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FOREWORD

Trends in Social Protection is a report published annually by the Ministry of Social Affairs and Health. Its purpose is to describe and analyse current trends in Finnish social protection in the light of past developments and decisions.

The outlook of the Finnish economy for 2000 appears good. However, even if the economic standing of municipalities is on the whole reasonably good, there remain significant differences in development between individual municipalities. This must be taken into account in developing the service system.

The positive economic development of the past few years is reflected in the number of benefit recipients. The numbers of social assistance and maintenance allowance recipients began to fall in 1998. The rapid reduction in unemployment has resulted in an accentuation of regional and structural features. Youth unemployment is relatively high. Ageing employees have difficulty in finding jobs, and the pressure to retire on unemployment pension will remain high unless we can create better opportunities for ageing employees to stay on in working life.

The structural problems affecting the labour market are evident. As advances in technology and international competition increasingly favour training and professional skills, those with inadequate training and work experience will be more likely to become unemployed than others. The recession has left a large number of people who are permanently dependent on last-resort social benefits intended primarily as temporary remedies. A more active approach to employment and social policy will be needed to improve the situation of such groups.

The main challenge facing social policy over the next few years is to combat long-term unemployment and raise the employment rates among the aged and the young.

The Government's new Target and Action Plan for Social Welfare and Health Care sets out targets and recommendations for social welfare and health care for the next four-year period. The plan underlines the importance of preventive action. The guiding principle is to enhance interdepartmental and regional cooperation.

Trends in Social Protection is mainly the responsibility of the Finance and Planning Department of the Ministry of Social Affairs and Health. The experts who took part in the preparation of the publication are listed on the next page.

Helsinki, December 1999

Kari Välimäki, Director General

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TRENDS IN SOCIAL PROTECTION IN FINLAND 1999-2000 EXPERTS

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SUMMARY

Trends in Social Protection in Finland 1999-2000. Helsinki 2000. 103 pp. (Publications of the Ministry of Social Affairs and Health, ISSN 1236-2050, 2000:9) ISBN 952-00-0798-9.

In 1994-1998, annual growth in Finnish GDP averaged 5 per cent, and nearly 4 per cent growth is expected for 1999. During the same period, employment has improved considerably. Nevertheless, the employment rate remains nearly ten percentage points lower than at the beginning of the 1990s. The low employment rate has raised the economic dependency ratio, or the number of non-employed relative to the number of employed. The current ratio is markedly higher than in the 1980s.

The deterioration in the economic dependency ratio has placed the income security system under heavy pressure. In spite of this, social protection expenditure as a proportion of GDP is expected to reach the pre-recession level and fall below the EU average in 1999. The steep decline in social protection expenditure relative to GDP in the past few years is due to a combination of factors: the rapid growth in industrial output, the improving employment situation, and straightforward cuts in social protection.

The ageing population — a challenge to employment targets

The main goal of Government economic policy is to improve the employment rate. The Government aims to raise the proportion of the employed in the working age population to 70 per cent. The ageing of the population makes it more difficult to reach this target unless we can manage to raise employment rates among those nearing retirement age. The employment rate among this age group has been low and the number of people affected will in the future grow even larger as the post-war baby-boom generation approaches retirement age. The Government's target is to raise the actual age of retirement as close as possible to the statutory retirement age for old-age pension, or 65 years.

Representatives of the central labour market organizations and employment pension institutions in a working group chaired by Mr. Kari Puro have agreed on new arrangements for private-sector employment pensions. The Government introduced a bill based on the working group's proposals to Parliament in October 1999. In addition to amendments reducing the attractiveness of unemployment pension, the Government also proposes raising the minimum age for individual early retirement pension from 58 to 60 years. Employment pension institutions would also be obliged to conduct a rehabilitation examination on disability pension applicants aged 58 or 59. According to the bill, the minimum age for part-time pension would remain 56 years until the end of 2002, at least. The measure is intended to help keep ageing people in working life until the statutory retirement age.

The higher age limits for unemployment pension and individual early retirement pension already introduced have postponed retirement. On the other hand, the option for the unemployed to retire on unemployment pension at the age of 60 still represents an important pathway to retirement. The systems for early retirement still require further development. As the pathways to early retirement are progressively blocked,

support must also be provided to help older people stay on at work. If this is not done, the ensuing pressure will take the form of unemployment or a renewed increase in disability pensions.

The aim of the National Programme on Ageing Workers (1997-2002) launched in 1997 is to fine-tune working life, social insurance systems and various other services to promote ageing workers' employment and continuing participation in working life. Promoting ageing workers' employment and working capacity and reducing stress at work all have an important part to play in securing a sustainable funding base for social protection.

Long-term unemployment is becoming an increasingly serious problem

Viewed internationally, the Finnish unemployment rate has dropped exceptionally rapidly since 1994. In 1999, the average unemployment rate is expected to fall to slightly above 10 per cent, the average rate across EU Member States. The rapid fall in unemployment is expected to continue through the year 2000.

Unemployment has become polarized in the past few years. While those who have become unemployed recently usually find a new job fairly rapidly, the labour market position of people who have difficulties finding work is becoming even worse. The average duration of unemployment periods is approximately one year. As a result of long-term unemployment, a considerable proportion of the working-age population are in danger of exclusion or have already become excluded from the labour market. Prolonged unemployment reinforces dependence on benefits systems and increases the risk of the emergence and accumulation of social and health problems.

Structural unemployment is currently higher than at the beginning of the 1990s. Its scope and depth can be grasped by taking a look at what sort of groups make up the body of the unemployed. Those with reduced employment capacity are mainly people who have received labour market support for a long time and those ageing long-term unemployed who are in the 'retirement channel' for an unemployment pension. This group is estimated to cover 170,000-180,000 people in 1999, or nearly 7 per cent of the workforce.

Promoting employment of people with disabilities

High unemployment has temporarily reduced the employment possibilities for people with varying degrees of disability. The number of unemployed jobseekers with disabilities is increasing with the ageing of the population. A large proportion of the disabled are pensioners. Gainful employment is the main source of income for only a fraction of them. The higher level of training among the disabled has improved their potential for working life, provided that access is secured to the necessary technical aids and personal assistant services.

Promotion of education and employment for the disabled is included in the EU employment guidelines. Under Finland's National Action Plan for Employment, social protection for the disabled is being developed with a view to providing incentives for education and employment. The Rehabilitation Allowance Act and the National Pensions Act were amended as of August 1, 1999 to guarantee access to vocational training and a higher level of rehabilitation allowance for all disabled young people of 16 or 17 years of age. The amendment is primarily intended to reach such severely disabled young people who would previously have had to take disability pension at the age of 16 without

any sustained assessment of their working capacity or intensive programme of rehabilitation. Another amendment took effect at the same time, giving those receiving no other pension than the disability pension under the National Pensions Act an opportunity to temporarily suspend their pension. To make employment a more attractive option for the disabled than pension benefits, a disability allowance equal to the special-rate disability allowance is payable while the pension is suspended.

According to the Government Programme, the policy for the disabled is to be reformed with a view to replacing support channelled through tax relief with direct assistance and services.

Target and Action Plan for Social Welfare and Health Care 2000-2003

In October 1999, the Government approved a new Target and Action Plan for Social Welfare and Health Care to cover the period 2000-2003. The plan includes both recommendations to the municipalities and the steps to be taken by the Government to reach the envisaged targets.

The plan underlines the importance of preventive action. The guiding principle is to enhance interdepartmental and intermunicipal cooperation. Emphasis is also placed on ensuring adequate numbers of staff with the appropriate skills, thus preventing stress and burnout within the social welfare and health care sector.

Pressures for reform in services for the elderly

The growing trend for the elderly to continue living in their own home poses a challenge to the municipalities to improve housing conditions and living environments and to provide services which support independent coping. Reinforcing preventive measures and rehabilitation and increasing and diversifying community care services can all contribute to this aim. The service funding system and fee policy should also be developed to support community care. It is also important that cooperation between municipal social service and housing departments, building renovation work, physical and community planning and the transport sector function smoothly and that the new technology and technical aids are fully utilized. One of the recommendations in the Target and Action Plan for Social Welfare and Health Care is that the municipalities should provide preventive house calls to people over 80 to assess their general level of fitness, housing conditions and service needs.

The number of old people in institutional care has fallen throughout the 1990s. The elderly nowadays enter long-term institutional care in a poorer condition than they used to be. This increases the need for staff and imposes new requirements in terms of service quality. Health centre wards have not experienced a similar reduction in volume to that which has taken place in old people's homes. Their primary challenge is to secure adequate resources for long-term hospital care for the elderly. Furthermore, they must ensure the quality of care in a situation where some health centre wards have been given over to provide continued care for specialized medical care patients and thus serve a lot of patients other than elderly persons in long-term care.

Introduction of free pre-school teaching — changes to daycare fees

The Government Programme includes the introduction of pre-school teaching free of charge for all six-year-olds. While it remains optional for the municipalities to provide pre-school teaching in 2000, it will

become mandatory as of the beginning of August, 2001. Participation in pre-school teaching is voluntary, and is at the discretion of the child's guardian. The aim of pre-school teaching is to improve the learning ability of the child and help children make the transition from nursery education to primary school.

According to a survey conducted by the Ministry of Social Affairs and Health and the Ministry of Education, 78 per cent of six-year-olds were participating in pre-school teaching in January 1999. About 90 per cent of municipalities stated that they could provide pre-school teaching for almost all applicants.

Child-care arrangements vary a great deal according to the age of the child. No more than 26 per cent of children under three are cared for outside the home, while two-thirds of children aged 3-6 are in municipal daycare. The number of children cared for with the help of private child care allowance has been rising continuously.

Children's daycare fees are to change as of the beginning of the year 2000. According to the proposed change, the maximum fee is to be increased from FIM 1000 to FIM 1100 per month and fees are to be collected for 12 months if the child uses daycare services throughout the year.

Problems among children and young people are on the increase

Although Finnish children and young people are generally speaking in reasonably good health, there has been a considerable increase during recent years in the occurrence of psychosomatic symptoms including tension, exhaustion, eating disorders and anxiety. Alcohol and drug abuse among children and young people is an escalating problem. Smoking has become more common among young girls. The number of abortions among women under 20 is rising.

There has been a long-term drop in the number of children taken into care, but more children are now coming under various forms of community care. One of the indicators of this trend is that the number of children placed in some form of care outside their home has been increasing throughout the 1990s. The number of child welfare measures would be even greater if a number of municipalities had not decided to refrain from measures that would have involved major costs. The new equalization system for major child welfare costs came into effect on March 1, 1999. The system is intended to equalize the financial burden on individual municipalities from major costs incurred through child welfare. The aim is to guarantee the provision of appropriate child welfare services as and when they are needed.

Health care expenditure reaching pre-recession levels

Health care expenditure has grown over the past few years, with rising expenses recorded for specialized medical care in particular. However, compared to the beginning of the 1990s, there has actually been a fall in health care expenditure. There remain large differences between municipalities in per capita health care expenditure, although the differences have narrowed since 1993.

The growth in expenditure on pharmaceuticals has slowed. In 1998 a number of legislative amendments took effect which have controlled the growth in expenditure on pharmaceuticals and reimbursement of medical expenses. Growth in 1998 was a mere 2.1 per cent, while the annual increase has been in the range of 10 per cent since 1994.

Patients' share of the financing of health care has grown, and an unreasonably heavy financial burden may have been placed on people who use a lot of health services. A ceiling is to be imposed on the client fees for municipal health care in 2000. At the same time, the municipalities will be given the option of raising the fees charged for certain social and health services.

New models are being sought for the provision of social welfare and health care services

In recent years, the municipalities have sought various solutions for the provision of health care. Some municipalities purchase their health services from neighbouring municipalities. In the Helsinki metropolitan area, efforts are being made to achieve greater efficiency in health care by reorganizing specialized medical care. As of the beginning of 2000, a new hospital district (HUS) will replace the hospital districts of Helsinki and Uusimaa. Purchaser-provider models are creating interest among municipalities in various parts of the country.

Welfare and health organizations and the private sector are important suppliers of social and health services, accounting for one-fifth of the overall provision. The services provided by NGOs and private enterprise mainly supplement the public services. Non-profit organizations primarily produce social welfare services, while private enterprises concentrate on health services.

Some private-sector and NGO services are provided under outsourcing agreements with the municipalities. Such agreements are more common in welfare services than in health care. The most common private-sector services purchased are for the institutional care of children and young people. In health care, outsourcing agreements mainly cover ambulance services and various examination and support services. However, some municipalities have also entered into major health care agreements with private service providers.

Housing costs have risen — social assistance expenditure has decreased

Housing costs have risen sharply in recent years. The rise in rents and the price of owner-occupied accommodation has been particularly rapid in the Helsinki metropolitan area and other centres of population growth. Housing costs have been rising faster than incomes, and this has begun to impair the supply of labour in growth centres.

With employment picking up, social assistance expenditure has begun to fall. Widespread long-term unemployment is, however, holding overall expenditure at a fairly high level. One factor which has contributed to the decrease in expenditure is the reduction in entitlement to social assistance implemented in 1998. The rise in the level of housing allowance has also reduced the need for social assistance.

Income differentials continue to grow

Income differentials between households have grown in recent years, with the top tenth in particular increasing its share of total incomes. Underlying factors include the rapid growth in capital incomes, the persistently high rates of unemployment despite the recovery in the economy, and cuts in various forms of cash benefits. The equalizing effect of income transfers and taxation has weakened since the mid-1990s.

Income differentials in Finland and the other Nordic countries remain relatively low compared to the other OECD countries. In most OECD countries, income differentials were greater in the

mid-1990s than in the mid-1980s. Since then, income differentials seem to have continued to grow in Sweden and Norway, for instance. Thus, the recent increase in Finland is by no means exceptional.

The brighter employment situation has slightly reduced the importance of income transfers for household income formation. However, working-age households are still considerably more dependent on income transfers than they were before the recession. The proportion of working-age households almost totally dependent on income transfers would also appear to be remaining at a higher level than before.

Different income trends were recorded for the different age groups in the 1990s, with the young faring worse than others. Compared to the past, a larger proportion of young households were now living below the relative poverty line.

Key words: social expenditure, social protection, financing of social protection, income distribution, social welfare and health services, cash benefits.

1. SOCIAL PROTECTION EXPENDITURE AND FINANCING

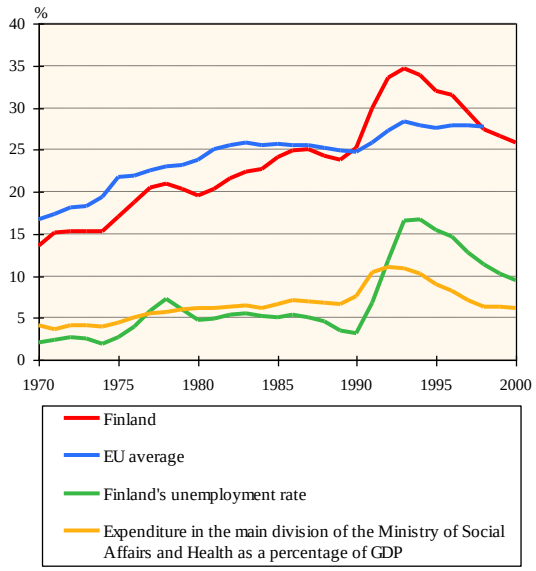
1.1. Trends in social protection expenditure[1]

In 1999, social protection expenditure is an estimated FIM 190.3 billion, or 26.5 per cent of GDP. In real terms, there will be a slight decrease in expenditure on the previous year. The ratio of social protection expenditure to GDP has fallen clearly below the EU average to reach the pre-recession level.

