the central government and the municipalities affects the possibilities of disabled persons to find a job, as well as the provision of services aimed at supporting them in finding employment. Even though helping the disabled to get jobs is economically profitable from the

point of view of the entire public sector and public economy, the distribution of the financial responsibility of various benefits and activities may cause different actors working with employment measures to be passive.

Financing issues will have a key role during the next few years when access to equal services for the disabled is being considered. Things that need to be looked at include the sufficiency of resources, particularly in small municipalities, and the division of financing responsibility between central government and municipalities, and co-payment by clients in different types of services. A closer look at the fees charged in service housing for the disabled is taken in the chapter on client fees (see 3.3).

2.3 Old Age

	1999	2000*	2001**	2002**
Expenditure on main category (€ million)	9 750	10 200	10 890	11 610
- of which, old-age pensions (€ million)	8 380	8 720	9 780	10 440
% of social protection expenditure	30.3	30.9	31.7	32.0
% of GDP	8.1	7.8	8.1	8.3
Old-age pension recipients on Dec 31	858 200	869 700	878 300	898 400
Residents in old people's homes on Dec 31	21 100	20 700	21 000	22 000
Elderly households receiving home help services during the year	84 300	83 000	86 000	87 000
Auxiliary service recipients over 65 during the year	103 400	104 700	105 000	107 000
Recipients of informal care allowance for the over–65s during the year	13 200	13 300	13 500	13 800

* preliminary data
** estimate

An older age structure means more expenditure on pensions and services for older people

A key objective of social protection is to ensure independent coping and functional capacity of older people for as long as possible. Expenditure on old age category has for years formed the biggest single category in all social protection expenditure. An estimated € 11,610 million (FIM 69,030 million) will be spent on this main category in 2002, which accounts for 32% of all social protection expenditure and 8.3% of GDP. Pensions and other income transfers account for 90% and social services for the remaining 10% of expenditure on old age category.

The above figures do not include expenditure on health care services used by the elderly. In 2002, the net costs of health care services provided by municipalities and the sickness insurance reimbursements paid by Kela for those aged 65 or more is estimated to total € 2,153 million (FIM 12,800 million).

Expenditure on the elderly is increasing year by year. The rise in pension costs is due to the increase in the number of old age pension recipients and a higher level of pensions. Due to a rise in life expectancy, the average time on pension in relation to years spent at work is also increasing. The crucial factors for expenditure on services are old people's health and general ability to cope and the range and costs of public services supply.

The majority of expenditure on old age category is spent on people aged 65 or more. An exception to this are costs of part-time pensions and individual early retirement and the old-age pension of people who have worked in professions with a lower age limit for pension than the general old-age pension limit. Most of the expenditure on services for the elderly is spent on care and services for the oldest people during their last years of life. The number of persons under 75 receiving services for older people has fallen.

When the economic effects of the ageing of the population are concerned, what is crucial is the economic dependency ratio, i.e. how many non-employed persons are supported by one employed person. An active approach towards being prepared for the changes in the age structure on the part of the society, municipalities, work and

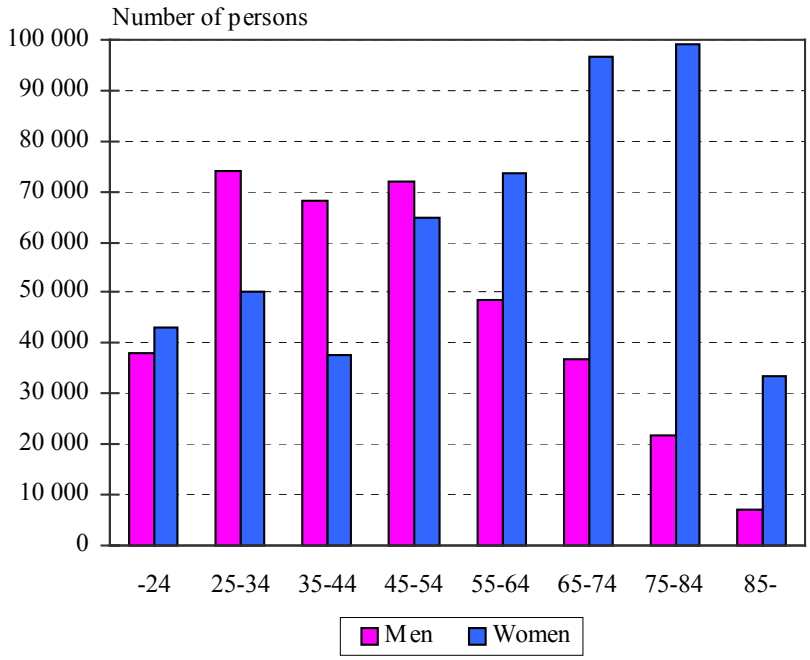
production can diminish the economic and social problems related to the ageing of the population. At the present moment, resources that could be used to finance care and services for older people, among other things, are taken up by unemployment.

Because of migration and differences in the birth rate there are great differences in age structure between regions. The proportion of the population made up of those aged 65 or more varies between 5 and 30%. Migration to the south and a low birth rate can be seen in the age structure of eastern Finland in particular. Many municipalities are already displaying the kind of age structure that is estimated for the entire country in 2030.

An ageing population affects the economy of municipalities. An age structure dominated by old people leads to a drop in tax revenue, at the same time as the need for social and health care services for older people increases. There is a danger that inequality with regard to access to service will increase between old people living in different parts of the country.

At the end of 2000, 62% of people over 65 were women and 38% were men. Clearly over half (57%) of all women 75 or older, and a little over one fourth of the men (27%) in that age group lived alone. Family relations played a significant role in the social position of old people, e.g. their need of social services.

Figure 30. People living alone, by age group and sex, December 31, 2000



Source: Statistics Finland

Trends in old-age pensions

A comprehensive and reasonable pension security is the basis for independent coping of the elderly. The trend in current pensions levels for old-age pensions follows the national pension index and the employment pension (TEL) index. The average level of old-age pensions is rising all the time, because the employment

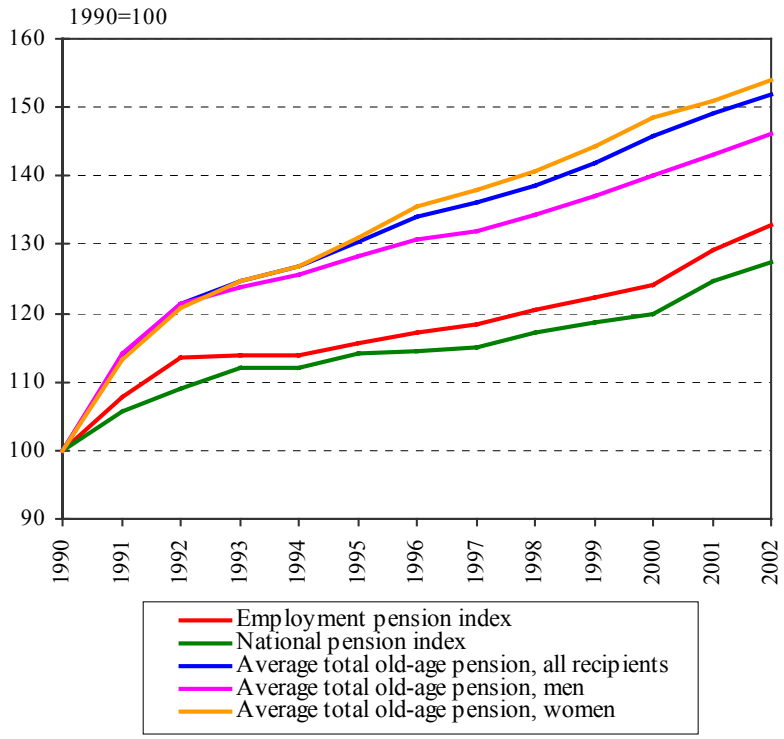
pensions of people now reaching retirement age are higher than the ones granted earlier. At present, the level of new old-age pensions is on average about half of the income earned at work. At the end of 2000, the average total pension of old-age pensioners was € 963 (FIM 5,718) per month, € 1,079 (FIM 6,409) for men and € 802 (FIM 4,756) for women.

The changes brought by the 1996 pension reform slowed down the rate of increase in pension levels (Figure 31). The changes brought about by the reform included making the national pension fully deductible, gradual reduction of the basic amount of the national pension, and introducing a separate TEL index for the over-65s. The remaining basic amount of the national pension was withdrawn at the beginning of 2001. Tax relief for pensioners has partly compensated the cuts made in pensions.

The purpose of index linkage is to maintain the real value of long-term social protection benefits. The annual adjustment of the TEL index is based on changes in the general wage and price level. Index adjustments for employment pensions for old-age pensioners are made using an index where changes in price level account for 80% and changes in earnings level account for 20%, whereas the calculation of pensionable salary and adjustments to the value of pension rights earned and to payable pensions up to the age of 65 continue to use an index where price level and earnings level each account for 50%.

The guidelines presented in the Ministry of Social Affairs and Health strategy for 2010 include changing the pension index so that it takes into account social justice and development trends in public economy.

Figure 31. Trends in old-age pensions 1990-2002



Total pensions for 2001 and 2002 are estimates

Rapid increase in the number of part-time pensions

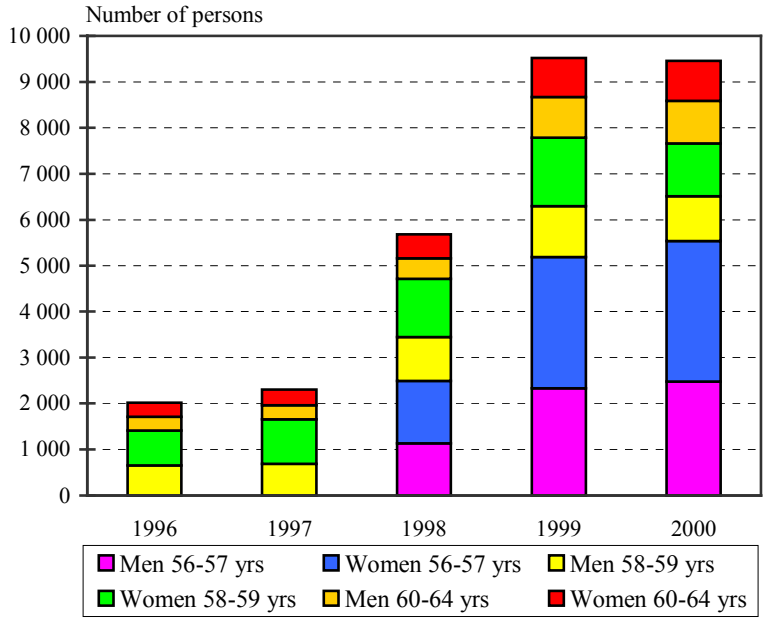
The purpose of part-time pensions is to improve the possibilities of ageing employees to cut down their working time, thus postponing their total retirement from working life and helping them cope at work longer. Part-time pension was included as part of the private sector pension benefits in 1987 and it was extended to apply in the public sector in 1989. The national Pensions Act does not include part-time pension.

The age limit for part time pensions was originally 60 years in the private sector and 58 years in the public sector. As of the beginning of 1994, the age limit was lowered to 58 years in the private sector. The level of part-time pension was increased to half of the difference between full-time and part-time salary. Before the reform, the level of part-time pension was affected by the age of retirement. It was also prescribed in 1994 that old-age pension is accrued not only for part-time work, as was earlier the case, but for the decrease in earnings level during part-time retirement.

From the beginning of July 1998 the part-time pension age limit was temporarily lowered to 56 years. The period of validity of the temporary act was later extended to the end of 2002. It was also agreed on in 1998 that employers are obliged to attempt to arrange part-time work for an employee who wishes to take up part-time pension. The act does not however prescribe that employees have the right to demand part-time pension.

After the 1998 reform the popularity of part-time pension rose even more rapidly than had been expected (Figure 32). The share of the population of full-time pensioners has shrunk during the same time. At the end of 1997 there were about 7,000 part-time pensioners. In August 2001 the corresponding number was 27,000, almost 16,000 of them in the private sector. In 2000 part-time pensioners made up 18% of all pension recipients in age group 55-59.

Figure 32. Part-time pensions granted in 1996-2000 by year of inception and by sex



Source: Pension Security Centre

The age-limit for taking up part-time pension will go up and the accruement of new pension will slow down from the beginning of 2003. The changes do not apply to those born in 1946 and earlier. Those born in 1947 and later are eligible for part-time pension at the age of 58. The cut in the level of pension accumulating on the basis of the drop in earnings level between full-time and part-time work diminishes the level of old-age pension granted after part-time pension. Part-time work qualifies for a new pension just like any other type of work.

The majority of today's part-time pensioners are office and management personnel; e.g. a large number of people holding various types of expert posts have applied for part-time pension. In recent years, part-time pension has spread to cover new fields and groups of people. More nursing staff, kitchen and maintenance staff and industrial workers have taken up part-time pension than earlier, for example.

Over 90% of part-time pension recipients consider their state of health to be good or moderately god. Part-time pensioners' assessment of their own health status is similar to that of full-time employees of the same age (58-64 yrs). Part-time pensioners also usually estimate their working capacity to be good. Women assess part-time pension to have a more positive effect on working capacity and coping than men. In part-time pensioners' own estimate, cutting down the amount of work has helped them cope at work better than earlier, when they were employed full-time. The growing popularity of part-time pension has however meant that more people in physically strenuous jobs are now part-time pensioners, and they do not rate their own state of health as positively.

In its present form, part-time pension is a very economical alternative for both the employer and the employee. The popularity of part-time pension has clearly followed the changes made in pension level. When the benefits were improved, there was an upsurge in the popularity of part-time pensions. However, the popularity of part-time pensions also corresponds to the development trend characterised by burn-out and the fact that mental health problems have become the leading cause for disability. Part-time pension may diminish problems of this kind. In the future, taking care of elderly members of the family may increase the interest in part-time pension among ageing employees.

Part-time pensions may have contributed to a slight reduction in the use of the path to unemployment pension. On the other hand, only few people taking up part-time pension have been in danger of being made redundant. The part-time pension system seems to have some improving effects of the employment situation, for a new employee has been taken on to replace about one in three part-time pensioners.

The number of new individual early retirement pensions has gone down somewhat as part-time pensions have become more common. On the other hand, there has been a trend for several years now for fewer new individual early retirement pensions to be taken up. It is proposed in the Ministry of Social Affairs and Health strategy up to 2010 that the degree of reduction of working capacity be taken into account in defining the level of part-time pension.

Reform proposals regarding old-age pensions

In November 2001, central labour market organisations agreed on a proposal concerning the improvement of employment pensions in the private sector (see chapter 2.2). According to the proposal, the age limit for the onset of

employment pension accruement would be lowered from 23 to 18 years, and the age limit for conclusion would be raised from 65 to 68 years. The new system would be based on flexible old-age pension age. Old-age pension could be taken up at the age of 62-68 years. From the age of 63 employees could choose whether they want to keep on working, thus increasing the level of their pension, or whether they want to take up the pension they have earned up to that point.

According to the proposal, two rules as to how pensions are calculated are used during transitional periods. In 2005-2010, the level of new pensions would be calculated based on the entire career as well as the last ten years of each employment relationship. The final pension would be based on the calculation that is more favourable to the employee. The final calculation model is to be decided on by 2008, and it would come into force from the beginning of 2011 at the latest.

The parties also proposed a reform concerning pension accruement on unsalaried periods, which would mean that temporary absences from gainful employment, e.g. due to illness, studies or looking after one's own children would also contribute towards pension.

Functional capacity of pensioners can be further improved

Today the life expectancy of 65-year-old men in Finland is 15 years, and that of women is 19 years. An 80-year-old Finnish woman can expect to live for about another 8 years, while the corresponding figure for men is close to 7 years. The greatest proportionate increase in life expectancy is predicted for the over-80s, which means that their share of pension-age population will grow.

The majority of pensioners are active people who are able to cope independently. The functional capacity of people aged 60-75 has improved, and nearly all people in this age group live in their own homes with no regular need of services. The Health 2015 programme approved by the Council of State set the target of continued improvement of the average functional capacity of the over-75s on the same lines as for the past 20 years. Deterioration of functional capacity speeds up in many cases around the age of 75, and particularly after 80 years of age.

Major reductions in functional capacity are slowly being postponed towards older age groups. People born later are healthier and more functionally capable than people of the same age who were born earlier. The functional capacity of the over-65s will probably continue to improve in the future as well, although the changes are relatively minor in the short run. The overall lack of functional capacity of old people and their general need of help will therefore probably not grow at the same rate as their numbers.

The living environment and the availability of services constitute a vital whole for the functional capacity of old people, both those living at home and those in institutional care. The need for intensive service forms is postponed, and the work of families and staff is made easier when environments and their technical solutions are planned so as to be obstacle-free and functional. The curbing of costs of services at home and in institutions calls for joint responsibility between the social and health care sectors as well as housing, transportation and other sectors of society.

Various types of third sector activities play a vital role in the maintenance of functional capacity of older people. Participation e.g. in the activities of pensioners' associations or sports

associations helps people keep up their social networks, which have a crucial effect on preserving the quality of life and maintaining functional capacity. Public subsidies for the work of these associations from Slot Machine Association and lottery profits are part of preventive elderly care which helps cut down the costs of public services.

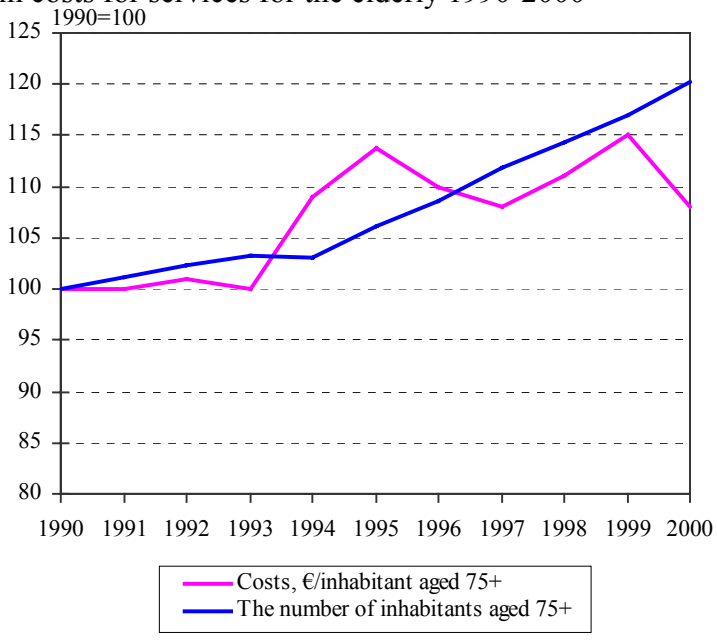
The elderly will continue to form a very heterogeneous group in terms of functional capacity in the future as well. The objective is that a treatment and service plan that takes individual needs into account as much as possible be drafted for all those in need of help, ensuring access to help and services corresponding to functional capacity and the need of services. A nationwide guide on treatment and service plans for the elderly is currently under preparation. It can be seen as positive that more and more municipalities have introduced individual indicators (e.g. RAVA and RAI) that assess old people's physical, mental and social functional capacity and need of help. The use of more versatile indicators also makes it possible to assess what is the best way of responding to service needs, the number of staff needed in service provision and the costs of different service alternatives.

More resources and innovation needed in services for older people

The expenditure on services for older people has shown varying development trends in recent years (Figure 33). Expenditure on services for older people is clearly lower in Finland than in the other Scandinavian countries. In order to secure a sufficient provision of high-quality services for the aged, more municipal and government resources are needed.

The level of government grants to municipalities was increased in the 2002 budget by € 32.7 million (FIM 194 million) to remedy the shortcomings in elderly care services and to improve the quality of services provided. The appropriation is not earmarked to be used for specific services, but it is targeted at inhabitants over 75 years of age. The appropriation improves the possibilities of the municipalities to mend the gravest deficiencies in e.g. the availability of home help and institutional care.

Figure 33. Trends in costs for services for the elderly 1990-2000



The costs include institutional care for older people (old people's homes), home help, housing services, informal care allowance and other forms of social services for the elderly. With the exception of institutional care for older people, the costs have been estimated on the basis of clients of different service forms and the number of visits to community care services.

There is hardly any room for intensifying the working pace of staff working in elderly care; actually there is a need to take on more staff. The development of salaries in elderly care has been modest, and salaries need to be adjusted to maintain the competitiveness of elderly care as a career alternative. In the future, improving productivity can therefore mainly be achieved by a rise in innovation-based productivity. In addition to sufficient and well-educated staff, a more effective utilisation of new technical aids and other forms of technology as well as continuous product development based on the needs of older people are needed in order to ensure the quality and quantity of services for older people. New working methods and networks of cooperation must be developed and the dissemination of good practices must be encouraged.

The Ministry of Social Affairs and Health has directed an appropriation set aside for it in the government's aid package aimed at the future towards an extensive project designed to utilise information technology in services for older people and people with disabilities. The project includes developing local and regional competence as well as models making use of IT-based services, equipment and technical aids to help independent coping. The project was launched in 2001 and is expected to go on until 2003.

More effective information guidance regarding services for older people

Since the constitutional reform in 1995, the right to necessary care has been a constitutional subjective right for all citizens. The government must provide adequate social welfare and health care services for everyone and promote public health. The public services for the elderly in Finland are part of general social and health care services, the provision of which is by law the duty of the municipalities.

In principle, older people are entitled to social and health care services in the same way as the rest of the population. There is thus no separate legislation in Finland on services for older people. Services for older people do not include any absolute subjective rights based on certain criteria guaranteeing access to a certain type of care or service. Neither are there any quantitative norms related to the provision of services. Ultimately this is a question of what kind of service is deemed in the municipalities to be most appropriate to suit the needs of each older person. The municipalities are the ones making choices with regard to the range of services offered and their scope.

In the 1990s, cost effectiveness came in many cases to be the most important factor affecting services for older people. The present aim is to make also the quality of services and a client-centred approach important areas of development in the municipalities.

In the 1990s, the national guidance of services for older people involved mainly information guidance. The Ministry of Social Affairs and Health attempted to improve the impact of information guidance by a quality recommendation concerning care and services for older people presented in April 2001 jointly with the Association of Finnish Local and

Regional Authorities. The recommendation is especially intended for municipal decision-makers and management responsible for the operational guidelines of care for older people and the allocation of resources for implementing them. The recommendation helps municipalities assess the appropriateness of their activities, the attainment of set objectives and the use of budget funds. It also provides guidelines for inhabitants, based on which they can assess the services provided in their own municipality.

The aim of the recommendation is to ensure that the structure of services provided corresponds to the needs of the elderly and that municipalities allocate sufficient resources to achieve the service objectives. According to the recommendation, every municipality should have a policy strategy concerning care for older people defining the objectives related to promoting the health and welfare of its inhabitants, as well as the areas of responsibility of different administrative sectors and interest groups in their implementation. The basis of the quality recommendation is the idea that strategic planning, objectives that can be measured and systematic monitoring of their attainment bring added value to services.

About one in two municipalities had a policy strategy for the care for older people in the spring of 2001, and many had decided to launch work towards drawing up one. One out of five municipalities had no strategy for care for older people or any plans to come up with one. There is no other information as yet of whether the national framework for high-quality care and services for older people has had any effect on municipal budgets, the contents or quality of services or the number of staff. The recommendation is known to have led to the hiring of extra staff and making fixed-term and temporary posts permanent in some municipalities.

The Ministry of Social Affairs and Health has launched a systematic implementation of the quality recommendation jointly with the Association of Finnish Local and Regional Authorities, Stakes, provincial governments and various organisations at a number of educational events throughout the country. Several nationwide service-related development projects have been initiated. The Ministry of Social Affairs and Health will also be appointing a follow-up group, whose task it will be to monitor and guide the implementation, functionality and development of services and to promote work on policy strategies for care and services for older people and development projects. Special attention will be focused on the development of the quality of services, prevention and rehabilitation and community-care services. The target is to achieve a functional service structure by 2010, when the growth of the proportion on pension-age population will speed up even further.

A guide on good care and services for older people, aimed particularly at social and health care staff, will be published as an aid to the recommendation. In addition, Stakes will compile key indicators to be used freely by all municipalities, with the aid of which it is possible to monitor and assess the implementation of policy strategies concerning services for older people and the development of services and to compare them with the situation in other municipalities.

Fewer old people in institutional care

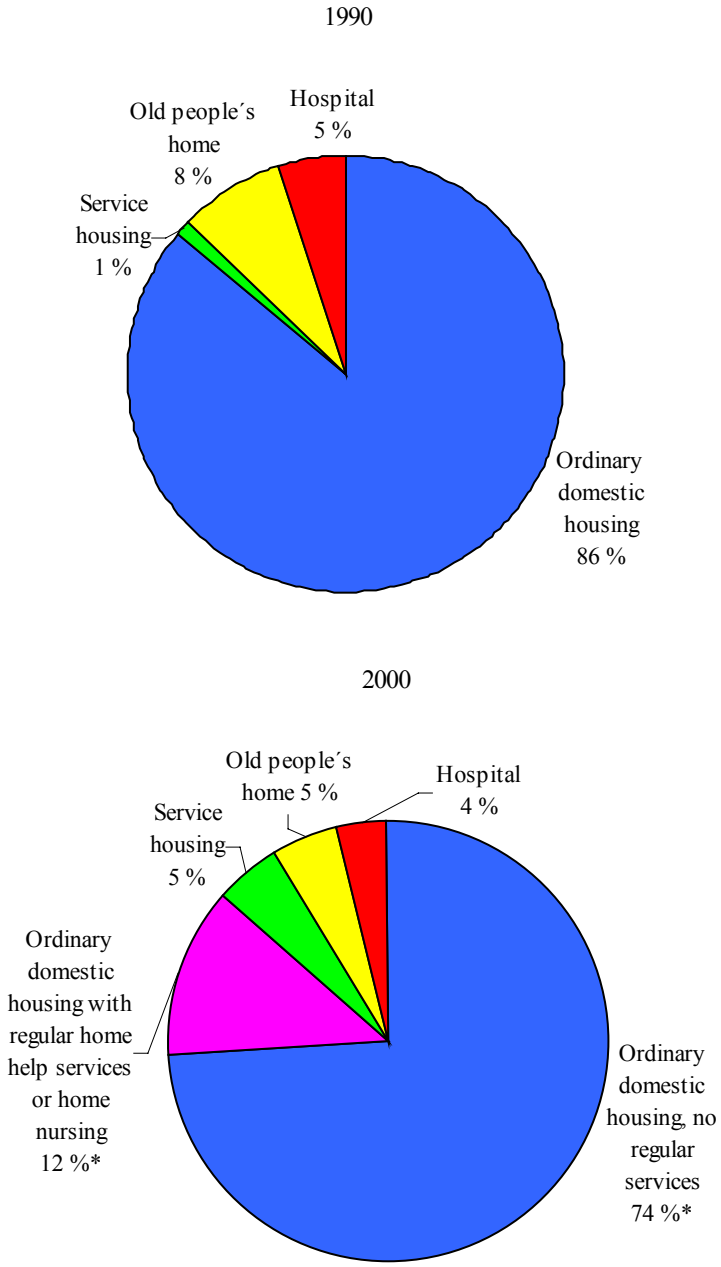
The basic guideline for national elderly care policy in Finland has for a long time been to have old people live at home as long as possible, with the aid of services and technical aids if needed. The majority

of people over 75 manage without regular social and health care services. A decreasing number of old people are in institutional care. Long-term institutional care has primarily been replaced by service housing (Figure 34). Service housing covers a variety of services, ranging from relatively minor service forms to intensive measures involving 24-hour monitoring. Continuous and regular provision of services at home (home help and home nursing) has not developed at the same pace as the volume of institutional care has diminished.

The majority, i.e. 75% of the elderly in old people's homes and other types of institutional care are women. One in ten of all women over 75 is in institutional care, which is almost twice the number of men of the same age. Men cope at home longer than women, thanks to help they get from their spouses, among other things. In 1999, almost two thirds of the people over 65 receiving regular home help or home nursing were women.

A growing number of people of advanced age live at home, in ordinary domestic accommodation. The rise in housing standards helps people cope at home. As the number of old people grows, it is neither possible nor desirable to increase the provision of service housing and old people's homes at the same pace, which means that a growing number of the elderly will be living in their own homes in future. An older age structure means that institutional care and service housing would have to be arranged for thousands of new people by 2010, if there were no change in the structure of services offered.

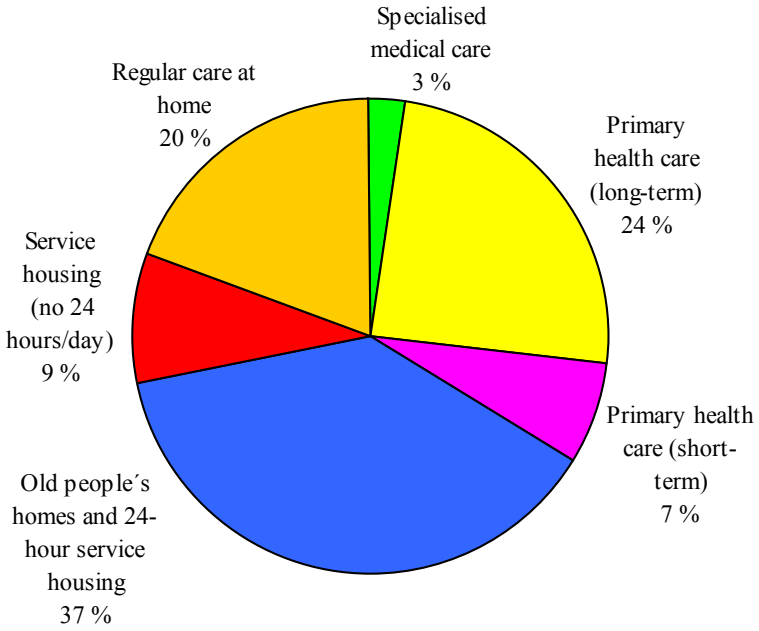
Figure 34. People aged 75+ and their housing type in 1990 and 2000



*) The division of those living in ordinary housing into regular service users and others is based on the 1999 home care survey. No corresponding data are available for 1990.

The increasing prevalence and treatment need of dementia poses one of the biggest challenges for social welfare and health care from the point of view of public economy. The prevalence of relatively advanced or severe cognitive disturbances shows a sharp rise with advancing age. The number of elderly people suffering from fairly advanced or severe dementia is about 80,000 at present, and it is expected to increase by about 15,000 people over the next ten years. Conditions causing dementia are one of the main reasons for need of long-term institutional care or services requiring 24-hour monitoring.

Figure 35. Social welfare and health care clients with dementia, December 31, 1999 (N=24,001)



Regular care at home means home help services, home nursing or informal care allowance. Primary health care and specialised medical care refer here to institutional care.

Source: Stakes

Need of improving home help services and service housing

The actors responsible for care and services for older people are faced with a double challenge - to curb costs and to improve the quality of services. In the 1990s, the most important approach to curbing costs in the public sector was to cut down on institutional care and to make do with a small number of staff. Another way of attempting to target services with greater precision has been the retargeting of services to ”those in greatest need of services”. The result of this strategy has been a significant reduction in home help and the extent of auxiliary services (Figures 36 and 37). The strategy is based on the assumption that those in need of less help can take care of themselves with the aid of relatives or by utilising private services. The risk with this kind of rigid priorisation or assessment of need is that decisions on whether to grant services are based primarily on medical grounds, and that service users and their families are excluded from decision-making. The preventive and rehabilitating role of community care services in maintaining functional capacity may also be greatly reduced.

In the allocation of increased resources to services, the strategy used by the municipalities has been to transfer costs to users (raised client fees) and other parties. Alternative forms of financing have been looked for primarily in the housing sector. Old people’s homes have been mainly replaced by service housing, the pricing of which is relatively free for the municipalities. Municipalities also fund a smaller share of the costs of housing services than of institutional care. A person living in service housing may receive Kela benefits (housing allowance, pensioners’ care allowance, health care reimbursements), which are not paid out to

people in long-term institutional care. Another factor behind the expansion of service housing in the 1990s was the support granted by the Slot Machine Association to organisations, foundations and associations for the construction of service housing.

Figure 36. Percentage of recipients of the main forms of care and services for older people in Finland, 1991-2000

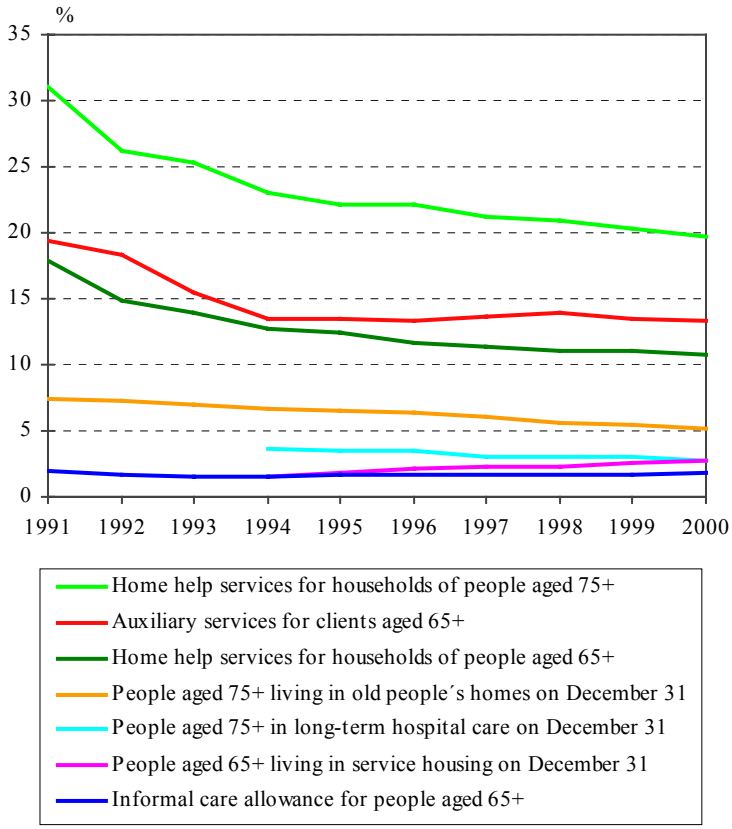
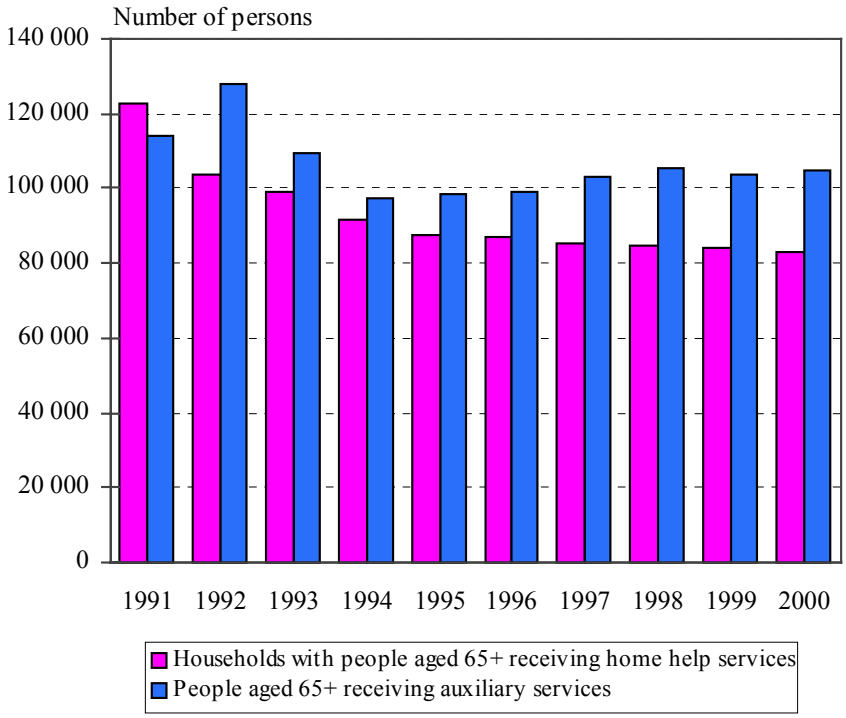


Figure 37. People aged 65+ receiving home help services and auxiliary services in 1991-2000



One of the key challenges for services for older people is the development and allocation of more resources to the older people living in ordinary homes. Providing services at home, in familiar surroundings, is often the most humane and at the same time also the most cost-effective approach. It also ensures that the remaining resources of the aged are best made use of, and that the participation of family members and others in caring for older people is maintained. The number of staff in home help services has been increased in recent years, but about one third of the input of work of home help staff is estimated to target people living in service housing. There is often no readiness for flexible increase of home help services and home nursing as the need of service grows, which may cause a feeling of insecurity among older people living at home and their relatives. People may be forced to leave their homes even in cases where living at home would still have been possible with the aid of appropriate services. The loss of familiar surroundings often reduces the mental resources of older people, causing depression.

There are great differences in the level of services included in service housing. There is a clear need to chart the diverse types of service housing and to find an appropriate role and target groups within the context of social welfare service provision. Service housing with no 24-hour monitoring is usually not suitable as a dwelling for old people with advanced or moderately advanced dementia.

Seamless chains of service are needed to boost the provision of functional services for the elderly. This means e.g. that a problem requiring specialised medical care is actually taken care of in specialised medical care facilities, without setting unfounded age limits, that rehabilitation is launched without delay within primary health care, and that upon discharge from hospital the patient has access to sufficient home help service and technical aids to ensure coping at home. A rehabilitative

approach is called for in all service provision.

The resources and success of prevention and rehabilitation have an effect on the long-term costs caused by the ageing of the population. Interest in the development of preventive out-reach work among the elderly is among other things seen in the launching of so-called preventive visits to the homes of old people who have reached a certain age. According to a survey by the Association of Finnish Local and Regional Authorities, such activities are under way in about 40 municipalities. The Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health and Stakes will be carrying out a project aimed at developing and assessing preventive home visits between 2001 and 2003.

The role of family caregivers under consideration

In addition to state of health, the need of social welfare and health care services is influenced by many social factors. In Finland, as in many other countries, family members and other relatives are often the ones with the primary responsibility for providing help and assistance to the elderly. An estimated 70% of the help received by the elderly comes from family members and other relatives. The role of relatives is an important one, both from the human and the economic point of view. Women act as family caregivers more often than men, but the number of men taking care of older relatives is also on the rise. Family caregivers of older people have often reached pension age themselves.

In assessing the prerequisites of family care of the elderly and the disabled, changes in family structures and ways of life must be taken into account. Trends in working life, the fact that family members are also working, and the social security of family caregivers also have an effect on how they are able to participate in the care of older relatives.