In 2000, the reduction in the ratio of social protection expenditure to GDP is expected to continue, with a nominal increase in social protection expenditure of FIM 4.2 billion, representing a real growth of 1 per cent. The increase in expenditure is due to growing medical and health care expenses and pension expenses.

The Government's budget proposal includes a nominal decrease in spending in the main division of the Ministry of Social Affairs and Health in 1999 and 2000. The expenditure in this administrative branch accounts for slightly less than a quarter of all social protection expenditure, or 6 per cent of GDP. (Figure 1)

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 1970-2000, %

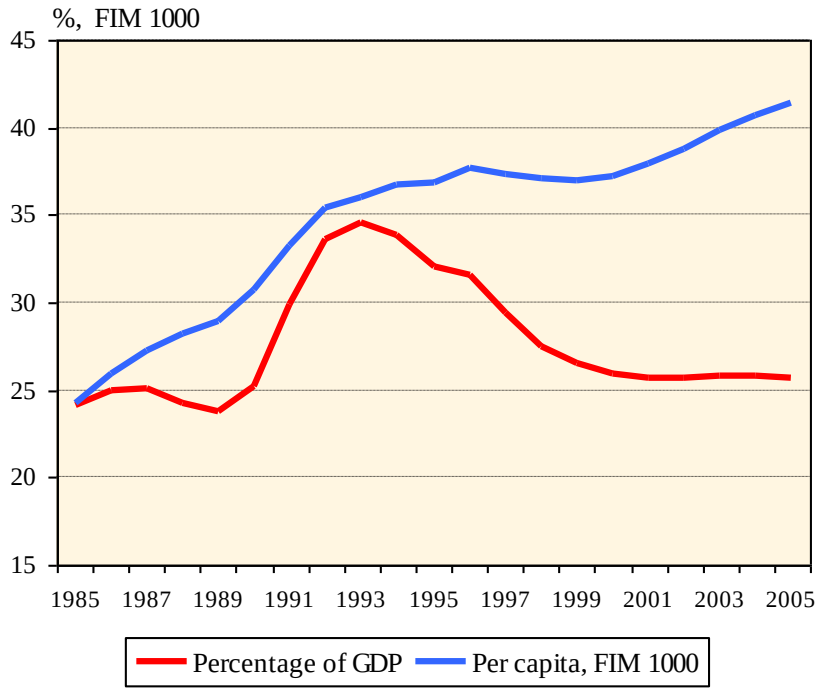


The rapid reduction in the ratio of social protection expenditure to GDP in the past couple of years is due to a rapid increase in production, a steep decline in unemployment and cuts in social protection. The real growth of GDP was 5.6 per cent in 1998 and, according to Ministry of Finance estimates, growth will

1 In line with other EU Member States, a changeover to net expenditure has taken place in statistics on social protection expenditure; in other words, client fees are no longer included. This must be taken into account when comparisons are made with statistics on previous years.

continue at nearly 4 per cent in 1999 and 2000. The combined effect of lower unemployment and cuts in social protection caused a real decrease in per capita social protection expenditure in the second half of the 1990s. The moderate level of wage increases has also served to slow the growth in earnings-related benefits and in the production costs of social welfare and health care services. Social protection expenditure will begin to rise again in 2000, with unemployment expenditure falling more slowly than the rise in expenditure in the other main divisions. (Figure 2)

Figure 2. Trends in social protection expenditure from 1985-1997 and forecast until 2005
At fixed 1999 prices



The number of benefit recipients is falling

The economic upturn in the last couple of years is apparent in the number of benefit recipients. The number of persons receiving unemployment security benefits continues to fall, even though the trend is regionally uneven. The number of persons receiving social assistance and maintenance allowance began to fall in 1998. In contrast, housing allowance expenditure is growing due to the 1998 adjustment to the income limits. The effects of this adjustment did not become fully apparent until 1999.

The recession has left a large number of socially excluded people who are permanently dependent on last-resort social benefits intended primarily as temporary remedies.

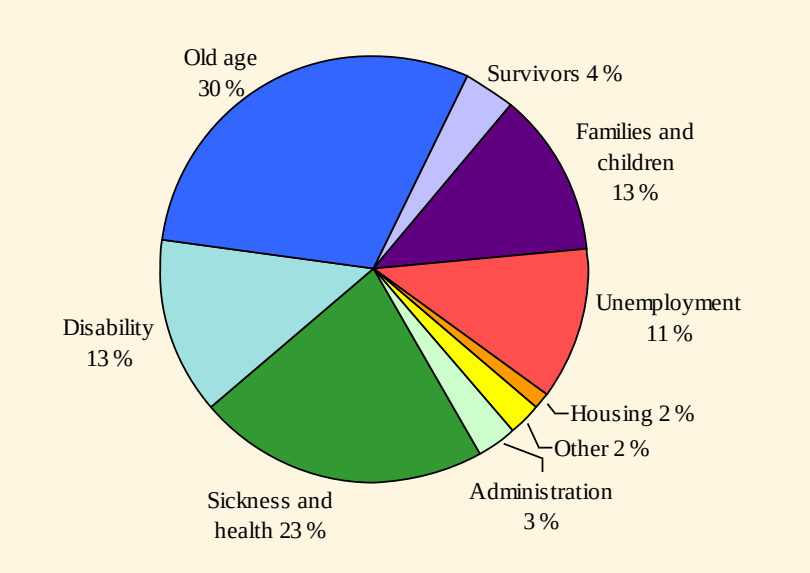
Long-term unemployment has for many become a permanent condition, a state of affairs reflected in the considerable increase in the uptake of unemployment pensions. The proposed amendments to unemployment pensions will scarcely be sufficient on their own to curb this trend. Unemployment pension will remain a primary path for retiring from work, in turn reducing the uptake of disability and individual early retirement pensions. Due

to the lowering of the minimum age for part-time pension, the number of people receiving part-time pension will grow significantly in 1999 and 2000.

The ageing population will bring a change in the structure of expenditure

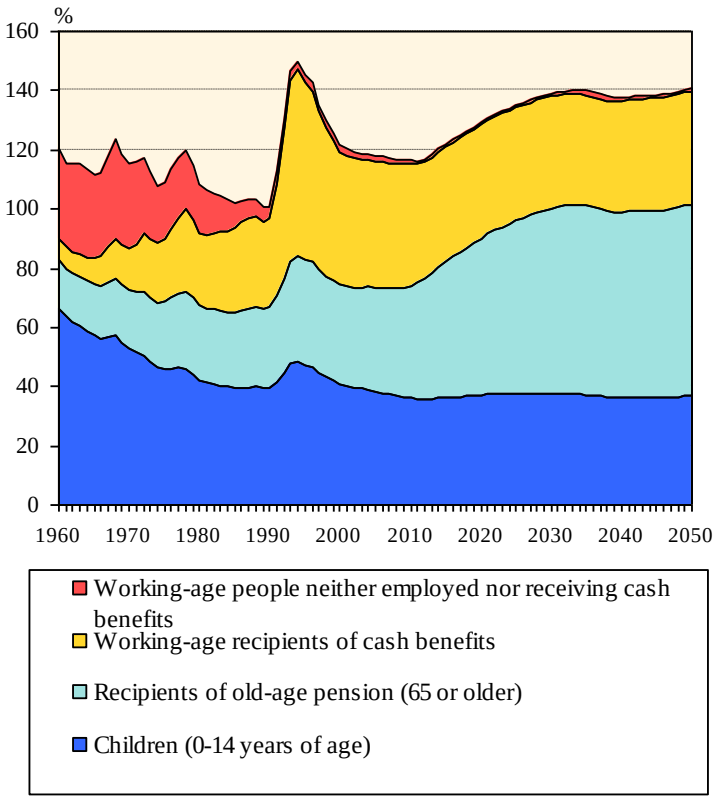
Old age is the largest main category of social protection expenditure, accounting for 30 per cent of the total in 1999. The ageing of the population will increase this expenditure even further; it is expected to take up nearly one-third of all social protection expenditure by 2005. The second largest category is sickness and health. Its proportion of total expenditure is also expected to grow, due both to the ageing of the population and to the rising costs of medical and health care. The proportion of unemployment expenditure was at its highest in 1993, when it accounted for nearly 16 per cent, a figure which has since fallen to less than 11 per cent in 1999. Besides the actual reduction in unemployment, this is also due to the lower proportion of the unemployed now receiving earnings-related unemployment allowance. (Figure 3)

Figure 3. Breakdown of social protection expenditure in 1999



The economic dependency ratio indicates how many non-employed persons are supported by one employed person. Mass unemployment caused a significant deterioration in the economic dependency ratio in the first half of the 1990s. Heavy pressure was placed on the income security system, since nearly everyone not gainfully employed from the age of 18 upwards is entitled to some sort of cash benefit. During the second half of the 1990s, the economic dependency ratio has improved along with the improvement in the employment figures. Improved employment both boosts tax revenues and reduces benefit expenditure, thus strengthening the financial base for social protection. However, even if economic growth should continue at a healthy pace, the significant growth in the number of people receiving old-age pension will cause an upturn in the economic dependency ratio once again after 2010. (Figure 4)

Figure 4. Development of the economic dependency ratio 1960-1998 and a projection until 2050



1.2. The financing of social protection expenditure

The financing of social protection expenditure is based on contributions by employers, the insured, the municipalities and central government. The long-term trend has seen a growth in the contributions by employers and the insured. The main reason for this is the growth in pension costs financed by employer and employee contributions. The employment pension and unemployment insurance contributions by employees introduced during the recession have permanently altered the financing ratio between employers and employees. During the recession, the deficit in the financing of the social protection system was, however, ultimately covered by increased government borrowing, which caused an increase in central government's share of financing. (Table 1 and Appendix 1)

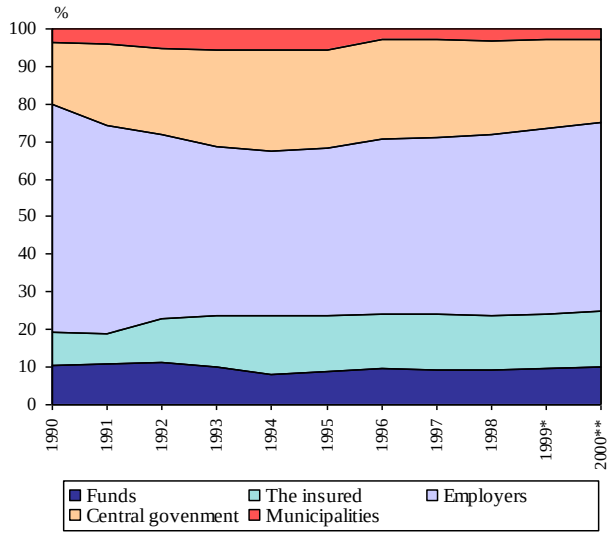
Table 1. Financing of social protection expenditure in 1997-2000, FIM billion

Year	*1997*	*1998**	*1999***	*2000***
Central goverment	***57,4***	***57,5***	***57,0***	***58,0***
- budget expenditure	40,1	39,7	39,0	38,6
- central government grants to the municipalities	13,9	13,2	13,0	14,5
- items outside the budget	3,4	4,6	5,0	4,9
Municipalities	***36,0***	***37,6***	***39,4***	***39,5***
Employers	***73,7***	***78,0***	***82,5***	***86,5***
- insurance contributions	57,1	60,5	64,2	67,7
- tax payments	8,9	9,1	9,6	9,4
- contributions unconnected to work	7,7	8,3	8,7	9,3
The insured	***27,9***	***27,7***	***27,8***	***28,2***
- insurance contributions	16,0	17,4	18,1	19,1
- tax payments	11,9	10,3	9,7	9,1
Interest and other capital income	***13,4***	***13,8***	***15,1***	***16,6***
Total	***208,4***	***214,4***	***221,8***	***228,8***
Clients fees	***8,7***	***9,1***	***9,5***	***9,8***

* preliminary data
** estimate

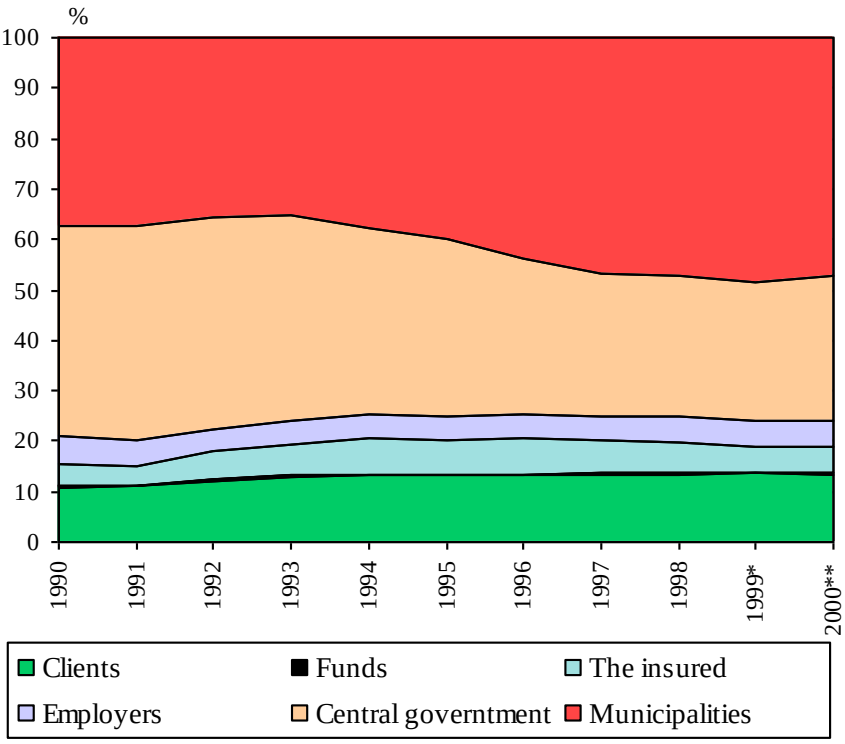
The financing structures of cash benefits, on the one hand, and social welfare and health care services, on the other, are markedly different. The bulk of cash benefits are financed by employers, the insured and central government. Income-adjusted cash benefits, such as housing allowances and labour market support, are in the main financed by central government. The municipalities' contribution to the financing of cash benefits is minor and has even been reduced in recent years. The only area where the municipalities account for a major share of financing is in social assistance and the various forms of support for the care of very young children. (Figure 5)

Figure 5. Breakdown of the financing of cash benefits, 1990-2000



The municipalities, in turn, play a major role in both the production and the financing of social welfare and health care services, accounting for around 60 per cent of total financing. This figure includes some 20 per cent covered by the grants paid to the municipalities by central government. (Figure 6)

Figure 6. Breakdown of the financing of social welfare and health care services, 1990-2000



1.3. The budget proposal for 2000 and social policy

The budget proposal for 2000 totals FIM 192.9 billion.[2] The expenses of the main division of the Ministry of Social Affairs and Health total FIM 43.0 billion, which is FIM 0.5 billion less than in 1999. Social protection expenditure is also financed from the other main divisions. Overall, the State budget accounts for approximately one third of the financing for social protection expenditure.

The final decisions on social insurance contributions and taxes are not made before the incomes settlement is resolved. Agreement has so far been reached on reducing unemployment insurance contributions and the higher-rate health insurance contributions collected on pension income. Cash benefits remain on the whole unchanged except for index adjustments.

The State budget proposal is based on a social welfare and health care policy which aims to maintain the Nordic welfare model. Social protection helps people to manage their own lives. The Government is committed to ensuring the quality and accessibility of social welfare and health care services throughout the country. The

2 Reduction of government debt by FIM 6 billion excluded.

Ministry of Social Affairs and Health has defined seven general strategic priorities to guide operations in its administrative sector: incentives and financing of social protection; stress at work and career continuity; preventing and combating social exclusion; healthy ways of life; functional capacity and a good living environment; ensuring access to social welfare and health care services and enhancing the effectiveness of care practices; promoting equality; and more effective control and guidance.

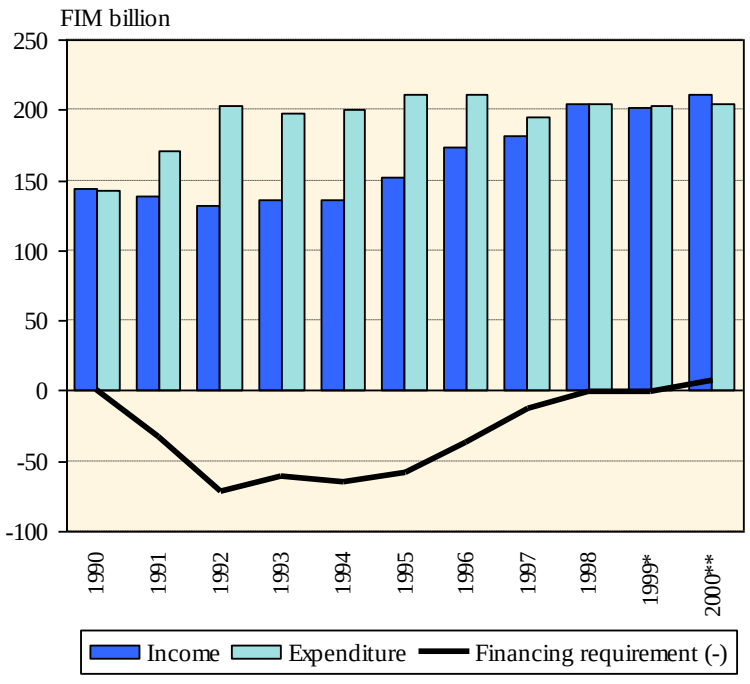
The budget proposal includes an important reform in the principle of the system: the municipalities' social welfare and health care services investment system is to be reformed in stages as of the beginning of 2000. The resources currently allocated to capital investment projects will be shifted to developing and enhancing the effectiveness of operations and reforming current practices in the municipal social welfare and health care services. The reformed system should be fully effective in 2003.

When the budget proposal was prepared, it was agreed, in accordance with the Government Programme, that the municipalities will be given the option of raising certain client fees charged for social welfare and health care services. At the same time it was agreed to impose an annual ceiling on the fees charged for health care.

1.4. Public finances

The consolidation of public finances continued in 1999, with the total public sector financing surplus rising to around three per cent of GDP. The debt ratio of the public sector (EMU debt per GDP) is also falling rapidly. According to Ministry of Finance estimates, the debt ratio will be down to 46.5 per cent by the end of 1999. The financial position of the public sector has been improved by the consolidation of central government finances. (Figure 7)

Figure 7. Central government finances 1990-2000



Source: Ministry of Finance

The central government financing deficit dropped to approximately 1.5 per cent in 1998 and is approaching zero in 1999. The surplus of the social security funds will remain at the previous level of more than three per cent of GDP in 1999. Municipal finances are more or less in equilibrium.

The outlook for the Finnish economy looks good for 2000. In 2000, central government finances will show a surplus for the first time since 1990. In terms of the national accounts the financing surplus is estimated to represent over 0.5 per cent of GDP.

In 2000, the consolidation of municipal finances will continue further and the surplus of the social protection funds will increase. Consequently, the total financing surplus of the public sector as a whole will rise to more than 4.5 per cent of GDP in 2000.

The generally bright economic picture also suggests a positive outlook for the municipalities. In 1998, the municipalities' aggregate annual margin increased by FIM 1.5 billion, although this was still insufficient to cover net investment. The annual margin is estimated to grow from FIM 8.9 billion in 1998 to FIM 9.2 billion in 1999.

The financial working group of the Advisory Board on Municipal Economy and Administration estimated in September 1999 that municipal economies will show a surplus as of 2000. In 1999-2003, the aggregate annual margin of municipalities and federations of municipalities will average FIM 13 billion. At the same time, the municipalities will be able to reduce their debts and increase their cash assets. (Table 2)

Even if municipal finances look good overall, the differences between the municipalities will remain significant. When we look at individual municipalities, the improvement in annual margins has mainly come in the large municipalities. The reasons behind the divergent trend of regional development include internal migration, changes in the distribution of corporate tax revenues, the high level of unemployment and other differences in the general trends affecting revenue and expenditure.

According to the 1998 financial statements, the annual margin of 71 municipalities was in deficit. The majority of these municipalities (42) had a population of less than 6,000. Estimates for 1999 indicate a slight increase in the number of these municipalities.

The annual margin is not, however, a straightforward indicator of a municipality's economic standing. Municipalities need the annual margin to finance investments and repay loans, and since their indebtedness and investment needs vary considerably, it is only to be expected that the margin will also vary from one municipality to another.

Table 2. Key indicators of the municipal economy, FIM billion, current prices

	1993	1995	1997	1999*	2000**	2003**
Action margin	...	-76,4	-73,2	-78,6	-80,2	-89,4
Tax revenue	47,8	57,9	65,4	71,5	77,7	88,2
Central government grants for current expenditure 1)	40,7	38	19,8	18,9	19,7	21,6
- of which administered by the Ministry of Social Affairs and Health	21,1	17,9	13,6	12,7	13,0	13,7
Other expenses, net	...	-4,0	-4,5	-4,8	-4,9	-5,1
Annual margin	10,3	13,1	7,4	9,2	12,3	15,1
Invetsments, net	6,6	5,6	10,8	12,5	12,0	12,5
Loan portfolio	31,6	25,8	25,9	27,6	27,6	23,6
Cash assests	12,2	19,0	15,7	14,5	15,8	19,4
Net liabilities (loan portfolio – cash assets)	19,4	6,8	10,2	13,1	11,8	4,2

* preliminary data

** estimate

1) according to the municipalities' own accounts

Source: Advisory Board for Municipal Administration and Economy

Since the social services and health care sector is labour-intensive, wage costs have a profound effect on municipal economies. The developments in municipal wage costs in the next few years will be affected by the incomes settlement for the municipal sector, which is still open at the time of writing.

The expenditure on municipal social welfare and health care services has grown in recent years. The bulk of this growth is due to the increase in health care expenses, with specialized medical care as the main growth item. However, according to a survey conducted by the Association of Finnish Local and Regional Authorities, the growth in health care expenditure in the largest cities slowed down in 1998. Total per capita health care expenditure in the major cities increased by only 0.7 per cent in 1998, compared to 2.7 per cent in 1997.

Falling unemployment, the coordination of housing allowance and social assistance as of 1998 and the adjustments to social assistance all serve to reduce municipal social assistance expenditure. In the longer term, the ageing of the population will increase expenditure on social welfare and health care services in the oldest age groups.

The improving employment situation has increased the demand for children's daycare places, but the fall in the birth rate will reduce demand again in the next couple of years. The number of children under school age is expected to fall by about 40,000 by 2005. Internal migration within Finland will increase the demand for and costs of daycare in areas of net population gain. Internal migration and the need to maintain the service structure will also mean that the reduction in daycare expenditure will not be as large as the fall in the number of children.

2. SOCIAL PROTECTION EXPENDITURE BY TARGET GROUP

2.1. Sickness and health

	1997	1998*	1999**	2000**
Expenditure on main category (FIM million)	39 695	41500	43 400	45 700
- of which cash benefits (FIM million)	7 493	8 000	8 400	9 000
% of social protection expenditure	21,3	22,1	22,8	23,5
% of GDP	6,3	6,0	6,0	6,0
Persons receiving national sickness allowance during the year	271 800	278 100	289 000	300 500
Primary health care				
- medical and health care visits/1,000 inhabitants	4 994	4 905	4 980	5 000
- dental care visits/1,000 inhabitants	987	955	1 020	1 040
- discharges/1,000 inhabitants	56	58	59	59
- bed days/1,000 inhabitants	1 574	1 578	1 580	1 580
Specialized medical care				
- outpatient visits/1,000 inhabitants	1 167	1 141	1 160	1 160
- discharges/1,000 inhabitants	181	176	180	190
- bed days/ 1,000 inhabitants	1 145	1078	1 100	1 160

* preliminary data
** estimate

Expenditure on sickness and health is estimated to total FIM 43.7 billion in 1999 and FIM 45.7 in 2000. Significant cuts were imposed on health care expenditure during the recession. Thus the expenditure in 2000 corresponds to the figure for 1992. The share of social protection expenditure attributable to sickness and health has grown in recent years and is still growing. The main expense items in this category are primary and specialized medical care, sick pay, national sickness allowance and other payments covered by national health insurance.

Big differences in health service costs and treatment practices

Municipal health care expenditure has been on the increase in recent years, with the focus of growth on specialized medical care. There are still major differences between municipalities in per capita health care expenditure, even if they have become less marked since 1993. In Helsinki, demand-adjusted expenditure on public health, specialized medical care and institutional care for the elderly is 18 per cent above the national average, whereas municipal expenditure on these items in the Päijät-Häme region is 13 per cent below the average. Apart from differences in demand, the differences in expenditure are also influenced by the use of different administrative models and Action practices.

A comparison of health care expenditure in major Finnish cities' over three consecutive years shows that the differences have decreased. Expenditure was highest in Helsinki and Oulu, and around FIM 1,000 lower per capita in Espoo and Tampere.

Information-based steering mechanisms are being applied to reduce the variation in costs and care practices. For instance, the Finnish Medical Society Duodecim and consultants' associations have implemented a joint project known as 'Current care' (evidence-based clinical practice) to draw up national care recommendations suited to

Finnish conditions. The purpose of the recommendations is to improve the quality of care and reduce variation in care practices. They provide practical support to doctors and can serve as a foundation on which to build regional care programmes.

Refunds of medical expenses going up

In 1998, national health insurance refunds of private sector medical fees came to nearly FIM 350 million. The number of payments were nearly 2 per cent up on the previous year, and this growth is expected to continue. On average, the national health insurance refund covers 38 per cent of the medical fee paid by the insured.

Refunds of expenses for examinations and treatment in the private sector came to a full FIM 340 million in 1998. The increasing use of private services means such refunds will continue to grow.

The number of persons receiving refunds for private dental fees increased sharply in 1998: 74 per cent growth on the previous year. The increase was due to the new right of those born in 1955 or earlier to be refunded for dental examinations and preventive dental care. Refunds of dental fees totalling nearly FIM 250 million were paid out to 660,000 people in 1998, of whom 293,000 were born in 1956 or later. Refunds for dental fees will continue to grow as entitlement is progressively extended to one more annual cohort each year. On average, the national health insurance refund covers 49 per cent of the dental fee paid by the insured.

Success in controlling expenditure on pharmaceuticals

There has been deceleration in the pace of growth in pharmaceuticals expenditure. A number of legislative amendments entered into force in 1998 aimed at slowing down the increase in pharmaceuticals costs and expenditure on refunds. In 1998 the expenditure on refunds grew by only 0.7 per cent, against an average annual increase of around 10 per cent since 1994. Total sales of pharmaceuticals came to FIM 8.2 billion in 1998. Refunds for medicine expenses totalled around FIM 3.4 billion, with payments going to 3.2 million people. About one million people received refunds for medication qualifying for special refunds.

The sphere of medication qualifying for special refunds was enlarged by Government decision in September 1999. The enlargement will be implemented in three stages by July 2000. This will increase drugs costs, although adjustments to the wholesale prices of drugs will bring some savings. Expenditure on refunds for medication will nevertheless grow more in 1999 and 2000 than in 1998.

There has been a rapid increase in the number of people receiving additional compensation for high annual medication costs. While less than 15,000 people received such additional compensation in 1990, their number rose to 83,000 in 1998 and is expected to grow still further.

The ageing of the population and introduction of new and more expensive drugs will create further pressures for growth in medication expenses. It is becoming increasingly important to ensure the appropriate use of medicines. Refunds should focus on drugs which help reduce the need for institutional care and improve the quality of life of the patients who use them. The three-year Rohto project, aimed at more rational use of medication, encourages doctors to assess their own working methods and care practices and to change them in the direction of optimal effect, safety and efficiency.

Expenditure on sickness allowance going up — the number of recipients of means-tested benefits going down

The national sickness allowance is paid to persons unable to perform their normal work due to sickness. Since 1996, sickness allowance has not been paid to people with earnings below a prescribed income threshold (FIM 5,578 per annum in 1999). However, a means-tested sickness allowance can be paid to people on no or low income once their disability for work has lasted for 60 days.

In 1998, sickness allowance totalling FIM 2.4 billion was paid out to 278,100 people. The average daily allowance was FIM 218. In 1999 and 2000 the number of recipients and the expenditure will continue to increase as the employment situation improves. The number of persons receiving means-tested sickness allowance rose until 1998, reaching 1,400, but has been falling slightly since the beginning of 1999.

Health care still mainly financed from public funds

The financing structure of overall health care expenditure has changed during the 1990s. The contribution of public financing, which accounted for 78-80 per cent of expenditure for a very long time, has fallen to around 75 per cent. The central government contribution to social welfare and health care services expenditure has fallen while the contributions from the municipalities and the Social Insurance Institution have grown. The financing contribution of households has risen by about 5 percentage points.

There seems to be unanimous agreement in Finland that the responsibility for service provision should remain with the municipalities in the future, that equal access to services should continue to be ensured and that the financing of services should continue to be mainly tax-based. This was also the view adopted in the Government Programme. Research indicates that the tax-funded model is more effective than other models in ensuring expenditure is held within the limits of economic growth and that equality of access is maintained. Administration and provision of services can be arranged in a variety of ways within the tax-funded model.

The financing system for services influences the operations and behaviour of the service providers and doctors and other medical staff. In hospital care, the preferred trend seems to be that the purchaser of a service agrees in advance with the hospital on the total budget for the services to be provided. Agreement only on detailed service prices or on the level of services required leaves open the question of how much the services will eventually cost.

Municipal doctors are usually paid a monthly salary. Family doctor experiments have also applied elements of capitation fees (determined by an agreed number of patients) and fees-for-service payments on top of a basic monthly salary. The OECD dealt with the salary system for municipal doctors in its 1998 report on Finland, in which it proposed a system where a monthly salary would be supplemented with capitation and fees-for-service payments. This would offer a way of controlling expenditure while still giving doctors more of an incentive to work in municipal institutions than has been the case so far.

Private insurance has hitherto accounted for a very small proportion of total health care expenditure in Finland, only about 2 per cent. Discussion on long-term care insurance is now spreading to Finland, too. However, there is no indication that the

proportion of private insurance will rise significantly over the next few years. Instead of insuring people en masse, private insurance tends to focus on more clearly defined objects.

Client fees at a high level — a payment ceiling is planned

Finnish health care client fees are among the highest in Europe. Although client fees will undoubtedly still have a role to play in health care financing in the future, the client fee system needs to be reformed to make it clearer and more transparent for both decision-makers and households. The aggregate client fees paid by an outpatient should be lower than the fees charged from a patient in institutional care. Advances in information technology make it possible to reduce the amount of paperwork related to collection of payments.

The Decree on Welfare and Health Care Client Fees has been amended to allow dependant family members to be taken into account in determining the client fee for long-term institutional care. Hitherto, a family's disposable income could be significantly reduced if the bread-winner were placed in long-term institutional care, since the fee equals 80 per cent of the client's net personal income. Under the amended decree, reduction of the fee according to individual circumstances must be considered in such cases.