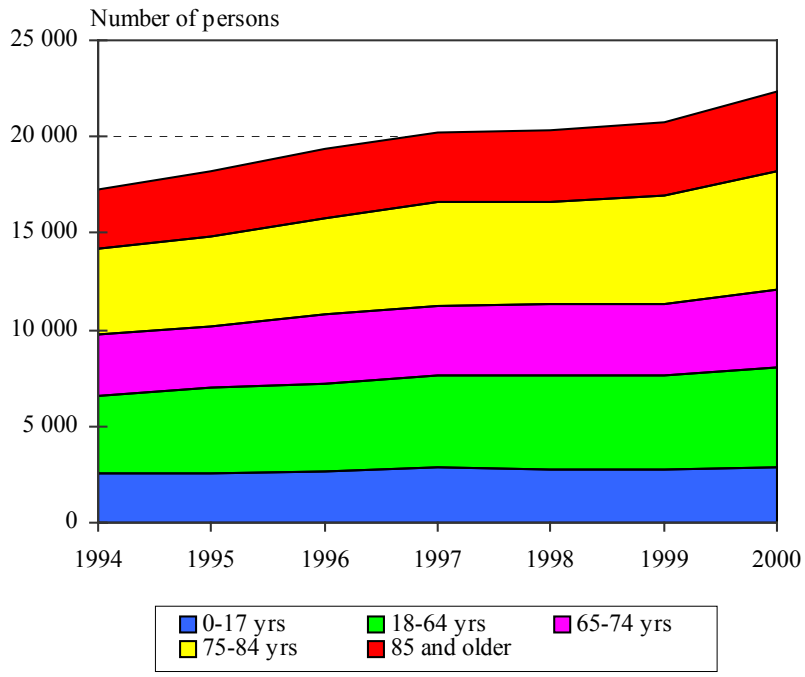
The system of informal care allowance to family caregivers was introduced in 1993. The informal care allowance system is a form of assistance tied to budgetary appropriation, and it can be given as a cash benefit or in the form of services. In 2002, the minimum informal care allowance to family caregivers is € 218.95 (FIM 1,302) per month.

Upon agreement, the compensation can be lower, if certain conditions are met. There is a great deal of variation between municipalities in the level of informal care allowance. In 2000, a total of € 41.5 million (FIM 247 million) and € 23.5 million (FIM 140 million) was used for cash benefits for family caregivers of the elderly and the disabled, respectively.

In 2000, 22,400 persons, two out of three of whom were aged over 65 (Figure 38), were cared for with the aid of informal care allowance. The number of family caregivers receiving the allowance was 21,700. Only a small proportion of the people taking care of a family member are covered by the informal care allowance system.

Dementia poses one of the greatest challenges for family care. The majority of family members of old people with dementia are not covered by the system of informal care allowance, and are caring for an old person who is not a regular recipient of social welfare and health care services. Special measures, particularly service guidance and counselling aimed at helping them cope, are needed to assist the family caregivers of people suffering from dementia.

Figure 38. People cared for with informal care allowance, 1994-2000



As of 2002, the amount of statutory days off of informal care allowance recipients engaged in regular care was increased from one to two days per month. At the same time, the number of people entitled to statutory days off in accordance with the informal care system increased, and family caregivers were covered by statutory accident insurance. The reform increases government expenditure by € 5.6 million (FIM 33.5 million) in 2002.

The development of informal care allowance to family caregivers will continue to pose one of the greatest development challenges within care of the elderly and the disabled in the years to come. Supporting family care as a part of social welfare and health care services is pertinent, taking into account the continuous growth of the proportion of old people and the need for different treatment and care alternatives.

Issues that need looking at in the future include e.g. the criteria for family caregiver relationship with regard to how demanding the care is, and what is the best way of taking into account the needs of different groups of family caregivers. In addition to the needs of care by the person cared for, the needs of family caregivers are influenced by factors such as the caregiver's labour market status. The needs of family caregivers can vary a great deal, depending of whether they are gainfully employed besides taking care of a family member, act as family caregivers instead of being employed elsewhere, or whether they are pension-age family caregivers, who in most cases look after an elderly spouse or a mentally handicapped grown-up child.

It must also be assessed what auxiliary services and services should be included in informal care allowance, and how they are individually prioritised according to the needs of the caregiver and person being cared for. The support can be in the form of economic assistance (e.g. care compensation, transportation compensation), services supporting care (e.g. auxiliary services), material help supporting other types of care (e.g. special equipment in the home, technical aids

making care easier) and promoting the coping of the caregiver (e.g. days off, stand-in caregivers, counselling, guidance, rehabilitation). Other things that require consideration include the nature of the family caregiver relationship between the municipality and the caregiver, with regard to the clarity of the caregiver's status, and the client fee policy related to family care support.

One alternative is to enact a separate law on informal care allowance or family care. This would ensure a more secure status for family care within the service system and legislation. Other issues that could perhaps be solved by legislation include the right of family caregivers to leave of absence or time off during the period they look after a family member.

Financing expenditure on the elderly

National pensions are financed primarily by employer contributions and by central government. When needed, the central government also makes so-called guarantee payments to the national pension fund to ensure its liquidity. In addition, € 404 million (FIM 2.4 billion) of value added tax revenues of 2000 were channelled into the national pension fund.

Employment pensions are financed through contributions by employers and the insured. Employees have contributed to their own employment pensions since 1993. In 2000, employee contributions made up one fifth of the total, while employer contributions made up 71%.

The main source of financing for services for the elderly are municipal tax revenues. Services are also funded by central government grants, client fees, Kela benefits and subsidies form the Slot Machine Association.

Table 7. Contributions to financing services for the elderly in 2000 (preliminary data)

	Expenditure, € million	Financing contributions (%) Central government	Municipalities	Employers	The insured	Clients
Old-age pensions						
- national pension	1 843	45	0	55	2	0
- employment pension	8 073	0	0	71	19	0
Institutional care for the elderly [1)]	619	19	61	0	0	20

[1]including client fees

The financing of services for older people has been criticised for not providing sufficient support for a service system offering community care-centred, individual alternatives. The system has also made it possible to transfer costs from one party to another without gaining any significant overall economic benefits.

A working group appointed by the Ministry of Social Affairs and Health looked into the significance of non-institutional and institutional care within the framework of the national pension system and social welfare and health care services. The most important proposals of the working group were the paying of unreduced basic national pensions to people in institutional

care as well, and the possibility to pay a pensioner´s care allowance to persons in institutional care. At present, deduction is made in the national basic pensions during long-term institutional care, and the paying out of pensioner´s care allowance is discontinued after three months of the onset of institutional care.

At the moment about 24,000 pension recipients, 20,000 of whom are old-age pensioners, are getting a reduced national basic pension due to institutional care. At the end of 2000, the average reduction due to institutional care was € 155 (FIM 920) per month, and for old-age pension recipients it was € 145 (FIM 860) per month. The payment of pensioner´s care allowance has been discontinued on around 22,7000 people. The cost effect of the abolition of institutional care limitations would be € 98.9 million (FIM 588 million) on the 2002 level, and it was proposed that it be financed jointly by municipalities and central government, 50% each. € 46.3 million (FIM 275 million) of the added costs would be national basic pension costs and € 52.6 million (FIM 313 million) would be pensioner´s care allowance costs.

Sustainable financing of services for older people requires the support of a positive development trend of the employment situation. In future, decisions on financing guidelines must be made in an operational environment with various types of pressures and challenges, in addition to the ageing of the population and an increasing need of services. These include guaranteeing basic social rights, internationalisation and new ways of financing and providing services, such as the expanding private service sector and systems using service vouchers. Assessment as to the cost, guidance and targeting effects on the attainment of the policy objectives for ageing policy of any possible changes is needed with regard to different population groups.

2.4 Social protection for widows and other survivors

	1999	2000*	2001**	2002**
Expenditure on main category (€ million)	1 250	1 280	1 340	1 400
- of which, survivors' pensions	1 210	1 240	1 300	1 350
% of social protection expenditure	3.9	3.9	3.9	3.9
% of GDP	1.0	1.0	1.0	1.0
Recipients of survivors' pensions on December 31	250 300	252 800	265 100	271 600
Recipients of child's pensions on December 31	28 250	28 500	28 400	28 300

* preliminary data
** estimate

Most recipients of survivors' pensions elderly widows

Expenditure of survivors' pensions and funeral grants is estimated at € 1.3 billion and € 1.4 billion in 2001 and 2002, respectively. This is almost 4% of total social expenditure.

The main form of survivors' pension is the widow's/widower's pension. At the end of 2000, a total of 252,800 people received widow's/widower's pension, 10% of them men. The number of men has been rising steadily since the reform of survivors' pensions in 1990. Most recipients of the widow's/widower's pension are elderly, 80% of widows being over 65 (Figure 39). The number of recipients of this kind of pension has been rising steadily as the population ages.

Survivors' pension more important for women

In 2000, the average total widower´s pension was € 1,181.69 (FIM 7,026), while that of widows was € 995.17 (FIM 5,917) per month. However, widow's pensions were higher than those of widowers, because the pension is based on the pension or pension rights of the person through whom the benefit is derived. The widow's/widower's pension is also coordinated with the recipient's other pensions. The more pension the recipient receives from other sources, the smaller the widow's/widower's pension.

The average level of widow's/widower's pension rose steadily throughout the 1990s. This is due to the fact that employment pensions increase year by year due to the maturity of the pensions system and the increase in wage and salary earnings. Survivors' employment pensions are raised each year by the amount of the employment pension index, which in addition to price increases takes into account trends in wages and salaries, whereas the survivors' pensions of widows/widowers receiving only the general survivors' pension is raised annually by the amount of the national pension index, which only takes into account trends in prices. Between 1993 and 1997 there was hardly any change in the national pension index (Figure 40).

Children under the age of 18 on the death of the person through whom the benefit is derived are entitled to survivors' pension. The child's pension ends when the child turns 18. Students under 21 continue to be entitled to their pension, however. In 2000, there were nearly 28,500 children receiving child's pensions. Almost 4,600 of them were under 10, 10,900 were 10-15, 6,200 were 16-17 years old and 6,800 were older. The number of recipients of child's pension has been falling slightly with the declining birth rate, and there are fewer recipients of child's pension in the younger age groups.

The average child's pension was € 286.93 (FIM 1,706) per month in 2000. Child's pensions have remained at the same level or even fallen slightly in recent years. The pensions of children over 18 have fallen in particular.

Figure 39. Age structure of recipients of widow's/widower's pension in 2000

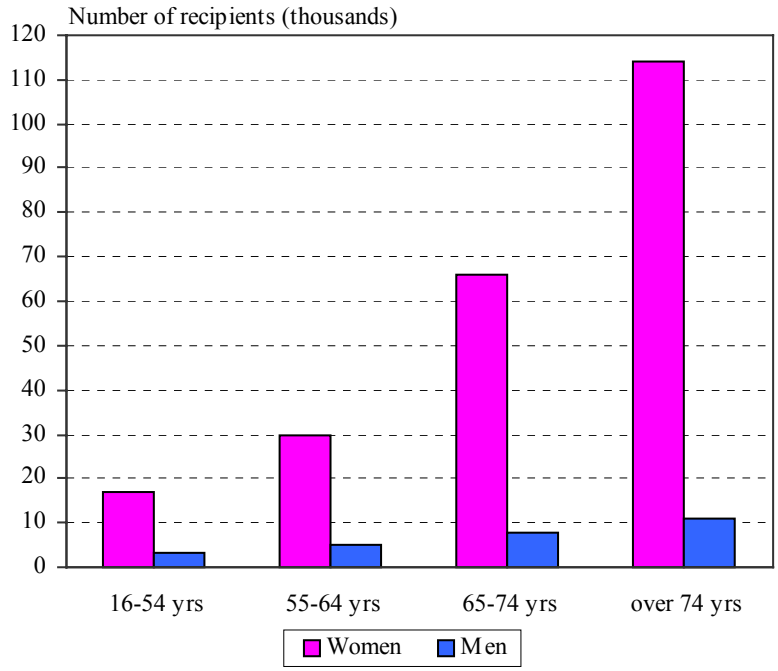
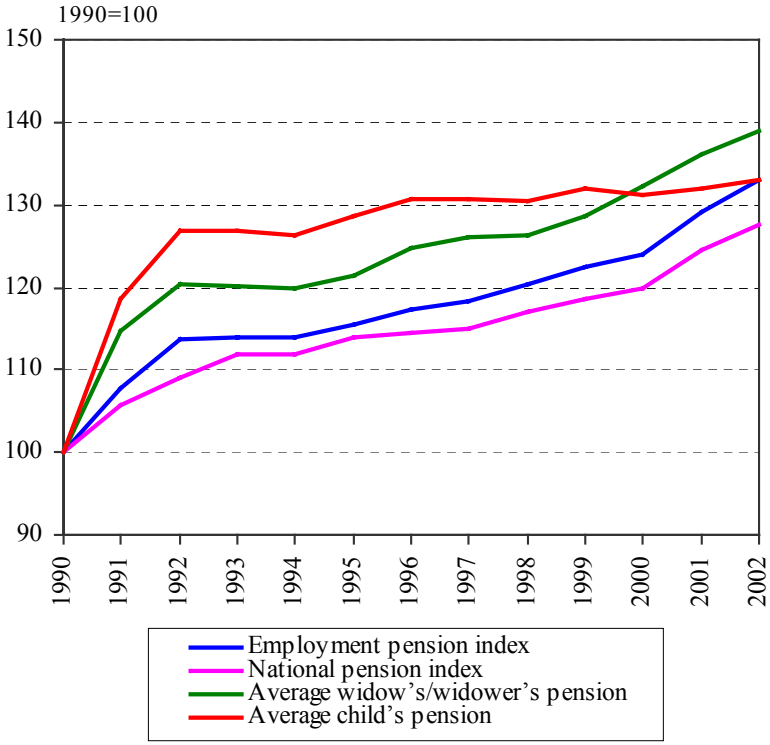


Figure 40. Trends in average survivors' pensions 1990-2002



Elderly women living alone have a low income level

According to an OECD survey, 43% of all Finns 75 or older belonged to the lowest fifth in terms of income in the mid-1990s. This corresponds to the figures in Holland and Great Britain, but it is clearly more than in Sweden and Germany. On the other hand, as many as 75% of women over 75 living alone belong to the lowest 20% in terms of income, while the corresponding figure in most other countries is 40-50%. The economic situation of a woman over 75 is considerably better, if her husband is still alive.

The value of the OECD comparison is diminished by the fact that costs of living are ignored. In Finland, a relatively large proportion of old people live in their own flats or houses, which means that housing costs are low and the small income is sufficient to guarantee a reasonable level of income. The income of elderly women has risen over the years and continues to do so, with more women going to work and being entitled to higher employment pensions.

Financing

General survivors' pensions are financed entirely by central government. Survivors' employment pensions are financed like employment pensions, i.e. through employer and employee contributions. Employees have been contributing to employment pensions since 1993.

Table 8. Financing of survivors' pensions 2000 (preliminary data)

	Expenditure, € million	Financing contribution (%)			
		Central government	Municipalities	Employers	The insured
General survivors' pension	40	100	0	0	0
Employment pensions	1 190	7	0	70	23

2.5 Families and children

	1999	2000*	2001**	2002**
Expenditure on main group, € million	3 990	4 010	4 050	4 100
- of which, cash benefits (€ million)	2 350	2 350	2 350	2 400
% of social protection expenditure	12.4	12.1	11.7	11.3
% of GDP	3.3	3.1	3.0	2.9
Number of mothers receiving parenthood allowance on Dec 31	48 960	48 570	48 400	48 400
Number of children in municipal daycare on Dec 31	215 000	200 400	197 000	194 000
Families receiving child home care allowance on Dec 31	73 030	72 550	70 800	69 600
Number of children receiving private day care allowance on Dec 31	13 820	14 060	14 000	14 300

* preliminary data
** estimate

Child allowance and daycare the main forms of support for families with children

The aim of the family policy support system is to create reasonable economic and functional conditions for families, allowing children to grow up in a secure setting. In 2002, family policy support[6] comes to about € 4.3 billion (FIM 25 billion), or about 3.1% of GDP. The main forms of support to families with children come from child allowance and daycare (Figure 42).

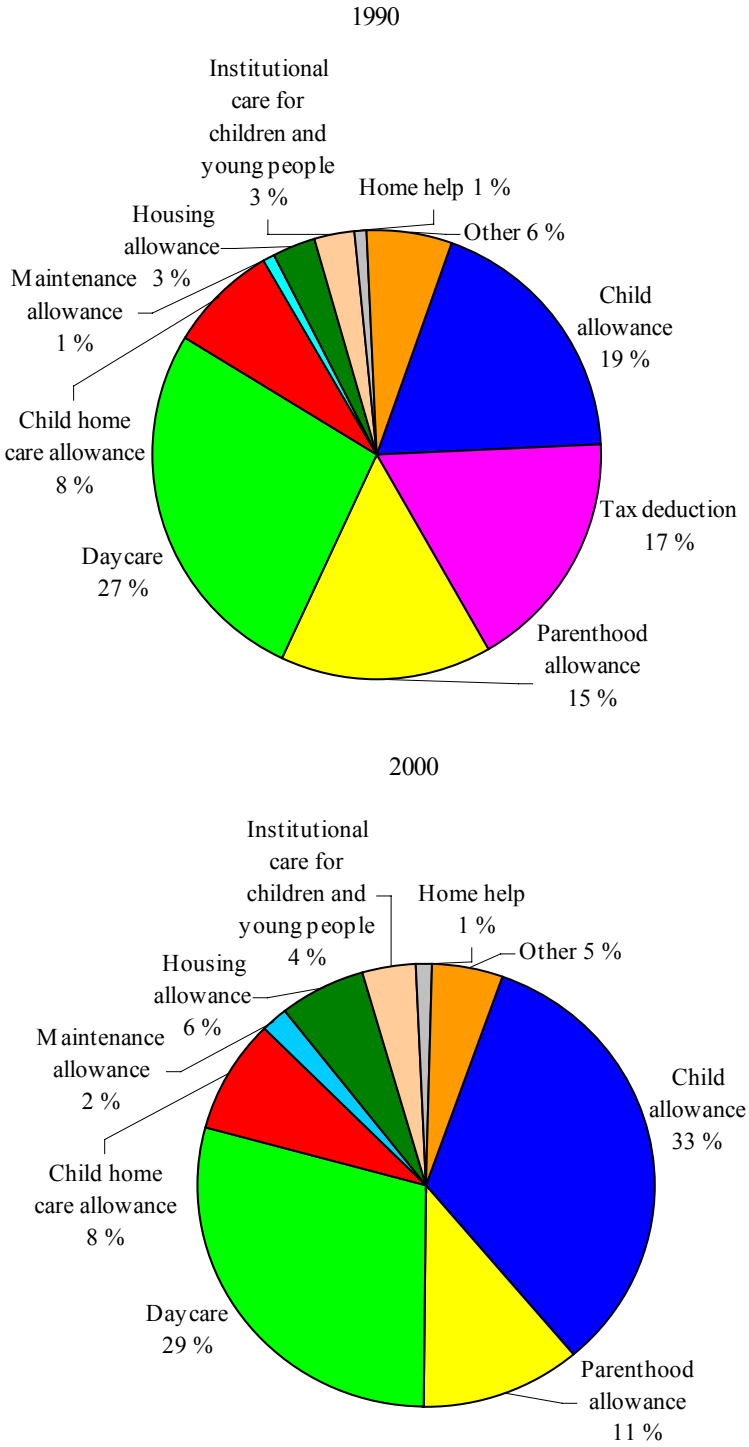
In 2001, expenditure on child allowance came to € 1.38 billion (FIM 8.2 billion), which was € 11 million (FIM 65 million) less than the year before, because the cohort born in 2001 was smaller than that leaving the system. According to population forecasts, the current trend is expected to continue. No changes have been made to child allowance payments since the cuts made in 1995. The purchase power of child allowances fell by about 11% between July 1995 and July 2001.

As of 1994, children in single-parent families have received a higher rate of child allowance. The number of recipients of this supplement for single parents is rising steadily. At the end of 2001, the supplement for single parents was paid on 158,140 children, or almost 1,000 more than in the previous year. The system of single-parent supplement is also abused to some extent. It is sometimes difficult to establish reliably whether a child's parents are in fact living apart, because the population register may not always contain the latest data or even an up-to-date address.

Expenditure on parenthood allowance came to € 500 million (FIM 2,973 million) in 2001, which was € 22 million more than the previous year. This was due to higher wages and salaries, which the parenthood allowance is based on, though the number of mothers receiving parenthood allowance fell. The number of mothers receiving minimum parenthood allowance has not fallen back to the low level in the pre-recession years, and their share of the recipients has settled around 27%. The number of fathers taking parental leave has increased steadily. In 2000 63% of fathers took paternity leave, while only 2% took parental leave.

6 Family policy support is a more extensive concept than the "families and children" concept of expenditure in this main category. It also includes general housing allowance paid to families with children and the support coming from the tax deductibility of child maintenance payments.

Figure 41. Distribution of family policy support in 1990 and 2000



In 2000, total expenditure on daycare was about € 18 million (FIM 105 million) less than the previous year. The reason for this is that the number of children in daycare has fallen, which was to some extent due to the pre-school reform. The total expenditure of municipal daycare was € 1.46 billion (FIM 8.7 billion), 15.6% of which was covered by client fees.

In 2001, expenditure on statutory child home care allowance came to around € 305 million (FIM 1,814 million), which was € 10 million (FIM 61 million) less than the year before. Expenditure on private child care allowance came to € 22 million (FIM 133 million). Municipalities may supplement statutory forms of support with municipal supplements. In 2000, a total of € 35.6 million (FIM 212 million) and € 19.8 million (FIM 118 million) were paid out in municipal supplements for home care allowance and in municipal supplements for private childcare, respectively. The municipalities use the municipal supplements in an attempt to reduce the demand for municipal daycare, and they have been introduced especially in the larger municipalities.

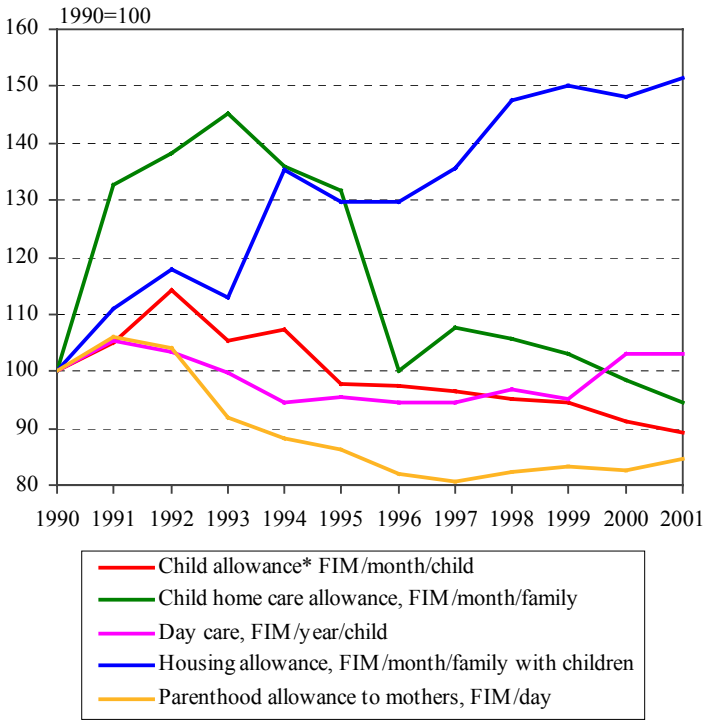
In 2000, a total of € 227 million (FIM 1.4 billion) was paid to families with children in housing allowance, which is € 4.4 million (FIM 26 million) less than the previous year. The reduction was due to a fall in the number of families with children receiving housing allowance. A total of 69,800 families with children were housing allowance recipients, which is a decrease by 5,900 from the year before. Two thirds of the families receiving housing allowance are single-parent families. Of all single-parent families, 42% received housing allowance, while the corresponding figure for two-parent families was 12% in 2000.

Reduced support for families with children

Support from society to families with children is now slightly lower than it was a decade ago. Since 1992, all children under school age have had the right to municipal daycare, child allowances have been both raised and cut at different times, family policy tax deductions have been abolished, the level of home care allowance and the minimum level of parenthood allowance has been cut (Figure 41). Of the various forms of family policy support, child allowance, home care allowance and the minimum level of parenthood allowance are not index-fixed. After the cuts made in 1995 and 1996, no changes in the levels of these benefits have been made. In 1998, the income levels entitling to full housing support were raised, which resulted in an increase in the level of housing allowance paid to families with children.

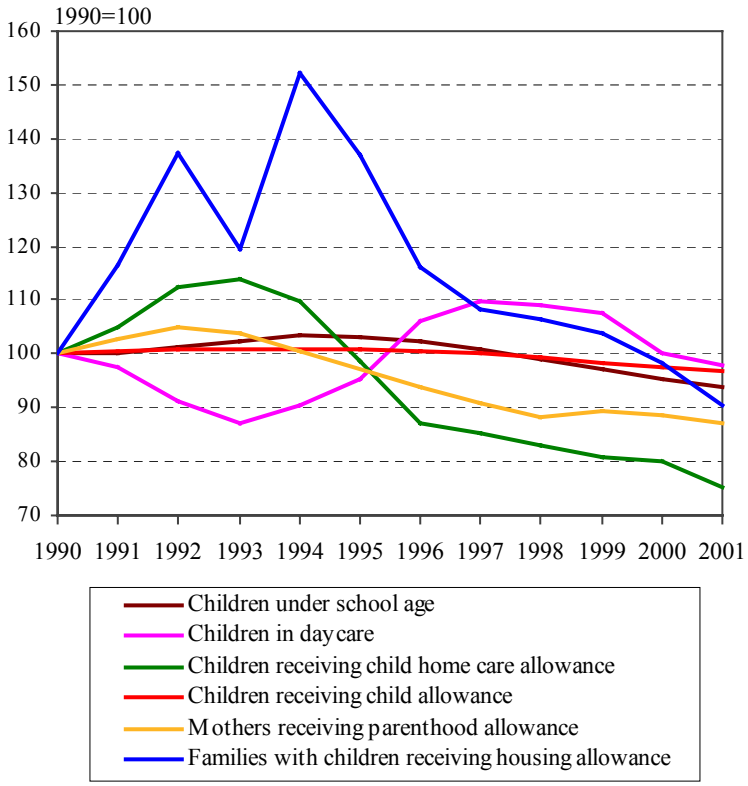
In recent years, the numbers of recipients of family policy benefits have decreased (Figure 42). Unless no changes are made in the level of various forms of family policy support, expenditure on families with children will fall as the number of children being born diminishes.

Figure 42. Real trends in family policy support, 1990-2001



*includes family policy tax deductions in 1990-1993

Figure 43. Recipients of family policy support at the end of the year, 1990-2001



Children under three usually stay at home, while older children go to daycare

Considerable changes took place in the provision of care for very young children in the 1990s. Since 1990, parents of a child under three years of age have been entitled to either municipal daycare for the child, or to child home care allowance. As of 1996, the right to municipal daycare was extended to cover all children under school age. The support systems for the care of very young children were reformed as of August 1, 1997, with the aim of clarifying and simplifying the systems and reducing the differences between municipalities in defining daycare charges.

At the end of 2000, 46% of children under school age were in municipal daycare, and 27% received child home care allowance. The use of private daycare has not been very extensive. About 3% of children under three were receiving private child care allowance. About 12 % of children were cared for during the parenthood allowance period. Another 12%, of 51,000 children, were outside the care systems eligible for support. These children are either cared for at home by unemployed parents or are children over three who are cared for at home but have no siblings under the age of three entitled to home care allowance.

Only 22% of children under three were cared for outside the home. The majority of them (73%) were cared for at home on either home care allowance or parenthood allowance. Three per cent of all children under three were not covered by any system. There are probably mainly the children of unemployed parents. In such a situation, the parent caring for the child at home tends to opt for unemployment benefit, if it is higher than the level of child home care allowance.

Childcare arrangements vary according to the age of the child. Of all children aged 3-6, 62% are in municipal daycare (Figure 44). The pre-school reform has reduced the number of 6-year-olds in municipal daycare.

The majority of municipalities have been successful in arranging daycare according to their obligations under the legislation on daycare provision. The larger municipalities have established new daycare centres, while smaller ones have increased the provision of family daycare. Sixty-six per cent of the children in municipal daycare were at daycare centres, and 34% were in family daycare (Figure 45).

It is estimated that the number of children requiring special care and education has increased. According to a recent survey, many municipalities have not been able to provide children in daycare with the support measures they need. There is especially a shortage of services by specialised pre-school teachers, speech therapists and psychologists.

The demand for daycare in the evening, at night and during weekends grew in the 1990s. The need for daycare in shifts has increased e.g. due to longer shop hours. In January 2001, about 7% of children under school age in municipal daycare were covered by municipal daycare in the evening, at night and during weekends. According to a recent survey, 32% of municipalities have a shortage of round-the-clock daycare.

In February 2002, the Council of State issued a decision in principle on national early education guidelines. The guideline contains the central principles of the Finnish early education system and the areas of emphasis.

Falling demand for daycare

At the end of 2000, there were 200,400 children in municipal daycare, which was 15,000 less than the previous year. The number of children in day care under school age has fallen, both due to a drop in birth rate and the preschool reform. However, the number of children in private daycare has increased slightly.

Figure 44. Care arrangements for children under school age on December 31, 2000

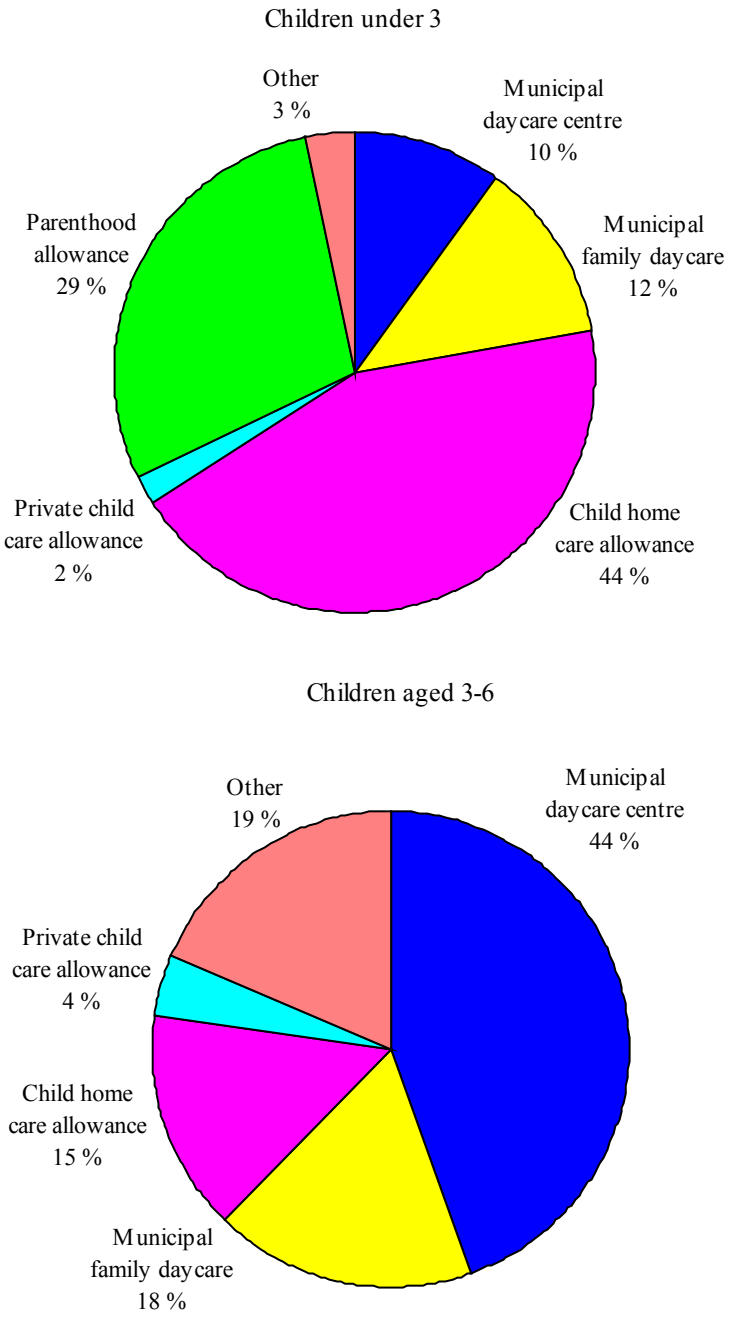


Figure 45.Trends in children's daycare places 1970-2000

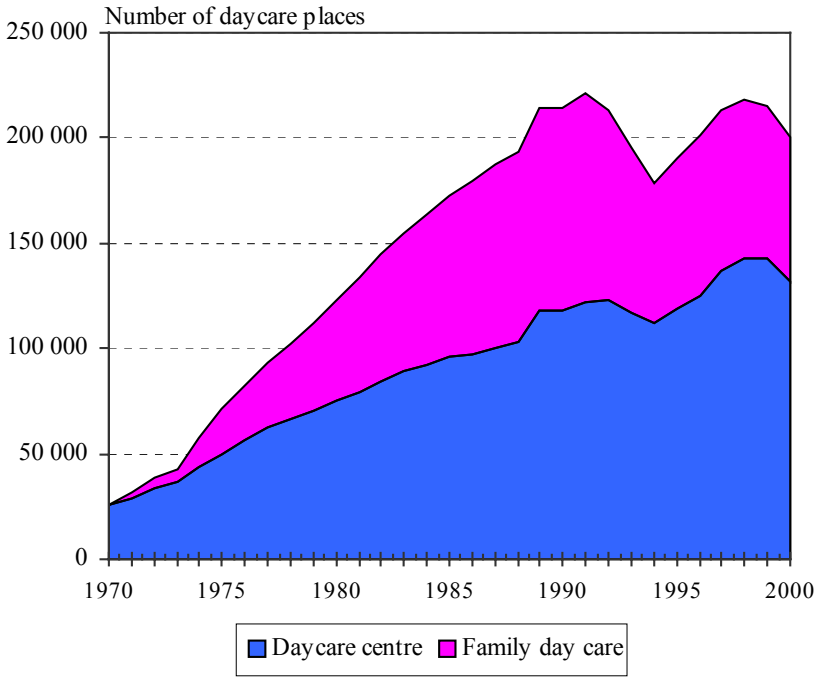
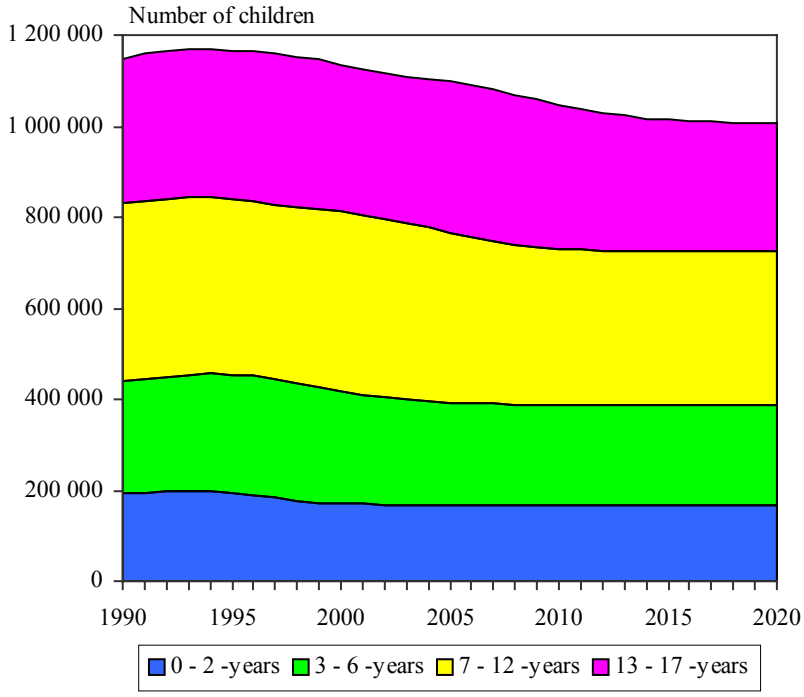


Figure 46. Children aged 0-17, 1990-2020



The need for daycare will continue to fall in the years to come. During the next five years, the number of children under school age is estimated to fall by about 14,000, according to population forecasts. This is due to a drop in the number of children being born (Figure 46). The cohort born in 2001 had about 9,000 fewer children than the cohort starting school that year.

Shortage of afternoon care for schoolchildren

At the end of 2000, there were about 6,500 children in municipal afternoon care. The legislation on children's daycare does not obligate municipalities to provide afternoon care for school-age children. In recent years, municipalities have been forced to cuts in afternoon care in order to be able to fulfil their obligation to provide daycare for children under school age. Afternoon care of young school children should be developed jointly with different administrative sectors and organisations. In recent years, church parishes and NGOs have increased their provision of afternoon care for young school children, but there is still a clear shortage in some municipalities.

The afternoon care provided for schoolchildren by voluntary organisations is the more expensive for the family than municipal care would be. In a situation where there is a shortage of afternoon care provided by the municipality, and the care provided by volunteer organisations is relatively expensive, there is a danger that many young schoolchildren are left without appropriate care.

Changes to daycare fees

In connection with the reform of the support system for the care of small children on August 1,1997, the grounds for setting municipal daycare fees were standardised. Under the new system, daycare fees are determined in percentages based on family size and income. In accordance with the Government Programme, client fees in the social and welfare sector were adjusted as of the beginning of 2001. The maximum children's daycare fee was raised from FIM 1,000 to FIM 1,100 a month. As of the beginning of 2000, daycare fees can be charged for 12 months for children who use the services all year round.

Daycare fees were raised as of the beginning of 2002 to correspond to the rise in the level of costs. The income limits used as basis for defining daycare fees were raised by about 6%, while the percentages remain unaltered. The highest monthly fee charged is € 200 (FIM 1,189), in which case the increase is about 8%. The maximum fee of second child of the same family is € 180 (FIM 1,070). There was also a slight rise in the lowest fee (€ 18, FIM 107). As a result of the reform, daycare fees of all families who had not been paying the highest fee decreased. As a consequence, the sum total of daycare fees increases by about € 3.9 million (FIM 23 million).

According to preliminary data from 2000, the total sum of daycare fee payments comes to € 229 million (FIM 1,361 million). The share covered by client fees of the total expenditure on daycare was 15.6%, or slightly more than the previous year.

No great change in the uptake of child home care allowance

The new child home care allowance system has been in use for over four years. The number of both recipients and children has been falling slightly. According to preliminary data, three were 70,800 families receiving home care allowance at the beginning of 2001, covering 106,000 children. The recipients of home care allowance thus had an average of 1.5 children. The average amount of home care allowance was € 347 (FIM 2,064) per month. Seventy-six per cent of child home care allowance recipients also receive a care supplement.

Increased uptake of private child care allowance

Private child care allowance provides an alternative to municipal daycare for parents who wish to make their own daycare arrangements for their children. The number of children qualifying for private child care allowance has been growing constantly. Over 14,000 children were covered at the end of 2001. The majority (76%) of the children were three or older. Half of the children covered by private home care allowance were in private daycare centres, while 39% were in private family daycare. Private child care allowance also offers the option of hiring a child minder to look after the child at home, but this option has not been used much, only 1,600 children being cared for in this way. The average level of private home care allowance was FIM 761 per month, the average fee for private daycare being FIM 2,330 a month per child. Twenty-one per cent of the children qualifying for private home care allowance also received care supplement.