A payment ceiling has been proposed for municipal health care fees as of 2000, in order to prevent unreasonably heavy financial burdens being placed on persons using a lot of services. Once the ceiling has been reached, the client would be allowed to use outpatient services free of charge and short-term institutional care at a lower fee. At the law-drafting stage, the planned payment ceiling was put at FIM 3,500 during a 12 month period not tied to a calendar year. In order to secure sufficient resources to cover basic municipal services, the municipalities will be allowed to raise some of the fees charged for social welfare and health services in 2000.

Public health trend largely positive

There has been a long-term improvement in public health in Finland. In a couple of decades, average life expectancy has increased by more than six years. The life expectancy of Finnish women is equal to the European average, whereas the life expectancy of Finnish men is slightly below the European average.

The various indicators of health, morbidity and general well-being paint a somewhat mixed picture of the trends in the 1990s. Mortality indicators suggest an improvement in public health. People's experience of their own state of health has also improved. In contrast, self-reporting indicates an increase in long-term morbidity and mental problems.

Circulatory diseases remain the largest single category of disease causing premature death, even though the morbidity rate for coronary disease, for instance, has fallen steeply. Hypertension, one of the most important risk factors in circulatory diseases, is the most common disease whose medication qualifies for special refunds under national health insurance.

The main problems affecting the health and general fitness of the population as a whole, alongside circulatory diseases, are musculoskeletal disorders, mental problems, allergies, diabetes and dementia. The category that causes the largest proportion of disability for work is mental problems. The incidence of serious mental problems on the level of psychosis has remained stable, but various forms of depression, in particular, have increased during the 1990s. Depression also features

prominently in new pension decisions. Musculoskeletal diseases were a growing cause of disability up to the 1980s, after which their incidence has fallen off slightly. As the population is ageing, musculoskeletal diseases will continue to cause a significant load on health care resources.

Allergies and asthma are among the most rapidly growing health problems. The treatment of allergies and, in particular, asthma has become more effective and hospitalization is not required as often as before.

With the ageing of the population, dementia is expected to become a major public health problem. It is estimated that the number of people suffering from dementia will rise to more than 90,000 in 2010.

Suicides are a major cause of death among young Finnish men. However, the mortality rate from suicides and accidents has fallen during the past decade. Meanwhile, alcohol-related mortality has risen. Alcohol has now become a more frequent cause of mortality for men of working age than suicide or accidents. Indeed, of all causes of death among men, 11 per cent are alcohol-related, while the proportion for women is 2 per cent. The trend in alcohol-related mortality has more or less closely followed the trend in total alcohol consumption. In 1998, alcohol consumption came to 7.1 litres per capita by official records, while the estimate for total consumption was 9.0 litres. Nine per cent of the adult population uses alcohol on a daily basis or almost every day. Population surveys suggest that this proportion has remained stable.

High costs from overweight

Extensive interviews have been conducted to build up a picture of public health behaviour. Public health surveys conducted in 1987 and 1995/96 investigated life styles which affect health, including smoking and alcohol consumption.

The percentage of adults smoking on a daily basis has fallen from 26 per cent to 23 per cent over less than a decade. Men smoke more frequently than women, with 25-44-year-olds smoking the most.

Obesity is a significant health risk which causes diseases that may load health care even more than smoking-related diseases. According to population surveys, the percentage of overweight adults has risen slightly. Eleven per cent of the adult population is overweight, and obesity becomes especially frequent after the 45th year of age.

Abuse of alcohol and drugs growing problem among the young

Young people's health habits have been surveyed for the past two decades. During the 1990s, the health implications of smoking, alcohol consumption and social exposure to drug abuse have become more serious. At the beginning of the 1990s, daily smoking increased among girls and decreased among boys. Among 14-year-olds, 17 per cent of girls and 12 per cent of boys smoke on a daily basis, while the figure for 16-year-old girls and boys is 30 per cent. The frequency of smoking as such among young people has remained unchanged during the past couple of years, but an increasing proportion of young smokers roll their own cigarettes. The use of snuff has grown significantly, particularly among boys.

The customary Finnish approach to drinking alcohol with the intention of getting drunk is also visible among young people. However, the increasing trend towards drinking to get drunk has tapered off during the past couple of years. On the

other hand, weekly drinking has become more frequent among young people, who have also become more accepting in their attitudes towards alcohol.

Experimental use and abuse of drugs has increased steadily during the 1990s, especially among the young, while drug-related problems have increased even faster than the figures for experimental use and abuse would indicate. Drug-related crime, for instance, is increasing rapidly and spreading throughout the country. Abuse of intravenous drugs, which has become more prevalent in the Helsinki metropolitan area especially, is reflected in an increased incidence of hepatitis and an HIV epidemic from shared needles.

Greater differences in health between population groups

Reducing health differences between population groups has been one of the main goals of Finnish health policy for a long time. However, despite the positive trend in life expectancy, the health differences between population groups have remained wide. Differences are particularly evident between the sexes, between social groups and between regions.

The difference in life expectancy between Finnish men and women is considerable. The life expectancy of a new-born baby girl is 80.8 years, while the figure for a new-born boy is seven years less, or 73.5 years. This difference is one of the largest in Western Europe; the difference in Sweden, for instance, is five years.

The differences in mortality between social groups have grown rather than diminished. Even though mortality has fallen across all social groups, the highest-educated group manifests the most favourable trend. Among men, differences in mortality according to civil status have grown; mortality among married men is much lower than among unmarried men, divorcees and widowers.

There are large and highly resistant regional differences in public health despite decades of health policy measures aimed at reducing such differences. People in southern and western Finland are healthier and live longer than those in eastern and northern parts of the country. There are also major differences in well-being between population groups within individual cities and municipalities. These differences have become more accentuated in recent years.

The Health for All 21 programme

Health equality is one of the main goals of the Health for All 21 programme, currently being prepared by the Government-appointed National Public Health Committee. The programme, which will cover the first two decades of the new millennium, is intended to provide a common basis for health policy and to promote the incorporation of health policy aims in all spheres of social policy.

Health issues to the fore in the EU

The EU has also been striving to promote consideration of health issues in a wider forum than just social welfare and health care policy. The Treaty of Amsterdam obliges all sectors of Community policy to take health considerations into account. Member States retain power of decision over national social and health policy, but decisions taken at EU level can have an indirect effect on practices and policy options at national level.

2.2. Disability

	1997	1998*	1999**	2000**
Expenditure on main category (FIM million)	26 554	25 500	25 500	25 700
- of which disability pensions and individual early retirement pensions (FIM million)	17 549	16 300	16 200	16 200
% of social protection expenditure	14,3	13,6	13,4	13,2
% of GDP	4,2	3,7	3,6	3,4
Recipients of disability pension on December 31 (no.)	295 000	288 000	289 200	282 800
Recipients of disability allowance on December 31 (no.)	11 600	11 600	11 600	11 600
Recipients of transport services during the year (no.)	3 370	3 200	3 000	2 800
Disabled households receiving home help during the year (no.)	55 100	58 600	60 000	61 000
Disabled recipients of informal care allowance during the year (no.)	6 620	6 290	6 300	6 300
Disabled recipients of informal care allowance during the year (no.)	7 590	7 640	7 700	7 750

* preliminary data
** estimate

No major changes in expenditure on disability

In 1999, social protection expenditure on disability came to an estimated FIM 25.5 billion, i.e. less than 4 per cent of GDP. The bulk of this expenditure, a good FIM 16 billion, comprised spending on disability and individual early retirement pensions. The expenditure on various services, a good FIM 5 billion, accounts for a fifth of overall expenditure on disability.

Expenditure on disability will remain largely unchanged in 1999 and 2000. Extensive take-up of unemployment benefits and unemployment pensions has reduced retirement on disability-related pensions; opting for retirement after a period of unemployment has become more prevalent. The reform in pension legislation which took effect in 1996 has also served to reduce pension expenses.

At the end of 1998, the average individual pension for recipients of disability pension came to FIM 5,160, and the average total pension to FIM 5,280 per month. Women's individual disability pensions amounted to less than 80 per cent of men's. Total pension for 54 per cent of the recipients came to less than FIM 5,400, while 16 per cent received a total pension in excess of FIM 7,500.

Low employment rate for the disabled

The high overall rate of unemployment has made it more difficult for people with disabilities to find a job. The employment rate for the disabled is below average and the proportion of pensioners high. Pension provides the main source of income for about three out of four persons receiving some disability-related benefit, while wages or salaries, entrepreneurial income or capital income are the main source for less than 20 per cent.

Disability allowance administered by the Social Insurance Institution (SII) provides financial assistance for disabled people who do not receive a pension, to help them cope with everyday activities, working life and study. Disability allowance is paid out on a three-tier system according to degree of disability, need for assistance and the amount of special expenses. The 1999

allowances were FIM 420, FIM 980 or FIM 1,820 a month. An indexed increment will be made at the beginning of 2000. Expenditure on disability allowance in 1999 equalled a good 2 per cent of the expenditure on disability pensions. The number of recipients of disability allowance has remained stable over a long period, at around 11,000. Many of the recipients do not have regular gainful employment.

The number of jobseekers with disabilities is steadily increasing. Their proportion among the unemployed population as a whole has varied according to the general unemployment situation. A figure of 11 per cent at the beginning of the 1990s fell to a 6 per cent low in 1994 due to the growing unemployment, only to rise again to 8 per cent in 1998 with the improving employment situation. At that point the proportion of the disabled among the long-term unemployed was 13 per cent. The employment offices usually verify disability on the basis of a medical certificate.

In 1998, 74,700 disabled jobseekers were registered as labour administration clients, of whom 62,500 were unemployed. Sixty-nine per cent of disabled jobseekers found a job or were placed in training, approximately the same percentage as the previous year. A higher proportion of those finding jobs were placed on the open labour market. The duration of unemployment is markedly higher for disabled people than for the non-disabled. The average duration of unemployment periods which ended in 1998 was 21 weeks, while the corresponding figure for the disabled was 34 weeks. The number of long-term unemployed with disabilities rose by a few per cent from 1997 to 1998.

The proportion of older people among disabled jobseekers has grown steadily. Currently around four out of ten jobseekers with disabilities are over 50. The long unemployment periods among this age group lengthen the average duration for the disabled as a whole.

The most frequent causes of disability were musculoskeletal diseases, respiratory diseases and mental problems. In all of these disease categories the number of disabled jobseekers has risen during the 1990s. The proportion of musculoskeletal diseases has been declining, while there has been a slight rise in the proportion of respiratory diseases. Mental problems peaked in the early 1990s, reaching 15 per cent, then fell temporarily and showed a slight rise again in 1997.

According to relatives of the mentally disabled and service providers' representatives, whose opinions were canvassed for the mental disability barometer compiled for the Finnish Association on Mental Retardation in 1999, access to work targeted specifically at the mentally disabled is fair, while access to newer forms of activity, such as supported employment and integrated forms of work, is not so good.

During 2000, the Ministry of Social Affairs and Health and the Ministry of Labour will be working with other ministries to prepare the necessary legislative amendments to eliminate obstacles and thus improve disabled people's chances of finding a job. For example, the 'future period' contributions large employers currently have to pay towards disability pensions may discourage the employment of disabled people.

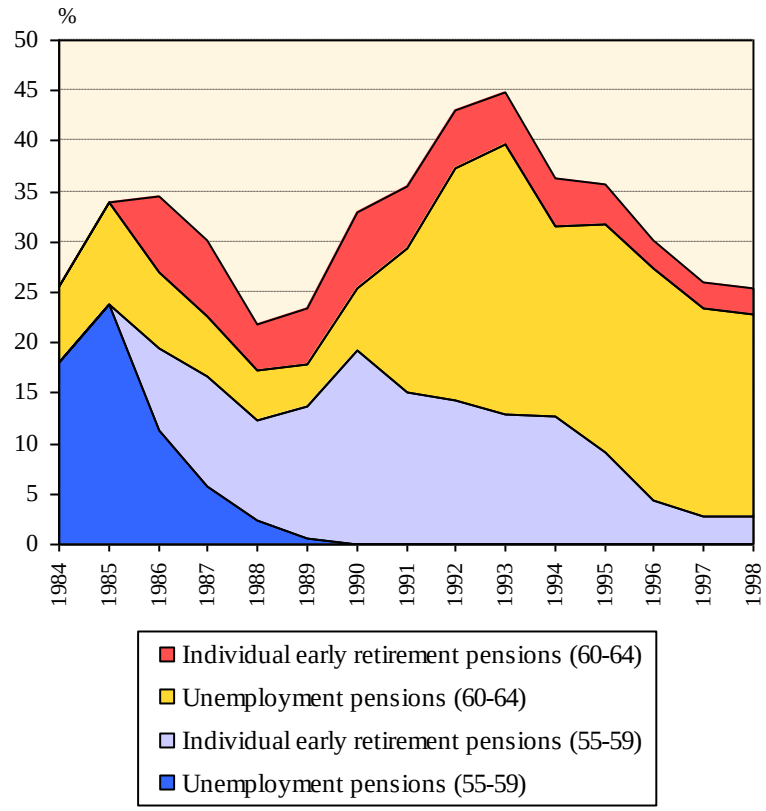
Disability and unemployment pensions as pathways out of working life

Currently 8.4 per cent of the working age population (15-64-year-olds) are on disability or individual early retirement pension. The number of recipients of a

disability pension does not provide a very precise measure of the actual number of people who lose their working capacity, as the number of people on disability pension is affected by the level of other social security provision, the definition of disability preferring entitlement to a pension, and changes in employment and working life. The most recent increase in the percentage of people on disability pension was largely due to the introduction of individual early retirement pension. In individual early retirement, inability to work through illness is defined less strictly than for the disability pension per se. The number of people taking individual early retirement peaked around ten years ago. In 1996, the minimum age for individual early retirement was raised from 55 to 58 years.

Currently around 40,000 people retire in Finland each year. One-third take up disability or early individual retirement pension. The number of new disability pensions has fallen to the level of the mid-1980s, and this trend is expected to continue. When we look at the 55-64 age group, we can see that early individual retirement has declined while the volume of new unemployment pensions has increased (Figure 8). In the current situation, raising the minimum age for individual early retirement pension to 60 years, as planned, will not affect the number of new pensions to any significant degree, as the number of individual early pensions taken up before the age of 60 is rather small already.

Figure 8. Percentages of new unemployment pensions and individual early retirement pensions in the 55-64 age group, 1984-1998



The average retirement age is 59 years. There are currently around 55,000 people of this age, but in a couple of years their number will exceed 85,000. If the relative retirement rates were to remain unchanged, the absolute number of people taking early retirement would grow rather rapidly to 50 per cent above the current level.

The rehabilitation subsidy introduced to replace fixed-term disability pensions may provide a significant alternative to unemployment pension if rehabilitation actually helps people to find work. The first data on the effects of the 1996 employment pension reform indicate that the change has been in the right direction. More rehabilitation subsidies were granted in 1997 than disability pensions for a specific period in 1995. At the same time, the number of open-ended disability pensions has fallen. In 1997, the average duration of the rehabilitation subsidy was about 10 per cent shorter than the duration of fixed-term disability pensions which ended in 1995.

Grounds for disability pensions

Circulatory diseases have declined considerably as grounds for disability pensions during the last two decades. Pensions granted on the grounds of musculoskeletal diseases increased sharply to the beginning of the 1990s, but have fallen away slightly since then. Changes in the percentage of pensions due to mental problems have not been as sharp, but a slight increase has been observable in the last few years. Figures 9 and 10 illustrate trends in the private sector only, since statistics covering both the private and the public sector are not available before 1996.

In 1998, 25 per cent of the new disability pensions and 16 per cent of the new individual early retirement pensions in the employment pension system were due to mental problems. One new phenomenon is the growth in the number of pensions granted on the grounds of depression: these now account for nearly 10 per cent of all disability pensions. For those under 45, mental problems are the most frequent cause of retirement on disability pension.

The growing percentage of employment pensions granted on the grounds of mental problems is a worrying sign of problems in working life itself and in the working capacity and fitness of certain population groups. Alongside musculoskeletal diseases, mental problems present one of the major challenges to the health care and rehabilitation system, working life and local communities. 'Treating' burnout, depression and other mental problems with early retirement is both expensive and inefficient. Special attention should be paid to the prevention of stress at work in the case of ageing workers, on the one hand, and to provision of mental rehabilitation for young people, on the other. The young suffering from mental problems run a high risk of exclusion from training and working life. Exclusion of young people from working life causes a variety of long-term expenses to society, due to pension costs, other social protection costs and crime.

Figure 9. New disability pensions in the private sector according to cause of disability, 1986-1998

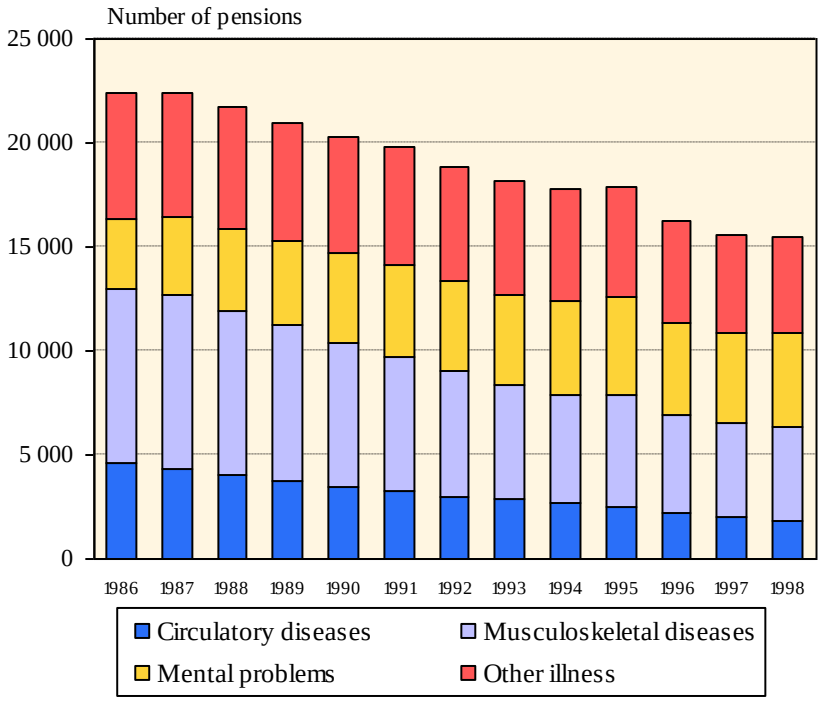
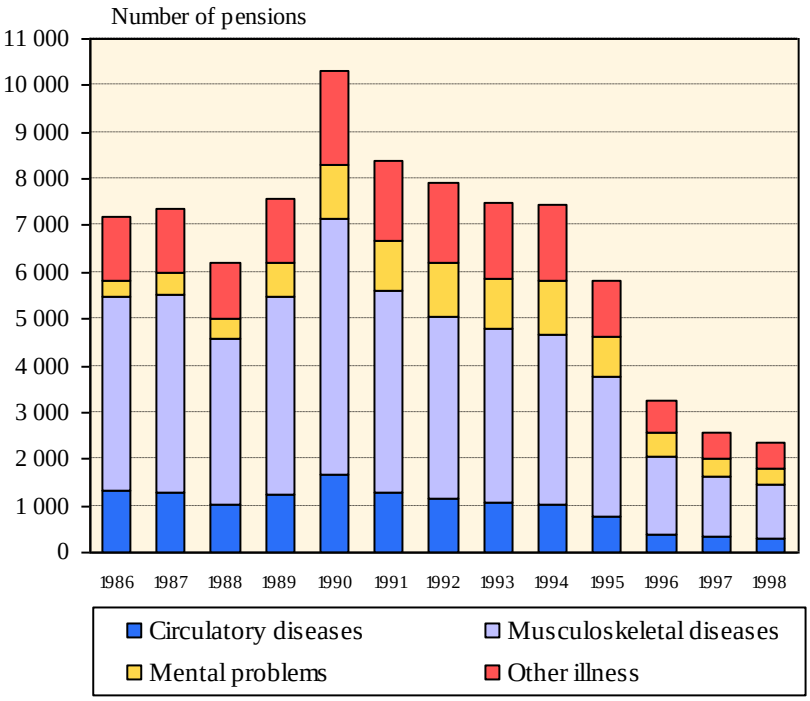


Figure 10. New individual early retirement pensions in the private sector according to cause of disability, 1986-1998



Measures to improve working capacity and postpone retirement

The resources devoted to rehabilitation have increased considerably during the 1990s. The Government reported on rehabilitation to Parliament in the autumn of 1998. From 1992 to 1997, expenditure on rehabilitation was estimated to have grown 20 per cent in real terms. In 1997, spending on rehabilitation came to an estimated FIM 6.3 billion, or 1 per cent of GDP.

According to the report, the key challenges for rehabilitation include maintaining the working capacity of working-age people and improving the employment potential of people with different degrees of disability. The Government also took the view that there was a need to clarify the division of responsibility between organizations providing rehabilitation, especially in rehabilitation related to working life and in vocational rehabilitation. Another aim was to improve the effectiveness of rehabilitation by strengthening the role of the rehabilitee in planning and implementation.

The responsibility for providing vocational rehabilitation is divided among a number of bodies: the Social Insurance Institution, accident insurance, traffic insurance and employment pension institutions, and the labour and education authorities. Only part of the rehabilitation expenses are included in social protection expenditure. In 1997, total expenditure on vocational rehabilitation amounted to an estimated FIM 975 million. Of this, services and treatments accounted for FIM 530 million and the remaining FIM 445 million covered expenses for income security during rehabilitation.

The Social Insurance Institution is responsible for providing vocational rehabilitation for people whose working capacity and potential for earning an income are significantly weakened due to illness, a defect or disability. In 1998, expenditure on such rehabilitation amounted to FIM 259 million, or FIM 16,340 per person. Expenditure is estimated to have increased slightly in 1999.

Rehabilitation under employment pension legislation has increased every year, but it still accounts for only a small proportion of vocational rehabilitation. It is estimated that employment pension institutions provided rehabilitation for 2,700 people at a cost of FIM 72 million in 1998.

In order to evaluate the effectiveness of vocational rehabilitation, the situation of participants after rehabilitation has been followed up. Participants' lives seem to have changed for the better thanks to vocational rehabilitation: the proportion of people with jobs or actively engaged in education or training is usually higher than before rehabilitation.

The Government Programme aims high: the goal is to raise the average working life leaving age by 2-3 years in the long term. The Government' approach is to promote early detection of impending loss of working capacity in order to facilitate an earlier start to rehabilitation. The goals of the Government Programme are largely in line with the National Programme on Ageing Workers (1997-2002), which aims to fine-tune working life, social insurance and the various services in ways which promote employment of ageing workers and their retention in working life.

Workplace health promotion (WPH) plays a major role in the National Programme on Ageing Workers. The source material for the 1998 WPH barometer was collected from 805 workplaces, where the three key

parties for WPH activities (management, personnel and occupational health care) were interviewed. According to the results of the barometer, WPH activities have been increased, they are widely known and varied, and people believe in their effectiveness. WPH activities at a workplace usually include various enhancements to work and the working environment, work planning and cooperation, training to improve the staff's professional skills, self-motivated education and instruction on the use of tools. Among measures taken to promote general fitness and health, physical exercise was most common, alongside opportunities for pursuing hobbies. The majority of workers came within the sphere of WPH. The impact of WPH was felt to be most apparent in the workplace climate and the improved physical fitness of the employees. WPH activities were considered to bring financial benefit and their cost equivalence was rated as good.

In small workplaces of fewer than 20 people, the WPH situation was weaker than in large workplaces. This must be taken into account in developing reimbursement practices and service supply. A challenge that concerns all workplaces is to pinpoint the workplace-specific development needs and shape WPH activities accordingly. Particular attention should be paid to preventing burn-out and managing change at the workplace. The content of occupational health care should also be diversified. It is essential for effective and productive workplace health promotion that the activities are consistent, well-organized, correctly focused and pursued with sufficient resources. Reliable tools should also be developed for measuring and monitoring WPH impact and its costs and benefits.

The representatives of the central labour market organizations and employment pension institutions in a working group lead by Mr. Kari Puro have agreed on arrangements concerning private-sector employment pensions. In October 1999, the Government introduced a bill to Parliament based on the working group's proposals. In addition to amendments reducing the attractiveness of unemployment pension (see section 2.6), the Government proposed raising the minimum age for individual early retirement pension from 58 to 60 years. At the same time, the opportunities for rehabilitation of people aged 58 or 59 would be increased by obliging employment pension institutions to conduct a rehabilitation examination on disability pension applicants of this age. According to the bill, the minimum age for part-time pension would remain 56 years until the end of 2002, at least. The measure is intended to help keep ageing people in working life until the statutory retirement age.

Reforms to promote vocational rehabilitation and employment of the disabled

Social protection for the disabled is being reformed to provide incentives for education and employment. The Disability Allowance Act and the National Pensions Act were amended as of August 1, 1999 to secure all disabled young people aged 16 or 17 an opportunity for vocational rehabilitation combined with a rehabilitation allowance of FIM 2,100 a month. Depending on the level of training, the rehabilitation allowance for a disabled young person is FIM 640-830 higher than the former rehabilitation allowance for vocational training. The new rehabilitation allowance combined with other benefits (most often child allowance and disability allowance) now provides a more competitive alternative to disability pension.

The amendment is primarily intended to reach such severely disabled young people who would formerly have taken disability pension directly at the age of 16 without any sustained assessment of their working capacity or intensive programme of rehabilitation. Young people who begin vocational rehabilitation at the age of 16 or 17 are eligible for rehabilitation allowance until they complete their first vocational qualification or until their rehabilitation comes to an end without one. This means that disability pension is not granted until the end of a rehabilitation period already in progress, even if the young person in question turns 18 during that period. Formerly, disability pension could be granted while vocational rehabilitation was still in progress, which was inefficient and did not encourage the person concerned to enter working life. The reform means that a person under 18 years of age can only be granted a disability pension after it has been confirmed that potential for vocational rehabilitation is lacking, rehabilitation has been interrupted due to illness, or rehabilitation has ended without a qualification.

In 1998, 642 young people aged 16 or 17 started receiving disability pension, while 224 took rehabilitation subsidy. The amended legislation is estimated to give rise to additional expenses of FIM 0.8 million in 1999, due to the replacement of disability pension and rehabilitation subsidy with rehabilitation allowance and related measures, child allowance and disability allowance. The additional expenses for 2000 are estimated at FIM 4.4 million. Savings are expected as of 2005. The higher the percentage of rehabilitation patients who find jobs instead of taking pension, the higher the savings will be.

There have been improvements to the position of people participating in rehabilitation in the form of apprenticeship training. The Rehabilitation Allowance Act was amended to include a provision that makes disabled people eligible for disability allowance administered by the Social Insurance Institution during a period of apprenticeship, subject to certain conditions. This enlargement of the scope of disability allowance will raise rehabilitation expenditure by a few million marks. On the other hand, it is also expected to help open up training and employment opportunities for people with disabilities and thereby to bring savings in the long term.

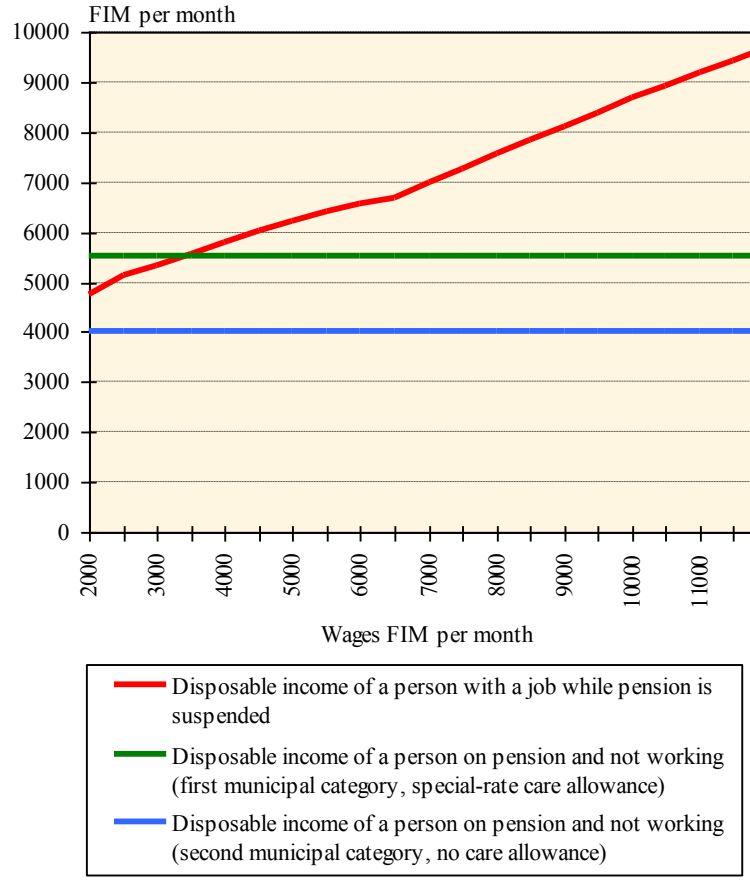
Another legislative amendment took effect on August 1, 1999, entitling persons receiving only the disability pension under the National Pensions Act to temporarily suspend their pension for a period of at least six months and a maximum of two years. In order to make work a more attractive alternative for the disabled than pension benefits, disability allowance at the amount of the special-rate disability allowance (currently FIM 1,820 per month) is payable while the pension is suspended.

At the end of 1998, about 48,800 people were receiving open-ended, full disability pension under the National Pensions Act. In 2000, the amendment is expected to reduce aggregate expenditure by FIM 9 million. The calculations are based on the assumption that an average of 3,000 pensions would be suspended annually.

The examples presented in Figure 11 show that persons whose disability pension is suspended can reach a disposable income equal to their pension at a relatively low level of earnings. The figure compares the disposable income of a person whose pension is suspended to the disposable incomes of people receiving full national pension. General housing allowance and pensioners' housing allowance, which are earnings-related, are included in the gross incomes. The examples show that even persons who receive special-rate care

allowance in addition to pension exceed their disposable income on pension at monthly earnings of FIM 3,500. For instance, people with monthly wages of FIM 5,000 receive a disposable income FIM 700-2,200 higher than their income on pension.

Figure 11. Disposable income of persons with suspended pension, examples calculated for 1999



1999 tax rules, municipal tax at 17 %, church tax at 1.2 %. Rent at FIM 2,000 a month.

Services for the disabled

Provision of equal access to high quality services and aids at a reasonable price is a key component of any policy for the disabled which emphasizes the improvement of people's working and functional capacity. During the 1990s there has been an increase particularly in the type of services to which the disabled are considered to have subjective rights. Such services include medical rehabilitation arranged by the Social Insurance Institution and certain other services under the Services and Assistance for the Disabled Act.