Parents usually pay a higher fee for private daycare than they would have to pay for municipal daycare. Some municipalities, especially the larger ones, pay municipal supplements for private daycare. The level of these supplements varies considerably between municipalities. Sixty per cent of children in private daycare receive municipal supplements channelled via Kela.

Subjective right to pre-school teaching for all 6-year-olds in 2001

The pre-school reform came gradually into effect beginning from August 1, 2000. As of August 2001, municipalities are required to provide pre-school teaching for children living in their area in the year preceding the start of compulsory education. In the academic year 2000-2001, provision of pre-school teaching was voluntary.

The majority of municipalities started providing pre-school education in the year 2000. According to a survey, about 89% of six-year-olds attended pre-school in the autumn of 2000. During the academic year 2001-2002, 93% of the cohort entitled to pre-school education will be attending pre-school.

Pre-school teaching can be arranged at a school, at a daycare facility as laid down in the legislation on daycare for children, or at some other suitable place as decided by the municipality. Municipalities may also purchase pre-school teaching from another public or private service provider. Attending pre-school is free of charge for the children. In the academic year 2001-2002, 18% of the children attending pre-school did so at municipal schools, 81% at daycare centres and 1% elsewhere.

Children at pre-school, with the exception of those whose compulsory education is brought forward, are not entitled to free travel to school. The arrangement of transportation is perceived as a problem particularly in sparsely populated areas, and may be a deciding factor in parents' decision not to send their children to pre-school.

Municipalities receive a central government grant for pre-school teaching on a per pupil basis, in accordance with the financing system for education and services. The government grant is thus higher than in the case of children's daycare.

Working group against lowering compulsory school attendance age

The agenda of Paavo Lipponen's second cabinet included charting the conditions of lowering the compulsory age of starting the

nine-year comprehensive school as of 2003. The working group looking into the effects of a lower school-start age stated in its memo that lowering the start of the nine-year comprehensive school to six years as of 2003 is not possible. The working group motivated its stand by stating that it has not been possible to assess sufficiently the experiences gained from the pre-school reform. Pre-school teaching should be developed further on the basis of experiences gained and assessments made.

If, however, a decision is made later on to lower the compulsory school attendance age, the most practical model would be to incorporate pre-school teaching as a part of compulsory education, according to the working group. This would mean that compulsory education would begin at six, and consist of a year-long pre-school and nine years of basic education. Since nearly all children are already attending pre-school, the new system would not mean a great change from the present situation. According to the working group, this would require all pre-school education of six-year-olds to be given at schools. This would cause reassessment of staff qualifications and increase the need for continuing education for teachers.

The working group stated in its memorandum that according to the current view, six-year-olds do not yet possess the qualifications (school maturity) to help them cope with the teaching provided in accordance with the current plans of study. Lowering school starting age by one year would also mean that it might be hard to reach the same objectives as at the moment.

It is also seen as a particular problem that after completing their basic education, young people of 14 or 15 would have to make important decisions concerning their subsequent studies affecting their entire future. Choosing vocations and careers at an earlier age than at present would very likely increase the drop-out rate and cause more people to make wrong choices.

Increasing internationalisation means added standardisation pressure; children in most European countries start school at an earlier age than in Finland. Increased mobility of labour also means that there is a need to bring the situation of children entering or leaving Finland closer to common European practice. As far as the labour market is concerned, a lower school-start age would be a means of making young people available for the market a year earlier than at present.

Experiences of the system for redistributing the high costs of child welfare

The number of children and adolescents placed in care outside the home grew throughout the 1990s. In 1991, there were 8,700 children and young people in care outside the home, or 0.7% of the age group. In 2000, the corresponding figure was 12,870, or 1.1% of the age group. Of the children and young people placed in care outside the home, about 7,300 were in custody, which is 500 more than in the previous year. In addition, there were also 49,300 children and young people in open care, which is 5,600 more than the year before. Open care refers to various support measures taken to create and maintain good conditions for the child by providing support for the parents and the family's ability to cope independently.

About half of the children and young people placed in care outside the home were in family care, about one third were in institutional care and the rest were placed elsewhere, e.g. in independent supported housing. The main reasons for placing a child or young person outside the home are the parents' alcohol or drug

abuse or mental problems, which often lead to neglect of the child or to domestic violence. A growing number of children and adolescents are also placed in care outside the home due to their own problems, including school-related problems, crime or drugs.

In connection with the 1993 reform of the government grants system, grants for municipal social welfare and health care services were reorganised on the basis of expected expenditure. This has caused problems for some municipalities in financing expensive special services that cannot be predicted in advance, such as long-term institutional care in child welfare cases. This problem is particularly acute in municipalities with a small population, where even the cost of the care of a single child may have a considerable impact on the budget.

A system for redistributing the high costs of child welfare has been in force since March 1, 1999. The purpose of the system is to redistribute the economic burden placed on an individual municipality by high child welfare costs and to channel resources so that child welfare clients receive appropriate services at the appropriate time, regardless of the financial situation of the municipality. The government grant is a fixed appropriation, and it covers half of the estimated costs of the redistribution. The municipalities finance the remaining sum. The appropriation reserved annually in the state budget for this purpose has decreased the government grant for municipal social welfare and health care costs by the same amount.

The implementation of the cost redistribution system is the responsibility of joint municipal boards of the special care districts. Municipalities are entitled to be reimbursed through the system for 70% of all costs exceeding FIM 150,000 per family per year arising from child welfare measures included in the welfare plan referred to in the Child Welfare Act.

In 2000, expenditure covered by the system for redistributing the high costs of child welfare came to FIM 371 million, of which government grants made up FIM 165 million (45%). There are considerable differences between special care districts in both the amount of expenditure and the degree of expenditure covered by government grants. A total of 263 municipalities received reimbursements in 2000. All municipalities with more than 10,000 inhabitants received reimbursements, whereas only 47% of municipalities with less than 10,000 inhabitants did so.

The system of redistributing the high costs of child welfare has brought with it a positive development trend in municipal child welfare work. Individual care plans are drawn up in more detail, cooperation between different actors has intensified, and placing children into care has proceeded in a more premeditated manner now that there is a possibility to get reimbursement for the costs. There is also more regional cooperation between municipalities.

According to a recent survey, one in five municipalities has benefited from the system. The system guarantees that small municipalities receive reimbursement for high unforeseen child welfare costs. In this respect the system has worked according to plan. Large municipalities have also benefited from the system. In larger municipalities, there are more child welfare cases in relation to the number of children and adolescents than in smaller ones. In this insurance-based system, reimbursements are paid where costs arise.

Some municipalities have felt the system to be unfair. Municipalities have not been

able to predict the amount of compensation coming to them, because it is calculated on the basis of reimbursements paid within the special care districts. There have been regional differences in the implementation of the joint municipal financing system.

Working group suggested adjusting level of child allowance

In its memorandum, the working group on child allowance proposed developing the child allowance system as a support system intended for all children, the purpose of which is to compensate the costs of raising a child to the family. The working groups estimated that the primary need of reform involves extending child allowance to cover 17-year-olds. The working group motivated this with the fact that the majority of 17-year-olds are still living at home with their parents, and most are students at either upper secondary schools or vocational schools. According to surveys, consumption is at its highest among children just before turning 18. At the present moment, over half of 17-year-olds are not covered by any benefit system. In case of a reform of the child allowance system, 17-year-olds would no longer be entitled to financial aid for students.

The second most important objective stated by the working group is adjusting the level of child allowance to compensate for the decrease in its real value, within the limits of the state economy. The last time child allowances were raised was in 1991. In connection with the family support reform the level of child allowances was raised, but nearly all family policy tax benefits were abolished at the same. The support given to raising children did in fact fall between 1992 and 1994. At the beginning of July 1995, child allowances were cut by about FIM 750 million per annum. Child allowance constitutes the largest single group of expenditure in the state budget at € 1,358.1 million in 2002, which is why even a slight increase in the level of child allowance constitutes a relatively large expense item. Raising the level of child allowance back to the July 1995 level would mean an added cost of about € 149 million per year.

In the view of the working group, the present system of paying out higher child allowance to families with several children is well motivated. Further, the working group considers that removing the higher rate of child allowance paid out to single-parent families from the child allowance system should be studied separately.

Improved coordination of work and family life

The working group charting coordination between work and family life has proposed several improvements to statutory parental leave and ways of increasing flexibility in the choices available for families. In accordance with the programme of Paavo Lipponen's second cabinet, possibilities of creating a system that guarantees fathers a month-long paternity leave, and the possibility to part-time maternity and parental leave should be investigated.

The working group's proposal includes extending the present paternity leave of 18 weekdays by 7 weekdays, which would mean a paternity leave of a total of 25 days. Fathers could have their paternity leaves in the present manner, i.e. simultaneously with the mother, either during the maternity or parenthood allowance period. Fathers could also have the paternity leave or a part of it immediately after the parenthood allowance period. Paternity leave could at most be divided into five periods. Part-time paternity leave would not be possible. The working group's proposal would mean more flexible use of parental leaves. The proposal would also be easy to implement from an administrative point of view. According to

the working group's estimate, extending paternity leave would mean an increase of about FIM 33 million in total expenditure.

In the future, part-time parenthood leave would be possible, with both parents working simultaneously part-time. This arrangement requires that the parents have a common view of dividing responsibility for child care, and the part-time arrangement must be at least of two months' duration. Both parents must reduce their work input by 40-60% of full-time work, and the level of earnings during part-time work must also decrease by 40-60%. The part-time arrangements would not apply to single parents, however.

The working group considered that the present system of reimbursing maternity, paternity and parenthood leave costs paid by employers as too complicated and requiring too much work. According to their view, the system of applying for reimbursement for annual leave during the parenthood allowance period must be simplified. A single reimbursement application would be made within six months immediately after the parenthood allowance period.

According to the working group, adoptive fathers should be given equal status with biological fathers with regard to family leaves. In the case of families with twins or more children being born at the same time, the so-called extension period would be made more flexible, so that the father could use the extension period during the time he is entitled to paternity allowance. In cases of surrogate mothers, the parents would be entitled to the same family leaves as other parents. The working group also proposes that the father be given the possibility to use the mother's maternity allowance in case of long-term illness of the mother.

The aim of the reform is to provide fathers of young children in particular better opportunities of taking care of their own children. As far as families are concerned, the use of statutory family leaves is inhibited, besides attitudes, by economic reasons, the challenges posed by working life and the increased awareness of costs in the workplace. The working group emphasises that the rules of the working life can only be developed in a positive direction by a joint effort, and so that various actors share a common view of the objectives and means of reaching them.

Can family policy have an effect on the birth rate?

In 2001, about 56,000 children were born in Finland, which is about 9,000 fewer than ten years ago (Figure 47). The low numbers of children being born are mainly explained by the fact that the small cohorts born in the 1970s have now reached childbearing age. The number of children being born has decreased especially in the provinces of Kainuu and Lapland, where migration to centres of growth is partly responsible for the decrease in the number of children. Particularly young people who have reached the age of starting a family are moving elsewhere to find jobs.

The Finnish fertility rate has however remained relatively high by European standards in recent years, being 1.74 in 2001. Of EU Member States, only Ireland, France and Luxembourg had a clearly higher fertility rate (Figure 50). The EU average was 1.53. What is really striking is the low nativity in southern Europe. The fertility rate in Sweden fell rapidly towards the end of the 1990s (Figure 49), being 1.53 at the end of 2000. It has been estimated that the recession affected the birth rate in Sweden, but not in Finland, despite the hardships caused by the economic slump.

There have been changes in fertility rate by age group in recent years. The fertility of

those under 25 has fallen, whereas that of the over-30s has risen. The fertility rate of women between 25-29 has taken a downward turn in the past few years (Figure 48).

The fairly constant fertility indices of recent years are due to the fact that having a second or third child is relatively common, but women are having their first child later than before. The average age of first-time mothers has risen in recent years. In 2000 it was 27.6 years. It seems that family policy support has enabled families that already have children to have more, whereas having a first child has become less common due to increased economic insecurity among the young. Statistics show that the number of families with several children is on the increase. At the moment 19% of all families with children have three or more children.

Finland invested in family policy particularly in the 1980s. Finland has been a forerunner in many family policy reforms, although cuts to many family policy benefits were necessary in the mid-1990s. At present the support aimed at families with children is near the European average, however.

Figure 47. The number of children born and total fertility rate 1970-2001

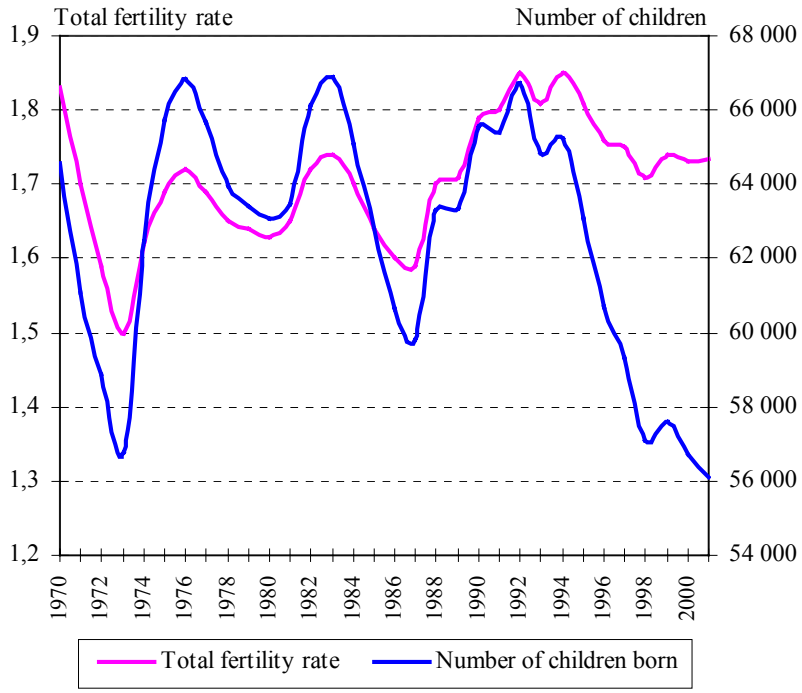


Figure 48. Age-specific fertility rate 1970-2000

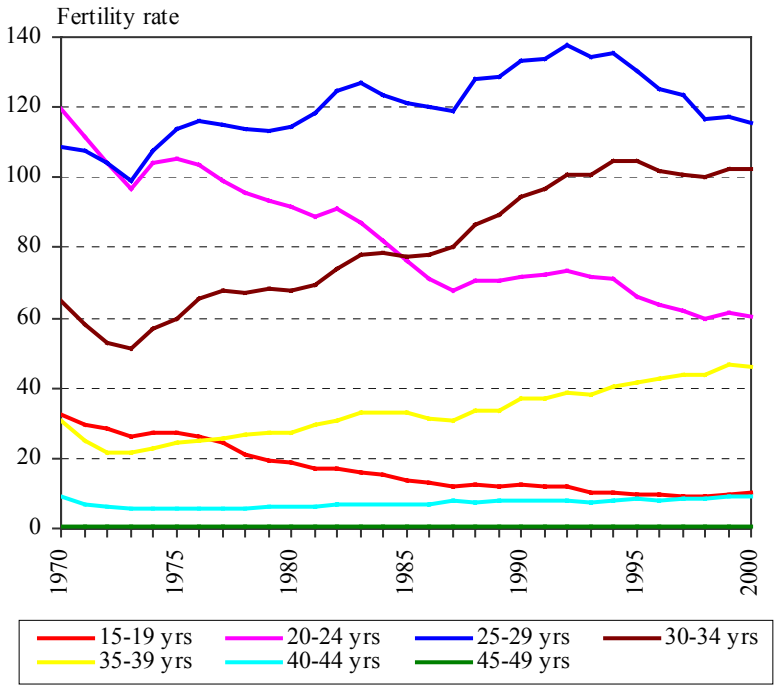


Figure 49. Total fertility rate in the Nordic countries 1960-2000

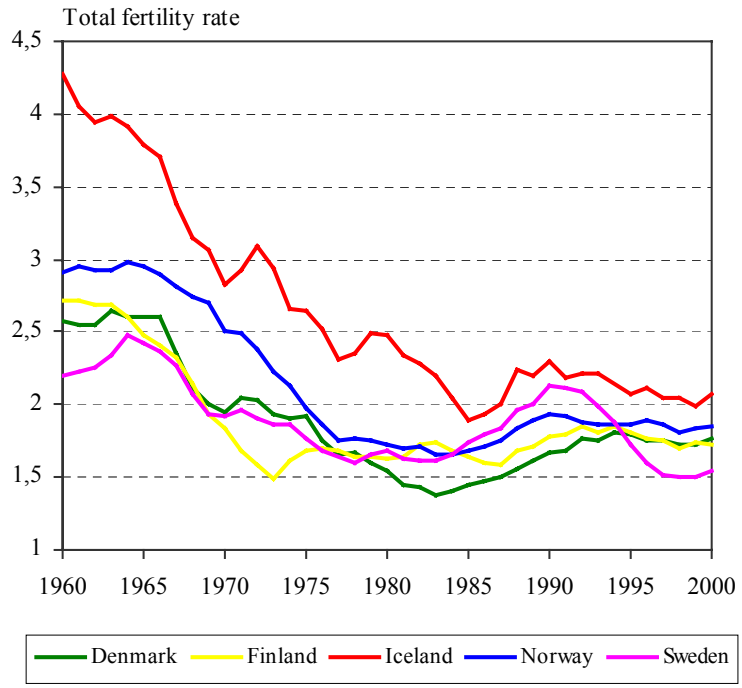
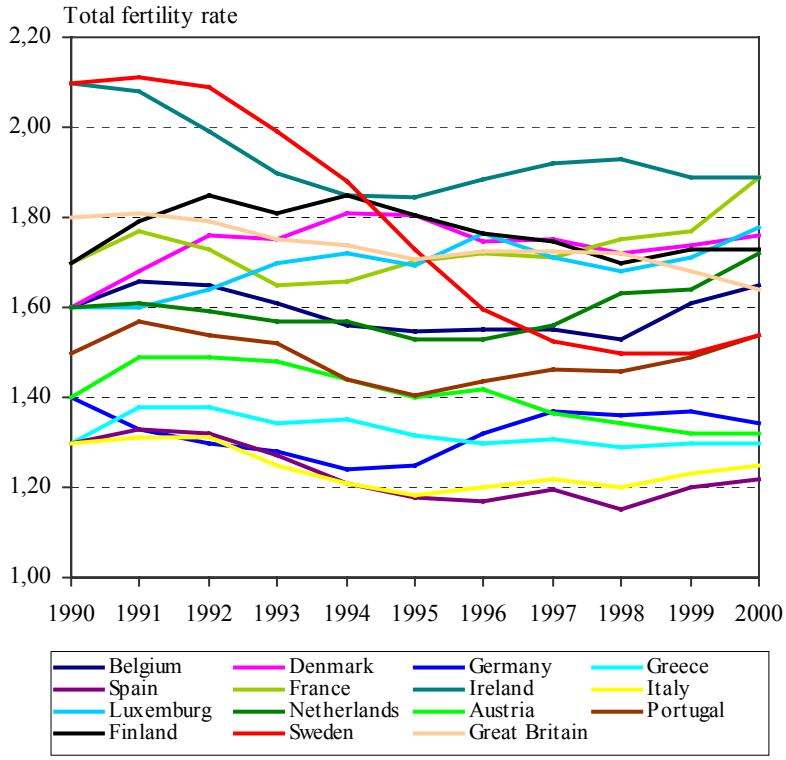
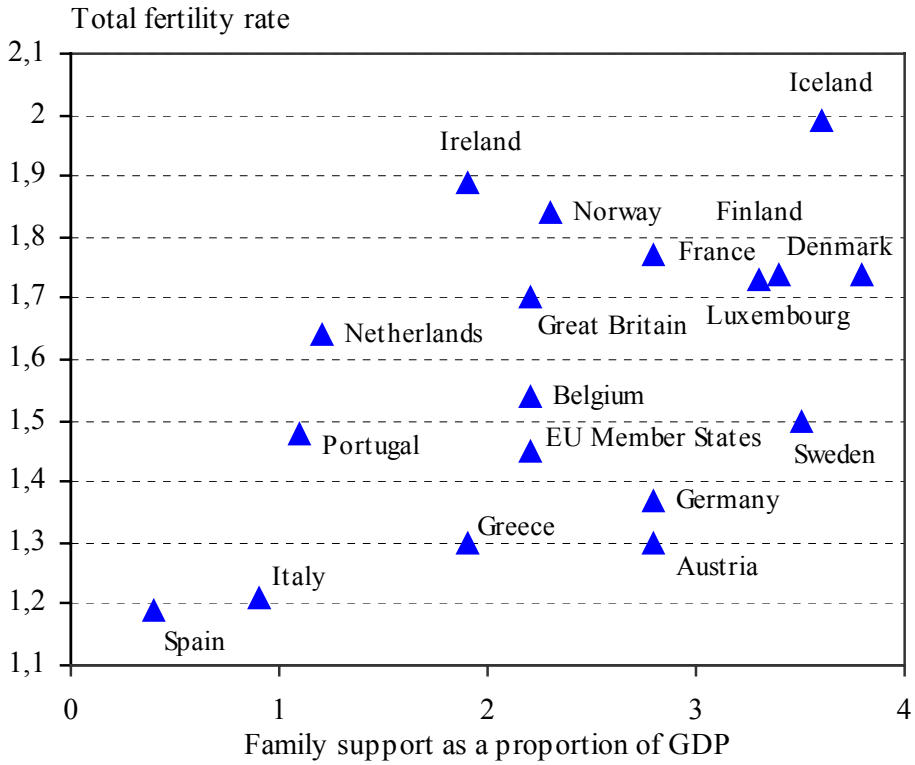


Figure 50. Total fertility rate in EU Member States 1990-2000



When looking at the impact of family policy on the birth rate, it seems that family policy measures have increased nativity somewhat, but not to the level of net reproduction. These measures include the extension of the maternity allowance period from 72 week days to 174 week days in 1974, and the considerable raise of the level of parenthood allowances in 1982. The right to municipal daycare of children under three, child home care allowance and child-care leave came into force in 1990, in addition to which adjustments to the level of child allowance have been made. The measures mentioned here did have an immediate impact on the birth rate, but the resulting rise was short-lived.

Figure 51. The relation of family policy support to GDP and total fertility rate in EU Member States and the Nordic countries in 1999

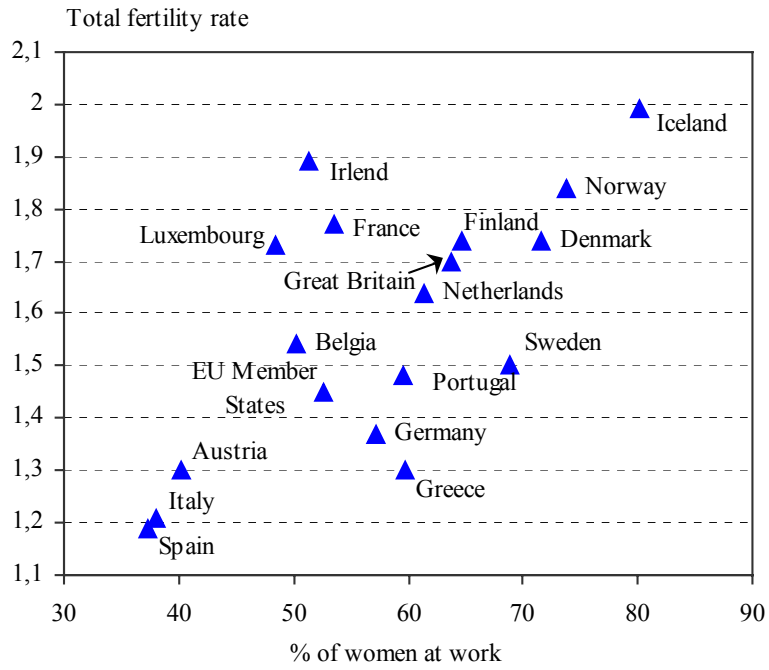


It is estimated that family support measures can have an impact on the timing of having children, but not on the number of children per family. Even though various forms of support have not been able to raise the birth rate sufficiently, they have stopped it from sinking to an even lower level.

With the exception of the Nordic countries, other European countries have invested clearly less in family support than Finland. There seems to be a positive correlation between the amount of family policy support and birth rate (Figure 51). The Nordic countries, with a high level of family policy support, also have a higher birth rate than other Western European countries. However, Ireland is an exception to this, with its high nativity and low level of support to families with children. The example of the Nordic countries would seem to indicate that developing family policy might have some impact on the birth rate.

It has been assumed that the fact that more women are going out to work as well as the rise in their level of education and earnings contribute to a falling birth rate. However, the Nordic countries, where women work outside the home more commonly than in other countries, also have a high birth rate, whereas Italy and Spain, where fewer women are working, have low nativity (Figure 52). It seems likely that the increasing popularity among women of working outside the home does not necessarily affect the birth rate. One might wonder whether the long family leaves and the daycare system have made it possible for Nordic women to combine work and family. Without a well-functioning daycare system this would very probably not have been possible.

Figure 52. Total fertility rate and the percentage of women at work in EU Member States and the Nordic countries in 1999



There are signs of the emergence of a ”singles' culture” in Finland, which includes a deliberate choice of not having children. In the future a decreasing number of women may be having children. According to the latest statistics, about 15% of middle-aged women have no children, and according to preliminary estimates the share of women with no children may rise to 20% in the years to come. In 2000, 25% of women aged 35 had no children, while the corresponding figure in 1986 was 18%. Childlessness in most common among highly educated women.

According to a survey conducted in Sweden, tolerance towards couples with no children has increased in society, which has also been thought of as lowering nativity. The decision to have children may be postponed. Getting a degree or professional competence, finding a job and having a successful career are things women consider important and which may cause them to postpone having children to a later date.

Family structures change - do we need new legislation?

The number of families with children has been decreasing in recent years. At the end of 2000 there were 612,600 families with children. At the same time, changes have also taken place in family structure. The number of cohabiting couples with children is growing all the time, accounting at present for about 16% of all families with children. The number of single-parent families is also growing due to a rising divorce rate; at the end of 2000 19% of all families with children were single-parent families. The number of reconstituted families has also been growing somewhat in recent years. At the end of 2000 there were about 47,000 reconstituted families, or about 8% of all families with children. A total of 97,000 children now live in reconstituted families.

As family structures change, the question has arisen of how family ties should be considered in granting benefits and setting client fees. In September 2000 a survey was published on the lives of reconstituted families, with the aim of clarifying what the legislative standpoint of these families ought to be. The specific aim was to find out how well the ”shared fridge theory” applied in social welfare law corresponds to the reality of reconstituted families' lives and whether it is perceived as being fair.

According to family legislation, only the parents of a child are responsible for its maintenance. A stepfather or a stepmother is thus not under any obligation to contribute to a child's maintenance. In social welfare legislation, however, the size of service fees and the need for social benefits and their amounts are determined based on the situation in the household where the recipient actually lives.

In reconstituted families, fees and benefits are determined on the basis of the total income of the husband and wife. For instance, the daycare fee of the child of a woman living in a reconstituted family is based on the income of both the mother and the man she is living with, but he is not under any obligation to contribute to the fee, since he is not the child's father and is therefore not obliged to provide for it.

Financing family policy expenditure

Maternity, paternity and parenthood allowances are financed out of health insurance, mainly through contributions from the insured and from employers. The government contribution to health insurance has been altered in recent years. As of 1998, central government has been making ”guarantee payments” to secure the liquidity of the health insurance fund, and since 1999 some of the revenue from value added tax has also been used to this end. In addition, as of 1999 central government has funded the minimum daily maternity, paternity and parenthood allowance expenditure. Child allowance is financed entirely by central government.

Municipalities receive a central government grant to finance their social welfare and health care expenditure. In 2000, the grant covered about one fourth of the expenditure on these statutory services. Many municipalities pay a municipal supplement for home care allowance and private care allowance, for which they do not receive any central government grant. Their contribution to financing these services is therefore higher than for other municipal social welfare expenditure. Client fees for daycare cover 16% of costs, and the percentage has remained at the same level in recent years.

Table 9. Financing expenditure on families with children in 2000

	Expenditure	Financing contribution (%)				
	€ million	Central government	Municipalities	Employers	The insured	Clients
Maternity, paternity and parenthood allowance	479	17	0	38	45	0
Child home care allowance [1)]	357	21	79	0	0	0
Child allowance	1387	100	0	0	0	0
Daycare[2)]	1458	20	64	0	0	16
Private child care allowance [1)]	41	12	88	0	0	0
Institutional care for children and young people [2)]	160	23	74	0	0	3

[1)] includes municipalities' own support
[2)] includes client fees

2.6 Unemployment

	1999	2000	2001*	2002*
Expenditure on main category, (€ million)	3 520	3 350	3 280	3 780
- of which, cash benefits (€ million)	3 190	3 040	2 990	3 490
% of social protection expenditure	10.9	10.1	9.5	10.4
% of GDP	2.9	2.5	2.4	2.7
Unemployment rate, %				
Women	10.2	9.8	9.2	9.8
Men	10.7	10.6	9.8	10.3
Recipients of earning-related allowance at year end	9.8	9.1	8.7	9.3
Recipients of basic allowance at year end	156 840	136 200	125 000	129 000
Recipients of labour market support at year end	17 510	16 530	17 500	18 000
No. of people in labour market training at year end	172 520	155 750	156 000	160 000
Recipients of	36 320	27 720	24 900	26 000
Unemployment pension at year end	52 240	54 290	59 450	61 700

* estimate

Unemployment expenditure rising in 2002

The slowdown of economic growth will have a negative impact on employment in 2002. Unemployment costs included in social expenditure are estimated to reach € 3,780 million in 2002, which is a clear increase from 2001. The supply of labour will continue to grow somewhat, but the number of job opportunities will be lower than this year. The average unemployment rate is estimated to rise to 9.8% in 2002.

Raises in unemployment benefit levels

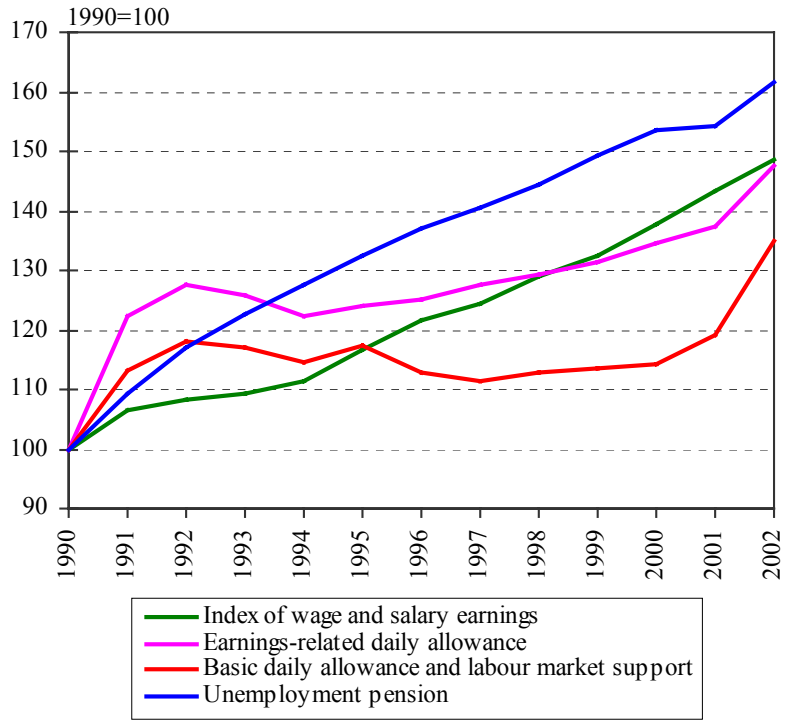
The level of unemployment allowance was raised at the beginning of 2002. The index-fixed adjustment implemented at the beginning of 2002 raised the basic allowance to € 21.91, and from March 1 another adjustment raised it to € 22.75 per day. The labour market support was also adjusted correspondingly, and labour market support child increments were raised to the level of other child increments. The child increment is € 4.31 for one child, € 6.33 for two children and € 8.16 a day for a minimum of three children.

The level of unemployment insurance was raised in March 2002 in accordance with the income policy agreement. The share of earnings in earnings-related unemployment allowance was raised from 42% to 45% of the difference between daily wage or salary and the basic unemployment allowance.

The raises implemented also increased the levels of other benefits. These are the education benefit paid out in accordance with the Act of Adult Education, the education allowance in accordance with the Act on Supporting Independent Study by the Unemployed, and the alternation leave compensation paid out in accordance with the Job Alternation Leave Experiment Act.

Severance pay will also be included as part of unemployment benefits, so that the earnings-related unemployment allowance of persons with a minimum of 20 years of registered work history who have been discharged for economic or production-related reasons is for 130 days raised by a severance pay supplement. The amount of the raise is on average about € 5 per day.

Figure 53. Average unemployment benefits 1990-2002 at current prices



At the end of 2001, job centres had 316,900 unemployed job seekers, which was 3,500 less than the previous year. 166,800 of them were men and 150,100 were women. The number of long-term unemployed who had been without a job over a year with no interruptions was 80,300, which was 6,500 less than the year before.

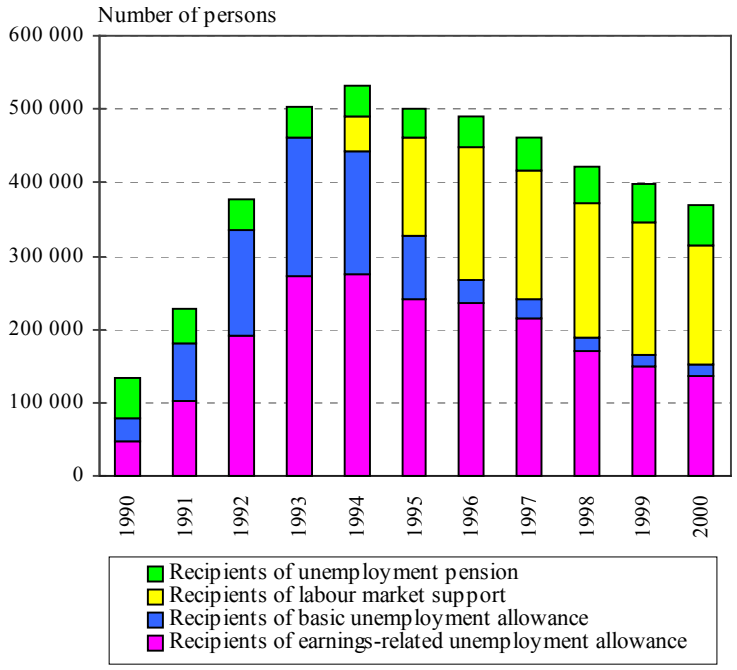
At the end of 2001 there were about 125,000 people receiving earnings-related unemployment allowance, while 17,000 received basic unemployment allowance and 156,000 labour market support. The number of labour market support recipients has not fallen as rapidly as that of other unemployment benefit recipients. The fact that long-term unemployment and youth unemployment continue at a high level is slowing down the fall in the number of labour market support recipients. 48% of all people entitled to labour market support had not fulfilled the work criterion to qualify for unemployment benefit, and 52% had exceeded the limit of unemployment allowance. 5,700 people received the integration allowance intended for immigrants, which corresponds to labour market support. The number of unemployment allowance recipients is expected to increase somewhat in 2002.

The number of recipients of unemployment pensions continued to grow. At the end of 2001 there were 59,450 recipients of unemployment pensions. The number of recipients will continue to grow. A person who is long-term unemployed and who has turned 60 may receive unemployment pension until reaching old-age pension age.

Rise of employment rate has stopped

The employment rate rose near 67% in 2000, remaining at the same level a year later. The employment situation of people aged 55-59 improved in particular. The number of wage earners increased by almost 40,000, while the number of entrepreneurs fell considerably.

Figure 54. Recipients of basic and earnings-related unemployment allowance, labour market support and unemployment pension 1990-2000, annual work year equivalent



The improvement of employment is mainly concentrated in southern Finland and centres of growth in other areas. Between 1995 and 2000 the employment rate rose most in the regions of Uusimaa, Häme, Northern Ostrobothnia, Pirkanmaa and Varsinais-Suomi, while a clearly slower than average rise was seen in the areas of Kainuu, Lapland, Northern Ostrobothnia and Etelä-Savo. The employment rate rose by less than 3.5% in these areas, while Uusimaa showed an increase exceeding 9%. When looking at the situation in a ten-year perspective, Uusimaa is the only region showing an increase in the number of employed. Between 1990 and 2000 the number of persons with a job rose by 34,000 in Uusimaa, while the number of employed fell by 22,000 in both Lapland and Häme.

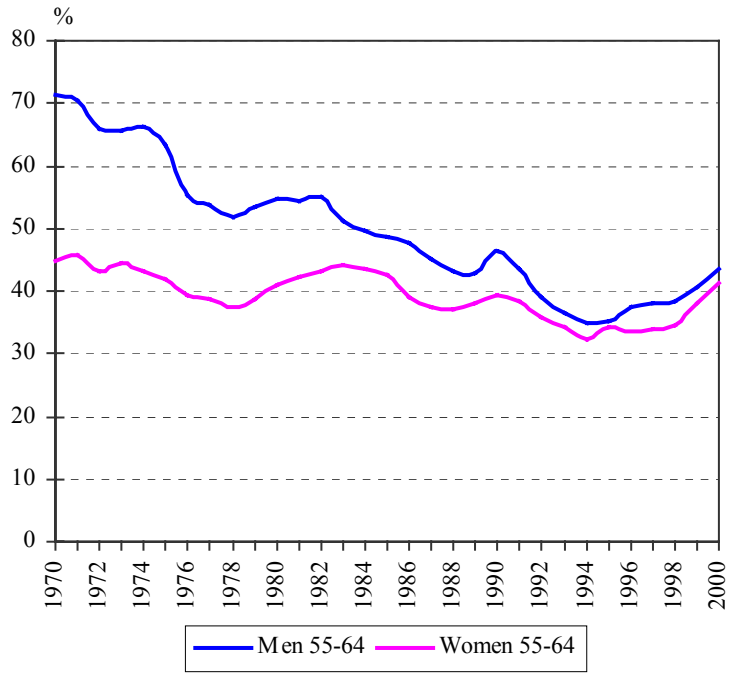
The migration that has steadily grown stronger since 1993 has brought more people to the same areas where the employment rate has gone up, whereas regions with no improvement in the employment situation despite economic growth have experienced losses. The migration has been particularly strong in the case of educated work force.

Employment situation of ageing workers improving

The main objective of EU's employment strategy is to reach a high level of employment. The target is to raise the employment rate to 70% of working-age population by the year 2010. The corresponding target for women is 60%, and for 55-64-year-olds 50%.

Finnish targets are mostly in line with those of the EU. Problems of ageing workers are however pronounced in Finland. Due to the age structure of the Finnish population, people of 50 will increase their share of the work force by 5% over the next ten years. The employment situation of the over 55s has improved surprisingly much in recent years. Managing the rise in unemployment caused by slower economic growth while preparing for a future shortage of labour poses a challenge for the next few years.