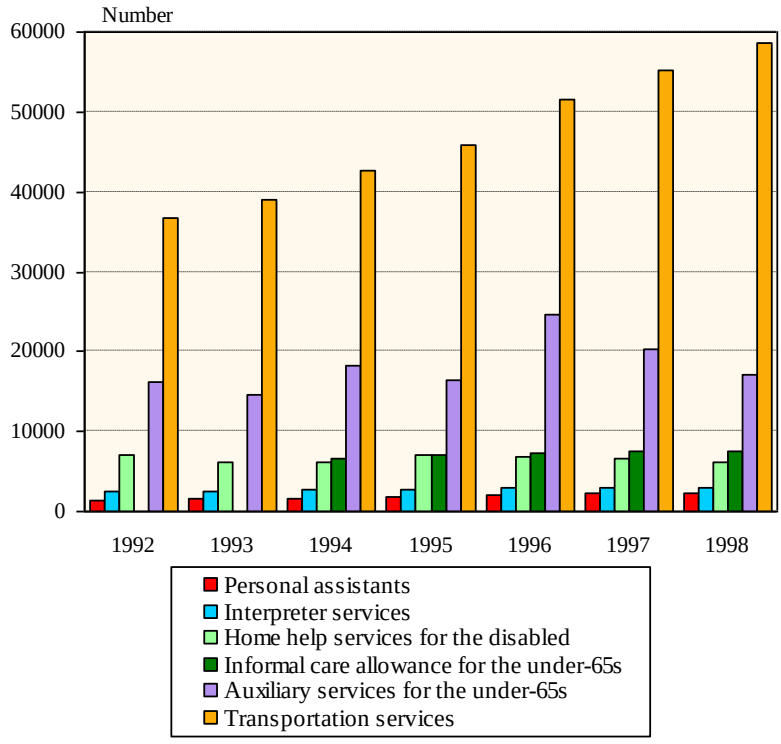
In terms of expenses and the number of patients, the medical rehabilitation provided by the Social Insurance Institution for the severely disabled has been growing continuously. The largest increases have been in the number of rehabilitation patients with mental problems and mental handicaps. In the case of severely disabled children, the rehabilitation provided is comprehensive, and the proportion of children under the age of 16 has risen, now accounting for

almost half of all severely disabled people who receive medical rehabilitation. In 1998, the expenditure on medical rehabilitation amounted to FIM 346 million, or FIM 21,830 per patient. The cost estimate for 1999 is FIM 375 million.

The current Services and Assistance for the Disabled Act has been in force in its entirety since 1994. From 1994 to 1997 real expenditure on services and assistance under the Act rose by more than a third. The growth in expenditure can be expected to continue, due to the new emphasis on community care and the need to develop services for the disabled. In 1998, expenditure on services for the disabled totalled an estimated FIM 715 million. Assuming that 1.2 per cent of the population annually receive services for the disabled as referred to in the Services and Assistance for the Disabled Act, 1998 expenditure would equal FIM 11,600 per recipient.

Transportation is by far the most widely used service among the disabled. In 1998, a total of 2,380 disabled people received help to pay for a personal assistant. There was almost no change in the number of disabled people receiving home help or people under 65 cared for with the help of informal care allowance. There was a fall in the number of clients using auxiliary services for the under-65s in 1997 and 1998. (Figure 12)

Figure 12. Disabled and chronically sick people receiving services for the disabled, home help services and informal care allowance, 1992-1998



Studies show that there is some inequality of access to services between different groups of disabled people. The position of mental patients, the mentally handicapped and people with brain damage and certain rare disabilities is particularly problematic. Rehabilitation provided by the Social Insurance Institution is no exception in this respect, as some groups of disabled people do not qualify equally. These issues are among the problems addressed in the proposals submitted by the 1996 working group on disability.

According to the benefit statistics of the Social Insurance Institution, there are about 30,000 people with varying degrees of mental handicap in Finland. Of these, some 6,000 are severely handicapped. The services needed by the mentally handicapped consist of the services intended for the population at large and special services for the mentally handicapped or other disabled people. About 21,000 people use the special services for the mentally handicapped.

The aim to reduce the proportion of institutional care in the care for the mentally handicapped has been successfully attained. Institutional care has been replaced with housing services, which have been the fastest improving service for the mentally handicapped over the past couple of years. In 1998, the number of people with mental handicaps in institutional care dropped by a further hundred. At the end of the year, institutions for the mentally handicapped cared for 3,150 people. The downward trend in the number of care days also continued.

In 1997, the staff working in institutions for the mentally handicapped averaged 4,300. Successful continuation of the ongoing alteration of the service structure in care for the mentally handicapped will require the transfer of staff from institutions for the mentally handicapped to the provision of assistance for independent accommodation within municipal community care services. The main development needs concern the volume and quality of housing services and the various forms of temporary care within community care. Severely disabled adults need small family community homes.

There has been a drop in the use of special services for the mentally handicapped provided by the Special Care Districts. The current aim is actually to provide services for the mentally handicapped primarily in the form of normal services for the population at large in their home municipality. The role of the Special Care Districts, meanwhile, is becoming increasingly clearly defined as one of arranging institutional care and serving as centres of expertise which support the municipalities' basic services.

It is estimated that there are almost 3,000 mentally handicapped people living at home with parents over 65 years of age. Most of these people will need housing services in the next few years. Other service needs include home care services, family care, day-time activities and support and guidance for the families of the disabled. A working group is to be established in 2000 to find ways to promote independent accommodation of disabled adults and related services, especially in the case of people in institutional care or living with their parents.

Improving the position of families with disabled children

The advances in thinking about care and the related technology are changing the lives of families with disabled children. An increasing number of severely disabled children are cared for at home. The care principles underlining community care and rehabilitation also receive broad support among parents of disabled children.

The current system of services and assistance for the disabled is extensive and not always easy to grasp. There are also defects in the supply and integration of assistance and services. A family with a disabled child may have dozens of partners to cooperate with. The division of labour between the various authorities does not always function smoothly and flexibly enough from the client's point of view. To provide a tool for managing the situation, it has been proposed that the care and

rehabilitation network should draw up a joint plan covering the necessary services and assistance. The Target and Action Plan for Social Welfare and Health Care recommends that the municipal social services and/or health care department should appoint a service counsellor for the client in cases where a number of service forms are needed simultaneously over a longer period of time.

Tax relief to be replaced by direct assistance and services

According to the Government Programme, the resources for the policy for the disabled will be reallocated on the basis of the proposals submitted by the 1996 working group on disability. Financial aid channelled through taxation will be replaced by direct assistance and services. The necessary legislative amendments will be prepared by 2001. The working group proposed the scrapping of tax relief for disability in central government and municipal taxation and the channelling of the resulting increase in tax revenues to increase services for the disabled and rehabilitation and to raise the level of direct support for the disabled. The aim is to concentrate support primarily on promoting the working and functional capacity of severely disabled people.

2.3. Old Age

	1997	1998*	1999**	2000**
Expenditure on main category (FIM million)	54 100	56 300	57 800	59 600
- of which old age pensions (FIM million)	46 600	48 500	49 900	51 600
% of social protection expenditure	29,1	30,0	30,3	30,7
% of GDP	8,5	8,2	8,0	7,9
Recipients of old age pensions on December 31 (no.)	836 700	843 900	851 100	860 800
Inhabitants in old people's homes on December 31 (no.)	22 300	21 400	21 200	21 000
Elderly households receiving home help services during the year	85 400	84 800	85 500	86 500
Auxiliary service recipients aged over 65 during the year	103 300	105 600	107 700	109 800
Recipients of informal care allowance for the over-65s during the year	12 700	12 800	12 900	13 000

* preliminary data
** estimate

Ageing of population causes increase in social protection expenditure on the elderly

Social protection expenditure on the elderly, an estimated FIM 57.8 billion in 1999, forms the biggest single category of all social protection expenditure. This accounts for an estimated 30 per cent of social protection expenditure and 8 per cent of GDP. Pensions and other income transfers accounted for 90 per cent of expenditure on this main category, while social services accounted for the remaining 10 per cent. These figures do not include expenditure on health care services used by the elderly.

Expenditure on the elderly is increasing year by year. The increase in old age pension expenditure is due to both an increase in the number of pensioners and a higher absolute level of pensions. The crucial factors for expenditure on services are old people's health and general ability to cope and the range of public services on offer.

At the end of 1998, the average individual pension of people on old age pension was FIM 4,920 a month and the total pension was FIM 5,440. The total pension for men came to an average of FIM 6,500, while that for women was FIM 4,700. Fifty-seven per cent of people on old age pension received a total pension of under FIM 5,000 a month, while 16 per cent received a total pension of more than FIM 7,500 a month. The percentage of pensioners who receive only the national pension is constantly falling. At the beginning of 1999, 9 per cent of those receiving the national pension as old age pension were receiving the full amount of the national pension. At the beginning of 2000, the employment pensions of people over 65 will go up by 1.4 per cent, while the national pension will rise by 1.1 per cent.

Finland's comprehensive pension security and public social welfare and health care services mean people of pensionable age need social assistance less often than people in younger age groups or old-age pensioners in many other countries. In the 1990s, 2-3 per cent of the over-65s have received social assistance each year. In

1998, the number of households of people over 65 receiving social assistance fell by 9 per cent. Old people generally need social assistance for short periods only.

People over 65 and their ability to cope

In 1997, the life expectancy of 65-year-old men in Finland was 15.0 years, while the corresponding figure for women was 18.9 years. An 80-year-old Finnish woman could expect to live for another 8.1 years, while the corresponding figure for men was 6.6 years. The life expectancy of Finnish women is among the highest in the world, while that of men has also increased. Even so, the life expectancy of 65-year-olds, for instance, is almost three years shorter for both men and women than in Japan, which tops the statistics.

There are few comprehensive studies suitable for comparison on trends in elderly people's functional capacity. A comparison of the results of the 'Mini-Suomi' study conducted in 1979-1981 and the FINRISKI-97 study show that the general fitness of people aged 65-74 has improved in many ways. Regional research projects have yielded similar results. Fewer studies have been made of people over 75, but some results indicate that the general fitness of the older age groups has also improved.

According to an OECD estimate, the improvement in elderly people's functional capacity has been most noticeable in the 65-80 age group. According to studies conducted in certain OECD countries, an average of 45-80 per cent of the remaining lifetime of 65-year-olds consists of 'active life' — defined as the person's ability to cope with everyday life on their own. Serious disabilities which limit independence usually occur during the last 1-2 years of life.

The functional capacity of people over 65 is likely to continue to improve, but in the short term the changes are not likely to be very great. The risk of reduced capacity to cope increases with rising age, so the increasing number of elderly people and increasing longevity in general will still cause an increase in the need for help and services. Finland will be one of the leading countries in the world in terms of the increase in the number of people over 80 years of age.

An obstacle-free environment supports independence

The ageing of the population poses an increasing challenge for the development of housing and other aspects of the human environment. The totality formed by housing, the environment in general and services is essential to elderly people's ability to cope on their own. The general ability to function and quality of life of elderly people can be improved through community planning, physical planning, housing policy and transport policy. The need for new service housing and for social welfare and health care services can be reduced if housing and the environment in general are planned from the outset so as to be suitable for all ages.

According to the traditional criteria for sub-standard housing, only an estimated one in seven people over 65 lives in such housing. Central heating, running hot water, a sewer connection and electricity are not enough in themselves to guarantee that elderly people can manage; many elderly people still live in environments which are not conducive to their ability to function and live independently, for instance in blocks of flats without lifts or in poorly planned housing in areas where local shops and services have become scarce. Three-storey buildings in Finland seldom have lifts, and even one in five buildings over three storeys have no lift. In

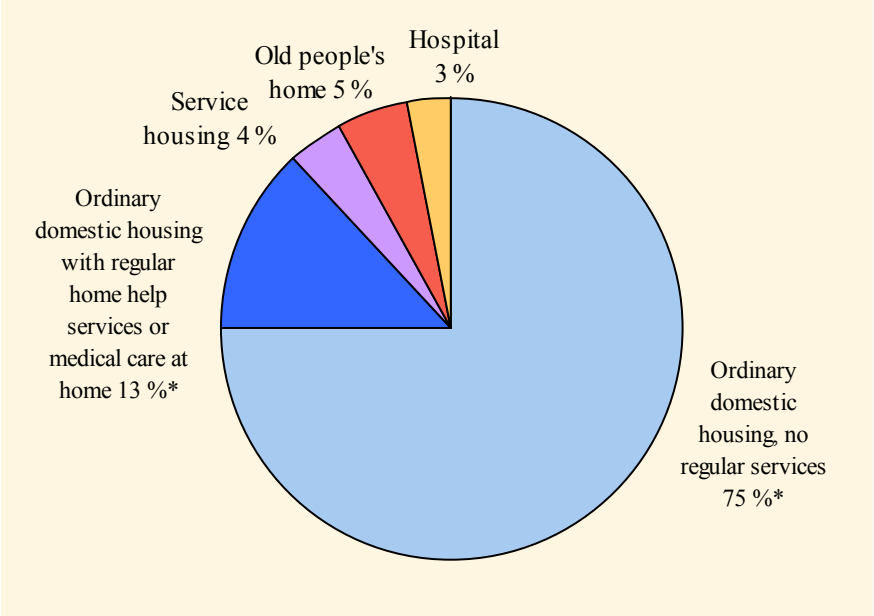
1997, 105,000 people over 65 lived in a block of flats without a lift. 32,000 of them lived in buildings with four storeys or more. Such deficiencies in housing and the general living environment mean increased social welfare expenditure and also detract from the quality of life of elderly and disabled people, causing feelings of insecurity and loneliness.

The Target and Action Plan for Social Welfare and Health Care for 2000-2003 encourages local authorities to ensure cooperation between the building sector, municipal housing departments and social services. Local authorities are further encouraged to improve the opportunities for home care by refurbishing apartments and making use of the latest technology and technical aids. In 2000, a project for joint purchasing of inexpensive lifts will be launched, including the development of new lift types.

A need for more non-institutional care

The majority of people over 75, 88 per cent, live at home in ordinary domestic accommodation. Most of them are not in need of regular social or medical services. Thirteen per cent of the over —75s receive regular weekly services in the home (home help services or home nursing). Four per cent of people over 75 live in service housing, while 8 per cent are in long-term institutional care (Figure 13). The numbers of elderly people in long-term institutional care and their proportion of those over 75 have fallen throughout the 1990s.

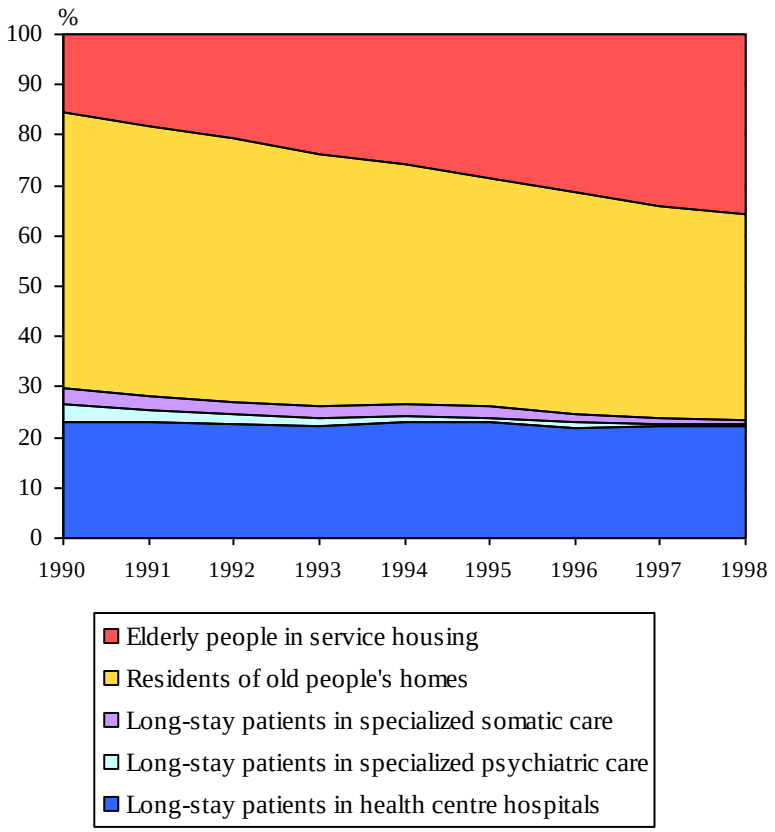
Figure 13. People over 75 and their type of housing in 1998



*) The division of those living in ordinary housing into users and non-users of services is based on data from 1997.
Source: Kauppinen 1998 and SOTKA

The structure of municipal services for the elderly has changed considerably during the last 10 years. Long-term institutional care has been reduced, to be replaced primarily by an increase in the volume of service housing. (Figure 14)

Figure 14. The structure of institutional care and service housing for the elderly, 1990-1998. Residents of old people's homes and service housing, and long-stay hospital patients aged over 75



Source: Kauppinen, 1999

In many municipalities, non-institutional care for elderly people who live in ordinary housing has not been increased or developed to any great extent, unlike the situation for service housing. The comprehensiveness of home help services has been greatly reduced, especially in the early 1990s when home help services were concentrated on the oldest people and those in poorest condition (Figures 15 and 16). The number of clients has fallen, but the level of help needed by individual clients has risen. The fall in client numbers for home help services for the elderly continued in 1998, although at a slower pace than hitherto. The use of auxiliary services remains lower than in the early 1990s; one of the reasons for this is thought to be the client fees for services.

Staff numbers in municipal home help increased in 1996 and 1997, but began to fall slightly in 1998. In 1998, an average of 13,700 people were employed in home help services. Most of their time was devoted to elderly people. There is, however, a shortage of staff. A lack of time and strict allocating of services may often lead to a situation where the preventive and rehabilitative aspect of home help services is in practice negligible, and where elderly people and their relatives feel insecure due to worry about access to services. This may in turn create increased demand for service housing and institutional care.

Figure 15. Percentage shares of the recipients of the main forms of care for the elderly in Finland in 1990-1998

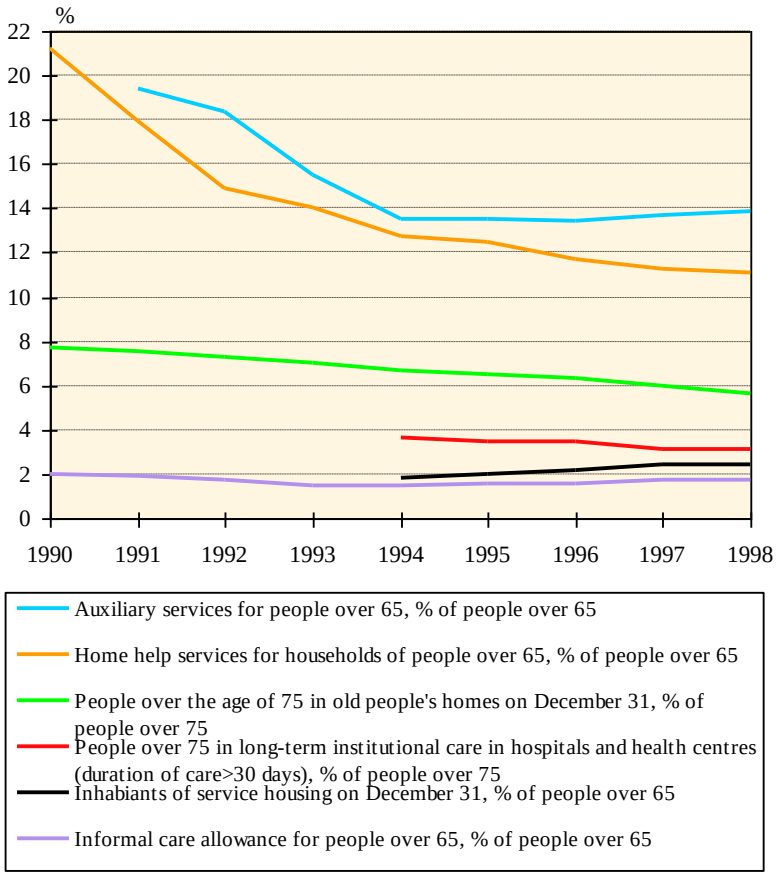
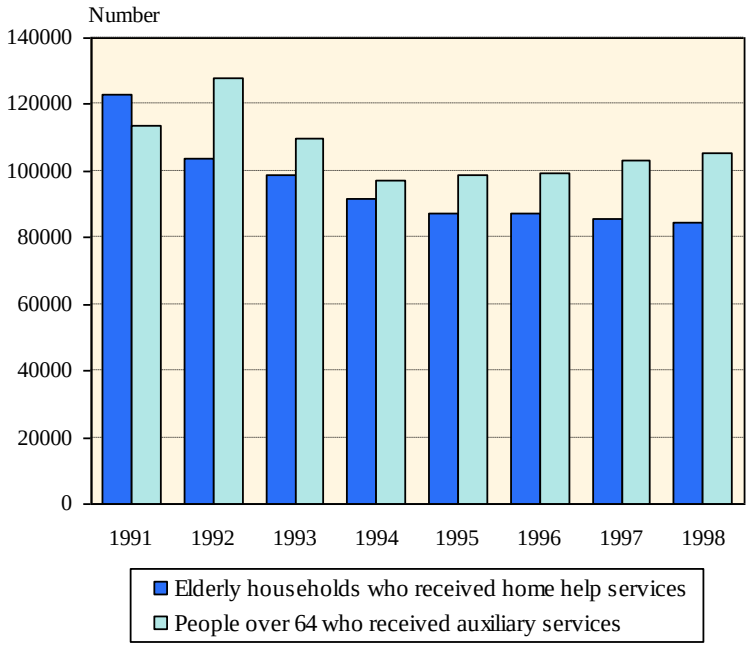


Figure 16. People over 64 who received home help services and auxiliary services, 1991-1998

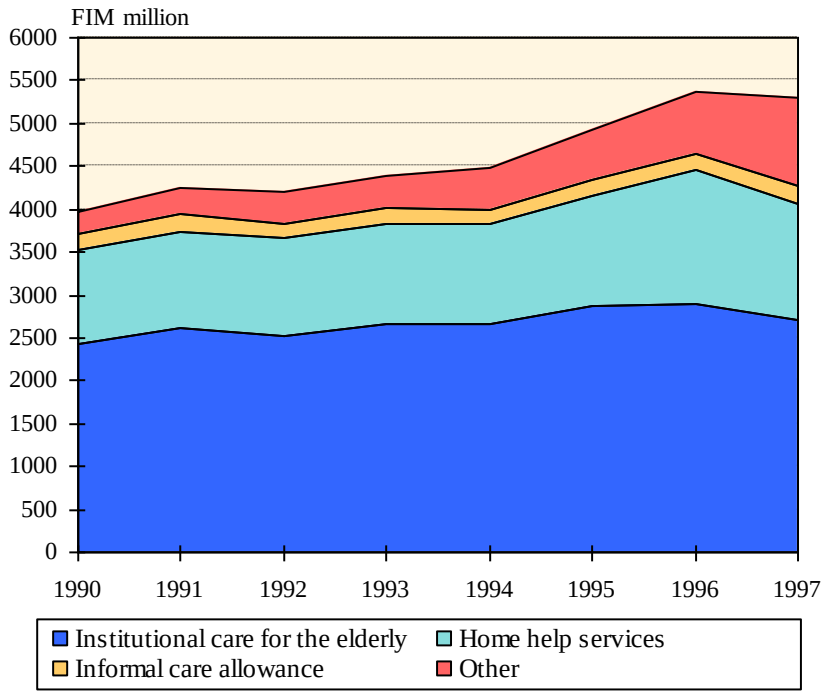


Not all people receiving home nursing are statistically recorded by age group. In November 1997, 12,720 of regular home help clients over 65 received home nursing only, while 14,430 clients received both home nursing and assistance with household chores.

Since the beginning of 1998, recipients of informal care allowance have had a statutory right to take at least 24 hours off per month during which they are tied to caring for someone on a daily basis. In 1998, statutory informal care allowance was used to provide care for 12,800 people aged over 65, the same number as the previous year. The average level of informal care allowance paid by the municipalities has gone up; in 1998, it was about FIM 1,700 a month, although there are considerable differences in the amount of the allowance between different municipalities. It was estimated in 1998 that informal care allowance for the care of family members in the home had reduced the costs of institutional care by about FIM 1.3 billion. The biggest savings were achieved by the municipalities in institutional care of the elderly.

Social services for the elderly are mainly used by people over the age of 75. The number of people over 75 years of age increased by 11 per cent from 1990 to 1997. During the same period, expenditure on social services for the elderly (excluding client fees) rose by 18 per cent in real terms. The highest rise was recorded in expenditure on service housing, day centres and other new types of activity. Meanwhile, expenditure on care for the elderly in old people's homes fell by 1.8 per cent in real terms. The number of bed days in old people's homes has been falling consistently. From 1997 to 1998, the number of bed days fell by 1.7 per cent. In 1997, the running costs per bed day at an old people's home came to FIM 340 excluding client fees and FIM 440 including client fees. In the same year, care in old people's homes accounted for an estimated half of the expenditure on social services for the elderly. (Figure 17)

Figure 17. Expenditure on social services for the elderly, 1990-1997



The quality of institutional care

Many changes have taken place in institutional care during the 1990s. The volume of long-term institutional care has fallen, while the average age of patients receiving such care has risen. Elderly people are now in a poorer condition than before when they enter long-term institutional care. The economic situation of municipalities and the changes in the structuring of care have influenced staff numbers and structure and the operation of the wards at hospitals caring for long-stay patients. Some staff have been hired with employment subsidies, causing a much higher staff turnover. Some health centre wards have been given over to provide continued care for specialized health care patients, and while this is a desirable development in itself, it may cause certain problems for elderly people in long-term care.

The situation and quality of institutional care varies from one region to the next and even between institutions in the same region. The quality of care is a function of many different factors: the general functional capacity of the patients, the numbers and structure of care staff, the physical care environment, the financial resources available, and the care and management traditions of a particular institution. Staff numbers for institutional care for the elderly fell by about 400 in 1998, to 18,240 employees (exclusive of staff in hospitals).

Despite the undoubted problems of the 1990s, there has also been some progress. For example, an increasing number of small, separate care units for dementia sufferers have been set up by municipalities across the country. Wards have also been divided into smaller units, either by altering their physical structure or by introducing new divisions of responsibility. Development projects have brought about changes in practices and hospital care traditions, including a reduction of routines in favour of more individual care and individual daily rhythms.

Areas of emphasis: prevention, rehabilitation and quality

Reforms of services for the elderly must focus on developing preventive and rehabilitative measures and providing a greater variety of non-institutional care. Housing and services should be combined to form a functioning whole. The accessibility of various types of local services should receive more attention. The wider the variety of services on offer, the more flexible and appropriate is the help available to elderly people with different needs. Experience shows that considerable savings can be made in institutional care for the elderly if adequate resources are set aside for preventive measures and rehabilitation. The rehabilitative approach also needs to be promoted in institutional care.

One of the approaches recommended in the Target and Action Plan for Social Welfare and Health Care is for the municipalities to offer preventive home visits to people over the age of 80. This would provide an opportunity to assess the general functional capacity, housing conditions and service needs of elderly people. Quality recommendations for services for the elderly will be drawn up in cooperation between a number of different bodies to support general quality management work in the municipalities.

The National Research and Development Centre for Welfare and Health (Stakes) is conducting a development project for institutional care for the elderly in cooperation with the municipalities during the period 2000-2003. The aim is to improve the quality of institutional care

and expand the range of services available. Improvement of staff skills and expertise will also be promoted, particularly in the care of dementia sufferers. The Ministry of Social Affairs and Health is to allocate funding to support supplementary training in the social welfare and health care sector, with the care of dementia patients as one of the areas of focus.

Alongside public service provision, new methods of provision and funding for services for the elderly have also been increasingly introduced. A system of service vouchers could provide more alternatives and freer choice of services to supplement municipal service provision. Service vouchers can be introduced once it is relatively easy for clients to assess the effectiveness, quality and costs of services, and once the supply of services is adequate. The Ministry of Social Affairs and Health is in charge of assessing the results of service voucher experiments and preparing a proposal for the application of voucher systems.

Funding of services for the elderly

It is thought that the change in the service structure has slowed the rate of increase in costs of services for the elderly. It is difficult, however, to distinguish the effects of the service structure on costs from the consequences of the recession, the effects of reallocating services and other factors. The change in the service structure has also affected the contribution of different funding bodies to the total funding of services for the elderly.

In social welfare services, the client contribution to the funding of services is higher than in health care services. The client contribution varies a great deal, however, between different services. For instance, in service housing and auxiliary services for the elderly, where the municipalities are relatively free to decide on the level of fees, the client contribution is usually much higher than in old people's homes.

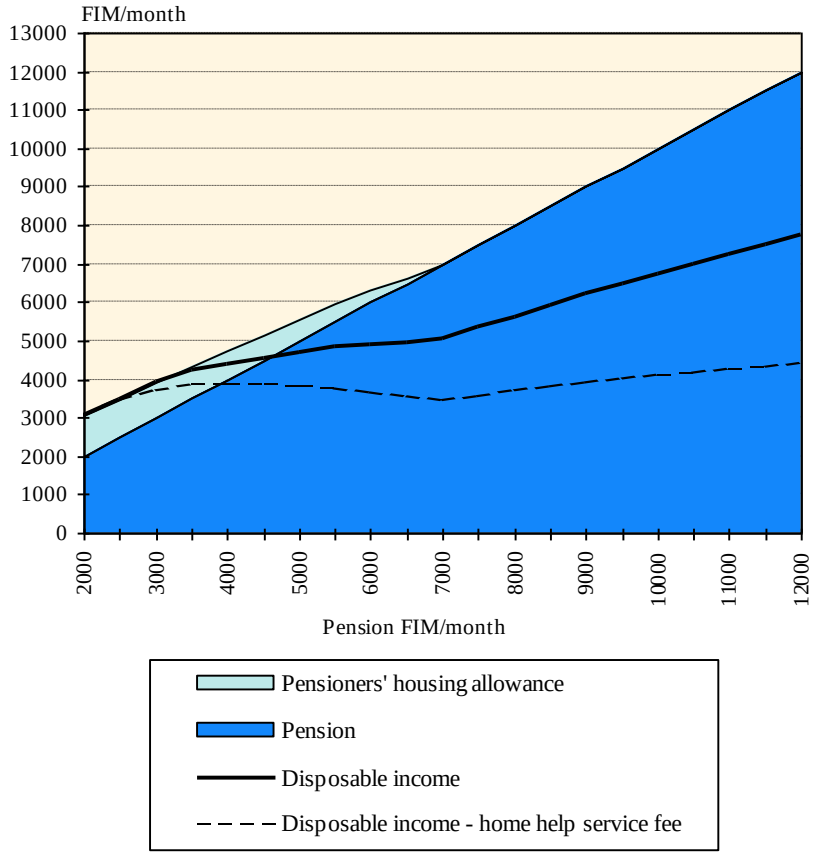
Services, housing and cash benefits together form an integral package in the lives of elderly people. The benefits paid out by the Social Insurance Institution (SII) are linked to the type of housing. The national pension is reduced for people in long-term institutional care. Housing allowance, care allowance and reimbursements for medical expenses are only paid to people who are not in long-term institutional care. The structure of services for the elderly influences the distribution of costs between the municipalities and the SII in such a way that the increase in non-institutional care and various forms of service housing care is causing an increase in SII expenditure.