Figure 55. Employment rate of people aged 55-64 according to gender 1970-2000



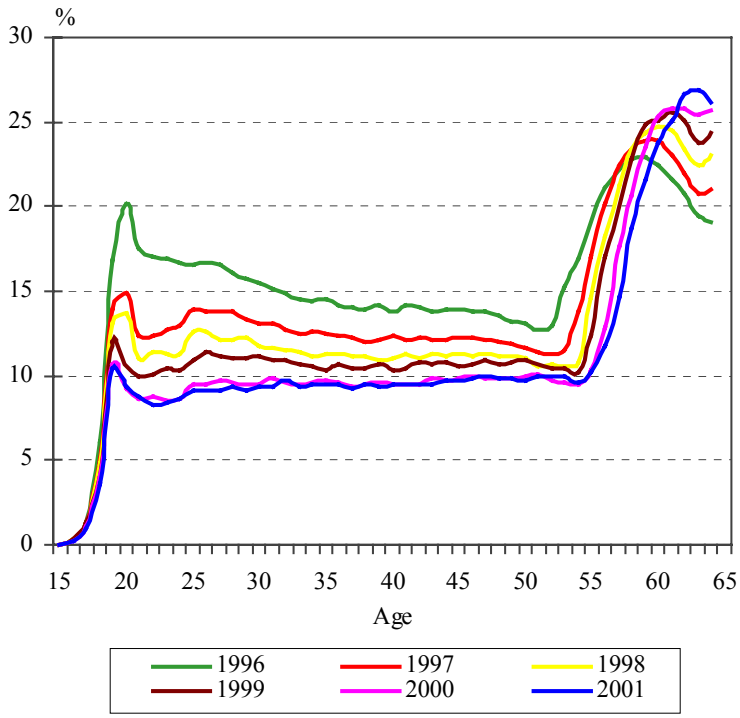
Changes in benefits to postpone retirement

In 2001, the average age of taking up a pension in Finland was around 59. The official retirement age is 65. At the beginning of 1997 the lower age limit of the avenue to unemployment pension was raised by two years, from 53 to 55. The raise of the age limit and strong economic growth have improved the employment situation of elderly workers (Figure 56).

Central labour market organisations reached an agreement in November 2001 on the development of employment pensions in the private sector. At the same time the working group appointed to study the reform of the unemployment benefit system submitted its report. The working group agreed on reforms to unemployment benefits over the next few years. The aim of the reforms is to improve further the employment situation of ageing workers.

The working group proposes that the age limit for qualifying for ”additional days” be raised from 57 years to 59. In future, those eligible for ”additional days” would also have to fulfil the requirement of having worked for a minimum of five years during the past 15 years at the point when the maximum amount of 500 days of earnings-related unemployment allowance is up. Additional days would qualify for allowance to the end of the month when the person is entitled to old-age pension, without reduction in pension due to early retirement. The person would still be able to look for a job should he wish to do so, and be entitled to unemployment allowance as well as additional days until the end of the month he turns 65. The proposal regarding additional days would replace unemployment pension in the future. The reforms of the employment pension system are described in the chapter on disabilities (2.2).

Figure 56. Recipients of unemployment allowance or unemployment pension as a proportion of age groups 1996-2001



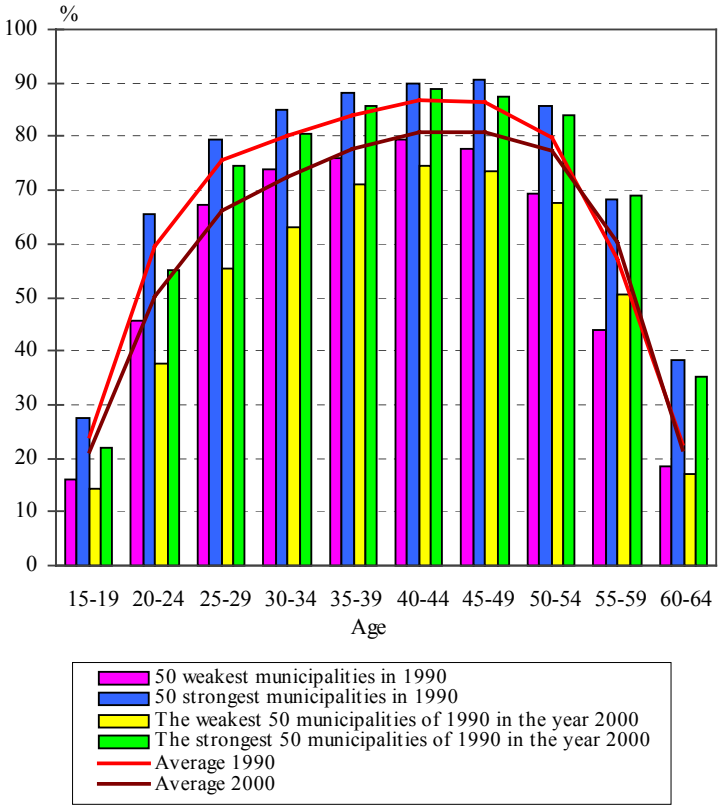
It is proposed that the reforms concerning additional days and unemployment pension enter into force after a transition period. According to the proposition, current regulations concerning eligibility for additional days would be applied in the case of people born in 1949 or earlier, whereas the right to additional unemployment allowance days would replace unemployment pension in the case of persons entitled to additional days after January 1, 2007. It is also proposed that the level of the allowance paid out during the additional days be adjusted closer to pension level. If the person entitled to additional days has a minimum work history of 20 years, the level of allowance is raised so that the percentage of the part exceeding earnings is 32.5.

Long-term unemployment and exclusion from the labour market

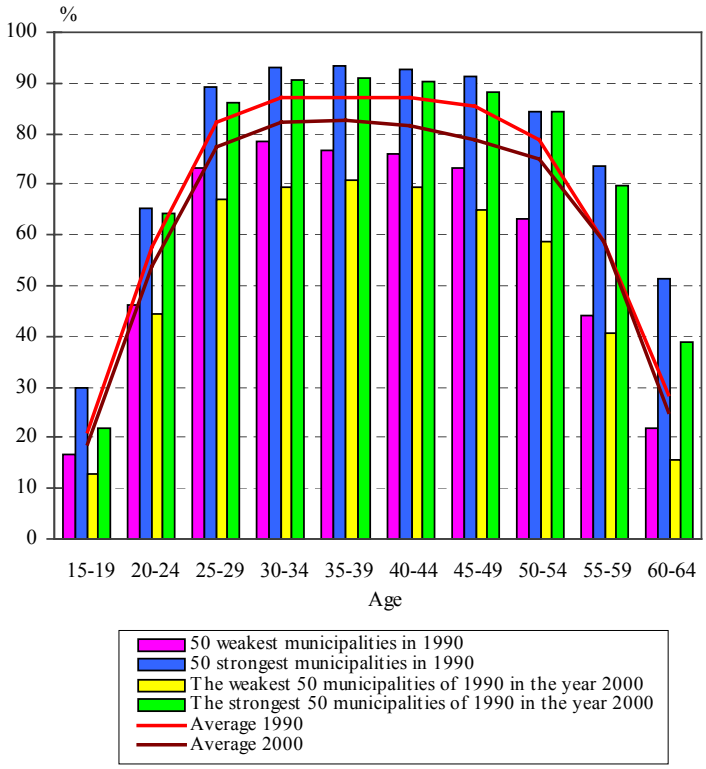
A key reason for exclusion from the job market is that the demand and supply of labour do not meet. After the recession there were changes in the structure of production and the demand for labour, both in industry and the service sector. This meant that a large number of people who had lost their jobs during the recession could not find a job as the economy picked up. Expanding enterprises have been able to recruit staff directly outside the pool of labour, or from among employed wishing to take on a new job. For the unemployed, getting a job has often required retraining. Although the total number of unemployed has been falling for some time, finding employment has been selective. The demand for labour focused first on persons who had only been without a job for a short while, whereas long-term unemployment continued to grow even during economic growth. The long-term unemployed are often elderly, and they also include people with disabilities, immigrants and people with a low level of education, with little working experience.

Figure 57. Employment rate by age group in twenty strongest and weakest municipalities in 1990 and 2000

Women



Men



The loss of jobs reached its height during the recession particularly in areas of high unemployment in eastern and northern Finland. Almost a third of the jobs in Kainuu were lost during the recession, and they have not been replaced despite the fast recovery of the national economy.

Active labour policy

Training of labour, practical work training and supported employment have contributed to a reduction in the number of the long-term unemployed. At the end of 2001 about 72,400 people were covered by education and employment measures, which was 9,800 less than the previous year. 34,400 were employed with the aid of salary-based employment administration measures, which was 6,200 less than the year before. 56% of those employed with these measure worked in the private sector. 5,000 persons were employed to replace an employee on job alternation leave. At the end of 2001 there were 24,900 people receiving labour training, or 2,800 less than the year before. An additional 3,000 people were employed with the aid of employment-related investments and some European Social Fund projects. All in all 2,9% of the work force were employed with the aid of these measures.

The significance of active employment measures is clearly lower in Finland than e.g. in Denmark or Sweden. The aim of the Finnish labour policy is to increase the number of active measures so that in case of increasing unemployment, one in three people made redundant would receive either labour policy or apprenticeship training.

Rehabilitative work activities

The Act on Rehabilitative Work Activities came into force on September 1, 2001. The Act enhances the entry into the job market of the long-term unemployed. Municipalities and employment agencies are obliged to work out jointly a suitable activation and service plan for each client. Municipalities are under the obligation of arranging rehabilitating work activities for long-term unemployed clients receiving labour market support or social assistance. In accordance with the provision concerning transition, the activation plan must be completed by December 31, 2002 at the latest for persons who fulfilled the criteria before the law entered into force. According to Kela statistics, there are about 70,000 people who meet these criteria. An estimated 6,000 new people are covered each month by the obligation to draw up an activation plan.

Rehabilitative work activities for the client must be arranged within three months of the completion of the activation plan, if no job or no labour administration measures supporting employment can be provided. Rehabilitative work activities must promote independent coping and access to the job market. Rehabilitative work activities do no constitute an employment relationship and they cannot replace work done in an employment or civil servant relationship. People under 25 are obliged to take part in rehabilitative work activities, if included in the activation plan.

Women's position in the job market has changed

The changes in the status of women in the job market can be summarised by the three development trends that started in the 1990s. An increasing number of jobs in the public sector are fixed-term jobs, the unemployment rate among women has exceeded that of men, and the employment rate of mothers with young children has fallen more than that of other groups. The unemployment rate of single mothers has risen in particular. The negative effects of these changes can be seen in the poorer benefits received by women. For instance,

in 2001 about one in four mothers only received the minimum parenthood allowance. The number of recipients of minimum parenthood allowance has multiplied compared with the early 1990s.

The public sector has been a significant employer of women since the 1970s. In 2000, 40% of employed women worked in the public sector. For men the corresponding figure was 16%. Privatisation and turning public companies into commercial enterprises meant that government jobs were transferred to the private sector in the 1990s, while the number of municipal jobs was reduced by cuts. However, in 2000 the number of people employed in the municipal sector was almost the same as before the recession. Fixed-term employment relationships are relatively common in the municipal sector. In 2000, almost one in four women working in the municipal sector was employed on fixed-term basis.

Thanks to the growth of the public sector, unemployment among women remained lower in the 1980s than among men. This changed at the end of the last decade. Women's unemployment rate has been higher than that of men since 1996. Men have been able find jobs in the private sector better than women.

In the early 1990s, single mothers with small children still made up a larger share of the work force than other mothers with small children. The unemployment rate of single mothers was even then slightly higher than that of other mothers, though, which is why the employment rate of single mother was below that of other mothers. In 2000 the employment rate of single mothers with young children was still clearly lower than before the recession. The employment rate of other mothers with small children seems almost to have reached the levels of the early 1990s (Figure 58).

In 2000 the employment rate of men and women was 69.4% and 64.3 %, respectively. The employment rate of Finnish men is the fourth lowest within the EU, while that of women is the fourth highest. Part-time work among women is not as common in Finland as in most EU Member States. When part-time jobs are changed into full-time employment (FTE), the employment rate of Finnish women is the second highest after Denmark. Since part-time employment among men is relatively rare in all EU Member States, this change does not have much impact on the ranking order among men (Figure 59).

Figure 58. Mothers of children under 7 as a proportion of the labour force and unemployed mothers as a proportion of the population 1991-2000

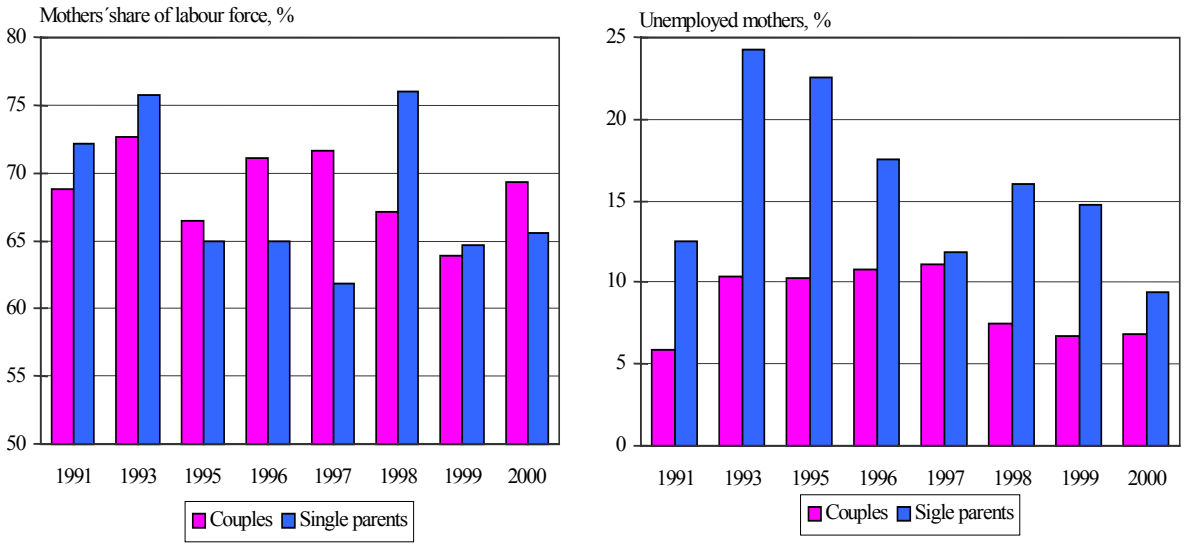
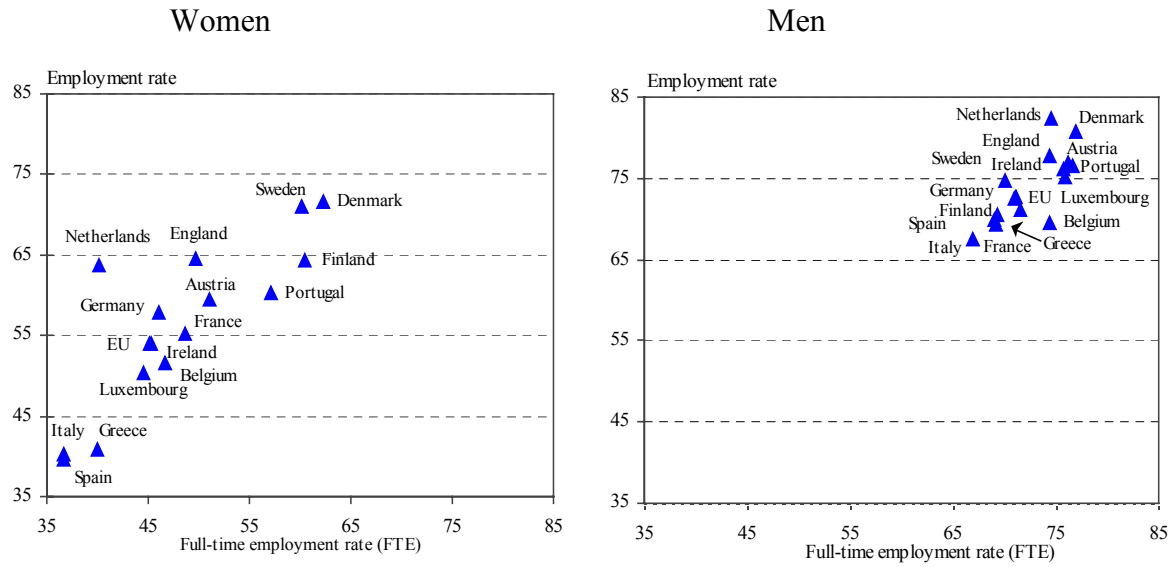


Figure 59. Employment relationships of women and men within the EU changed into full-time employment in 1999



Financing of unemployment expenditure

Labour market support and basic unemployment allowance are financed entirely by the central government. Earnings-related unemployment allowance is financed by a combination of employer and employee contributions and by central government. An unemployment insurance payment for wage earners was introduced in 1993. The relative contribution of employers, employees and central government to the earnings-related unemployment allowance has varied slightly from year to year. Unemployment pensions are made up of national pension and employment pension. Employers finance about four fifths of employment pensions, while the remaining fifth comes from employees. National pensions are financed by central government and by employers' insurance contributions.

Table 10. Contributions to unemployment expenditure in 2000

	Expenditure € million	Financing contribution (%) Central government	Municipalities	Employers	Employees
Basic daily allowance/labour market support	895	100	0	0	0
Earnings-related daily allowance	1 306	37	0	39	24
Unemployment pension					
national pensions	47	47	0	53	0
employment pensions	574	2	0	74	24

2.7 Housing subsidies

	1999	2000	2001*	2002**
Expenditure on general housing allowance (€ million)	497	454	401	415
Recipients of general housing allowance on Dec 31 (no. of households)	207 000	170 350	158 460	163 000
- of which, families with children	80 100	75 40	69 840	70 000
Expenditure on pensioners' housing allowance (€ million)	216	230	243	257
Recipients of pensioners' housing allowance on Dec 31	160 280	16154	163 500	165 100
Expenditure on student housing supplement (€ million)	101	147	202	207
Recipients of student housing supplement on Dec 31	91 550	141 590	143 000	145 000

* preliminary data
** estimate

Housing costs rising faster than other costs

During the 1990s, public support for the housing market was reduced and prices were deregulated and allowed to follow the market. Rents continued to rise throughout the 1990s, and the increase was significantly faster between 1996 and 2001, over 4% per annum. Between April 2000 and March 2001 rents in new tenancies rose by 4.1%. The fastest rise in rents was in the Helsinki metropolitan area and other growth centres. Rents in the Helsinki area are over 40% higher than elsewhere, and the difference is growing steadily. When the average rent for a studio flat in Helsinki is € 16 per square metre, the corresponding rent in other parts of the country is € 10. The average rent for flats of any size in the Helsinki area is over € 10 per square metre.

A trend similar to that seen in the case of privately funded rental flats is also in evidence in government-subsidised flats. In addition to the fact that their rents have been raised, tenancies have become increasingly difficult to obtain, particularly in the Helsinki metropolitan area. Only one in four applicants was able to obtain a rental flat, and in the Helsinki area only one in five. In 2000, more than 215,000 families applied for a government-subsidised rental flat, two in five of them in the Helsinki metropolitan area. At the end of 2000 over 50,000 were on a waiting list for a rental flat in the Helsinki area. While the demand for housing as well as rents in the Helsinki metropolitan area are rising constantly, some areas have a problem with unlet rented accommodation and housing developments whose maintenance involves considerable costs for the municipality. The shortage of housing in growth centres poses an obstacle to workforce mobility and employment in general, since housing of a reasonable size and price cannot be found where work is available.

After a drop in prices in the early 1990s, the price of owner-occupied accommodation has been rising rapidly since 1995. The rise in price level came to a halt during the first part of 2001, but it is expected to pick up again. Prices in the Helsinki area have increased by over 10% annually. The nominal prices of flats in old buildings have already exceeded the peak seen at the end of the 1980s. The price trend has been more moderate elsewhere in

Finland, but it is accelerating in growth centres, such as Tampere and Oulu. A flat in the Helsinki area costs on average € 2,070 per square metre. The price gap between the Helsinki area and the rest of Finland has widened; at the moment the price per square metre of flats in the Helsinki area is twice that elsewhere in Finland.

In 2001, the cost of housing went down due to a cut in the interest rate. The nominal interest rate on new housing loans was at its highest in 1993, at about 13%, but last year it had fallen below 5 %. Due to low interest rates and rising housing prices households have been taking out large mortgages, which is why the volume of household mortgages has risen considerably over the past few years, reaching € 27 billion. This exceeds the 1991 level by almost 50%, and shows an increase of over € 17 billion compared to 1998.

Housing construction was at a much lower level in the 1990s than during the preceding decades. Compared with the 50,000 housing units per year constructed previously, annual production is now under 30,000 units. The lowest output was in 1996, when only just over 20,000 units were built. The supply of housing is responding slowly to the growing demand, but new construction is hampered by a shortage of suitable plots and high prices. Construction costs have now risen above the limit for government-subsidised housing, which is why not all rented housing planned can be built. Producers are focusing increasingly on valuable owner-occupied housing in growth centres. The halt in the increase in prices also caused a drop in the construction of owner-occupied accommodation in 2001.

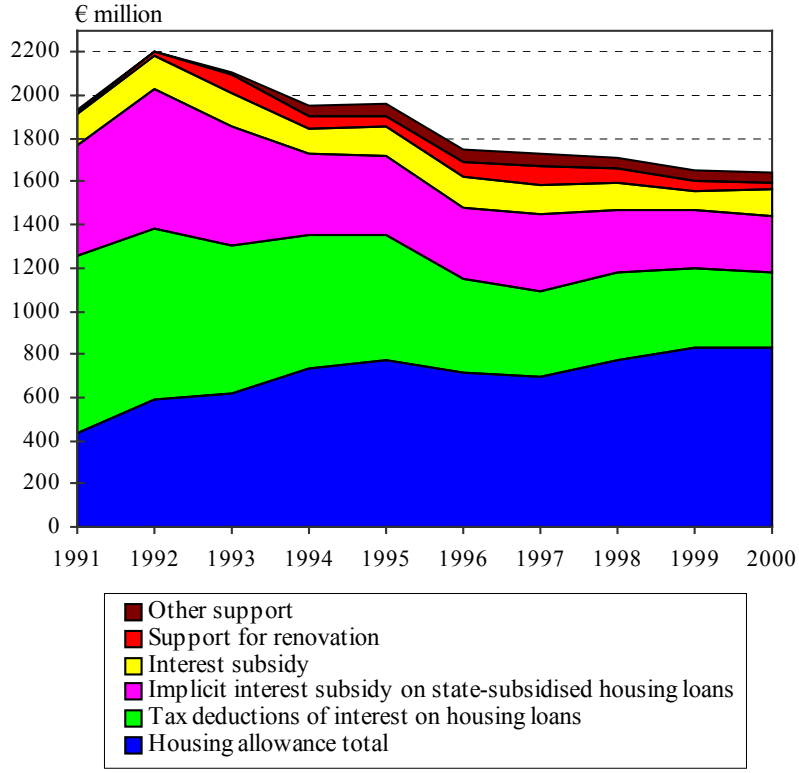
Housing costs rose throughout the 1990s, especially in rented accommodation. The earnings of people in low-income brackets have been rising at a much slower rate. After a long period of improvement, homelessness has begun to increase again in recent years. It is estimated that there are already over 10,000 homeless, most of them men, but the number of homeless women and young people is also increasing, which is a new phenomenon.

Less overall support for housing

Housing and housing construction are supported through direct housing allowance systems, interest support, grants and tax relief. The direct housing allowance system consists of general housing allowance, student housing supplement and pensioners' housing allowance. The forms of interest support are the ASP scheme (government subsidy for first home purchase), government-subsidised housing loans and the interest support system. Direct housing grants focus on certain special groups and on renovation work. The main form of tax relief is the tax-deductibility of interest on housing loans.

The overall level of support for housing has been around FIM 10 billion, and in 2000 it was € 1.63 billion. Housing allowance now makes up about half of all forms of support, while its share in the early 1990s was about one fourth (Figure 60). Tax relief has been considerably reduced due to a change in the tax-deductibility of mortgage interest in 1993 and the fall in interest rates; the same has happened to interest subsidy. Support for housing construction has fallen slightly, in line with the economic trend, and so has support for renovations. The criteria for receiving housing allowance have been altered and re-focused several times.

Figure 60. Total expenditure on housing subsidies 1991-2000, € at current prices



Source: Ministry of the interior

Housing subsidies really needed

In 2001, the total expenditure on housing subsidies was € 1.6 billion. 51% of this was made up of means-tested direct forms of support, 27% was production support and 22% was tax deduction of interest on housing loans. The biggest individual form of support among the general allowances was that provided through the tax deductibility of interest on housing loans, while the ASP interest support and some types of renovation support constitute smaller general support systems. The means-tested forms of support are housing allowances, the implicit interest subsidy on government-subsidised housing loans, support for renovation (excluding housing corporations) the implicit interest subsidy on government-subsidised rented housing, and interest subsidy for rental housing production.

The direct forms of housing subsidies for households are subject to means testing. Housing allowance is granted in relation to household income, assets, occupation density and housing costs. The purpose of the allowance is to enable even those on low incomes to attain a reasonable standard of housing. The allowance enables housing costs to be kept at a reasonable proportion of the household's monthly income. Due to the strict means testing, even a very low level of income leads to a cut in housing allowance.

Housing costs are taken into account either as real costs or according to the size of the household, the maximum size of housing and maximum costs per square metre for the specific region. A basic deductible is deducted from the reasonable housing costs, its size depending on the size of the housing, its location and the income of the household. Housing allowance is the equivalent of 80% of reasonable housing

costs, minus the deductible. The recipients of housing allowance thus always have to pay some of their housing costs themselves.

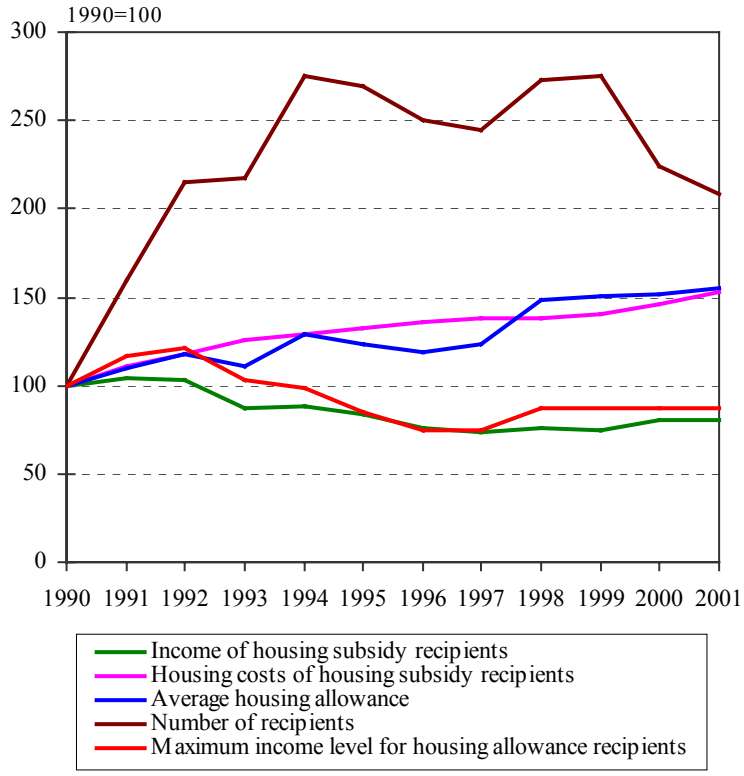
General housing allowance is meant for households on a very low income. The rise in unemployment also caused a considerable rise in the need for housing allowance. Because it became necessary to cut housing allowance expenditure through a tightening of means testing at a time when income levels were falling and rents rising, the remaining recipients of housing allowance were largely households relying mainly on income security benefits. Some 65% of the recipients of general housing allowance are unemployed.

General housing allowance was originally meant as a form of support for families with children, but nowadays only 46% of recipients are families with children. About half of them are single-parent families. In December 2001, a total of 158,500 households received housing allowance averaging FIM 1,142 per moth. In 1998 and 1999 both the number of recipients and the average amount of allowance rose slightly, due to a raise in the levels of housing allowance, while in 2001 and 2001 it fell somewhat, especially due to the fact that student couples were transferred to the student housing supplement system. This has raised the proportion of the unemployed as housing allowance recipients, although their actual number has fallen somewhat.

Unemployment, and particularly long-term unemployment, caused the number of recipients of housing allowance to almost triple in the 1990s (Figure 61). In order to reduce housing allowance expenditure, the income limits for receiving the allowance have been lowered several times over the years. At the same time, the housing costs of recipients of housing allowance have gone up. The average housing allowance has been raised in order to cover the increasingly high housing costs of recipients with lower incomes. Households with even lower incomes than before are forced to spend an increasing proportion of their income on housing costs. The maximum levels of rent per square metre qualifying for housing allowance were raised as of the beginning of 2002 in order to correspond better to actual rent levels.

There are separate housing systems for pensioners and students, which differ in some details from general housing allowance. The pensioners' housing allowance system is directly tied to pensions, and its key aim is to ensure that pensioners can continue to live in the familiar environment of their own homes instead of having to move into an institution. This is why the conditions for type of dwelling are much less strict for pensioners' housing allowance than they are for general housing allowance. The key aspect for further development of the system is its relationship with services for the elderly. Last year there were 165,000 recipients of pensioners' housing allowance, receiving an average € 123 per month.

Figure 61. Trends in housing subsidies 1990-2001



Student housing supplement is available to students living in rented accommodation with the exception of families, and to all students living in accommodation owned by them. The student housing supplement is part of the system of financial aid for students, and its level has from the beginning been tied to the level of rents in student housing. The rent norm has not been adjusted since 1995. At the end of 2001 there were 151,000 recipients of student housing allowance averaging € 153 per month. The student housing allowance is part of the financial aid to students, and its means testing is based of the principles applied in granting financial aid to students. The percentage used, 80%, is the same that is applied in general housing allowance. Student housing allowance is only paid out during months of study, which is why only a small minority of students receive the allowance during the summer.

The housing allowance system has had to respond to rapid economic change. There has been fairly strong fluctuation in the supply and demand for housing. Although the higher employment rate is directly reflected in the need for housing allowance, it will improve the situation in the long term, if the supply of housing is adequate. As the employment situation and the housing market stabilise, it will be easier to develop housing allowance as part of social policy by taking into account the different housing markets for various population groups and regions.

Financing of housing subsidies

General housing allowance, pensioners' housing allowance and student housing supplement are funded entirely by the central government.

2.8 Social assistance

	1999	2000	2001	2002*
Social assistance expenditure (€ million) (net)	401	395	400	400
% of social protection expenditure	1.2	1.2	1.2	1.1
% of GDP	0.3	0.3	0.3	0.3
Households receiving social assistance during the year	292 000	271 700	260 900	252 000
Individuals receiving social assistance during the year	492 690	454 350	440 700	427 500

*estimate

Social assistance as a last-resort social security benefit

Social assistance is a last-resort form of economic assistance used in social protection. Its purpose is to ensure the right to a reasonable level of income to all those unable to secure the protection guaranteeing a life worthy of a human being. According to the Act on Social Assistance, the purpose of social assistance is to promote independent coping, besides securing a reasonable level of income to families and individuals. In practice, social assistance is granted on the basis of a social assistance calculation, which charts the applicants' expenses qualifying for social assistance, and the income and assets at their disposal. The expenses qualifying for social assistance consist of a basic amount and expenses that are taken separately into account (additional amount). The basic amount increases at the same rate as the national basic pension index. The real level of the basic amount of a person living alone did not increase in the 1990s. No index adjustment was made to the basic amount in 1994 or 1996-1998. The inclusion of a 7% deductible of housing costs in the basic amount of social assistance in 1998 lowered the net amount paid out to recipients of social assistance.

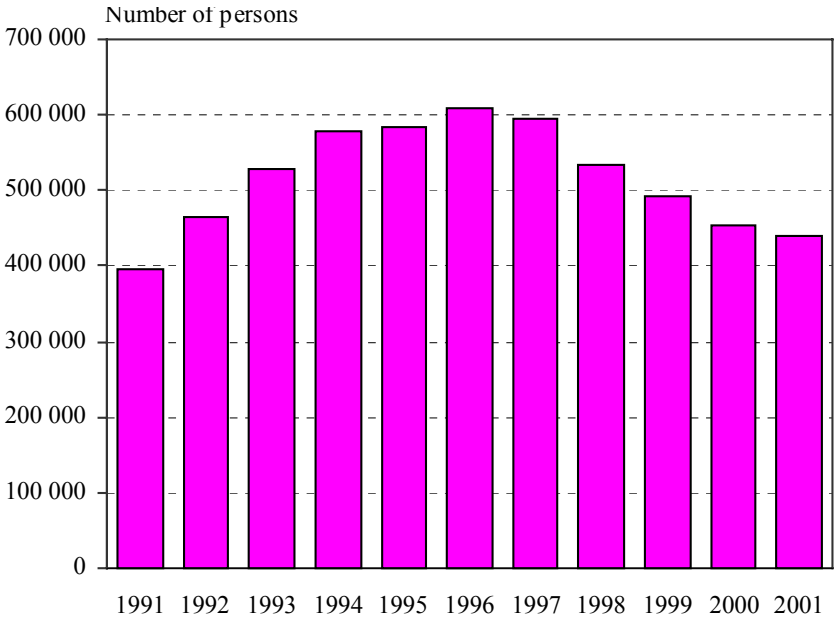
The purpose of the recent social assistance reforms has been to activate clients, to prevent prolonged reliance on assistance and subsequent social exclusion, and to encourage the acceptance of even short-term employment. Measures aimed at reaching these objectives include the extension of the use of preventive social assistance, combination of social assistance and small amounts of earned income, and incentives related to rehabilitative work activities.

Number of social assistance recipients falling slowly

The number of households receiving social assistance was almost doubled in the early part of the 1990s. At its peak in 1996, about 350,000 households with a total of 610,000 people were receiving social assistance. The number has been decreasing gradually since 1997, but the number of recipients is still relatively high compared to 1990. The number of recipients has been affected by the changes in conditions, in addition to development trends in the general employment situation and changes in primary benefit systems. The 1998 reform of the Social Assistance Act included the inclusion of 7% of necessary housing costs in the costs to be covered by the basic amount of social assistance.

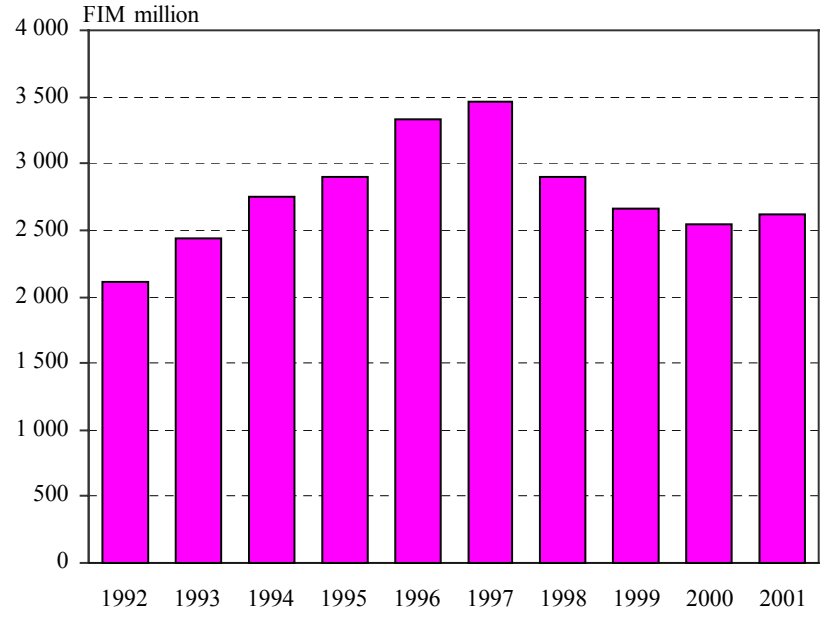
There were about 14,000 fewer recipients of social assistance in 2001 than the year before, but the downward trend slowed down somewhat. The number of households receiving social assistance continued to fall in all provinces, most of all in Central Ostrobothnia.

Figure 62. Social assistance recipients annually 1991-2001



The improvement of the general employment situation has not been reflected as a corresponding fall in social assistance expenditure, although over half of assistance recipients are unemployed. The recipients of social assistance have not been the primary target of the growing demand in the labour market. The expenditure on social assistance grew by 6% in the early part of 2001 compared to the year before.

Figure 63. Total expenditure on social assistance 1992-2001, FIM million at 2000 price level (the figure for 2001 is an estimate)



Single men were the largest group of social assistance recipients, with an almost 40% share of all recipients in 2000. Single-parent families made up about 10%, as did families with children and couples with no children. Households with single childless women made up about one fourth of all social assistance recipients.

The number of families with children fell the most among recipients of social assistance in the late 1990s (1996-2000). The fall was slowest in single parent families, where reliance on social assistance was also clearly most common. There were fewer young people among new assistance recipients. In 2000, the number of students and junior salaried employees fell the most among all social assistance recipients, whereas the reduction was slow among the long-term unemployed and households consisting of pensioners.

Increased need for long-term social assistance

The risk for exclusion increases significantly as economic problems are prolonged. The average time of reliance on social assistance grew in the 1990s, at the same time as the proportion of long-term clients and single-person households increased. In 1990, about 12% of social assistance recipients received assistance almost throughout the year. In 1997 the figure was almost 25%, after which there was a slight turn downward. Even though the number of households receiving long-term social assistance continued to fall in 2000, their relative share grew compared to the year before. In 2000, long-term clients - 65,800 households - made up 24% of all social assistance recipients.

Long-term (10-12 months) social assistance was most commonly paid out to single men, childless couples and families with children with two providers. Long-term assistance was rare among single mothers and single women. The proportion of long-term clients was clearly higher in urban municipalities compared to rural ones.

A key reason for long-term reliance on social assistance are accumulated economic problems due to long-term unemployment. Most of these households apply for social assistance to supplement other benefits or wage or salary earnings. A need for prolonged social assistance has also been observed particularly in the Helsinki metropolitan area due to high housing costs. According to a recent survey, the risk for long-term reliance on social assistance is increased by being single, having a low level of education and being under 20 or aged 30-49. A background as an entrepreneur and a lack of a stable socio-economic background position are also linked to long-term need of social assistance.

Figure 64. Households receiving social assistance according to type of household, %

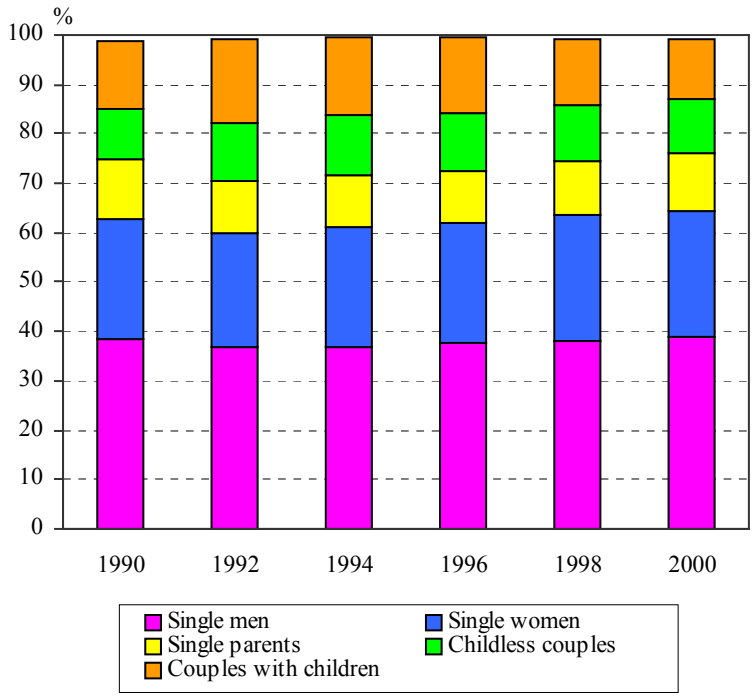


Figure 65. The poverty-reducing effect of social assistance

Poverty level: as a proportion of the population, persons belonging to households whose disposable income calculated per consumption unit is less than 50% of the median income of all households.

The importance of social assistance as a means of compensating for a low level of income, i.e. as a reducer of the relative poverty level increased in the 1990s. Without social assistance, an increasing proportion of the population would fall under the 50% median income limit (Figure 65).

It has been seen as a structural problem of the social assistance system that primary benefits forms of assistance, mainly basic unemployment benefits allowance, must to a large extent be supplemented by social assistance. According to statistics, almost half of the households receiving social assistance were ones where the provider was also a recipient of labour market support. Especially in large cities, it has been necessary to accept higher costs of housing as qualifying for social assistance than the ones used as basis for housing allowance, because the maximum housing costs qualifying for housing allowance are lagging behind real costs. The coordination of primary and last-resort social protection has been deliberated e.g. by the housing allowance coordination group, which presented its memorandum to the Ministry of the Environment on November 21, 2001.

Adjustments to grounds for granting social assistance

The amendment to the Decree on Social Assistance that entered into force on April 1, 2001 defined in more detail the expenditure to be covered by the additional amount of social assistance. ”Special need” of an individual or a family can involve long-term reliance on social assistance, long-term or serious illness and various needs related to children’s hobbies. Municipalities are also obliged to process social assistance applications without delay.

Increase in preventive social assistance

According to the principles of the Nordic welfare state, public support systems should function in a way pre-empting the need to seek help from unofficial sources. It is a crucial weakness of the present social assistance system that it cannot take the assistance recipient’s actual situation and subsequent support needs into account flexibly enough.

The amendment to the Act on Social Assistance that entered into force in April 2001 widened the scope of preventive social assistance, and municipalities were instructed to grant preventive social assistance more intensively than hitherto. The aim of preventive social assistance is to encourage security and independent coping of individuals and families, and to prevent exclusion and long-term reliance on social assistance. The preventive assistance can be granted for paying rent dues, for measures aimed at activating the recipient, and to alleviate the effects of overindebtedness or a sudden deterioration in the person’s financial situation. It can be used to prevent people from being driven into a situation where they would have to rely on long-term social assistance. In the long run, this will also generate savings. An estimated FIM 80 million (€13.5 million) will be used on preventive social assistance in 2001, while the corresponding figure in 1999 was about FIM 25 million (€ 4.2 million).

Social assistance and activation measures

In connection with the implementation of active social policy measures, changes were made in the Act on Social Assistance, with the aim of increasing incentives to participate in the degree of incentive of measures promoting employment. The changes came into force on September 1, 2001. In accordance with the new Act on Rehabilitative Job Activities, persons receiving social assistance due to long-term unemployment participate in the drafting of an activation plan, and possibly also in rehabilitative job activities. Participants receiving social assistance are paid an additional activation supplement of € 7 per day of participation as of the beginning of 2002. People participating in rehabilitative job activities are also entitled to social assistance compensation to cover their travel costs.

The obligation of recipients of social assistance to seek employment has also been redefined. Social assistance recipients are obliged to register as job seekers at the employment agency, unless they are unable to accept work due to reasons defined by law. If a person refuses to accept an offered job or to participate in a labour policy activation measure activity, the result can be a reduction of the basic amount of social assistance. The same is true for refusing to draw up an activation plan, and in the case of under 25s, for refusing to participate in rehabilitative job activities.

Coordination of social assistance and earned income

A three-year experiment aimed at increasing incentives to work will be implemented, in which part of the earned income would not be taken into account when granting social assistance. In accordance with the temporary amendment of the Act on Social Assistance, a minimum of 20% of the earned income of the person or family applying for social assistance would not be taken into account when granting the assistance. However, the amount of earned income not taken into account could not exceed € 100 per month. The amendment is in force between April 1, 2002 and March 31, 2005. It is estimated that about 12,000 recipients of social assistance will seek work as a result of the amendment. The disposable income of an additional 60,000 households in receipt of social assistance is also expected to rise. It is estimated that the experiment increases municipal social assistance expenditure, while reducing government expenditure on housing allowance and increasing municipal tax revenue.

The financing of social assistance

The municipalities meet all their social assistance expenditure, but they do receive a government grant to finance their social welfare and heath care services. In 2001, the grant covered about 24% of the costs of municipal social welfare and health care services. In 2002 the government grant is about one per cent higher, or 25.3% of the calculated running costs of municipal social welfare and health care.

3 Social Services and Health Care

3.1 Views on services by the population and clients

The level of support for and satisfaction with social welfare and health care services continues at a high level among the population. As was stated in Chapter 2.1., according to a EU Member State survey, almost 80% of Finns are either very satisfied or satisfied with the health care provided in Finland. The figure is the highest among EU Member States.

Finnish surveys published in 2001 indicate that the level of satisfaction with social welfare and health care services is high.

In autumn 2000, over four fifths of the respondents were of the opinion that the Finnish welfare state is worth its costs. The share of those agreeing with this view increased in the 1990s, according to studies by EVA, The Centre for Finnish Business and Policy Studies.

Table 11. Citizens' views on the importance of the welfare state and on the privatisation of public services, % of respondents

	1992	1996	1998	2000
Although maintaining good social protection and other public services is expensive, the Finnish welfare state is worth the cost				
Totally or largely agree	61	72	74	85
Hard to say	15	12	11	7
Totally or largely disagree	24	16	14	9
A large part of public services in our country should be privatised in order to make service provision more effective				
Totally or largely agree	52	40	35	32
Hard to say	22	22	26	16
Totally or largely disagree	26	38	39	53

EVA surveys have also charted the views of citizens on the privatisation of public services in order to increase effectiveness. In the early 1990s about one in two respondents had a favourable attitude towards privatisation. In the autumn of 2000 the share of those taking a positive view towards privatisation had fallen to one in three, while over half of the respondents had a negative attitude towards privatisation.

In the EVA survey, respondents were also asked to name the most important areas of public economy that need to be developed. The presumption behind this was that the state of the public economy would allow more investments in some areas. Health care came out as the clearly most important area, 64% of citizens felt it to be the primary target for development in the public sector. The degree of support was clearly higher than that for the second most important area of development, i.e. the police and inner security at 41%.

Women considered health care as the most important area to be developed more often than men. When looking at different regions, the support for health care was very evenly distributed. There were differences seen according to the age or

employment status of the respondents. Of people aged 18-20, only 49% put health care into first place, whereas 72% of those aged 51-60 did so. Students, entrepreneurs and people in a leading position put less emphasis on health care than others, but half of them or even more felt health care to be the most important public sector area in need of development.

According to the survey by Efektia, a consulting and research company, published in autumn 2001, the level of satisfaction with municipal services still remains high. It was at its highest in 1993 and at its lowest in 1989.

The majority of service users are satisfied with the most important basic service forms. According to the survey by Efektia, a total of 85% of parents were satisfied with lower comprehensive schools, grades 1-6, and 75% with higher comprehensive schools, grades 7-9. The degree of satisfaction with upper secondary schools was 79%. The highest degree of satisfaction was seen with the education given and schools in general. The state of school premises and equipment leaves the most to be desired.

Service users are satisfied with municipal health care centres, which was also the case in the previous survey conducted in 1997. Three out of four respondents were satisfied with the quality of care, traffic connections, the willingness of staff to be of service, and the availability of medicines. Long waiting times and difficulties in getting an appointment were still the main causes for dissatisfaction. About one third of the clients were dissatisfied with the waiting times, and about one fifth with getting appointments.

Children's daycare services receive a high grade from the users, as indicated e.g. by the fact that 95% of the respondents were satisfied with the daycare place. 84% of users were satisfied with maternity and child welfare clinics, whereas the degree of satisfaction with elderly care showed a decline compared to 1997, 18% of the respondents expressing their dissatisfaction with the services provided. Areas perceived as being most in need of improvement are home help and more housing and service accommodation for the elderly. Increasing the provision of private housing and service accommodation receives the least amount of support.

Surveys conducted in the old people's homes of the City of Helsinki showed that the degree of satisfaction of families towards the care received by elderly family members had increased from 1998 to 2001, when 92% of the respondents were either very satisfied or satisfied with the care, and the average grade given by relatives as describing the quality of care was 8.3 (max. 10). Three years earlier the corresponding figures were 86% and 7.3.

3.2 Service costs and provision

Net per capita municipal expenditure on social welfare and health care services averaged about € 1,815 in 2000. In urban municipalities the figure was € 1,865, in densely populated municipalities € 1,700 and in rural municipalities € 1,780.

In nine municipalities, per capita expenditure exceeded € 2,185. The highest per capita figure was 1.95 times the lowest. The differences between municipalities were considerable, even after differences in service needs had been taken into account.

The provision of municipal social welfare and health care services consists primarily of services provided by the individual municipalities and joint municipal boards. Service procurement from companies and the third sector is limited to various service

components and individuals actions, or to fairly limited packages.

The consequences of doctors' strike beginning to show

The 2001 strike by doctors lasted over five months. It is estimated that the cost effect of the agreement that ended the strike was 10.5%, or nearly twice that of the income policy agreement. According to the joint wage statistics of the Municipal Labour Market Institution and the Finnish Medical Association, the average monthly earnings of municipal doctors will increase from € 4,460 to € 4,930. The agreement increases municipal and joint municipal board expenditure by nearly € 100 million. In addition, municipalities and joint municipal boards are obliged to contribute towards the costs of reducing the number of patients on waiting lists and getting services back to normal. The City of Helsinki, for instance, was planning to use about € 17 million in 2001 to reduce the number of people on waiting lists e.g. by purchasing procedures and services from service providers outside Helsinki and Uusimaa Hospital Group.

Extension of the private sector

The Mehiläinen concern has become the leading provider of private health care services in Finland. The company was established in 2000, when Sairaalaosakeyhtiö Mehiläinen and the Turku-based concern Tohtoritalo merged. The merger also involved the capital investment companies Capman Capital Management Oy and Sitra, which together own the majority of the company. At the end of 2001 the concern was about to extend its operation to Vaasa and Kuopio.

Coxa, a joint replacement hospital will be starting its operation in Tampere in autumn 2002. The joint replacement hospital is a limited company, owned by the German hospital company Wittgensteiner Kliniken AG, four hospital districts, four municipalities and the Invalid Foundation.

Attention on distribution of RAY subsidies

In 2002, RAY (Slot Machine Association) subsidies totalling € 279.5 million will be granted to over 1,100 non-profit associations or foundations, € 84 million of which are investment subsidies. The investment subsidies enable the start of construction and acquisition of about 1,300 dwellings for groups with special needs. The majority of the subsidies, € 126 million, are however targeted at securing the operation of various associations, and € 71 million goes to funding various types of experiments and development work. The development projects involve e.g. the treatment of mothers suffering from substance abuse, providing afternoon care for schoolchildren as well as increasing the funding for anti-drug campaign work and work among immigrants.

The reduction of obstacles to competition between providers of social welfare and health care services has been discussed in many connections. In 2001, for example, the effects of RAY subsidies on competition were discussed. In 2001 the Act on Slot Machine Association Subsidies was approved, stating that one of the general grounds for granting subsidies is that the granting of the subsidy is only estimated to cause slight distortion in competition and the market. According to the same Act, a subsidy recipient may also hand over practical responsibility to another party for arranging the activities on the premises for which subsidy has been granted, if the purpose of the operation remains unaltered. The arranger of operation may also be a private enterprise. The purpose of these amendments has been to reduce obstacles to competition .

The question of how to take the competition into account in the future when subsidies are distributed was also the subject of discussions between the Ministry of Social Affairs and Health, the Ministry of Trade and Industry, the Federation of Finnish Enterprises, Employers' Confederation of Service Industries in Finland, the Association of Finnish Local and Regional Authorities and the Association of Voluntary Health, Social and Welfare Organisations YTY. At present the situation seems to be such that at least the sectors of substance abuse, mental health and disability have not yet reached a stage where they could benefit a great deal from competition. The interest of enterprises is mainly focused on elderly care services. In connection with new elderly care investment projects of the Slot Machine Association subsidy recipients are guided to take into account the legislation concerning public acquisitions and competition.

Overcapacity of laboratory operation

There are about 1,500 clinical laboratories in Finland. According to some estimates, the present laboratory capacity exceeds the real need by 50%. As automated analysis methods were developed, production costs fell already in the 1980s clearly below the sales prices linked to the Social Insurance Institution's (SII) refunding rates. The trend has not affected the SII's refunding grounds or the number of refunds. Refunds paid by the SII that are clearly higher than average production costs have created an oversupply in the field, enabled companies to reap large profits and to use them to fund other operations.

In 2001, the overproduction of laboratory services and the obvious failings of the system were remarked on e.g. in the state auditors' report for the year 2000, as well as in the report on the provision, costs and reimbursements of laboratory investigations compiled by a group of rapporteurs.

Need for clarification of several sources of funding

Social welfare and health care services are funded by public means in many ways. The overall significance of the mutual relationships involving interaction and incentives of the parties involved in the financing (central government, Social Insurance Institution, the Slot Machine Association and clients) is hard to grasp and understand in full.

The drawbacks of funding coming from a variety of sources are now being recognised. At worst they lead to operation that is both ineffective and unfair, from the point of view of the entire operation and individual clients. This issue emerged e.g. in connection with the national health care project. State auditors also pointed out this issue in their report for the year 2000, stating that the present multichannel funding system of social welfare and health care services needs comprehensive reform. A similar conclusion was drawn by the Basic Services 2000 working group appointed by the Ministry of Finance.

Extending the duration and scope of purchased services

In accordance with models combining services provided by the public and the private sector, services or projects belonging to the sphere of interest of the public sector can be provided jointly by both sectors. The models are often based on extensive long-term agreements between the public and the private sector. According to these models, the public sector commissions the services and may contribute to financing of the investment, and the private sector actor finances, plans, builds and provides the services based on

the wishes of the public commissioner of services for a given amount of money.

This kind of partnership model involving both the public and the private sector can be seen as an extension of purchase agreements, both with regard to their duration and their extent. Municipal service purchase agreements are often agreements of one to two years in limited areas of service or operation (e.g. laundry services). In the case of the partnership model the period of agreement is usually several years and covers an extensive field of services. Models may be found between these two extremes where the agreement is in force for a few years' time and the agreement's range is relatively extensive. There is more emphasis on the know-how and negotiating power of the commissioner in the partnership models than in the traditional provider-purchaser models.

An actual partnership model has not been applied in the health care sector in Finland. A first in the case of the education sector was seen in the early autumn of 2001, as the City of Espoo decided to give the project of constructing an upper secondary school, swimming baths and a sports centre to the project company NCC Finland, which also includes ABB Installation and Sodexho Ltd. The City only provides the education given at the school. As commissioner the City purchases the time it needs the facilities for its own use. At other times the facilities are at the disposal of the project company, and they can be let to other tenants. The project company has full responsibility for maintenance and basic repairs. The building complex is to be completed by the end of June 2003, after which a service period will commence, ending at the end of June 2028.

Besides the introduction of the provider-purchaser model, the 1991 health care reform in England also meant the awakening of interest towards the use of private funding in health care, in accordance with the so-called PFI (Private Finance Initiative) model. In most cases this involves construction of facilities by the private sector commissioned by the national health care system. The PFI model did not have much impact until the late 1990s, when the government took a more favourable view of the model than before. The PFI model is estimated to account 22 per cent of NHS capital expenditure by 2003-2004 .

Quality recommendations and other recommendations increasingly common

In accordance with the Target and Action Plan on social and health care for 2000-2003 approved by the Council of State, quality recommendations for municipal quality assurance work are being prepared jointly by the Ministry of Social Affairs and Health, National Research and Development Centre for Welfare and Health (Stakes), the Association of Finnish Local and Regional Authorities and service users. When necessary, the recommendations will also include recommendations regarding grounds for determining the number of staff. Recommendations will be drawn up, in a staggered manner, at least in the following areas: elderly care, mental health services, school health care, housing services for the disabled, and anti-drug work.

In spring 2001 the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued a quality recommendation for elderly care and services for the elderly. The quality recommendation on mental health services was given in November 2001. The municipalities are not bound by the recommendations, but they can be used as a basis for further development of municipal services. Recommendations on the other areas mentioned in the Target and

Action Plan as well as on technical aids are under preparation.

Reformed guidelines on the provision of specialised medical care entered in to force at the beginning of October 2000, recommending the regional concentration of coronary angioplasty, knee and hip replacements as well as surgery on children and young people suffering from arthritis.

The purpose of the project entitled Current Care (Käypä Hoito) of the Finnish Medical Society Duodecim and associations of specialised doctors is to draft national care recommendations that can help raise the standard of care and reduce variation in treatment practices. The recommendations formulated as easy-to-read summaries help doctors in their work and act as a basis for drawing up regional treatment programmes. By the end of 2001, over 30 recommendations had been completed. The newest recommendations dealt with the treatment of schizophrenia, ovarian cancer, the surgical treatment of refractive errors and the treatment of hypertension.

The results of operation to be evaluated in public

Differences in access to care, treatment practices and the outcomes of care have been the focus of increasing attention in recent years. There are great differences in the treatment frequencies of even the most common diseases. At their greatest, the differences in the frequency of basic surgical procedures are five-fold, or even ten-fold in the case of more unusual procedures. There are also significant differences in the waiting times between hospital districts, as well as in the outcomes of treatments. For instance, the number of renewed hip joint replacements with relation to the amount of population varies between hospital districts, being three times higher in some districts compared to others. The variation is even greater in the case of knee joint replacement surgery. One in ten patients treated in hospital gets a hospital infection. This is particularly common in connection with surgery, intensive care and cancer clinics, where the treatment given is expensive. 3,000-4,000 patients die each year as a result of hospital infections. It is estimated that a third of these deaths could be prevented.

Information on costs, availability and outcome of care has begun to be published on the Internet in many countries. A similar trend can be expected in Finland as well. The rapporteur charting the availability of specialised medical care in Finland proposed that the population be informed regularly of the waiting times for care, and that the information be made available in electronic form for free inspection, taking into account data secrecy aspects.

Investing in IT

The implementation of the strategy aimed at utilising IT in social welfare and health care has been continued, especially by extending and boosting the Makropilotti IT project. The Act approved by the Parliament on the experiment concerning the introduction of a seamless chain of social welfare and health care services and an electronic information system with individual social security cards gave new regions the possibility to participate in the development and implementation of the operation and technical reforms included in the strategy. The Ministry of Social Affairs and Health approved the Satakunta region, actors in the Helsinki metropolitan area as well as actors in Pirkanmaa and the Raahe area as new areas participating in the experiment. The Ministry has also given National Research and Development Centre for Welfare and Health (Stakes) the task of making proposals e.g. to solve issues concerning electronic data filing.

The Ministry has also given Stakes the responsibility for the national coordination and evaluation required in connection with the seamless social welfare and health care services experiment. The project of establishing IT-supported seamless services is one the projects implemented in 2001-2003 with funds included in the so-called future package of the Ministry of Social Affairs and Health. With these funds, a social welfare e-consultation project has also been launched. It is aimed at promoting the development of web-based work forms within social welfare with the aid of IT, as well as making the information needed in this work more readily available.

Other areas of emphasis include the promotion of independent coping among the elderly and the disabled. The ITSE project aims at raising the level of competence of social welfare and health care staff and citizens by providing training and creating new networks of cooperation. The operation focuses on utilisation of the possibilities offered by technology in communication and housing.

Thanks to the financing provided by the future package, additional funding of about € 10 million can be used in 2000-2003 for the IT development projects described above, in addition to the usual funds earmarked for research and development. The basic funding has been used to help other regional development projects, e.g. setting up compatible IT systems, video conferencing links and services providing information. EU structural funds also play a significant role in this.

Focus on securing the availability of labour

There are about 233,000 employees providing social welfare and health care services in Finland, 121,000 of them in health care and 112,000 in social services. In the 1990s the average age of social and health care staff rose from nearly 39 to 43. Unemployment in the field remained below that in other sectors, and diminished towards the end of the decade. The level of unemployment in health care was clearly lower than that in social welfare services. A shortage of health care centre doctors and specialised doctors began to be seen in the late 1990s. The availability of staff will probably continue to deteriorate, for a considerably large number of social and health care staff are estimated to retire between 2001 and 2010. It is estimated that 50,000 or even more municipal social welfare and health care employees will be retiring from work during this period.

According to the estimate of the committee anticipating the future need for labour in social and health care, 6,300 more employees are needed to cover the services for the over-65s to compensate for the present shortage of staff within elderly care. The committee estimates that an additional 12,000 employees are needed by 2010 to fill the growing need for social and health care services. The increase between 1995 and 2015 in the number of persons employed in the social welfare and health care sector is estimated by the committee to be about 59,000 (1.1%/year) according to the basic career alternative, and about 78,000 (1.4%/year) according to the needed career alternative.

One of the key proposals of the committee was increasing the number of places available for students in social and health care education. According to the committee, the number of places in basic vocational social and health care education should be increased by 640-1,140 per year, i.e. to the total of 8,500-9,000 in 2002-2010. The corresponding increase need at polytechnics was estimated to be 350-1,050 a year, or to the total of 7,200-7,900, and that at universities (excluding doctors and dentists) 130-330 a year, or to the total

of 1,400-1,600. The committee also wanted to increase the number of medical students as of autumn 2001. This objective was reached when the number of students accepted to medical schools was increased from 480 to about 550. Increasing the number of medical students even further has since been discussed e.g. in connection with the national health care project.

Centres of excellence getting started

The aim of centres of excellence in the field of social welfare is to boost the connections between practical work, education and research as well as special competence on regional and local level. The operation of the centres of excellence was made permanent as of the beginning of 2002, when their duties were defined and funds covering their basic operation were guaranteed with the aid of an Act that entered into force at that time.

The centres of excellence operate on a provincial basis, covering all municipalities in the region. Participation in the operation of the centres of excellence is voluntary for the municipalities, but the goal is for all municipalities to take part in work of the centre of excellence in their region. A Swedish-language centre of excellence caters to the needs of the Swedish-speaking population.

In addition to municipalities, the key founders and partners of the centres of excellence are universities, polytechnics and other educational institutions in the field, regional councils, provincial governments and social welfare and health care organisations. National Research and Development Centre for Welfare and Health Stakes is a central partner for all centres of excellence.

At the end of 2001, preparations were under way in different parts of Finland for setting up permanent organisations and for recruiting staff. The state subsidy intended for funding basic operations comes to € 3 million in 2002. It is divided between the regional centres of excellence according to the number of inhabitants and surface area. Besides regional centres, a Swedish-language centre of excellence also receives basic funding, based on the size of the Swedish-speaking minority.

3.3 The role of client fee policy in the financing of services

3.3.1 Starting points

The national client fee policy of social welfare and health care services includes the principles and goals observed in Finland in defining grounds and levels of client fees. The client fee policy includes both the out-of-pocket payments by users of municipal services and the sickness insurance deductible.

Client fees can have two types of objectives, i.e. ones focusing on financing the service as well as ones mainly aimed at guiding the use of the services. Financial objectives are related to guiding how big a share of the costs is covered by the individual service user or household, and how much is funded jointly by taxpayers or the insured. This also includes the issue of how financial responsibility for financing the services targets different population groups.

Client fees and deductibles have also been used to have a certain desired effect on the demand, supply and structure of services. The possibilities of affecting the choices and costs of those who need, use and provide services vary between different sectors in social welfare and health care.

Client fees have had no impact on the amount of state grants since 1994. Especially in health care, client fees are

often paid to service providers, such as hospitals.

The expenses arising from the use of private health care services are reimbursed to citizens through the health insurance system. The significance of voluntary insurance as a reimburser of costs due to sickness is modest. Private treatment insurance is not yet available in Finland. The care supplement to pension recipients paid out by the Social Insurance Institution (Kela) and other cash benefits granted on the basis of disability are intended to compensate the special costs, disadvantages and need of help due to disability or sickness.

In 1999, the revenue from client fees in the municipal social and health care sector was about € 950 million (FIM 5,655 million), or about 9% of social welfare and health care expenditure (Figure 12). As of 2000, the introduction of the personal annual limit of health care costs and free preschool education have contributed to a slight reduction in client fees as a source of funding for social and health care expenditure.

An ageing population, increasing service needs, basic social rights, new ways of financing and providing services, attempts at social protection that includes incentives as well as internationalisation are all part of the operating environment of the client fee policy. The change in service structure affects the generation of fee revenues, and client fees have an impact on the development of services.

The increase in the number of service alternatives poses a challenge for the grounds for client selection in the public sector, client fees and the choice of services to be financed with public funds. Internationalisation means increased pressure to lower the tax rate. On the other hand, several countries have introduced new models of funding long-term care. Statutory long-term care insurance has been introduced in Germany and Japan, and a care allowance system funded with tax revenue has been adopted in Austria.

Table 12. Operating expenses of municipal social and health care and revenue from client fees in 1994-1999 at 1999 prices.

	1994	1996	1998	1999
Total expenditure on social and health care				
Expenditure, € million	10 339	10 705	10840	10 973
Revenue form client fees, € million	973	1 008	920	951
Revenue from client fees, % of total expenditure[1)]	9.4	9.4	8.5	8.7
Of which				
Specialised medical care				
Expenditure, € million	3 030	3 145	3 278	3 296
Revenue form client fees, € million	228	217	182	191
Revenue from client fees, % of total expenditure	7.5	6.9	5.5	5.8
Primary health care				
Expenditure, € million	2 138	2 191	2 156	2 180
Revenue form client fees, € million	255	255	239	246
Revenue from client fees, % of total expenditure	11.9	11.6	11.1	11.3
Children's daycare				
Expenditure, € million	1 153	1 357	1 434	1 475
Revenue form client fees, € million	171	206	221	226
Revenue from client fees, % of total expenditure	14.9	15.2	15.4	15.3
Institutional elderly care				
Expenditure, € million	669	687	632	640
Revenue form client fees, € million	113	123	122	127
Revenue from client fees, % of total expenditure	16.9	17.9	19.3	19.8
Home help services				
Expenditure, € million	376	415	404	438
Revenue form client fees, € million	50	54	58	60
Revenue from client fees, % of total expenditure	13.2	13.1	14.4	13.6
Other service forms for the elderly and the disabled				
Expenditure, € million	434	537	561	671
Revenue form client fees, € million	47	54	58	66
Revenue from client fees, % of total expenditure	10.8	10.0	10.3	9.8

[1)] The financing share of the services mentioned in the table is slightly higher (9-10%), because the total expenditure on social and health care includes e.g. children's home care allowance.

Sources: the Association of Finnish Local and Regional Authorities and the Ministry of Social Affairs and Health.

According to section 19 of the Constitution, which entered into force in 2000, "central government must ensure, in the manner more closely stipulated by law, sufficient social and health care services to everyone, and promote the health of the population". That is why the contents of the client fee policy and related solutions must also be looked at in light of the Constitution.

When assessing client fee policy, it must be taken into account that there are special issues related to the fees in health care services and services aimed at children, the disabled and older people. For instance, the potential for raising the level of deductibles varies between the groups.

3.3.2 Current state of client fee policy within social welfare and health care services

The underlying principles of client fee policy and its objectives were last extensively looked at in the early 1990s by the committee on social and health care client fee policy. The principles defined for client fee policy by the committee were as follows:

1. The services are primarily funded by tax revenue.
2. Social justice. In order to achieve this, it was deemed necessary to adjust the fees for continuously used services to the user's ability to pay.
3. Equal treatment of service users regardless of their municipality of residence. This was not seen as preventing variation between municipalities in the level of fees.
4. Supporting the general objectives set for social and health care. In the committee's opinion, fees, terraced fees or services free of charge can be used as a means of guiding the population to utilise services that are appropriate from the point of view of society as a whole.
5. Increasing the level of municipal independence and responsibility in defining client fees.

The present system of client fees is based on the work of the committee. The starting point was that services that are free of charge are defined by law, in addition to which there is a decree specifying maximum fees for individual services. The municipalities can make decisions on their own fees within these limits.

The degree of national regulation varies between different types of service. There are some service forms, such as informal care allowance to family caregivers and service housing fees for the elderly that are not covered by any special regulation.

Several adjustments have been made to the Act and Decree concerning client fees over the years, the ones on client fees on children's daycare and the personal limit on health care costs, both of them defined by law, being the most important. In addition to this, a procedure-based day surgery fee has been introduced, among others. Changes have been made in the deductible of medicines reimbursed by health insurance, travel expenses and private doctors' fees as well as the costs of examination and treatment, all of them increasing the deductible.

The acts and decrees on client fees have been passed at different times over the years. The changes are often poorly coordinated with other client fees, changes in service structure as well as economic and social policy decisions. When client fees have been changed, the focus has often been on a single fee, which is why broader client fee policy perspectives have in many cases been ignored. It has become increasingly unclear what social policy or other objectives are being pursued with the changes in client fees. There is a clear need for clarifying the goals of client fees in the social welfare and health care sector.

The set of client fee norms that has emerged as a result of the changes is very hard to grasp for clients and other parties involved. There are only a few experts in Finland who are well versed in client fee regulations in both the social welfare and the health care sector. People working with fee issues on a daily basis are not familiar with regulations pertaining to different periods, their details or regulations that leave room for interpretation. The set of norms and the client fee policy based on it do not fulfil the transparency criterion as far as clients, municipalities or state authorities are concerned.

Changes in the service structure and operating environment of client fees as well as future perspectives speak for a reassessment of the goals and principles of the client fee policy. The goals set for the client fee policy are affected by several factors: a comprehensive view of the key objectives of social protection and the role of services as promoting and ensuring public health and functional ability and social security; general aspects pertaining to costs and funding of public services (e.g. the requirements set for the tax rate), and attempts to guide the use of services (incentives for clients, providers and municipalities).

3.3.3 Different types of client fees and their effects

The client fees have been adjusted according to the type of service and the interests for their use on the part of society as a whole and the individual client. Services are provided free of charge in cases when it is in the society's interest to further their use. Some forms of client fees are flat fees based on service performance,which do not vary between service providers (e.g. daily fee for short-term hospital care). The client fee can also be in the form of a deductible (i.e. the client covers a certain percentage or sum of the cost of care). The deductible can also include a certain upper limit of expenditure, in which case the client pays 100% of the care up to a certain limit, after which insurance coverage or personal annual limits are applied.

Some fees are adjusted according to income level. These are used e.g. in children's daycare, regular home help services and home nursing as well as long-term institutional care. The level and accruement of these fees is affected by employment, wage and pension level as well as capital income.

Income-fixed fees are a means of income equalisation, in addition to taxation and income transfers. This may result in incentive traps, and possibly in some problems of the legitimacy of social protection. In a system mainly funded by tax revenue, the justification of income-based client fees can be called to question from the point of view of the principle of universality and basic social rights.

Services that are free of charge have given rise to claims that free services are used needlessly, which increases costs, and that they are not highly regarded. Claims of this kind have, however, been estimated to be poorly motivated, at least in health care[7].

Within the health care sector, client fees can mainly be used to have an impact on first-time visits, in which case the client has real power to make decisions. In later stages of the service chain doctors play a crucial role in decisions on service use. In the case of some other health care services, such as dental care, clients have more say.

Raising client fees and deductibles does not necessarily have a direct impact on total service expenditure, but they are a means of income transfer from service users to taxpayers and the insured who do not use the services. The higher the increases in fees, the more often should there be cases of exemption or lowered fees. This would increase administrative costs. The effects of increased client fees have a regressive impact on income distribution. In most cases the fees lead to increased differences in income distribution, since people with low incomes are the primary target of fees and their accumulation. The effects of substitution should also be taken into

[7] Different types of client fees have been described and assessed in more detail in the report by J. Niemelä entitled Terveydenhuollon asiakasmak-sut. Mistä tosiasiasa on kyse. Ministry of Social Affairs and Health report 1999:2.

account: raising the client fee of one form of service may increase the demand for another form of service replacing the first one, if the price of the latter is not raised.

3.3.4 Special issues relating to client fees

The level and accumulation of client fees and deductibles in out-patient care

There is often an attempt to coordinate the social welfare and health care service for clients, but separate client fees can be charged for all services provided. From the point of view of the users, and other actors as well, it is important to look at the total burden of costs in addition to individual fees.

For households in need of a lot of services, income-based client fees in may be substantial, even at fairly low income levels. The accumulation of flat fees and deductibles may also constitute a considerable expense. Even though individual services are moderately priced, the burden of the sum total of fees and deductibles may be such that the level of income of the household is significantly reduced (Table 13).

In the coordination of fees, municipalities can utilise the possibility included in the decree on client fees to lower fees from the level of normal income-based fees. The grounds for lowering the fees are however neither clear nor uniform.

The minimum disposable income households should have after paying client fees has not been defined in out-patient care. Some municipalities have defined the minimum level independently, mainly for the use of people living in service housing. In extreme cases, people with moderate to high incomes in open care may have less disposable income (income to be disposed of freely after deduction of service fees, deductibles and housing costs) than those in institutional care. This may lead to two kinds of effects. Firstly, the fact that out-patient care is relatively expensive may encourage clients to seek, either on their own initiative or on that of relatives, institutional care which is unwarranted with regard to need of treatment or care. Secondly, it is possible that high client fees in out-patient services are an obstacle to sufficient utilisation of out-patient services, which leads to a deterioration of the client's state of health. In both cases, the result increases public expenditure. In terms of guidance, it is important to set and define client fees so that they guide clients to seek appropriate care, but do not prevent the use of services.

The structure of expenditure of people living at home is different from that of people in long-term institutional care, and life is more economically unpredictable. Ensuring a greater economic margin for people in out-patient care is well motivated, also from the point of view of independent coping and activity.

It is not easy to give national guidelines on the amount of disposable income in out-patient care, particularly if the goal is to specify a definite sum. That would mean that it would be necessary to specify what is a reasonable sum of money to be used on housing, food, clothes and other consumption, which would lead to the same type of procedure as in granting social assistance. In that case, the need for continuous care would have a crucial effect on how people's life conditions are defined. On the other hand, this is also a question of equality. It would be a problem if the amount of disposable income would be significantly different in different parts of the country between people in similar economic and other circumstances.

Table 13. An example of the sickness insurance deductibles and client fees of one client during one care period (figure from 2001), €

	Fees Taxi/ bus	Municipality/health centre or joint municipal board health centre	Hos- pital	Pharmacy	Municipality/ social welfare sector	Sickness insurance reimbursement
Trip to health centre	25.2					16.0
Health centre doctor		20.2				
Pharmacy				42.1		16.8
Trip home	25.2					16.0
Trip to hospital	20.2					10.9
Outpatient clinic			20.18			
Trip home	20.2					10.9
Trip to hospital	20.2					10.9
Ward care (6 days)			139.8*			
Trip to health centre						
Ward care (14 days)		317.9**				
Pharmacy				67.3		29.4
Trip home	25.2					16.0
Home help (14 days)						
Trip to health centre	25.2					16.0
Health centre doctor						
Pharmacy				15.5		21.0
Trip home	25.2					
Home help (14 days)					88.3	
Fees (gross)	186.7	338.1	158.9	159.8	176.6	
Reimbursements	112.7	-	-	67.3	-	
Fees net	74.0	338.1	158.9	92.5	176.6	

Total fees, gross € 1,021 (FIM 6,065)
Reimbursements € 180 (FIM 1,070)
Total net fees € 840 (FIM 4,995)

* no fee charged for day of discharge, because patient transferred to health care centre, and no outpatient clinic fee charged due to immediate admittance

** no basic fee charged due to immediate transfer from hospital

Upper limits for client fees

One way of preventing the accumulation of an unduly high fee burden and of combining various social policy objectives is the use of upper limits in the case of client fees. There are different alternatives of defining the limits: they can be related to the extent (scope) of coverage, exact sums, the income level of the person in question, or they can be either individual or family-fixed.

The present national upper limits for client fees and deductibles do not apply to income-based fees. In addition to actual fixed upper limits, various types of 'lower upper limits' are in use in the municipal social welfare and health care services. In addition to that, there are upper limits of client fees, health care centre fees, successive care periods and short-term institutional care of people under 18. Exceeding the 'lower upper limits' requires separate observation, in addition to which the reaching of the actual upper limit for client fees must be monitored. In the case of health insurance, an annual upper limit is used for travel and medicine expenses. There is also an annual upper limit for rehabilitation travel costs. The health insurance upper limits are personal.

It is felt to be a particular problem with the system of upper limits for client fees that separate upper fees for deductibles do not always ensure a reasonable total burden of costs for the client. The administrative costs of monitoring the upper limits have also been perceived as a problem, especially in the municipal sector.

The committee of client fee policy proposed that an income-based upper limit for the total annual amount of client fees in social welfare and health care services be introduced. When the upper limit is reached, the fees charged would gradually decrease. It was suggested that primarily the kind of service for which a procedure-based flat fee is charged be included in the system. The upper limit could also be applied to families.

The 1996 working group on disability proposed investigating the possibility of introducing a joint upper limit for fees in open care in the social welfare and health care sector, which would include the most common client fees and deductibles, including Kela medicine reimbursements.

Combining the upper limits of medicine costs, travel expenses and municipal client fees seems well motivated from the client's point of view. In practice, the monitoring of fees paid by clients of two actors with different legislative backgrounds, such as the municipal sector and Kela,, in order to reach a common upper fee limit would lead to considerable problems. This is among other things due to the fact that the municipal upper limit of client fees applies partly to families, and that of health insurance to individuals. Another problem that would be hard to solve is who (Kela or the municipality) should cover the expenses exceeding the joint upper limit of fees and deductibles.

Income-based fees and income traps

Client fees are used as a means of income equalising, in addition to taxation and income transfers. The grounds for income taxation, income transfers and client fees have to some extent been developed separately in Finland. This is why their joint effect may lead to distortions, such as income traps (earning more income does not increase the amount of disposable income, because income-based client fees go up) and unemployment traps (accepting work is not economically profitable).

Effective marginal tax rate refers to the proportion of increase of gross income missed out by the household, when taxation, income support benefits and client fees are taken into account. Taxation as well as client fees and income transfers adjusted to gross income lead to high marginal tax rates and income traps in children's daycare and open care of the elderly.

Due to income-based client fees, clients pay very different amounts for the same service. Especially in open care, the use of income-based client fees could be evaluated from the perspective of to what extent their use is appropriate in income equalising.

The committee on client fee policy motivated income-based long-term service with social equality. On the other hand, the problem with income-based fees is their impact on client behaviour and the effects of the implementation of the universal principle and the legitimacy of financing. It is hard to combine progressive taxation and income-based income transfers with income-based client fees without giving rise to income and incentive traps.

When using income-based client fees, the relation of fees to insurance systems must also be taken into account. High client fees may cause particularly people with high incomes to protect themselves from risks by taking voluntary insurance. This may result in the divergence of services according to population groups, as well as demands for lower taxes.

The ability to pay is related to income transfers and taxation. In principle, there are many ways of dismantling income traps, e.g. by changing the grounds for taxation, housing allowance or the client fee system.

The definition of income used in setting client fees affects both the size of the fee and the revenue municipalities get from client fees. Different definitions of income as a basis for client fees make it difficult to compare fees and to assess the burden they constitute for clients. In assessing the client's ability to pay for long-term institutional care, the client's net income is taken into account. In the case of services in the home and in children's daycare the monthly fee is based on the gross monthly income of the family, but so that part of social income transfers do not affect the size of the fee. Municipalities are free to define the income used in setting fees for housing services. Changing the concept of income used as the basis for setting fees has bee proposed as one alternative to prevent the creation of income traps, primarily in connection with services for the elderly.

Differences between fees in out-patient and institutional care

The service structure affects revenue from fees and income transfers, since the client fees and income transfers used in out-patient care and institutional care differ from each other. For example, at present the level of national basic pension falls and the care supplement of pension recipients is discontinued after three months of institutional care. The benefits received by a client and their amount, as well as the services given and the fees charged are all influenced by whether the care received is defined as out-patient or as institutional care. The problem here is that instead of being based on the need of care, the contents and place of care provided for a client may be based on the financing of services, client fees and income transfers. Increasing diversity in service provision has also made it more and more difficult to draw a line between out-patient and institutional care.

The grounds for fees in out-patient and institutional care have differed from each

other, because institutional care always includes room and board in addition to care. There is increasing pressure, at least in the long run, to abolish the distinction between out-patient care and institutional care as the basis of setting fees, in addition to income transfers. In that case, costs of housing, food, care and other services could be used separately as the basis for setting fees, regardless of the type of accommodation.

At the end of 2001, the working group on out-patient and institutional care proposed that pension recipients in long-term institutional care should receive their national basic pension in full, and that they could also be entitled to pensioner´s care allowance.

Client fees and service vouchers

In recent years there has been increasing interest towards models that share the common feature of separating financing and service provision. These models include various applications of the service voucher system. Service vouchers have been used with relative success in children's daycare and in some other forms of social services.

Issues that are important in introducing the service voucher model are the provision and price of services, client's deductible (client fee), ensuring the quality of services and taxation. The service voucher system must also be assessed in relation to the goals of client fee policy and the regulations concerning client fees. With regard to taxation, it should be made clear when service vouchers are considered personal income, and when they are regarded as part of public service provision.

The system of service vouchers has been motivated by increased freedom of choice on the part of clients, promoting increased provision of services based on demand in general. Additional motivation includes raising the effectiveness of services, or giving rise to new services, municipal savings thanks to increased competition, as well as an increase of the price/quality ratio that may be achieved by competition. The use of service vouchers has also been considered to raise the users' awareness of costs, when they choose the service provider and possibly also participate in the financing of the service.

The service voucher model may cause problems of equality among those needing service, especially if the value of the voucher is the same for everyone and the fees charged of users are set freely. The service voucher system can be tailored, so that its effect on income distribution can be regulated. However, administrative costs to municipalities are the higher the more the individual needs of service users are taken into account as a basis of service voucher use.

Other problems with the use of service vouchers include quality assurance and incomplete information. Service vouchers are suited to be used in connection with services in fields where there are real alternatives keeping the price and quality of services on a reasonable level, i.e. there is a possibility for the development of a real market. This way service users can choose between different alternatives, with regard to price and cost of services. It can also be added that vouchers are primarily suited for use in connection with services where the problem of incomplete information regarding the effects, quality and costs of service is as little as possible.

In the case of many social welfare services and most health care services, voucher recipients or their families are not able to assess the quality of care acquired, total costs of care to the client, or the outcome of care. In such cases, the help of the party providing the service is needed for making

the decision concerning the use of the service covered by the voucher. This may for its part lead to an increase in the use of services that is already strongly affected by supply.

The use of service vouchers probably makes it possible for service providers to raise prices, especially if there is no genuine, hard competition. Such competition has been extremely rare so far in social welfare and health care services.

Possible use of service vouchers in health care involves several other aspects. Illness often involves a chain of treatment consisting of various stages both in the hospital and outside it. If a service voucher were given for one part of the treatment chain, it would probably be more of an obstacle to a seamless chain of care. Because Kela reimburses travel costs due to illness, the issue of increased travel costs arising as a result of voucher use would also need to be addressed. Since a significant number of patients get hospital infection during their stay at hospital, and many operations have to be repeated (e.g. hip and varicose vain surgery), there must be clear guidelines for service voucher use in such situations. It may also be added that service vouchers have not been introduced within health care in any European country.

Differences in client fees between municipalities

In addition to differences in municipal taxation, there are also differences in client fees between municipalities, especially in client fees for elderly care services. Different fees are charged for the same service, and people having the same need of service receive very different services with regard to contents and quality.

From the viewpoint of municipalities it is important that regulations on fees give a sufficient possibility to take local conditions and needs into consideration. On the other hand, it must also be monitored and assessed whether the present client policy fee guarantees the basic social right and equality of citizens. It is very likely that in the future thought will be given to whether at least uniform basic service fees should be set for the entire country (or lower and upper limits for fees), or whether municipalities should be given more decision-making power, which would enable them to take local factors into account even more freely than is the case at present.

The equality of citizens and the fact that income security is nationally defined speak for some degree of national regulation of client fees. Uniform fee systems may be easier to coordinate with other social policy systems and taxation. The problem of income traps is also more difficult to solve if there are great differences in the level of fees between municipalities.

Fees based on personal or family income?

The fact that benefits and obligations are individually based is the main guideline of Finnish social policy. Income-based client fees set according to the ability to pay include both personal fees and fees taking into account the income of the entire family. The fees of regular, continuous service in the home as well as children's daycare fees are based on total family income, whereas the fees for long-term institutional care are based on personal income.

In principle, defining the ability to pay according to family or personal income may guide the use of services. If the level of client fee is only affected by the user's own income, the amount of client fees paid by a household depends on who in the family is using the service. The starting point has been that income-based fees

should primarily depend on the ability of the household to cover the fee, since family members have a joint economy and responsibility to look after each other. Furthermore, taking only the clients' own income into consideration does not always give the correct picture of their actual ability to pay.

People may consider that the present system is unfair primarily in cases when they feel that not all family members benefit from the service received. Another problem involves situations where family members look after a family member in need of care more than is customary, in which case a reduction of client fees may well motivated, in addition to possible granting of pensioners' care allowance and informal care allowance. Problems may also arise for the spouse staying at home and the family when the spouse with the larger income is placed in long-term institutional care. Defining the client fee for institutional care on the basis of combined income of both spouses has been suggested as a possible solution for this problem.

The present upper limits for deductibles and client fees are personal. However, the fees of children under 18 are taken into account together with the fees of their parents or providers.

Housing services for the disabled

Housing services for the disabled can be provided on the basis of the Social Welfare Act, the Services and Assistance for the Disabled Act and the Act on Special Care of the Mentally Handicapped. The fees charged from the client differ according to which Act the client receives the services. Problems with client fees are related to ambiguities concerning the relationship between different acts. Several working groups have proposed that the relationship between the acts should be defined more precisely.

According to the Act on Client Fees, housing services provided as a form of special care in accordance with the Act on Special Care of the Mentally Handicapped as well as special services related to service accommodation in accordance with the Services and Assistance for the Disabled Act are free of charge, unless the person receives compensation for this purpose on the basis of some other Act. People in need of service accommodation pay rent in the normal manner, i.e. only housing-related services are free of charge.

There has been some uncertainty as to what the special housing services are that are free of charge in service housing for the severely disabled. Another thing causing problems has been uncertainty as to when a person with a mental handicap is entitled to housing services free of charge as a special form of care. The Act on Special Care of the Mentally Handicapped does not define severe disability as a condition for receiving special care, as does the Services and Assistance for the Disabled Act. It is also a problem in some municipalities that service housing for the severely disabled has been arranged on the basis of the Social Welfare Act, with the motivation that this Act is the primary one to be applied. In such cases the economic status of the severely disabled person may be weakened, since fees may be charged for service accommodation and home help arranged in accordance with the Social Welfare Act.

The question of level of fees for common services for different groups in society and the level of fees for special services for special groups is one of the issues that need to be solved in client fee policy. To what extent the disabled and people with long-term illnesses should have a special status in legislation concerning services, fees,

income transfers and taxation and what sort of deductible can be required of them are all part of the same question. It should be considered as a general starting point that the economic situation of the severely disabled should not be weakened by the Act according to which their services are provided.

The fees of new service forms

There are increasing forms of service for older people and the disabled where the fees are not subject to separate regulation. In such cases the only limit to fees is the production cost: the fee may only be as high as the cost of producing the service. At the present moment, the most commonly arising need to regulate costs occurs in connection with fees related to informal care allowance and service accommodation.

A liberal client fee policy may encourage municipalities to develop new forms of service, which may in general be seen as a positive phenomenon. Problems may however arise if unregulated client fees lead to a distortion of the service structure, great inequality between clients and unreasonably high costs. Another basic alternative is to allow the levying of fees only when legislation on client fees includes guidelines for doing so. This principle was applied until the early 1990s. This might however lead to reduced interest towards developing new types of service.

Taking private assets into account

In 1990s committees and working groups presented differing views on whether personal assets should be taken into account in setting client fees. The position adopted towards private assets can be seen as significant, both in principle and as an increasingly important issue, as the level of affluence increases among the population. Private assets do not affect client fees, with the exception of capital income. When considering the impact of private assets, a broader perspective is needed as to what would be the drawbacks (e.g. for the legitimacy of social protection or the fairness/differentiation of the service system) and possible advantages (e.g. improving the national efficacy of capital utilisation and fortifying the financial basis of services) of taking private assets into consideration in setting client fees.

There are an increasing number of cases where client's private assets are also taken into account when decisions concerning services are made, most of them involving older people with private assets who are guided to use private services. Municipalities have also in some cases began to cover part of the expenses of private services out of social assistance funds, because this is a better alternative economically for the municipality than the provision of public service. Clients may also be obliged to cover part of the fees with their savings or by realising some of their assets.

Excluding clients from service because of their assets is not compatible with the present regulations and the implementation of the universal principle of care. Furthermore, taking assets into consideration in setting client fees is difficult to arrange from the administrative point of view. In future, it is possible to take assets more extensively into account by tightened property taxation, instead of using them as basis for client fees.

3.3.5 Summary

The objectives of social welfare and health care client fee policy should be made clearer. In making decisions on client fee systems it is important to assess alternative client fee policy guidelines with regard to the goals of social and health care policy (e.g. the reduction of differences in health,

the primary nature of out-patient care, increased job offers to clients), other social policy systems and the total costs and financing of services. Unsuccessful client fee policy solutions may increase total expenditure on the part of the society as a whole.

Client fees and deductibles always have an impact on the distribution of income and wealth. The size of the impact of fee increases varies according to the client fee type, and on how service use (health and functional ability) and taxable income are distributed among the population.

Client fees are ultimately related to the role of individual and joint responsibility in different risk situations. Client fee policy can be used to change the economic risk distribution related to illness, reduced functional capacity and other service need situations.

Other important issues include the impact on the demand for individual services on the one hand, and on total demand and provision of services and their structure in the public and private commercial as well as non-commercial sector (organisations, family care) on the other.

The future role and significance of client fees in social and health care services should be regarded sector by sector. For instance, clients have very limited sovereignty in decision-making related to service use in many sectors of social welfare and health care services, such as care of the mentally handicapped, mental health services and specialised medical care. There are also differences in the need of services between clients, ranging from very short-term to even permanent need.

It is also important to look at service financing as a whole. Changing the status of one form of financing affects the status of others. What is the appropriate relation between tax revenue, insurance (mandatory and law-based or voluntary) and client fees in service financing, how does changing priorisation of client fees and tax-based financing of services in particular affect the status of different population groups and municipalities, who gains and who loses when different client fee alternatives are applied - these are all key issues that need to be addressed. When setting client fees for public services, their relation to insurance systems also needs to be looked at. High fees may increase the willingness to take private insurance as a means of protection against risks.

The incomes of households are at present equalised by taxation, income transfers and client fees. Using client fees as a means of income equalising may be well motivated, but there are also risks involved. Since it is very likely that the dismantling of income traps needs to be investigated in the future as well, there should be a consensus as to how extensively client fees should be used as a means of income equalising.

Even if client fees as a source of financing services were kept more or less at their present level, some thought might be given to whether the share of flat fees and income-based fees should remain at its present level, whether the share of flat fees should be increased, whether upper limits for different fees should be combined, and how fees can be incorporated in the overall development of income protection benefits.

In order for the fee practices used to fulfil the financing and guiding objectives set for client fees, clarity and transparency of the fee systems are one condition that needs to be met.

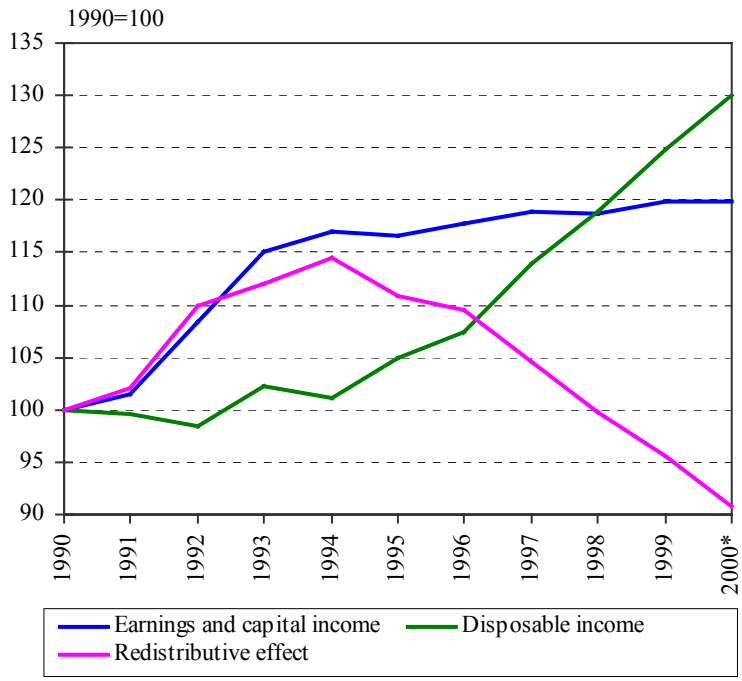
4 Income distribution

Rapid increase in income differentials

Income differentials between households have grown rapidly since the mid-1990s. Behind this trend is an increase in capital income. Especially the top tenth has increased its income share. The equalising effect of income transfers and taxation has weakened since the mid-1990s (Figure 66).

The weakening of the income-equalising effect of income transfers is partly a result of improved employment. As employment returns closer to pre-recession levels, the income formation of households is once again based more on earned income. In this respect, the weakened redistributive effect of income transfers compensating for lack of earned income is consistent. At present, high levels of capital income contribute to increased income differentials, which is why the significance of income transfers as equaliser of income differentials has weakened. In addition, the level of some benefits is lagging behind the general income trend.

Figure 66. Trends in income differentials and redistributive effect of income transfers 1990-2000



Income differentials: Gini coefficient, the higher the figure, the greater the income differentials, 1990=100. Income/OECD consumption unit.

Redistributive effect (Kakwani): reduction of income differentials by income transfers received and paid (taxes), 1990=100.

Uneven income trend

The brisk economic growth during the last few years has not been equally reflected in the income of all households. The income trend has been most favourable in the upper income brackets, with an annual rise by almost 8 % in the real disposable income of the top tenth between 1995-1999. In the lowest tenth, real income growth remained below an average of 1% per annum in the same period. According to preliminary data, this trend continued in 2000. The greatest increase in income (6.6%) was seen in the top tenth, while that of the lowest tenth was the smallest (0.4%).

Table 14. Changes in the ratio of different percentile points of income distribution 1990-1999

	P90/P10	P80/P20	P60/P40	P50/P10	P90/P50	P95/P50	P95/P10
1990	2.48	1.79	1.19	1.56	1.59	1.82	2.84
1991	2.43	1.78	1.19	1.55	1.57	1.81	2.81
1992	2.35	1.75	1.20	1.51	1.55	1.81	2.74
1993	2.39	1.75	1.19	1.50	1.59	1.87	2.80
1994	2.44	1.78	1.19	1.51	1.62	1.89	2.84
1995	2.49	1.79	1.19	1.52	1.64	1.90	2.90
1996	2.58	1.84	1.21	1.57	1.64	1.92	3.01
1997	2.67	1.89	1.22	1.61	1.66	1.99	3.21
1998	2.73	1.93	1.23	1.63	1.68	2.01	3.26
1999	2.72	1.91	1.22	1.62	1.68	2.02	3.28
Change 1990-1999, %	10.0	6.9	2.6	4.0	5.7	11.1	15.6

By using income ratios of percentile points, problems due to large extreme values in the calculation of income distribution measures based on a sample data can be partly avoided. An increase in the number of large capital gains and income from options in the late 1990s has made it more difficult to interpret the changes in the income distribution. Various measures of variability are used in an attempt to compress information on income distribution into a single figure. This means that a lot of information on income distribution is lost. The focus of interest might be e.g. the trend in income differentials between people on middle income and low income, of which the distribution figure does not necessarily reveal much. The aim may not be to compare the income trend of low-income earners to the income trend of the relatively few people with a high income, but to the changes in the level of income of the majority of population. One way of doing this is to calculate relations between different points of the income distribution scale. Median income (P50), which is the level of income that half of the population are below, can be compared to the level of income (percentile point) under which the lowest decile (tenth) of income earners is found. In 1999, the median disposable income of households was 1.62 times the income limit under which the lowest decile

was found. In 1990 the corresponding figure was 1.56, indicating that the income differential between low-income and middle-income earners had increased somewhat. In a similar manner, the income level (P90) under which 90% of households are found can be compared to the median income (P90/P50). The income differential between people with relatively high incomes and people with middle incomes also increased in the 1990s. The trend in income relations reveals that the increase in income is concentrated at the top of the scale. The relation of the 95 per cent point to median income (P95/P50) or the 10 per cent point (P95/P10) has increased significantly more that the relation of the 90 per cent point to these income limits (P90/P50 and P90/P10).

Capital income increases income differential

The growing income differentials in the late 1990s were largely due to an increase in capital income and the fact that such income focused mainly on high-income households. The changes in other sources of income were less pronounced. Income transfers (excluding employment pensions) were slightly less effective in reducing income differences. This was due to the fact that income transfers accounted for a lower percentage of income than during the recession. This was partly offset by income transfers being focused more than before on low-income households. When interpreting the results, interdependency between income categories should also be borne in mind. For instance, the increase in capital income in the upper income brackets also increased the amount of taxes paid on them, which changes the redistributive effect of taxation (Table 15).

Table 15. Decomposition of Gini coefficient of disposable income by income source in 1994-1999

	Income from wages and salaries	Entrepreneurial income	Capital income (excluding imputed rents	Imputed rents of owner-occupied dwellings	Employ-ment pensions	Income transfers received (excluding employment pensions)	Direct taxes and social insurance contributions	**Total = Gini coefficient %**
1994	26.2	3.9	2.9	1.9	4.1	-4.3	-13.9	**20.9**
1995	25.8	4.1	3.5	2.0	4.5	-3.8	-14.4	**21.6**
1996	27.4	3.1	4.1	2.0	4.4	-3.8	-15.0	**22.2**
1997	27.3	3.7	5.1	2.1	3.9	-3.8	-14.9	**23.5**
1998	27.7	3.8	6.1	2.2	3.5	-3.5	-15.2	**24.5**
1999	27.8	3.5	8.1	2.2	2.9	-3.3	-15.5	**25.7**
Change 1994–1999, percentage points	1.7	-0.5	5.3	0.3	-1.2	1.0	-1.6	**4.9**

Due to rounding, the change may not correspond exactly to the difference calculated from the table.

Income from dividends, capital gains and other forms of capital income are extremely sensitive to changes in economic fluctuations. Their increased significance may also increase the sensitivity of income distribution to economic fluctuations. Slower economic growth may reduce capital income of households rapidly, which would also reduce income differences. An economic slowdown can of course have other effects which may increase income differences. Weakened employment is one such factor. However, the connection between employment and income differences is not as clear as it is sometimes made out to be. The impact on income differences of changes in employment also depends on how the changes are focused. If a person who is long-term unemployed, living alone, and receiving labour market support finds employment, the impact on income distribution differs from that in a situation where a short-term unemployed person receiving earnings-related unemployment allowance, living in a family where other members are employed full-time, gets a job. Correspondingly, the direct effects on income distribution of a rise in unemployment are partly dependent on what groups are most affected by the rise in unemployment.

Great differences between aims and distribution of income transfers

Income equalisation between low and high-income individuals or households is often seen as the main goal of income transfers. In addition to this, income transfers equalise the income differences between different family types. However, a primary objective of income transfers is also to equalise the income of individuals during their lifetime, in which case the purpose is to compensate for loss of income due to various risk factors. The level of benefits and the size of insurance contributions are in such cases more or less dependent on each other. In recent years, this dependency between insurance contributions and benefits has been emphasised. In practice, the varying goals of different income transfers may well be merged in the same benefit. Due to the varying aims of income transfers there are also great differences in how they are distributed across different income brackets (Table 16).

Table 16. Distribution of certain income transfers by income quintiles in 1999, % of benefit expenditure

	I	II	III	IV	V	Sum total
National basic pensions and their supplements (excluding housing allowance)	31.1	32.8	18.7	9.2	8.1	100.0
Widow's/widowers' pensions (excluding housing allowance)	34.0	7.8	15.5	26.8	15.9	100.0
Children's pensions	22.4	12.8	24.5	28.2	12.0	100.0
Housing allowance to pensions recipients	40.3	44.9	8.5	2.3	4.0	100.0
Sickness allowances to the insured	17.8	17.5	16.6	27.3	20.8	100.0
Parenthood allowance to the insured	22.4	23.3	25.5	17.4	11.4	100.0
Total employment pensions	7.4	21.3	22.5	22.0	26.8	100.0
Employment pensions: old-age pensions	6.9	21.1	22.6	21.2	28.3	100.0
Employment pensions: disability pensions	8.9	21.1	24.2	23.7	22.0	100.0
Employment pensions: unemployment pensions	5.6	16.4	20.1	30.4	27.4	100.0
Employment pensions: survivors' pensions	8.1	23.6	19.9	19.8	28.6	100.0
Total unemployment allowances	35.8	21.7	19.7	13.8	9.0	100.0
Earnings-related unemployment allowance	19.0	23.5	25.5	18.8	13.2	100.0
Labour market support and basic unemployment allowance	64.7	18.5	9.8	5.2	1.7	100.0
Child allowances	27.5	24.2	20.9	17.2	10.2	100.0
Young children's home-care and private day care allowances	49.3	21.4	14.8	10.0	4.6	100.0
Study grant (including housing supplement, Social Insurance Institution)	50.3	21.7	14.8	8.2	5.0	100.0
Social assistance	59.0	21.5	11.5	5.3	2.6	100.0
General housing allowance	70.7	19.5	6.6	2.5	0.7	100.0
Total income transfers received	19.7	22.1	20.1	17.9	20.2	100.0
Income transfers paid	4.9	9.5	15.2	22.6	47.9	100.0
Disposable income	10.3	14.3	17.5	21.7	36.2	100.0

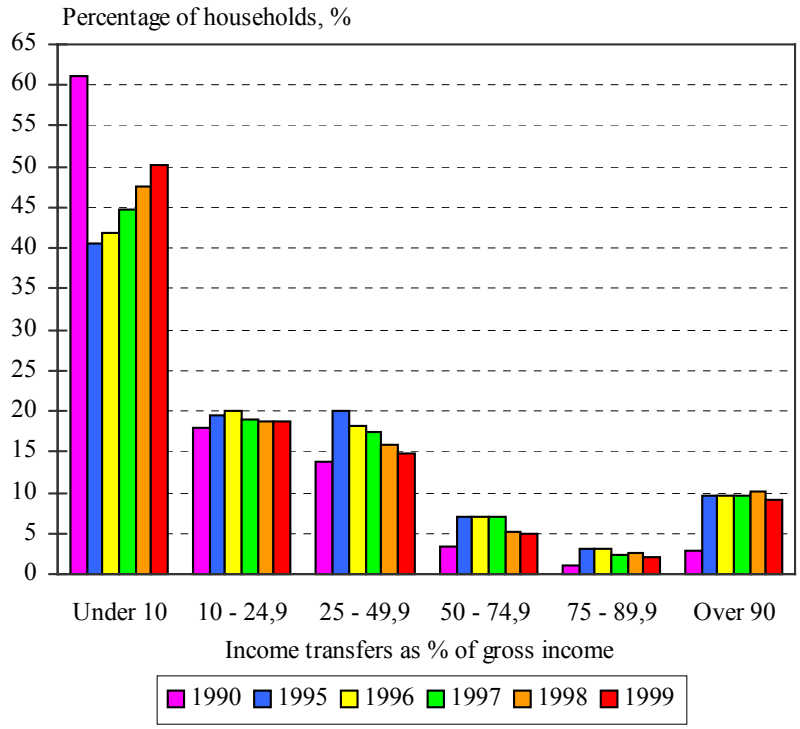
The recipients of income-tested benefits are usually on low income during the time they receive the benefit. If the average time during which benefit is received is short, a significant proportion of the total amount of benefits may be received by middle-income households on an annual level. Whether the income of a possible spouse or other household members is taken into account in incometest is also of importance in the distribution of income-tested benefits. In addition, part of the income can be excluded from the incometest. For instance, the level of national basic pension is primarily affected only by the size of the pension recipient's own employment pension. Similarly, the social assistance of 18-year-olds living at home with their parents is only dependent on their own income and the expenses used as the basis for social assistance.

Table 16 shows how income transfers are distributed when households are ordered by their disposable income. This means that these benefits are already included in the households' disposable income. In addition, the income distribution effects of other benefits and direct taxation are also included. The table can primarily be seen as reflecting how minor adjustments in benefit level focus on different income brackets. The results shown in the table are also fairly sensitive to the way in which the incomes of different household types are compared (equivalence scale), since it affects the position of different household types within the distribution of income.

Continued high dependence on income transfers

Households' dependence on income transfers increased in the early 1990s. The income formation of an increasing number of working-age households was based on various income transfers. Towards the end of the 1990s, the reliance on income transfers fell as the employment situation improved. Despite this positive trend the number of long-term unemployed remains high. The number of households in the best working age that are almost totally dependent on income transfers is still on nearly the same level as during the recession years (Figure 67). The majority of working-age households dependent on income transfers are single-parent families or people living alone. Most of them are unemployed or pension recipients.

Figure 67. Income transfers as a percentage of gross income in households where the reference person is aged 25-54

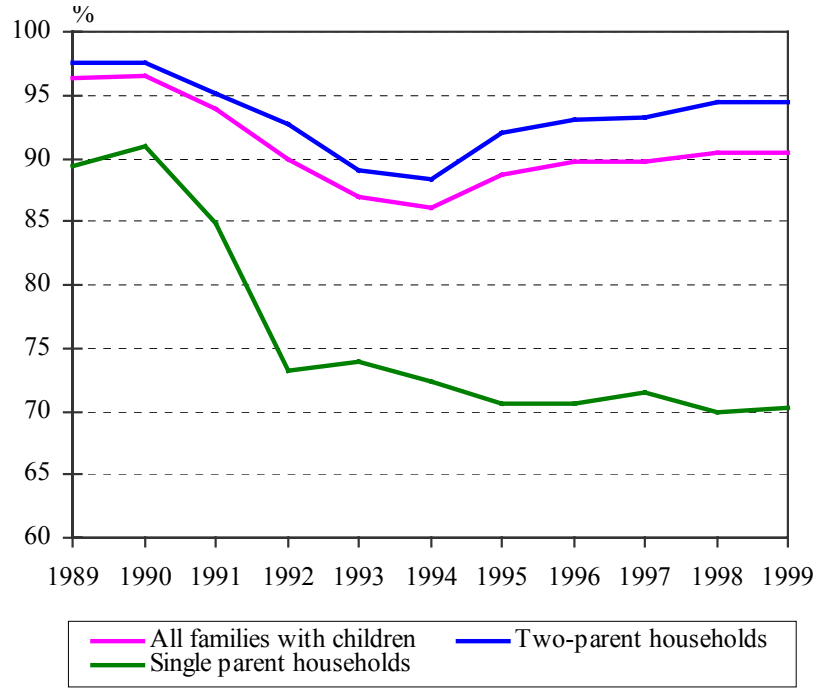


Income transfers received as % of gross cash income. Income transfers also include transfers between households. The reference person is generally the member of the household with the highest income.

There is growing concern in some European Union Member States over the situation of children growing up in families with weak links to working life on the part of the parents. This may even mean that the children are living in actual poverty. Besides causing problems at the present moment, this also weakens the future prospects of the children. Traditionally the poverty rate among children has been low in Finland by international comparison. This is partly due to the good employment situation of families with children. In the early 1990s, the employment situation of single-parent households in particular was still exceptionally good by international standards. Results of studies on childhood poverty have also shown results supporting this view. Compared to many other countries, a relatively large percentage of the income of even low-income families with children in the Nordic countries consists of earned income.

During the recession, the employment situation of families with children deteriorated. There were a growing number of children in families with neither parent at work. Towards the end of the 1990s the employment situation of families with children improved once more, but this was mainly true of families with two providers. The brisk economic growth in the latter half of 1990s did not generate similar improvement in the employment situation of single parents. (Figure 68).

Figure 68. Employment situation of families with children: proportion of children with at least one family member at work



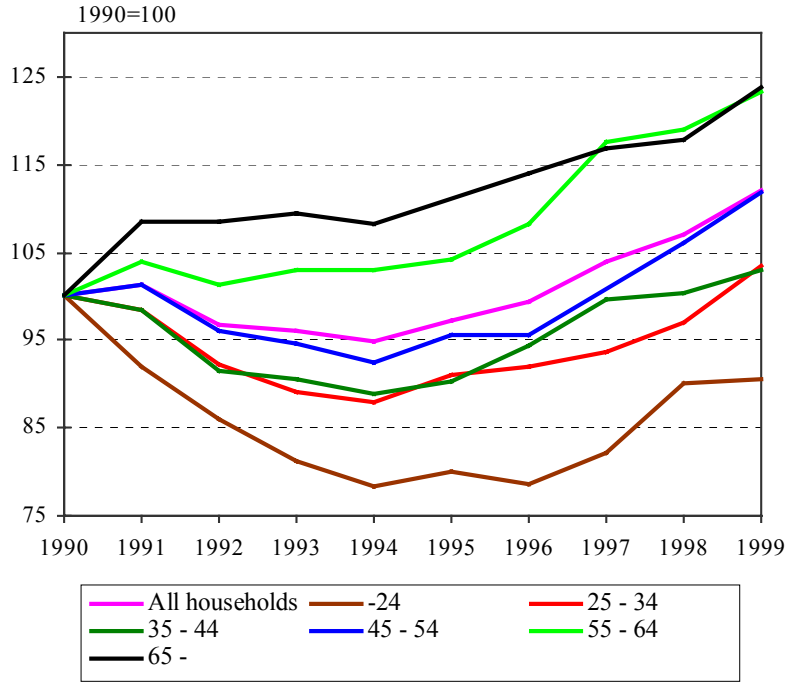
At work: Persons working as employees or entrepreneurs for a minimum of six months during the year

Income trends in different age groups

The steep economic fluctuations have been reflected in different ways in the income trends of different age groups. In the early years of the 1990s, the economic position of young people in particular was weakened. Older age groups were less affected by the recession than people of working age. The income trends of different age groups have subsequently been more even. At the end of the 1990s, the incomes of elderly households increased less than those of people of working age (Figure 70). In this sense, the trend is similar to that of the years of fast economic growth in the 1980s; the income growth of the older age groups was weaker than that of other age groups at that time, too.

When studying trends in average income by age group, as in Figure 69, the income of elderly households is increased by the retirement of new age groups with higher employment pensions. The change in the level of income does not reflect the average income trend of elderly households who were included in the group at the beginning of the period of observation.

Figure 69. Trends in average real incomes of households by age group, 1990-1999



Real disposable income, 1990=100. The figure examines only changes in income, with the index illustrating each age group's average income set at 100 in 1990. Thus, differentials in income levels between the various age groups do not come out.

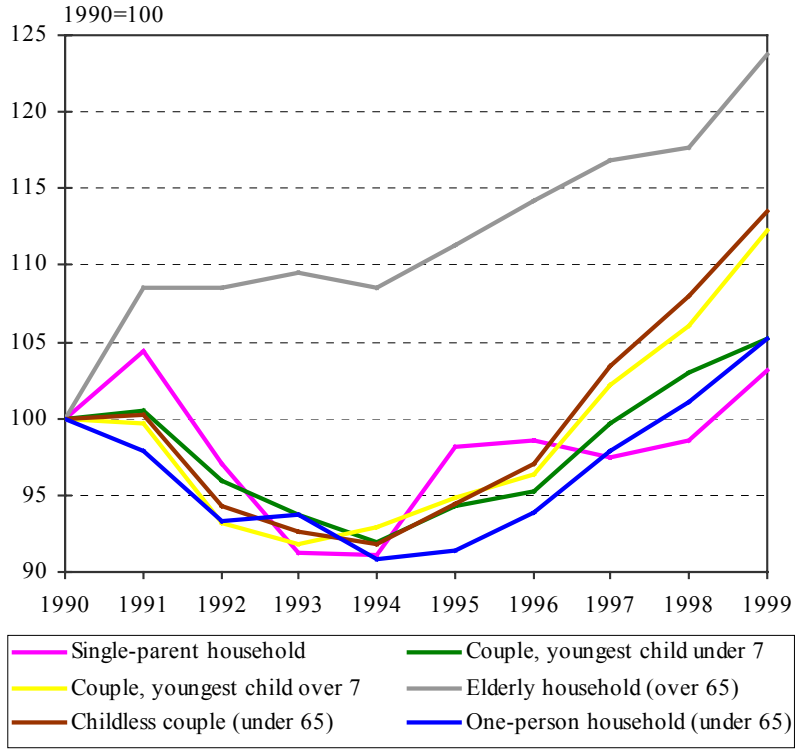
Increased income differences within family types

During the recession years of the early 1990s the real income of working age population fell in all family types of working age. Only after the mid-1990s did the income levels start nearing the pre-recession levels (Figure 70).

For a long time the income trend of single parents remained modest. According to 1999 data, a turn for the better seems to have taken place also in the incomes of single parents. The weak income trend of single-parent households in the 1990s is not just a Finnish phenomenon. A similar trend has also been observed in Sweden, where the poorer employment situation of single parents compared to others seems to be the factor behind this trend, just like in Finland.

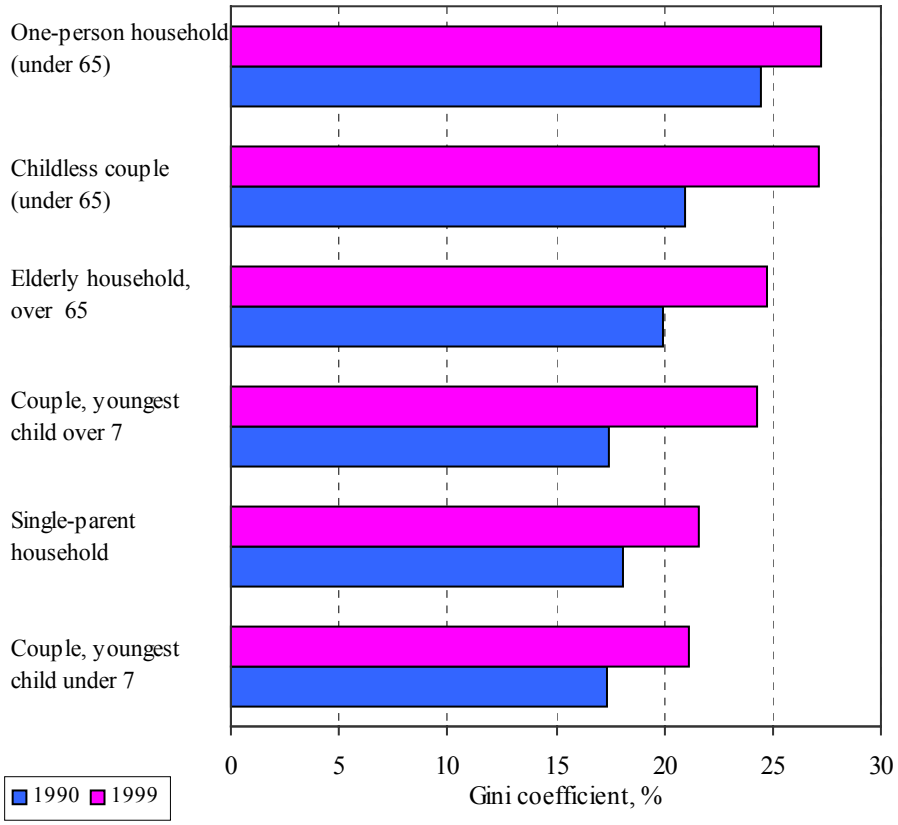
The increase in income differentials in the late 1990s was caused by increases both within family types and between family types. Within group differentials increased in all family types.

Figure 70. Trend in real incomes of households of working age in different household types, 1990-1999



Real disposable income, 1900=100. NB: Random variation in the sample data may result in overestimation of annual income changes, especially in categories with relatively small sample sizes (e.g. single parents).

Figure 71. Income differentials within family types in 1990 and 1999



Relative poverty on the rise again?

In income distribution comparisons, relative poverty is often defined as a situation in which a household's disposable income is less than half of the median income for all households. Such comparison endeavours to take into account differences in household size and family type. In 2000, about 200,000 people, or 4% of the population, belonged to households whose income level was below the relative poverty line according to this definition.

There was a clear increase in relative poverty in the mid-1990s. The increased incomes of people at work and the improved employment situation raised the average income of households and also the relative poverty line. At the same time, a number of benefits important to people with low incomes were either cut, or the index increases attached to them were omitted. Due to strong economic fluctuations, the use of the relative poverty line in describing economic trends in the 1990s is problematic. At one time, the relative poverty line fell sharply, which explains the drop in relative poverty seen at the beginning of the 1990s. A different picture emerges of the development in the 1990s if the 1990 poverty line is used. Based on a fixed poverty line, the poverty rate showed a clear upward trend during the recession, after which the rise was halted.

By the end of the decade the rise in relative poverty finally seemed to have levelled off, although the positive income trend of households still raised the poverty line. According to preliminary data from 2000,

the poverty rate has again taken an upward turn. This is mainly due to the raise in the poverty line attached to median household incomes.

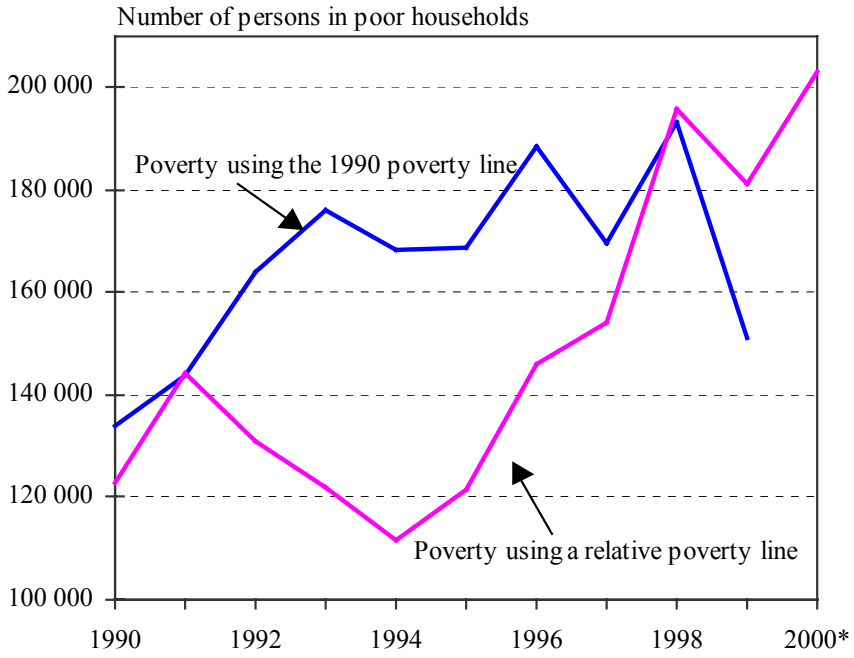
The budget proposal for 2002 included several reforms improving the position of low-income households. Even before this, the level of national basic pensions was raised in the summer of 2001. As of the beginning of 2002, granting new child increases to pension recipients was begun. Child increases can be granted to national basic pension or employment pension recipients for each child under 16, either the recipient's own or that of spouse. The level of sickness allowance and rehabilitation allowance of low-income groups will be raised as of April 1, 2002. The reforms improve the income security during illness of the unemployed about to get employment, students, people undergoing rehabilitation and people on low income or no income by offering more extensive coverage.

A raise in the level of labour market support and basic unemployment allowance entered into force as of the beginning of March 2002. The raise also affects the size of the earnings-related allowance. In addition, the income-based portion of the earnings-related unemployment allowance was raised from 42% to 45% of the difference between daily salary and basic allowance. The child increase of the labour market support was increased as of the beginning of 2002 to the same level as in the case of earnings-related and basic unemployment allowance. The increments also raise the levels of some other benefits (education supplement, education allowance, job alternation leave compensation).

The criteria for defining general housing allowance changed at the beginning of 2002. The maximum housing costs qualifying for housing subsidies were raised, so that housing allowance cover real housing costs better than before. As of the beginning of April 2002 part of the earnings of social assistance recipients are excluded from the income test. This is a three-year experiment, during which the effect of the change on the employment and amount of support of recipients is monitored.

The combined effect of reforms is weakened by links between different benefits and taxation. A raise in the level of unemployment allowance may in time reduce the housing allowance received by the household. Part of the increase of unemployment allowance is lost in taxes, especially since many municipalities raised their local tax rates for 2002. The position of those households in particular that are receiving social assistance even after the reforms enter into effect is not affected much by the improvement of the benefits. The structure of their income will undergo slight changes, but their level income is still based on social assistance.

Figure 72. Poverty using a fixed and relative poverty line, 1990-2000

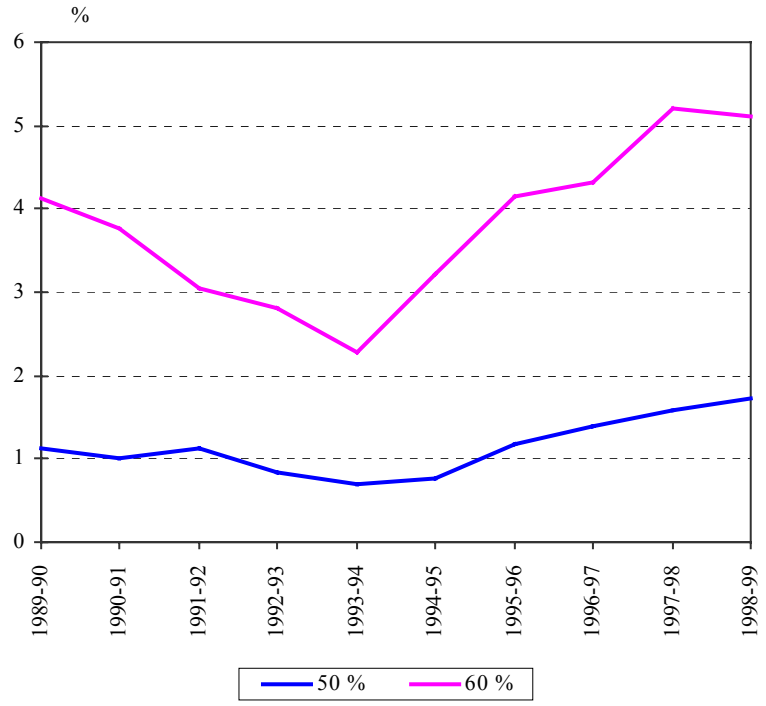


Income definition: Disposable income/OECD consumption units. Preliminary data for 2000, Statistics Finland.
The figures based on a relative and a fixed 1990 poverty line are different for 1990, as an adjustment was made to the 1990-1993 figures due to a revised definition of ”income”.

Estimations on the prevalence of poverty are largely dependent on what kind of income limits, income definitions or other definitions are used. For example, Eurostat, the statistics bureau of the European Union often uses 60% instead of 50% of median income as poverty line. Raising poverty line to 60% of median income increases relative poverty from 3.6% to 9% in 1999. According to this definition, a total of 460,000 people live in households below the poverty line. The consumption unit scales used in comparing households of different sizes also have an impact on the poverty rate of different family types. The Eurostat practice differs from the one commonly used in Finland, i.e. the ”old OECD” scale (see Table 17).

The effects of being on low income year after year are even more negative than those of being on low income for a limited time. Partly due to deficiencies related to statistical data, few poverty studies covering several years have been carried out in Finland. Short-term studies can be made by using the two-year panel approach of the income distribution chart. The result based on two-year panel material of the trend in poverty resembles that based on annual comparison The proportion of population living under the poverty line for two successive years remained almost unchanged in the early 1990s, but there was an upward turn in the latter part of the decade.

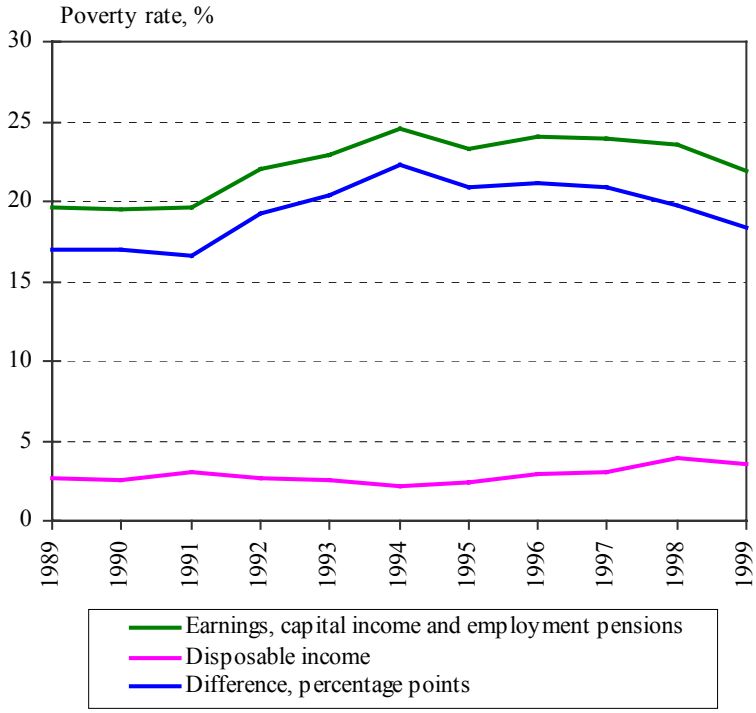
Figure 73. Share of population who were under the poverty line during both years, %



For the latter year, the poverty line of the previous year has been used adjusted by change in consumer prices.

The poverty-preventing impact of income transfers can be illustrated by comparing the poverty rate based on disposable income to that based on earned and capital income. In addition to earned and capital income, employment pensions are often included, because they are based on the level of earnings before retirement as well as career length. Since the income of e.g. the long-term unemployed and households only receiving a low employment pension is very low, the poverty rate is clearly higher than that based on disposable income only. The poverty rate is additionally increased by the rise in median income, since the taxes paid by households have not been taken into account as an income-reducing factor. The rise in median income raises the poverty line. On the other hand, low-income households pay relatively little in taxes, so their income is increased less by the exclusion of taxes. There was a sharp rise in the poverty-reducing effect of income transfers during the years of recession, but the effect has returned closer to pre-recession levels, e.g. due to the improved employment situation.

Figure 74. Poverty rate using different definitions of income 1989-1999



In the latter part of the 1990s the relative poverty of single-parent households increased in particular (Table 17). Income transfers play a significant role in the income formation of single parents. The trends in income transfers with relation to general income trends have thus a great impact on the poverty level. On the other hand, the employment situation of single parents has improved less than that of other family types.

The high poverty rate of single parents is partly also due to compilation of statistics. Most data on income transfers used for income distribution statistics come from various administrative registers. As an exception, data on both maintenance support and the maintenance allowance paid by municipalities are gathered by interviewing households. At least the amount of municipal maintenance allowances seems to be clearly underestimated in the interview data. If the municipal maintenance allowances reported in interviews with single-parent households are replaced with a maintenance allowances calculated by a model reflecting the structure of the household at the end of the year, the poverty rate of single-parent households is about half of that reported above. This model assumes that all those entitled to municipal maintenance supplement have in fact applied for it. There is also another factor that weakens the value of statistics. Households are classified and their consumption needs (consumption units) are defined according to family structure at the end of the year. Particularly in the case of single-parent households, family structure is reflected in the amount of income transfers received during the year. The structure of the household may however have changed during the year, in which case the maintenance support, maintenance supplements and child allowances received during the year do not necessarily correspond to family structure as defined at the end of the year. The household may only have received maintenance support, maintenance

allowance and the higher child allowance of single parent-families during part of the year.

The poverty rate of men and women living on their own shows differing variation according to age. Women under 30 living alone have a higher poverty rate than men of the same age living alone. This is mainly due to the fact that a greater proportion of women living on their own are students, and the incomes of female students are smaller than that of male students. When looking at older age groups, a different picture emerges. The poverty rate of men between 30-64 is higher than that of women. This is caused by the higher numbers of long-term unemployed men. In addition, a greater proportion of unemployed women living of their own are covered by the earnings-related unemployment allowance.

Table 17. Relative poverty rate in different household types in 1994 and 1999, %
Poverty line: 50% of the median income of that year

	OECD consumption units			Eurostat consumption units		
	1994	1999	Change, percentage point	1994	1999	Change, percentage point
Single-parent households	2.8	8.7	5.9	3.4	9.9	6.5
Couple, youngest child under 7	2.3	3.8	1.5	1.5	1.7	0.2
Couple, youngest child over 7	1.3	2.7	1.4	1.1	2.4	1.3
Elderly household (over 65)	0.4	1.0	0.7	1.1	2.3	1.2
Childless couple (under 30)	6.7	6.5	-0.2	7.9	8.5	0.6
Childless couple (30-64))	1.2	1.6	0.4	1.4	1.6	0.1
One-person household (under 30)	15.7	18.0	2.4	25.0	25.8	0.8
- of which, men	11.5	12.1	0.6	18.8	19.3	0.5
- of which, women	20.8	23.4	2.6	32.8	31.7	-0.9
One-person household (30-64)	3.6	3.8	0.2	7.2	8.9	1.7
- of which, men	5.5	5.5	0.0	11.3	11.6	0.3
- of which, women	1.5	1.8	0.3	2.6	5.7	3.1
Other households	0.7	2.4	1.7	0.5	2.2	1.7
All households	2.2	3.6	1.3	2.7	4.1	1.3

Percentage of people below poverty line in each household type.
Due to rounding, the difference in the rate of poverty in 1994 and 1999 does not necessarily correspond to the indicated change.
Definition of income: Disposable income of household/consumption unit
Consumption units:
Eurostat: Consumption unit scale used in the Eurostat ECHP survey
OECD: the 'old' OECD consumption unit scale used by Statistics Finland

The majority, or about 70%, of the population living below the poverty line belong to households with no members at work. As expected, the largest groups are made up of unemployed and students, both of which groups included about a fourth of the people below poverty line in 1999. In many studies, student households are excluded, since the low income of students is seen as an often temporary feature linked

to a certain period of life. Study loans are also not taken into account as income. If they were taken into account, the share of student households among all households below the poverty line would fall by about 5 percentage points. The largest economically active group consists of entrepreneurs, most of them self-employed persons without paid employees. There is some scepticism towards the results on poverty among entrepreneur households. Strong fluctuation of annual income is typical for entrepreneurs, which means that some years may be almost without any income at all. There are also particular problems related to the definition of income among entrepreneurs.

It was stated above that raising the poverty level to 60% of median income increases relative poverty 2.5-fold compared to the 50% limit. The raise also changes the structure of poverty. The proportion of households with wage and salary earners and pension recipients increases, while that of students and entrepreneurs decreases.

Table 18. Distribution of population below poverty line according to socio-economic position of household reference person in 1999, %

	Poverty line, % of median income	
	50 %	60 %
Unemployed	27.7	26.6
Students	25.3	15.8
Entrepreneurs and self-employed persons	13.8	9.5
Pensioners	9.0	13.6
Others	8.7	8.5
Workers	5.7	13.4
Farmers	5.0	4.2
Other employees	4.5	6.2
Upper-level employees	0.3	2.2
Total	100.0	100.0

The reference person is usually the member of the household with the highest income.

Housing costs, poverty and economic problems

Variation in housing costs makes it difficult to interpret poverty indicators, and may give rise to ambiguous situations, e.g. when comparing different regions. A low-income household may be entitled to housing allowance and supplementary social assistance due to high housing costs. As a result, the income of the household exceeds the poverty line. The housing costs of another low-income household may be significantly lower, so that the level of housing subsidy and social assistance is also low, or they are not granted at all. This way the income of that household may fall below the poverty line.[8] Since housing allowance and social assistance only cover part of the housing costs, the net income of the ”poor” household is higher after housing costs than that of the household above the poverty line with high housing costs.

If relative poverty is calculated on the basis of net income after housing costs, there is a considerable increase in the poverty rate.

[8] The situation of those living in owner-occupied dwellings is adjusted by the accumulation of imputed housing income, which increases the incomes of these households.

Especially the poverty rate of families with children and single-parent households becomes high (Table 19). Taking into account partial payments of housing loans would increase the poverty rate of two-parent families with children even more.

Annual housing costs have been estimated according to the situation at the end of the year. This practice is not applicable in situations where the family has moved during the year due to a change in family structure. For instance, a young person moving away from home at the end of the year after finding a job is easily classified as being on low income. The method overestimates slightly the proportion of people with low incomes among young people living alone and single parents. Furthermore, the automatic deduction of housing costs from income may put too much emphasis on the economic problems of families with children and large households. It has been assumed in comparing the incomes of households of different sizes that the consumption needs after housing costs increase at the same rate as in an assessment in which housing costs have not been deducted from income. This may not necessarily be true, and a slightly different equivalence scale might well be applied in comparing the incomes of households of different size.

Taking housing costs into account also changes the relative status between regions. According to the traditional definition of income, poverty rate is highest in rural municipalities and lowest in the metropolitan Helsinki area. When measured by net income after housing costs have been deducted, the poverty rate increases in all regions, rural municipalities showing the lowest poverty rate.

The difficulty of interpreting poverty assessment is illustrated by the fact that when interviewed, the majority of the households classified as having a low income after deduction of housing costs did not report any recurring problems in paying bills or partial payment of loans. For instance, almost a third of two-parent families with the youngest child under 7 were below the poverty line, when the assessment was based on disposable income after the deduction of housing costs. The majority of these families did not, however, report recurring problems in settling bills. Only about 8% of the households had recurring problems in paying bills, in addition to living below poverty line.

The loose connection between poverty due to low income and problems in paying bills is not necessarily a conflicting result. The relatively small proportion of households reporting problems with settling bills may also be a result of low-income households having adapted their spending according to their modest income. Thus, the rarity of payment problems does not provide enough evidence of a sufficient income.

Table 19. Poverty after housing costs, and the household's own report on recurring problems with bill payment or partial loan payments in 1999 as a proportion of population according to household type, %

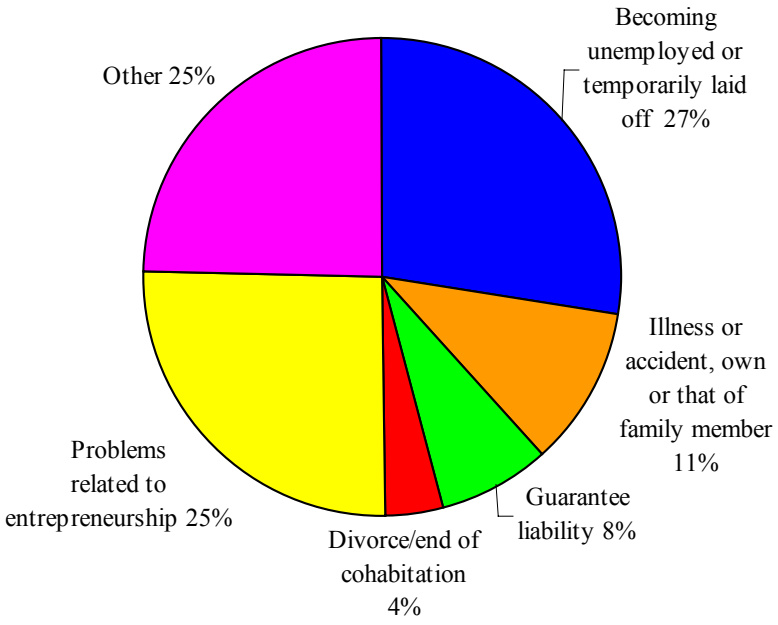
	Below poverty line			Above poverty line		
	Total	Problems in bill payment	No Recurring problems	Total	Problems in bill payment	No Recurring problems
Single-parent households	41.3	15.5	25.8	58.7	12.4	46.3
Couple, youngest child under 7	31.3	7.8	23.5	68.7	4.1	64.7
Couple, youngest child over 7	15.4	3.8	11.6	84.6	5.2	79.3
Elderly household (over 65)	4.4	0.3	4.1	95.6	2.0	93.6
Childless couple (under 30)	25.6	6.3	19.4	74.4	5.2	69.2
Childless couple (30-64)	4.5	0.6	3.8	95.5	4.6	90.9
One-person household (under 30)	26.2	3.4	22.8	73.8	7.0	66.9
- of which, men	16.5	1.7	14.8	83.5	8.1	75.5
- of which, women	34.8	4.9	30.0	65.2	5.9	59.2
One-person household (30-64)	8.9	2.3	6.6	91.1	11.8	79.4
- of which, men	10.1	2.3	7.8	89.9	13.3	76.7
- of which, women	7.4	2.2	5.2	92.6	10.0	82.6
Other households	6.6	1.3	5.4	93.4	6.2	87.2
All households	16.5	4.0	12.4	83.5	5.5	78.1

Poverty line: 50% of disposable median income calculated per consumption unit after deduction of housing costs. Housing costs do not include partial payments of housing loans. The definition of income after housing costs does not include imputed housing income. Problems with bill payment: the household reported that during 1999 it had often been in a situation with not enough money to pay bills (rent, daycare, phone, electricity, groceries and others, including credit card bills) by due date, or the household had more than once been in a situation with not enough money for partial loan payment or loan interest payment.

Overindebtedness diminishing

Overindebted households are one group suffering from serious financial problems that traditional poverty analysis does not bring out. Like poverty, overindebtedness is very hard to measure. Evaluations of the number of people in excessive debt, and the changes therein vary according to the method used. In 1999, there were about 100,000 households who considered themselves to be overindebted. The reduction seen in the number of overindebted households that started in 1998 continued. Households reported unemployment and problems related to entrepreneurship as the main causes for their excessive debts (Figure 75).

Figure 75. Overindebted households according to main cause for excessive debt in 1999



In 2001, about 40,000 people were covered by debt rearrangement schemes. About 66,000 debtors had applied for a court decision on debt rearrangement by the end of 2000, and it had been granted to most applicants, 11-13% of the applications being rejected. Almost 15,000 approved schemes have already been completed.

According to data gathered by credit information company Suomen Asiakastieto Oy, the number of people with payment defaults started to decrease in 1998. The peak of new cases of payment defaults had already been reached some time before, in 1995. After a four-year falling trend, the number of new cases of payment default began to rise again slightly in 2000. The slight increasing trend continued in the early part of 2001, but the total number of people with payment defaults continued to fall.

The government programme includes an agreement concerning the alleviation of the situation of overindebted persons and their families. The committee appointed to consider the reform of regulations concerning the period of limitation of debts gave its report in summer 2001. The committee proposed that after a court decision, neglected debts would become statue-barred in 15 years' time. The report was not unanimous, and the feedback it has received has also been conflicting with regard to the period of limitation. Many comments expressed a wish for fast relief of the situation of overindebted persons, and considered there to be urgent need for reform. On the other hand, many were worried that the reforms might encourage debtors to neglect payment of debts, and that problems of equal treatment of individual debtors might ensue.

In November 2001 the government gave the Parliament a proposal for reform of the Execution Act. According to the proposal, orders to pay could be enforceable for 15 years. In cases where the creditor is a private citizen, or has suffered damage as a result of crime, the time limit would be 20 years. The deadline would be calculated based on the final court decision. The regulation would apply to civil law receivables. The majority of receivables recovered by execution authorities are taxes and public fees, for which a five-year

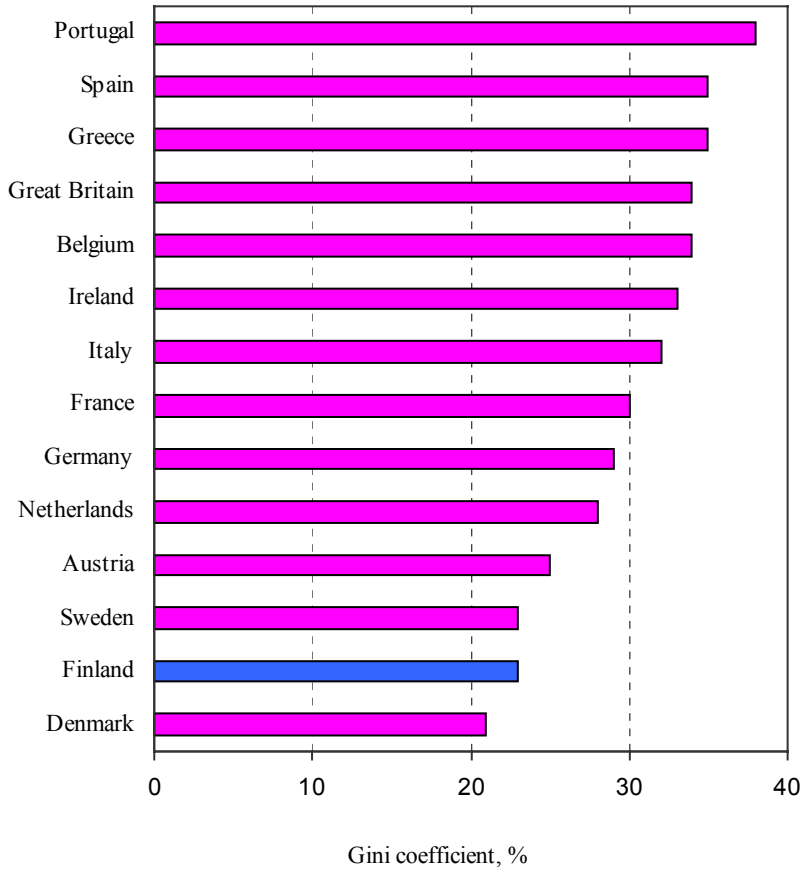
period of limitation applies. Fines and child maintenance payments also have a five-year period of limitation, so the new regulations concerning the period of limitation would have no effect on their collection. In practical terms, the reform would mean that consumer debts would be covered by the 15-year period of limitation, unless the collector is a natural person carrying on a trade. Principal debts could also be collected from private persons acting as guarantors for a period of 15 years, except in exceptional cases when also the creditor is a private person. On the other hand, a private person who has paid the debt of another person as a guarantor could collect the amount paid from the principal debtor for 20 years. According to the proposal, the time limits would be applied retrospectively for a maximum of ten years before the law enters into force on March 1, 2003.

The debts of people accepted into debt rearrangement schemes are usually annulled after a five-year payment scheme. The difference in the position of those accepted for debt rearrangement and those left outside can thus be considerable. Reform of the law concerning rearrangement of debts of private persons is currently being prepared at the Ministry of Justice. The objective is to extend the coverage of debt rearrangement to overindebted persons whose debt rearrangement application has been rejected, or would be rejected based on an obstacle defined by law.

Income differentials compared with other countries

Compared to most other EU countries, income differentials in Finland are relatively small. In international comparison, the Nordic countries form a separate group with clearly smaller income differentials than those found in other countries.

Figure 76. Income differentials in EU Member States in 1997

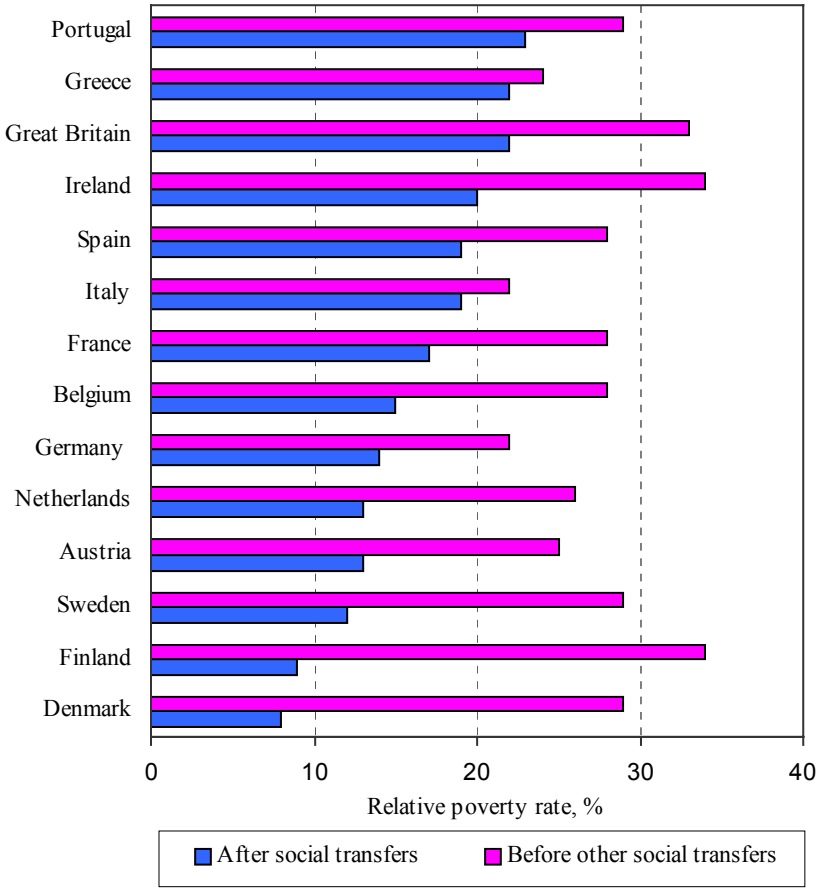


The greater the Gini coefficient, the greater the differences in income.

Source: Eurostat, ECHP

The relative poverty rate measuring the proportion of low-income population is lower in Finland and the other Nordic countries than in other EU Member States. This is largely due to the impact of social transfers. If social transfers, with the exception of old-age pensions, are excluded from the survey, the relative poverty rates of Finland, Denmark and Sweden are above the EU average. Compared to other EU Member States, the poverty-reducing effect of social transfers is significant in Finland. The poverty-reducing effect may be overestimated in formal assessments of this kind. Social transfers and the taxes levied to finance them may reduce employment. This might again increase poverty rate in surveys where social transfers are not yet included in income (Figure 77).

Figure 77. Relative poverty rate in EU Member States in 1997. Relative poverty rate, %

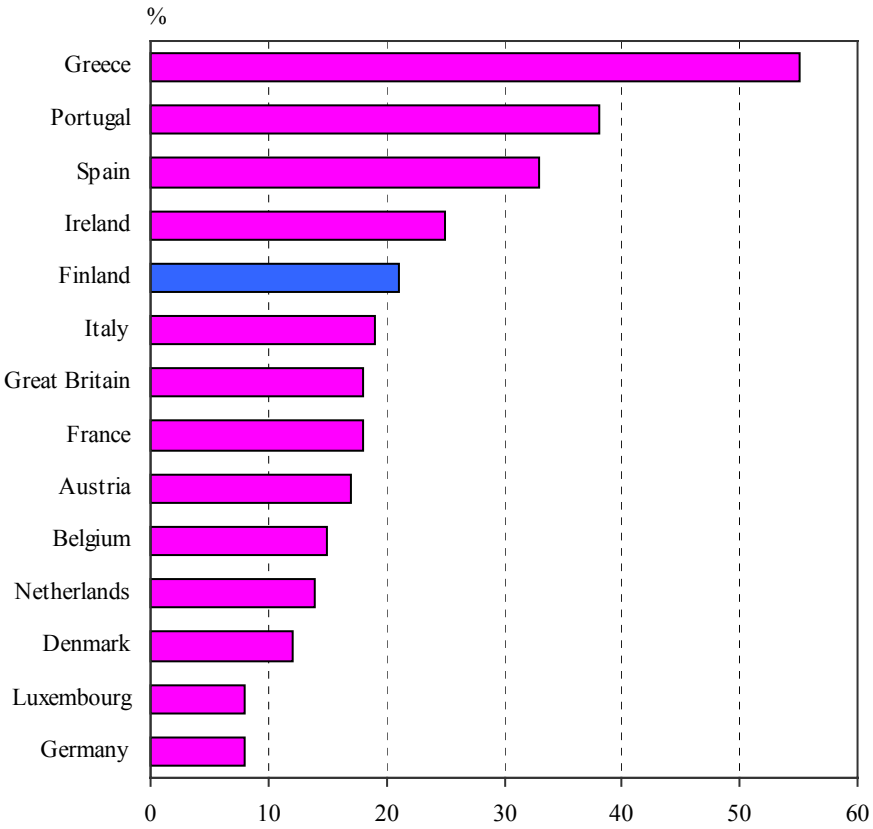


Source: Eurostat, ECHP

In Figure 78, poverty in each country has been defined in relation to median income in that country. Countries with a high level of income thus also have a higher poverty limit than countries with low income levels. This is why poverty rates in different countries cannot be used as such to compare the incomes of people with low income in different countries. Measured by purchasing power of income, the Finnish poverty line is clearly lower than e.g. in Denmark, Germany and Great Britain. The lowest poverty lines are found in Portugal, Greece and Spain. In spite of this, these were among the countries with high relative poverty rates.

There are several problems involved with international statistical comparisons of income distribution and poverty. The comparability of data is limited, and the economic problems related to e.g. high housing or health care costs are not necessarily brought out. Eurostat, the statistics bureau of the European union, has gathered data on economic problems based on the households' own reports. According to these data, economic problems seem to be relatively common in Finland, although still clearly less common than in some Mediterranean countries (Figure 78). The results of the survey are rather difficult to interpret. Unlike relative poverty rate, which reflects income distribution within a country, the answers reflect differences in the level of income between countries. There may also be great cultural differences in the way people respond to surveys of this kind.

Figure 78. Percentage of people who have experienced economic problems in some EU Member States in 1996



A variable with six categories. Proportion of those with "difficulties or great difficulties in making ends meet on their income".

Source: Eurostat

5 Poverty and Social Exclusion in Finland and the EU

The concept of "social exclusion" is used as a means to focus attention on the social mechanisms that produce or sustain deprivation. Exclusion differs from being "poor" as it implies not simply having limited resources but of not sharing in opportunities (economic, social and civil) that the majority have.

At the European Council in Lisbon, March 2000, the Member States of the European Union (EU) took a major initiative by making the struggle against poverty and social exclusion one of the central elements in the modernisation of the European social model.

As a result of the European Council in Nice, December 2001, National Action Plans for Social Inclusion(NAPs/Incl) were prepared in each EU Member State and published in June 2001. The NAPs/Incl outline Member States' priorities and the detailed description of the policy measures in place or planned for a period of two years in accordance with the four jointly agreed common objectives.

These four common objectives are:

- facilitate participation in employment and access by all to the resources, rights, goods and services
- to prevent the risks of exclusion
- to help the most vulnerable
- to mobilise all relevant bodies

The aim has been to harmonise the structure and contents of the different states' action plans in order to facilitate a reciprocal learning process, while safeguarding the Member States' key responsibilities in policy making and delivery. The EU's strategic goal of greater social cohesion requires not necessarily common solutions but at least a shared comprehension and analysis of differing approaches to tackling social exclusion.

From the individual NAPs/incl came a Joint Report, issued by the EU Commission and Social Protection Committee for the European Council of Laeken, December 2001. This Joint Report analysis's and brings together the different strategies and major policy measures in place or envisaged by all EU Member States in accordance with the common objectives for tackling poverty and social exclusion. It is the first time that the EU has endorsed a policy document on poverty and social exclusion, along with a set of common indicators, and thus represents the further strengthening of European co-operation in this area.

As for developments this year, during the first half of 2002 attention will concentrate on organising a process of mutual learning, supported by the new Community Action Programme which is planned to start in January 2002. The Community Action Programme, or Social Exclusion Programme (SEP), is a key element in the Open Method of Co-ordination which was agreed at the Lisbon Summit, March 2000. It is seen as a complementary and supporting role in the process of preparing, implementing and monitoring the NAPs/incl.

During the second half of 2002 conclusions will be drawn from the dialogue between Member States and the Commission, to take place in the Social Protection Committee, on the experience of the first year of implementation in order to consolidate the objectives and to strengthen co-operation in the run up to the second wave of NAPs/incl.

Combating social exclusion and poverty in Finland through universal social policy

Poverty and social exclusion is a new feature of Finnish society, that has its roots in the recession of the early 1990's. However the poverty rate in Finland remains among the lowest in the EU, and national sources indicate that the number of people suffering from severe social exclusion ranges from 30 000 to 60 000, just 0.6-1.2 per cent of Finns.

The Joint Report notes the different social policy systems between EU Member States and how this has influenced the nature of their NAPs/incl. The Finnish NAP/incl, along with other highly developed welfare systems, including Denmark, The Netherlands and Sweden, has been most successful in both ensuring access to basic necessities and keeping relative poverty well below the EU average of 18 per cent in 1997. In Finland the relative poverty rate was 9 per cent. In Sweden the relative poverty rate was 12 per cent, and in Denmark it was 8 per cent. For these countries the issue of poverty and social exclusion is based on preserving the established national social policy system and tends to be narrowed down to a number of very particular risk factors.

In contrast, Member States with less developed welfare systems, such as Greece, Portugal, Spain, Italy and Ireland, poverty and social exclusion are likely to be a fundamental problem, and thus have used the NAPs/incl to undergo a more fundamental revision of their social policy system. In all these countries, the relative poverty rate is above the EU average and is especially high in Portugal at 23 per cent and Greece at 22 per cent.

By advocating the basic Nordic principles of universal social welfare and health services and a comprehensive income security system Finland has been able to minimise levels of poverty and wider social exclusion. For this reason, the Finnish NAPs/incl has adopted measures aimed at improving and reinforcing the universal system. However there is a greater emphasis upon the primacy of work as well as listing a specific number of risk factors and vulnerable groups which include the long term unemployed, people with intoxicant abuse problems or mental health problems, youth and families with children in difficulties, homeless people, and immigrants.

Finland can also be clustered with those Member States, such as Denmark, Sweden and the Netherlands where social policy is decentralisation and participation and the mobilising of all stakeholders is part of the normal administration. Finland possesses established systems and traditions for negotiations both between the State and the municipalities and between labour market organisations in the fields of income, taxation, employment as well as social policy. Co-operation has also become more frequent with citizens' organisations and the third sector. This model of action is to be continued and improved in the development and implementation of the Finnish NAP/incl.

The primacy of work and the persistent of long term unemployment

There is wide acceptance across EU Member States that employment remains the key way of preventing and alleviating poverty and social exclusion. One of the eight core challenges identified in the Joint Report is the promotion of policies to improve employability, especially those furthest from the labour market, along with policies designed to allow the successful reconciliation of work and family.

Finland's keys to improved employment levels, currently 67.5 per cent (set against the EU employment goal of 70 per cent), is the reduction in the number of long term unemployed and to improve the employment potential of people with few skills. Finland aims to facilitate participation in employment by all persons capable of work by welding together financial incentives, activation measures and policies to reconcile work and family life.

While all NAPs/incl prioritise employment the Joint Report highlights that differences in emphasis can be found. These tend to reflect differences in the employment situation across Member States. Countries with high employment and low unemployment, such as the Netherlands, Denmark, Sweden and Ireland, emphasise the need to increase labour participation of specific groups, such as older people, women, immigrants, people with disabilities, also with a view to tackling current labour shortages. On the other hand, countries where unemployment and especially long-term unemployment is a widespread problem concentrate on more comprehensive policies to encourage job creation and increase the employability of the long term unemployed and young people. Long term unemployment is defined, in accordance with the ILO, as being unemployed for 12 months or more.

In Finland long-term unemployment has not decreased as much as would have been desirable and affects a core of hard-to-place people. The EU Social Inclusion indicators show that Finland has seen significant reductions in long term unemployment over the last five years and is now below the EU average of 3,6 per cent in 2000. Finland's long term unemployed has decreased from 5,5 per cent of the total active population in 1995 to 2,8 per cent in 2000. However, long term unemployment remains relatively high in relation to a number of other EU member states. In 2000 the long term unemployment rate was 1.5 per cent in the UK, 1.3 per cent in Sweden and 1,0 per cent in Denmark. The highest rates in 2000 were found in Ireland at 6,4 per cent and 5,9 per cent in Greece.

In Finland, obstacles to employment have been removed by eliminating disincentive embodied in the tax-benefit system. New types of services and subsidised work have been developed to promote employment of less highly educated and skilled persons. Rehabilitation for work, and any associated supporting measures aimed at decreasing long term unemployment and increasing a person's control of his or her life, are key methods identified by the NAP/Incl in putting an end to social exclusion.

In the reconciling of work and family, the Finnish system can boast of a universalised child day-care system, that allows women to integrate into the workforce, along with extensive parental leave and allowances and individualised entitlements to social security. The Finnish NAP/Incl also foresees the development of afternoon activities for schoolchildren.

Vulnerable groups requiring targeted help

As well as focusing on employment the NAP/incl also highlights groups that require targeted help due to there pressing need and/or they have previously been underdeveloped. Such groups include poor or over-indebted families with children, the prevention of widening economic and social segregation between both regional and residential areas, vulnerable young people, immigrants, the homeless and those suffering from mental illnesses.

Young people at risk of poverty and social exclsuion

The Finnish NAP/incl pays close attention to social exclusion as experienced by young people. It focuses upon the transition to adulthood where disadvantage and exposure to risks can have a fundamental effect upon future employment prospects and wider social inclusion.

In many ways Finland can still be viewed, even after the recession, as having few symptoms of extensive exclusion amongst young people in relation to other EU Member States, with low rates of early school leavers; long term unemployment among young people declining and still only a very small number of drug misusers. However, the persistent of youth unemployment (15-24 year olds), at 21,4 per cent in 2000, and a focus upon specific exclusion risks are features of the Finnish NAP/incl.

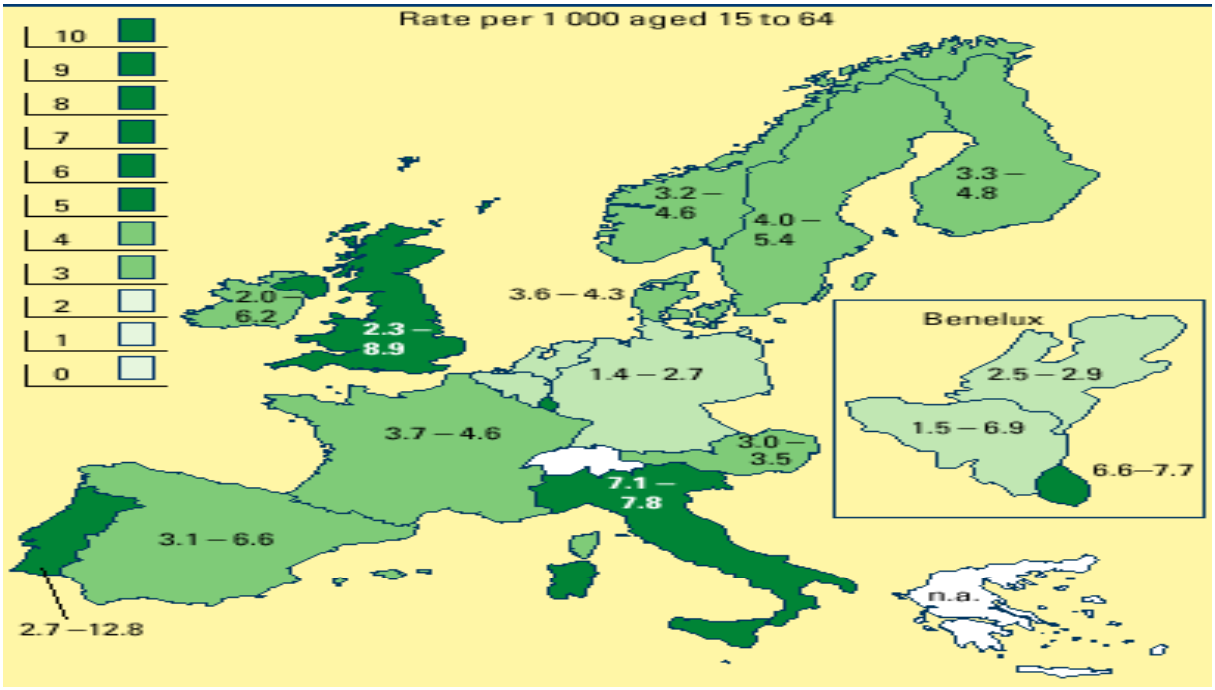
In relation to early school leavers (18-24 years) not in education or training Finland has a low level compared to other EU Member States. From 1995 it was 12,8 per cent of all young persons, and has steadily declined to 9,8 per cent in 2000. This is well below the EU average of 18,5 per cent in 2000. In relation to other Nordic countries, Sweden has a rate of 7,7 per cent and Denmark 11,7 per cent in 2000. However, within Finland a gender gap remains, with 12,5 per cent of early school leavers being men, and only 7,2 per cent being women.

The Finnish NAP highlights a concern for those who are in danger of ending their studies by providing additional support to help continue their education or training. Such initiatives include youth workshops aimed at those who have broken off from school or have left with low results and rehabilitation trials for those aged 15-17 to prevent those still in compulsory school from dropping out at the first available opportunity.

Substance abuse amongst the young is acknowledged as both a cause and consequence of poverty and social exclusion across EU Member States. In Finland the use of illegal drugs remains low by EU standards. However, the availability and consumption of illegal drugs has been increasing swiftly amongst young people, though the use of hard drugs remains rare amongst all age groups, see figure below.

Definition: “Problem Drug use” is defined as “injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines”.

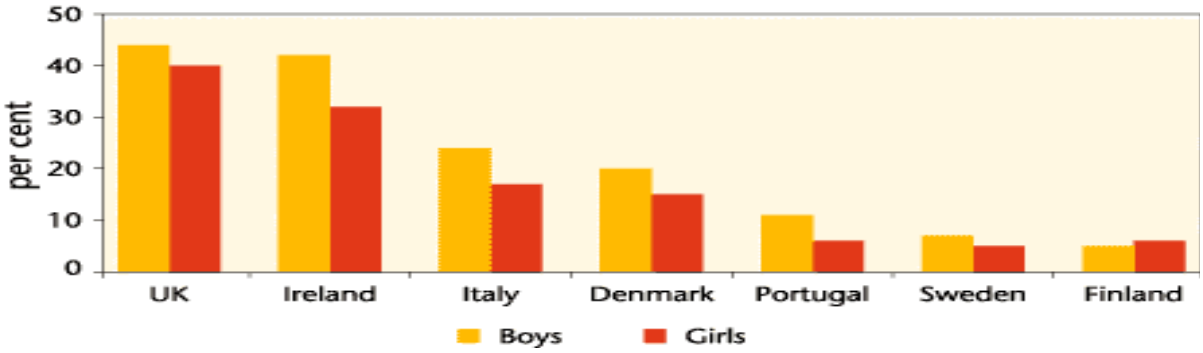
Figure 79. National prevalence estimates of problem drug use in the EU and Norway 1996-98



Source: European Monitoring Centre for Drugs and Drug Addiction, 2001 Annual report on the state of the drugs problem in Europe. (http://annualreport.emcdda.org)

Substance abuse amongst the young is acknowledged as both a cause and consequence of poverty and social exclusion across EU Member States. In Finland the use of illegal drugs remains low by EU standards. However, the availability and consumption of illegal drugs has been increasing swiftly amongst young people, though the use of hard drugs remains rare. In 1999, a study conducted on 15-16 year olds showed that about 10 per cent of the age group had experimented with cannabis at least once. As compared to 1995, the prevalence of the use had doubled.

Figure 80. The percentage of 15 and 16 year old pupils reporting experience of any illicit drug in 1995

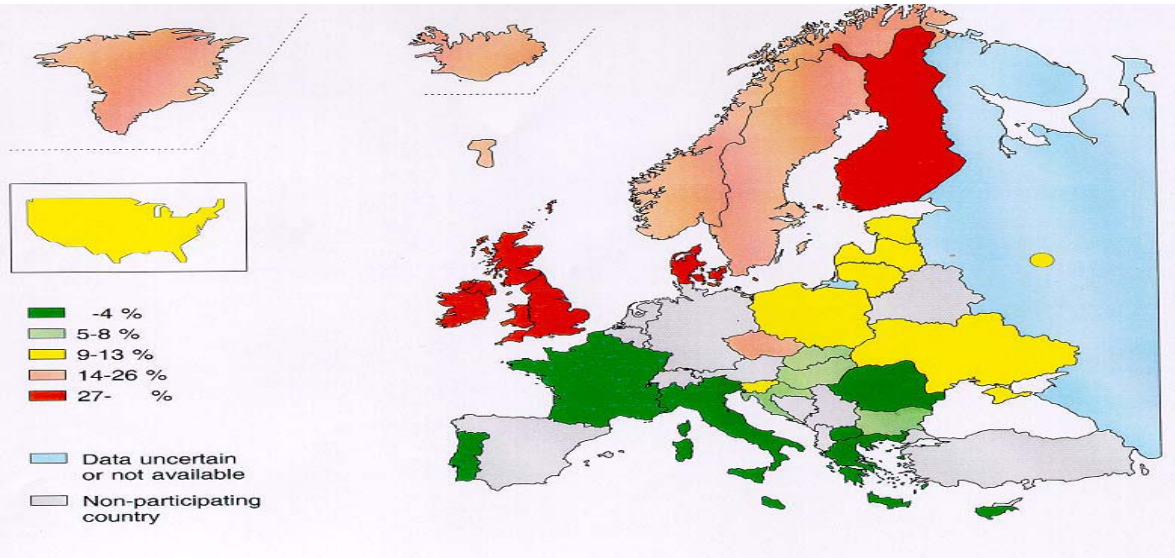


Björn Hibbell et al, The 1999 ESPAD report -The European School Survey Project on Alcohol and Other Drugs, 2000.

However, in contrast to many other EU Member States there, as yet, has not been the normalisation of drug use in Finnish youth culture. Traditionally the limited use of drugs can be attributed to high levels of employment and social inclusion, being outside of major drug trafficking destinations and relative isolation from drug sub-cultures. However, in all these respects Finland is changing, with the opening up of borders, persistent long-term unemployment and the globalising nature of modern youth cultures.

Alcohol remains the dominant intoxicant in Finland. Increased attention has focused on the use of alcohol among young people, and the increasing of adverse effects associated with heavy "binge-drinking", in other words, drinking to intoxication.

Figure 81. Proportion of all students who have been drunk 10 times or more during last 12 months 1999



Source: Swedish Council for Information on Alcohol and Other Drugs (Can) web site: www.can.se

The alcohol consumption can be expected to increase in the years to come. Finland's membership of the EU will see the relaxing of import restrictions on alcohol from other EU countries from 2003, which along with possible tax reductions, is likely to cause a rise in consumption.

The main objectives of Finnish alcohol policy remains the prevention and reduction of the social health related problems caused by alcohol consumption. Within the NAP/Incl, the Target and Action Programme for Social Welfare and Health (TATO) (2000-2003) lays emphasis on preventing the consumption of alcohol and drugs among young people. There is still a culture of regulation in Finland, which does not exist in much of the EU.

It appears that despite the recession high levels of young Finnish persons still remain active and socialised persons. What remains key to efforts in tackling social exclusion is the extent to which the Finnish strategy of early intervention in the interests of social inclusion will be enough to keep the levels of social exclusion as experienced by young people at there current low levels.

The homelessness and the mentally ill

Others prominent groups within the Finnish NAP/incl that are viewed as requiring special attention and targeted policies include the homelessness and those suffering from mental illness.

Homelessness can perhaps be seen as the most extreme form of social exclusion.. The Joint Report notes that the information on homelessness in the NAPs/incl is generally poor with only a few Member States providing an estimate on the number of homeless. For those Member States that did the numbers are: Denmark (4500), Austria (20000 of which 3000 are sleeping rough and the remainder is in supported housing), and the Netherlands (20000-30000). There are indications that homeless populations comprise rising proportions of women, young people, people of foreign origin, persons with mental health and/or addiction problems.

In Finland there are around 10000 single persons and 800 families suffering from homelessness, and is most prominent in centres of growth, particularly the Greater Helsinki area. Most of the homeless are ordinary, quite often employed, men who may have lost their home as a result of divorce for example. The objective of Finland's programme for the reduction of homelessness is to stem the increase in homelessness and to bring about a downturn in the number of homeless people by 2004. It is aimed to produce 1000-1200 new dwellings for the homeless. It is proposed to develop the selection of tenants in such a way that the homeless and other people in especially urgent need of housing are given priority in tenant selection by all types of owners. The programme will also ascertain the extra need for serviced accommodation, and it will develop supporting services for homeless people and other special groups.

Finland was one of many Member States to raise the issue of mental health. All agree on the need to tackle mental health problems through various sets of policy measures, relying in particular on greater local and regional co-operation, better provision of outreach and emergency accommodation services and specific training for health and social services' employees.

In Finland emphasis has been on the rehabilitation of people with mental health problems and increased municipal funding for community care, rehabilitation and withdrawal treatment for mental health patients and young drug addicts. The goal of quality recommendations for the mental health area is to ensure the availability and uniform quality of services. The Finnish NAP/Incl also pays attention to improving mental health services for children and youths. There are to be improvements in the exchange of information, measures to support open care for children and youths with mental problems, and regional co-operation.

Diverse strategies to combat poverty and social exclusion across the EU

For Finland the NAP/incl is useful in two ways. Firstly, it gathers together, on a broad basis, all the measures that are approved in different administrative sectors to combat poverty and social exclusion. Secondly, it indicates that the traditional model of social security based on universalism is a good tool against poverty and social exclusion.

For Finland the main challenge ahead is how to reconcile the action plan approach and universal system in a way to benefit both approaches. The Finnish NAP/incl in emphasising policies designed to upgrade the universal support and services system can be seen as an endeavour to address

problems in a durable manner. However it also recognises that many of the challenges in tackling poverty and social exclusion necessitate a greater emphasis on activation measures and the use of special targeted actions.

The Joint Report concludes that despite all Member States having fulfilled the commitment agreed in Nice very different approaches to tackling poverty and social exclusion exist, as a consequence of diverse social policy systems persisting and a wide variation in levels of poverty experienced by Member States. Equally, the Joint Report emphasises that the NAPs/Incl vary greatly in terms of achieving the overall goal of providing a comprehensive analysis of key structural risks and challenges, and framing their policies in a long term strategic perspective with an integrated approach.

Finland intends to remain within the Nordic traditions of the welfare state. However, the need to address new risks and encourage the primacy of work has seen new policies and measures that do not necessarily fit neatly into the traditional Nordic model, such as rights to benefits being based more on paid employment or job seeking obligations rather than residency. These changes do not signal any fundamental move to a more continental style social policy system. Finland maintains that the universal provision of services is the key to most of the problems faced. However they signal that Finland, like all EU Member States, needs to adapt their social policy system, particularly in terms of activation measures, when it is perceived that traditional methods do not work in the best interests of those facing poverty and social exclusion.

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APPENDIX 1

SOCIAL PROTECTION INDICATORS

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
I SOCIAL PROTECTION EXPENDITURE AND FINANCING												
Social protection expenditure												
Social protection expenditure, € million	22 095	27 519	28 670	29 700	30 200	31 161	31 289	31 607	32 161	33 020	34 400	36 200
GDP, € million	87 968	81 895	82 851	87 846	94 953	98 535	106 889	115 969	120 485	131 229	135 200	139 700
Social protection expenditure/GDP	25.1	33.6	34.6	33.8	31.8	31.6	29.3	27.3	26.7	25.2	25.4	25.9
Social protection expenditure, €/inhabitant at 2000 prices	5 316	6 130	6 227	6 354	6 374	6 519	6 448	6 407	6 429	6 370	6 460	6 680
Social protection expenditure by target group												
- sickness and health care	27.5	22.7	20.7	19.7	20.3	20.7	21.3	22.0	22.4	23.1	23.9	23.6
- disability	15.0	14.7	14.7	14.5	14.5	14.3	14.3	13.9	13.8	13.3	13.1	12.8
- old age	28.6	27.3	27.5	27.3	28.1	29.0	29.1	29.5	30.3	30.9	31.7	32.0
- survivors	4.0	3.9	3.9	3.8	3.8	3.8	3.9	3.9	3.9	3.9	3.9	3.9
- families and children	13.0	12.5	11.8	13.3	13.0	12.1	12.3	12.4	12.4	12.1	11.7	11.3
- unemployment	5.9	12.8	15.6	15.2	14.0	13.5	13.0	11.7	11.0	10.1	9.5	10.4
- housing	0.7	1.1	1.1	1.4	1.5	1.2	1.2	1.4	1.5	1.4	1.2	1.2
- other	1.8	2.2	2.0	2.0	2.0	2.3	2.4	2.1	2.1	2.0	2.0	1.9
- administration	3.5	2.8	2.6	2.8	2.8	3.1	2.7	3.1	2.6	3.1	3.0	3.0
- total	100	100	100	100	100	100	100	100	100	100	100	100
Contributions to the financing of social protection expenditure, %												
- central government	25.0	29.4	30.3	30.4	29.1	28.3	26.9	25.5	24.7	24.1	23.4	24.2
- local authorities	15.6	15.2	15.1	15.9	16.7	16.2	17.3	18.2	18.8	19.2	19.0	18.7
- employers	44.1	36.7	34.7	33.0	33.7	35.3	35.5	36.6	37.2	37.4	37.5	37.3
- the insured	8.0	10.4	12.3	14.3	13.7	13.1	13.4	12.9	12.8	12.2	12.0	11.8
- property income	7.3	8.3	7.6	6.4	6.9	7.2	6.8	6.9	6.6	7.1	8.1	8.0
- total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1	100.1	100.0	100.0	100.0

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
The Ministry of Social Affairs and Health's main division expenditure in the State budget												
Ministry of Social Affairs and Health's main division expenditure, € million	6 548	9 058	9 053	9 007	8 498	8 110	7 559	7 232	7 052	7 277	7 645	8 004
Government grant to municipalities for operating costs of social services and health care, € million	3 279	3 554	3 459	3 096	3 018	2 682	2 280	2 162	2 134	2 193	2 352	2 515
Ministry of Social Affairs and Health's main division expenditure as a percentage of total government expenditure	27.7	28.9	26.6	27.0	24.7	24.1	24.1	22.1	19.8	18.9	22.8	22.7
Expenditure of municipalities												
Municipal operating costs on health care and social services, € million	6 912	7 987	8 411	8 470	8 871	9 326	9 706	9 901	10 201	10 755	11 200	11 400
Municipal social services and health care personnel	232 200	237 500	225 300	228 000	224 600	232 300	235 300	233 700	232 800	237 300	239 000	240 000
- of which women	90.8	90.8	90.8	90.7	90.9	90.8	90.9	90.9	90.9	90.9		
Government debt												
Government debt, % of GDP	11	34	53	59	64	68	66	61	57	51	46	46
II SICKNESS AND HEALTH CARE												
Sickness and health care expenditure (net), € million	6 075	6 257	5 949	5 864	6 144	6 462	6 676	6 943	7 196	7 629	8 200	8 550
Cash benefits	1 337	1 288	1 169	1 145	1 201	1 221	1 260	1 337	1 417	1 524	1 580	1 630
- daily sickness allowance	515	533	451	441	424	399	401	422	458	494	520	560
- sick pay	690	620	605	590	660	710	740	790	820	890	910	920
Services (net)	4 739	4 969	4 780	4 719	4 943	5 241	5 416	5 605	5 779	6 105	6 620	6 910
- primary health care	1 880	1 999	1 541	1 572	1 625	1 708	1 663	1 715	1 762	1 881	2 000	2 090
- specialized health care	2 063	2 032	2 278	2 177	2 293	2 432	2 549	2 641	2 692	2 791	3 050	3 180
- sickness insurance	661	781	802	811	860	929	1 015	1 072	1 135	1 242	1 370	1 440
Life expectancy and infant mortality												
Life expectancy, years												
- men	70.9	71.7	72.1	72.8	72.8	73.0	73.4	73.5	73.7	74.1		
- women	78.9	79.4	79.5	80.2	80.2	80.5	80.5	80.8	81.0	81.0		
Infant mortality,(1/1000)	5.6	5.2	4.4	4.7	3.9	4.0	3.9	4.2	3.6	3.8		

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
Morbidity												
Recipients of daily sickness allowance	397 900	355 100	293 300	283 200	284 400	275 000	271 800	278 100	286 900	296 300	297 800	299 300
- of which women, %	55.1	54.6	54.5	55.1	55.5	56.0	56.0	55.8	55.9	56.0	56.0	56.0
Absences due to sickness as percentage of total working days, %	3.8	3.4	3.8	3.5	3.5	3.4	3.4	3.4	3.5	3.9	3.7	3.7
Number of persons caught an occupational disease	9 100	8 000	7 000	6 700	5 800	5 700	5 000	4 800	5 200	5 000		
Prescriptions/inhabitant	6.1	6.0	5.9	5.7	6.0	6.3	6.4	6.6	6.8	7.3	7.5	
Bed-days and discharges of health care												
Primary health care, wards												
- discharges/1.000 inhabitants	51	46	48	51	52	58	57	59	60	62	63	64
- bed days/1.000 inhabitants	1 676	1 544	1 525	1 542	1 571	1 620	1 575	1 595	1 578	1 594	1 600	1 630
Specialized health care, wards												
- discharges/1.000 inhabitants	162	179	182	183	187	193	194	191	189	189	190	191
- bed days/1.000 inhabitants	1 552	1 464	1 359	1 294	1 242	1 190	1 158	1 093	1 051	1 015	1 000	1 020
Reimbursements of National health insurance. Number of recipients (1.000)												
Medicines, basic refunds	3 127	3 117	3 057	2 954	3 056	3 123	3 133	3 098	3 136	3 187	3 210	3 230
Medicines, special refunds 75/100%	813	834	902	904	895	912	928	942	953	981	1 020	1 050
- of which women, %	56.2	57.7	57.4	57.1	56.7	56.5	56.3	56.1	56.0	55.8	56.0	56.0
Private doctors´services	1 481	1 340	1 326	1 262	1 302	1 340	1 333	1 360	1 361	1 394	1 476	1 560
- of which women, %	65.0	65.6	65.3	65.8	65.5	65.4	65.4	65.6	65.6	65.6	64.8	65.0
Private dentists´ services	167	215	241	253	269	288	382	666	467	470	628	650
- of which women, %	55.6	52.4	50.4	50.8	51.3	51.8	53.9	56.7	54.5	54.1	54.9	55.0
Private examinations and treatment	845	729	684	635	634	661	675	715	718	739	767	800
- of which women, %	66.4	66.4	66.4	66.8	67.7	67.7	67.7	68.1	67.8	67.9	67.5	68.0
Transportation	615	543	485	506	521	553	558	561	564	573	563	565
- of which women, %	57.4	56.5	54.4	53.5	54.4	53.3	53.4	53.4	53.6	53.6	53.4	54.0

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
III DISABILITY												
Expenditure on disability, € million	3 312	4 042	4 210	4 303	4 394	4 447	4 466	4 421	4446	4 406	4 520	4 640
Cash benefits	2 769	3 101	3 426	3 573	3 611	3 664	3 665	3 641	3 533	3 390	3 470	3 540
- disability pensions	1 869	2 136	2 207	2 214	2 257	2 293	2 342	2 300	2 320	2 354	2 470	2 550
- individual early retirement pensions	351	576	641	686	713	681	610	529	458	393	350	330
- military injuries indemnities	293	360	340	299	295	288	286	278	269	265	250	250
Services (net)	543	616	636	692	730	782	825	889	960	1 010	1 050	1 090
- institutional care for the disabled	151	156	159	150	135	131	133	128	127	133	140	150
- services for the disabled	253	301	295	345	395	465	502	541	539	571	600	620
- rehabilitation	139	159	182	197	200	186	190	220	294	306	310	320
Disability pensions												
Recipients of disability pensions on December 31	300 930	308 540	309 730	310 630	309 510	301 780	294 990	288 050	282 050	276 300	275 900	276 700
- of which women, %	47.0	46.7	46.5	46.5	46.6	46.7	46.7	46.8	46.8	46.8	46.8	46.8
Services												
Disabled persons in institutional care on December 31	4 390	4 870	3 630	4 000	3 770	3 650	3 370	3 200	3 000	3 000	3 000	3 000
Households with a disabled person receiving home help services during the year	7 920	7 090	6 120	6 210	7 000	6 970	6 620	6 290	6 580	6 370	6 500	6 600
IV OLD AGE												
Expenditure on old age, € million	6 312	7 515	7 881	8 099	8 480	9 031	9 096	9 329	9 748	10 199	10 890	11 600
Cash benefits	5 642	6 808	7 142	7 343	7 648	8 127	8 203	8 414	8 769	9 150	9 780	10 440
- old age pensions	5 347	6 448	6 751	6 967	7 272	7 597	7 840	8 056	8 377	8 724	9 320	9 940
Services (net)	670	707	739	756	832	904	893	915	979	1 049	1 110	1 160
- institutional care for the elderly	409	426	449	449	482	486	454	459	483	496	530	550
- open care of the elderly	261	281	290	307	350	418	439	456	496	553	580	610
Pensioners												
Recipients of old age pensions, on December 31	737 150	762 570	776 810	789 390	804 060	822 520	836 700	843 900	858 200	869 700	878 300	898 400
- of which women, %	63.5	63.1	62.7	62.5	62.3	61.9	61.7	61.5	61.4	61.1	61.0	60.8
Recipients of part-time pensions, on December 31	430	1 210	2 260	4 470	5 440	6 100	6 930	10 920	18 280	24 530	31 300	38 200
- of which women, %	52.8	57.5	54.4	54.6	53.6	53.1	54.2	54.7	54.1	54.4	54.5	54.5
Services												
Persons in old people's homes on December 31	26 620	25 350	24 210	23 410	22 950	22 910	22 270	21 420	21 070	20 660	21 000	22 000
Elderly households receiving home-help services	124 010	103 780	99 100	91 680	86 750	87 410	85 400	84 820	84 280	82 980	86 000	87 000
Elderly clients receiving auxiliary services during the year	200 170	128 000	109 720	93 950	97 970	99 210	103 300	105 620	103 420	104 740	105 000	107 000

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
V SURVIVORS												
Expenditure on survivors, € million	890	1 067	1 118	1 130	1 144	1 175	1 208	1 217	1 252	1 281	1 340	1 400
- survivors' pensions	840	1 010	1 066	1 083	1 098	1 136	1 167	1 176	1 210	1 239	1 300	1 350
Pensions												
Resipients of widows/widower's pension on December 31	194 780	212 430	220 040	225 050	230 830	238 380	243 450	247 550	250 300	252 800	265 100	271 600
- of which women, %	98.2	95.6	94.4	93.5	92.7	92.0	91.3	90.7	90.1	89.6	89.0	89.0
Recipients of children's pensions	28 430	29 080	29 530	29 630	29 340	29 250	29 340	28 880	28 250	28 480	28 400	28 300
VI FAMILIES AND CHILDREN												
Expenditure on families and children, € million	2 879	3 439	3 378	3 942	3 920	3 775	3 836	3 918	3 993	4 007	4 030	4 100
Cash benefits	1 670	2 204	2 159	2 725	2 615	2 324	2 333	2 356	2 347	2 348	2 350	2 400
- parents' allowance	527	635	575	526	507	466	460	456	467	478	500	520
- home care allowances	376	540	543	551	513	343	349	375	361	357	340	370
- child allowance	689	933	932	1 531	1 475	1 412	1 410	1 405	1 397	1 387	1 380	1 380
Services (net)	1 209	1 234	1 219	1 217	1 305	1 434	1 503	1 563	1 646	1 660	1 680	1 700
- child day care	988	991	934	930	1 000	1 108	1 159	1 199	1 249	1 229	1 250	1 260
Recipients of parents' allowance on December 31												
- mothers	54 910	57 660	57 070	55 210	53 340	51 570	49 870	48 430	48 960	48 570	48 500	48 400
- fathers	1 300	1 850	2 050	2 210	1 930	2 210	2 030	2 190	2 810	2 220	2 200	2 200
Families receiving home care allowance on December 31	81 210	92 570	95 820	95 380	84 480	73 980	75 490	74 360	73 030	72 550	70 800	69 600
Children in municipal day care on December 31	200 200	182 300	174 300	180 800	189 900	217 300	219 700	218 500	215 100	200 400	197 000	194 000
VII UNEMPLOYMENT												
Unemployment expenditure, € million	1 299	3 527	4 476	4 523	4 220	4 221	4 061	3 683	3 519	3 345	3 280	3 780
Cash benefits	1 103	3 261	4 213	4 221	3 961	3 900	3 719	3 354	3 187	3 041	2 990	3 490
- basic daily allowance	145	751	974	863	455	158	138	102	87	83	90	100
- earnings-related daily allowance	375	1 833	2 553	2 498	2 187	2 179	1 993	1 591	1 411	1 306	1 190	1 410
- labour market support	0	0	0	220	688	896	861	901	894	812	820	1 020
- unemployment pensions	445	392	389	399	409	403	451	504	567	621	680	740
- labour market training benefits	124	192	214	186	190	220	223	194	160	145	130	130
Services	196	267	263	302	260	322	342	330	332	304	290	300
- labour market training for adults	118	175	173	205	158	216	232	202	198	180	160	160

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
Unemployment												
Unemployment rate, %	3.1	11.7	16	16.6	15.4	14.6	12.7	11.4	10.2	9.8	9.2	9.8
- female	2.7	9.6	14.4	14.9	15.1	14.8	13.0	12.0	10.7	10.6	9.8	10.3
Number of unemployed persons, average	82 000	292 000	405 000	408 000	382 000	363 000	314 000	285 000	261 000	253 000	238 000	254 000
- of which women, %	40.2	39.0	42.0	42.6	46.6	48.5	49.0	49.8	50.2	51.8	50.7	51
Recipients of unemployment allowances, during the year												
Earnings-related daily unemployment allowance	171 300	489 300	596 200	544 400	468 200	468 800	418 300	369 800	334 800	296 400	305 400	320 000
- of which women, %	51.1	43.3	47.9	50.0	53.0	53.7	55.4	58.3	57.5	58.9	59.2	59
Basic daily unemployment allowance	126 100	325 900	363 100	280 500	215 300	93 600	58 900	50 800	45 700	42 100	43 650	46 500
- of which women, %	40.8	38.5	38.9	39.1	38.4	42.3	41.6	43.4	44.4	45.7	45.9	47
Labour market support	0	0	0	123 600	270 000	314 900	308 600	322 600	311 800	307 500	271 300	294 200
- of which women, %				42.7	39.9	41.9	43.7	46.2	47.2	47.9	48.7	49
Pensions												
Recipients of unemployment pension on December 31	55 490	43 720	42 790	42 960	39 150	41 410	44 860	49 390	52 240	54 290	59 450	61 700
- of which women, %	54.9	54.2	52.6	51.8	51.7	51.9	52.0	52.0	52.0	52.4	52.0	52.0
VIII HOUSING												
Expenditure on general housing allowance, € million	161	313	320	411	441	387	365	440	497	454	401	415
Recipients of general housing allowance (on December 31, households)	110 490	192 830	182 370	227 560	213 820	191 880	184 610	205 590	207 000	170 350	158 460	163 000
IX OTHER												
Main category of other expenditure												
Expenditure on other, € million	401	601	581	591	615	710	747	671	664	671	670	680
Cash benefits	208	358	399	415	440	517	540	448	422	421	420	430
- social assistance (net)	182	280	337	388	419	489	511	430	401	395	400	400
Services (net)	193	243	182	176	176	193	207	224	243	250	250	250
- care for alcoholics and drug abusers	75	68	61	65	69	73	76	73	80	87	95	100
Social assistance												
Households receiving social assistance during the year	181 600	258 900	292 600	329 400	339 000	349 600	344 700	313 400	292 000	271 700	260 900	252 000
Average duration, months	3.9	3.9	4.3	4.8	5.1	5.4	5.6	5.4	5.4	5.5	5.5	5.5
Alcohol, tobacco, drugs												
Daily smokers, percentage of 15-64 year-olds												
- men	33	33	29	29	28	28	30	30	27	27	29	
- women	20	21	19	19	19	19	20	20	20	20	20	

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
Alcohol consumption, l/inhabitant												
- in official statistics	7.7	7.2	6.8	6.6	6.7	6.7	6.9	7.0	7.1	7.0	7.4	
- illicit	1.2	1.3	1.4	1.4	2.1	2.1	1.9	1.8	1.7	1.8	1.8	
- total	8.9	8.5	8.2	8.0	8.8	8.8	8.8	8.8	8.8	8.8	9.2	
A-clinics, number of clients during the year	38 500	35 500	3 410	35 400	35 600	38 200	38 500	39 000	39 300	41 800		
Youth clinics, number of clients during the year	3 000	2 600	2 600	2 700	2 700	3100	3 550	3 450	4 050	4 450		
X POPULATION AND INCOME												
Income												
Disposable income per capita, € at 2001 prices	11 460	11 240	10 560	10 220	11 010	10 930	11 550	11 930	12 430	12 360	12 770	
Income differentials												
(Gini coefficient. the higher the figure the greater the differential, 1990=100)												
Factor income (earned income + capital income)	100	108	115	117	117	118	119	119	120	120		
Gross income (factor income + income transfers received)	100	99	102	101	104	106	110	114	118	122		
Disposable income (gross income - taxes)	100	99	102	101	105	108	114	119	125	130		
Disposable real income, 1990=100												
Single parents	100	97	91	91	98	99	97	99	103			
Other families with children (youngest child under 7)	100	96	94	92	94	95	100	103	105			
Other families with children (youngest child over 7)	100	93	92	93	95	96	102	106	112			
Elderly households (over 65)	100	109	110	108	111	114	117	118	124			
Childless couples (under 65)	100	94	93	92	94	97	103	108	113			
Single persons (under 65)	100	93	94	91	91	94	97	103	105			
Others	100	97	95	95	98	100	105	108	109			
Poverty												
Risk of poverty (Percentage of persons living in households whose disposable income is less than 50 % of the median disposable income for all households)	2.5	2.6	2.4	2.2	2.4	2.9	3.0	3.9	3.6	4.0		

	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001*	2002**
XI SOCIAL INSECURITY												
Suicides, accidental deaths and violent crimes												
Number of suicides	1 512	1 451	1 397	1 387	1 388	1 247	1 322	1 228	1 207			
Accidental deaths	2 815	2 706	2 574	2 584	2 644	2 577	2 729	2 841	2 724			
Violent crimes (murders, manslaughters and assaults)	21 424	19 891	19 438	20 735	23 130	25 421	25 777	26 542	27 163	28 878		
Drug-related crimes	1 969	2 399	3 063	3 172	3 944	6 059	7 015	8 280	9 287	10 771		
- done by women, %	13.4	13.4	13.8	12.5	13.5	14.4	13.8	13.4	14.1	14.6		
Divorce and abortions												
Divorces	13 127	12 949	12 753	13 751	14 025	13 795	13 507	13 848	14 030	13 913	13 452	
Legal abortions	12 232	11 071	10 342	10 013	9 884	10 437	10 238	10 744	10 819	10 930		
Children and young people placed outside home and in open-care												
Placements outside home												
- total	..	9 410	9 670	10 210	10 697	11 124	11 764	12 010	12 224	12 870		
- of which taken into custody	..	6 382	6 393	6 403	6 478	6 474	6 803	6 778	6 802	7 316		
Children and young people in open-care												
- total	..	..	24 690	27 820	30 690	33 270	35 810	38 630	43 680	49 350		
Recipients of maintenance support												
Children receiving maintenance support	73 090	85 580	92 590	98 480	103 100	106 810	107 900	108 500	108 960	107 960	107 900	107 600

*) forecast
**) estimate

Sources: Ministry of Social Affairs and Health
National Research and Development Centre for Welfare and Health (Stakes)
Statistics Finland
Institute of Occupational Health
Central Pension Security Institute
Social Insurance Institution
SOTKA database

APPENDIX 2

Average pension and social insurance contributions[1]

	1994	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001**	*2002***
EMPLOYERS									
National pension insurance [2]	3.41	3.39	3.45	3.24	3.25	3.21	3.16	3.00	2.6
Sickness insurance [2]	1.91	2.05	2.05	1.77	1.74	1.70	1.69	1.69	1.7
Unemployment insurance [2] [3]	5.40	4.50	2.90	2.91	2.81	2.78	2.53	2.27	2.1
Employment pension insurance [4]	15.60	16.60	16.80	16.70	16.80	16.80	16.80	16.60	16.8
Municipal pension insurance	18.90	20.30	21.00	20.80	21.20	21.40	21.70	22.20	22.4
INSURED GROUPS									
Wage-earners	**8.32**	**8.32**	**7.70**	**7.90**	**7.60**	**7.55**	**7.20**	**6.70**	**6.7**
National pension insurance	1.55	0.55	0.00	0.00	0.00	0.00	0.00	0.00	0.0
Sickness insurance [5]	1.90	1.90	1.90	1.90	1.50	1.50	1.50	1.50	1.5
Unemployment insurance	1.87	1.87	1.50	1.50	1.40	1.35	1.00	0.70	0.4
Employment pension insurance	3.00	4.00	4.30	4.50	4.70	4.70	4.70	4.50	4.4
Retired persons	**7.45**	**6.45**	**4.90**	**4.90**	**4.20**	**3.90**	**3.20**	**2.70**	**1.9**
National pension insurance	2.55	1.55	0.00	0.00	0.00	0.00	0.00	0.00	0.0
Sickness insurance [5]	4.90	4.90	4.90	4.90	4.20	3.90	3.20	2.70	1.9

1) Annual average. Employers' contributions and unemployment and employment pension insurance contributions paid by the insured as a percentage of salaries. National pension and sickness insurance contributions paid by the insured as percentage of taxable income in the municipal taxation.

2) The average weighted with the total payroll in the various payment categories.

3) The progressive employers' unemployment insurance contribution introduced during 1993. The level was 3.75% of the salary if the annual total payroll was less than € 168.188; for larger amounts the contribution was 6% of the total.
In 1994 the contributions was 3 % up to € 168.188, otherwise 6,3 %.
Since 1995 the annual limit of salary has been € 840 940 and the contribution s as follows:

Year	Contribution when the annual salary is ≤ € 840 940,%	Contribution when the annual salary is > € 840 940, %
1995	2.0	6.1
1996	1.0	4.0
1997	1.0	4.0
1998	0.9	3.9
1999	0.9	3.85
2000	0.9	3.45
2001	0.8	3.1
2002	0.7	2.7

4) Employment pension contribution

5) During 1991–1998 a surcharge on sickness insurance contribution was levied if taxable income in the municipal taxation exceeded € 13 455. The surcharge was levied on amounts in excess. The surcharge was as follows:

Surcharge of sickness insurance, %-units	1991	1992	1993	1994	1995	1996	1997	1998
	1.0	1.5	1.5	1.9	1.9	1.45	0.45	0.45

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