From the client's point of view, the present service funding system and payment policy do not provide optimum support for choosing home care as the first alternative. Different criteria are applied in determining the fees for regular home care, auxiliary services, housing services and long-term institutional care. On the whole, non-institutional care for the elderly is usually less expensive for society than institutional care. In order to provide the best possible basis for a service-policy based on non-institutional care, home care should also be less expensive for the users of the service. In the present situation, it might be cheaper for them to be in institutional care, as the client fee for long-term institutional care (80 per cent of net income) covers food and lodging, care and medication. Meanwhile, elderly people in non-institutional care must pay for housing, food and medication in addition to client fees.

It is important for the fairness of the payment system that it does not produce poverty traps. A poverty trap is a situation

in which the disposable income after service fees is lower the larger the gross income of the person concerned. The poverty traps experienced by elderly people are caused by the combined effect of progressive taxation, income-deductible allowances — usually housing allowance — and a client fee for home help services which rises according to the level of gross income. (Figure 18)

Figure 18. Income formation for a pensioner living alone in 1999



Tax rules for 1999; municipal tax at 17.55 per cent, church tax at 1.2 per cent. The highest monthly fee for continuous and regular home help services and home nursing services permitted by the decree on client fees. Rent at FIM 1,700 a month.

2.4. Social protection for survivors

	1997	1998 *	1999**	2000**
Expenditure on main category (FIM million)	7 181	7 400	7 800	8 200
- of which survivors' pensions (FIM million)	6 941	7 150	7 550	7 900
% of social protection expenditure	3,9	3,9	4,1	4,2
% of GDP	1,1	1,1	1,1	1,1
Recipients of survivors' pensions on December 31	243 450	247 550	258 600	266 100
Recipients of child's pensions on December 31	29 350	28 900	28 900	28 900

Expenditure on survivors' pensions and funeral grants will come to an estimated FIM 7.8 billion in 1999 and nearly FIM 8.2 billion in 2000. This is about 4 per cent of total social expenditure. The 1990 reform of survivors' pensions continues to cause an increase in the number of recipients of widow's/widower's pension. The reform extended the right to such pensions to widowers and, under certain conditions, to former spouses.

The main form of survivors' pension is the widow's/widower's pension. The number has been rising steadily as the population ages. At the end of 1999, there were an estimated 260,000 people in receipt of widow's/widower's pension. In 1998, the average widow's/widower's pension was FIM 2,268 a month.

There has been an annual average of around 29,000 children receiving child's pension. In 1998, the average child's pension was FIM 1,556 a month.

2.5. Families and children

	1997	1998 *	1999**	2000**
Expenditure on main category (FIM million)	22 810	23 400	23 700	23 900
- of which cash benefits (FIM million)	13 874	14 000	13 900	14 000
% of social protection expenditure	12,3	12,5	12,5	12,3
% of GDP	3,6	3,4	3,3	3,2
No. of mothers receiving parenthood allowance on December 31	49 900	48 400	48 400	48 200
No. of children in municipal daycare on December 31	219 700	218 500	220 000	218 000
Families receiving child home care allowance on December 31	75 500	74 400	72 000	71 500
No. of children receiving private day care allowance on December 31	9 700	12 800	14 000	14 000

* preliminary data
** estimate

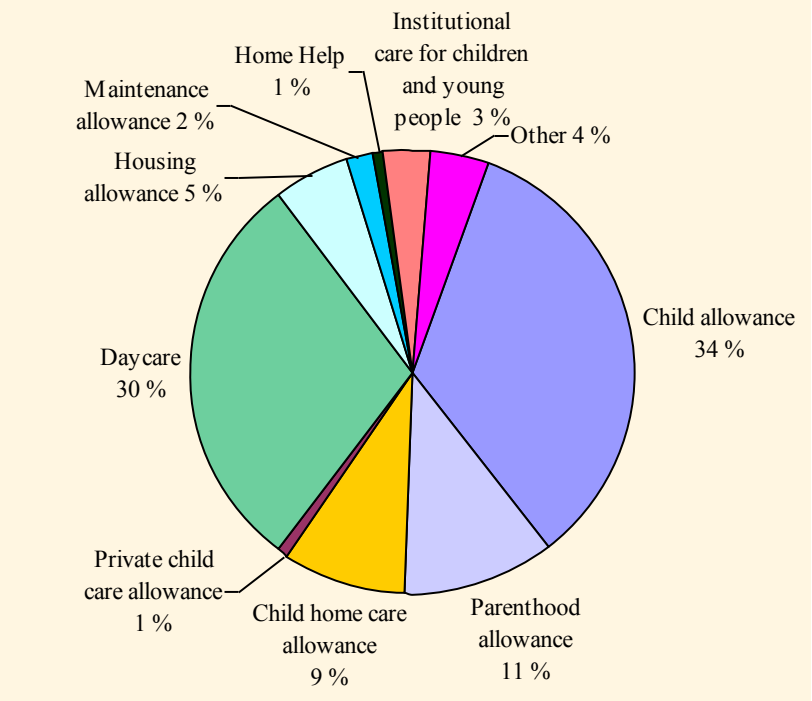
Child allowance and daycare the main forms of support for families with children

The aim of the family policy support system is to cover the expenses arising from providing for children in order to ensure that childcare does not place an overwhelming financial burden on families. In 1998, family policy support came to about FIM 25 billion or about 3.6 per cent of GDP.[3] Expenditure on family support has not changed much in the last few years. Child allowance and daycare provision are still the main forms of support for families with children. (Figure 19)

Expenditure on child allowance came to FIM 8.4 billion in 1998. Expenditure has fallen slightly in recent years due to the falling birth rate, and this trend is expected to continue. 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 steadily rising. At the end of 1998, the supplement for single parents was paid for 154,000 children, which was 3,400 children more than the previous year.

[3] Family policy support is a more extensive concept than the 'families and children' concept of expenditure in this main category. It also includes benefits such as the general housing allowance paid to families with children under the social expenditure main category 'housing'.

Figure 19. Distribution of family policy support in 1998



Expenditure on parenthood allowance came to FIM 2.7 billion in 1998. Expenditure in this category has fallen at a steady rate in recent years due partly to the fall in the birth rate. The fall in expenditure has also been due in part to the fact that the economic recession caused an increase in the number of mothers receiving only the minimum parental allowance from 6 per cent to 28 per cent.

According to advance estimates for 1998, total expenditure on children's daycare will come to about FIM 350 million more than the previous year. The reason for this is that the number of children in daycare has increased. The improved employment rate has also caused an increase in the demand for daycare. According to preliminary data, the total 1998 daycare expenditure will come to FIM 8.5 billion, 15 per cent of which will be covered by daycare fees.

In 1998, expenditure on statutory child home care allowance came to FIM 2.0 billion, which was FIM 128 million less than the previous year. The new form of support, private child care allowance, was paid to a total of FIM 107 million. Uptake of part-time care allowance has been very limited. Municipalities may supplement statutory forms of support with municipal supplements. In 1998, a total of FIM 191 million in municipal supplements for home care allowance and FIM 57 million in municipal supplements for private child care allowance were paid out through the Social Insurance Institution. The municipalities pay municipal supplements in an attempt to reduce the demand for municipal daycare. Municipal supplements have been introduced especially in the larger municipalities.

In 1998, housing allowance to a sum of FIM 1.3 billion was paid to families with children, about FIM 64 million more than the previous year. The increase was due to the increases in the level of housing allowance introduced at the beginning of 1998. Housing allowance was paid to 82,000 families with children, and 61 per

cent of these families were single-parent families. The number of families with children receiving housing allowance fell slightly on the previous year.

Care for very young children

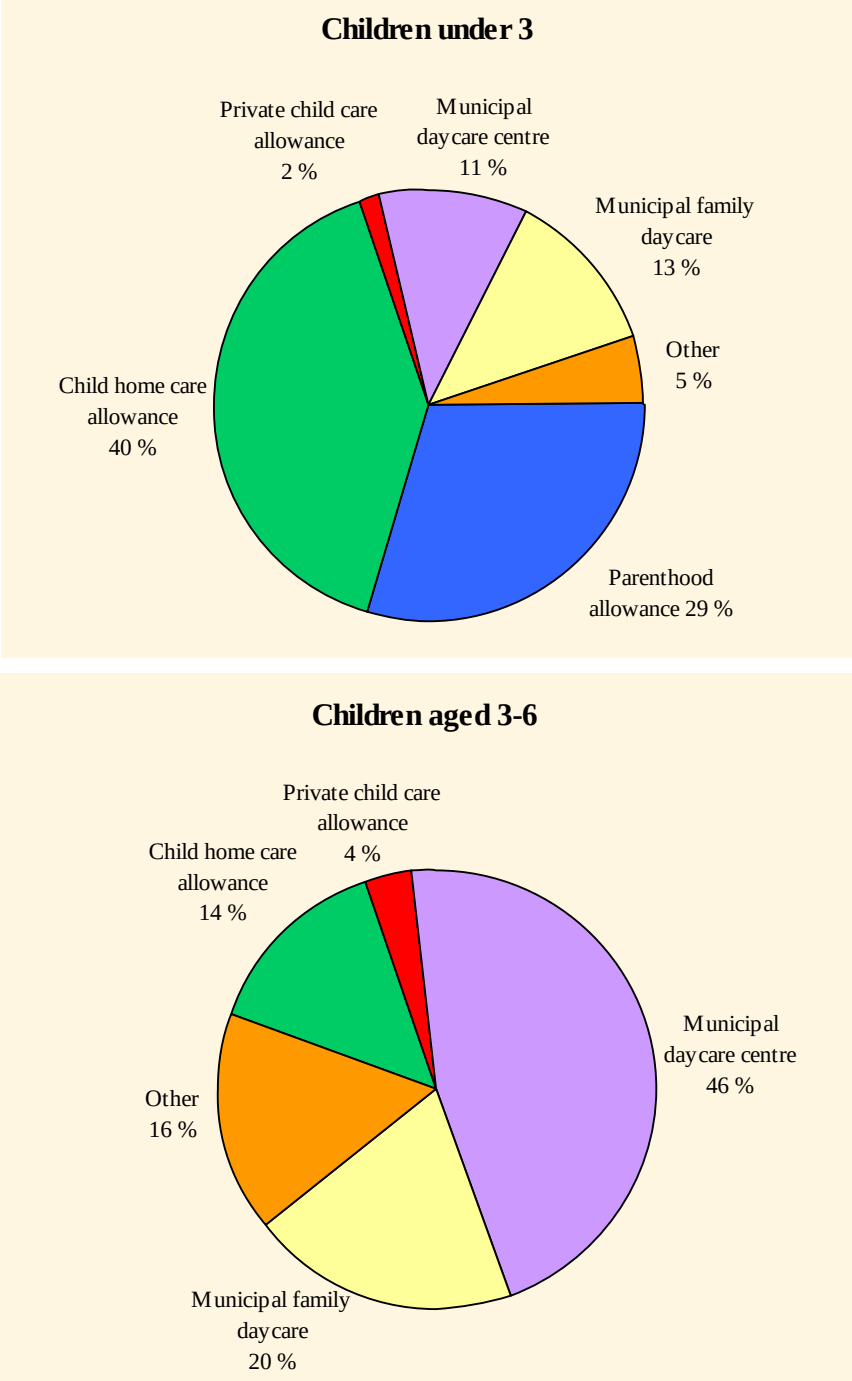
Considerable changes have taken place in the provision of care for very young children during the 1990s. As of 1990, parents of a child under three years of age have been entitled to either municipal daycare for the child or to child home care allowance. As of 1996, the right to municipal daycare was extended to cover all children under school age. The support systems for the care of very young children were reformed on August 1, 1997. The aim of the reform was to clarify and simplify the systems and reduce the differences between municipalities in daycare charges.

At the beginning of 1999, 48 per cent of children under school age were in municipal daycare, while 25 per cent received child home care allowance (Figure 20). In the last few years, private daycare has only accounted for a very low percentage and no statistics are available. About 3 per cent of children were receiving private child care allowance. About 12 per cent, some 50,000 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 who would confer entitlement to home care allowance.

Only 26 per cent of children under three are cared for outside the home. The majority (69 per cent) of children were cared for at home with the help of either home care allowance or parenthood allowance. Five per cent of children under three were outside all support systems. These 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, which is generally higher than child home care allowance**.**

Child care arrangements tend to vary a great deal depending on the age of the child. Two out of three children aged 3-6 are in municipal daycare. (Figure 20)

Figure 20. Care for very young children on December 31, 1999



Falling demand for daycare

According to a study carried out by the Ministry of Social Affairs and Health, there were 219,900 children in municipal daycare at the end of January 1999. The number of children under school age in daycare had increased by about 9,000 since 1997. Meanwhile the number of children of school age had fallen. About 7,000 schoolchildren were in daycare, 2,000 fewer than two years earlier. Sixty-five per cent of children were in daycare centres, while 35 per cent were in family daycare. Most municipalities have successfully arranged daycare according to their obligations under the new legislation on daycare provision. The larger municipalities have established new daycare centres, while the smaller ones have increased the provision of family daycare. According to the study, there was a shortage of places in daycare in 28 municipalities, with two municipalities being over 300 places short.

There has been discussion recently concerning the municipal daycare rights of children whose parents are at home. It has been suggested that their right should either be limited to just half-day care, or removed altogether. If the right were limited to half-day care this would have a very negligible effect on total daycare expenditure. Parents' long-term unemployment may increase the risk of social exclusion for their children, and in such a situation daycare can be essential in providing children with a secure and stimulating environment.

For parents to take up alternatives to all-day daycare, there must be alternative services on offer in the municipality. During the economic recession, drastic cuts were made in open daycare, club and supervised play facilities. Pressure on all-day daycare could be reduced by developing such facilities once again.

Demand for daycare will begin to fall away in the near future, as demographic forecasts indicate the number of children under school age will fall by about 34,000 over the next five years due to the fall in the birth rate. The number of children born in Finland this year will be about 7,000 less than the number starting school.

The legislation on children's daycare places no obligation on the municipalities to provide afternoon care for school children. In recent years, the municipalities have been forced to close afternoon care places for school children in order to cope with their obligation to provide daycare for children of pre-school age. Afternoon care for young school children should be developed through cooperation between different administrative sectors and interested organizations. In recent years, the church parishes and the Mannerheim League for Child Welfare, in particular, have increased their provision of afternoon care for young school children.

Changes to daycare fees

In connection with the reform of the support systems for the care of small children on August 1, 1997, the grounds for determining municipal daycare fees were also unified. Under the new system, daycare fees are determined in percentages based on family size and income. The maximum daycare fee became FIM 1,000, and the minimum fee FIM 100 per month per child. In introducing the reform, it was estimated that total daycare fees for the country as a whole would remain at about the same level as under the old system. According to preliminary information on 1998, the total payments received for daycare totalled around FIM 1.3 billion. Daycare fees accounted for approximately

15 per cent of total expenditure, i.e. about the same as in 1997.

According to a study by Stakes and the SII on the care of small children, 13 per cent of children received free daycare. The highest daycare fee was paid for 38 per cent of children; 45 per cent of the children in all-day daycare in Helsinki and 61 per cent of those in Espoo were in the highest fee category.

The Government programme includes an adjustment of client fees in the social welfare and health care sector as of the beginning of the year 2000 in order to boost the income from these fees by FIM 350 million annually. The need to raise client fees will also affect children's daycare fees. The Government proposes raising the maximum daycare fee from FIM 1,000 to FIM 1,100 a month, and further proposes that daycare fees should be charged for 12 months for children who use the services all year round. Such a reform would increase income from daycare fees by about FIM 85 million a year, out of which FIM 80 million would derive from raising the upper limit of the maximum fee. The reform was to be introduced as of the beginning of 2000.

The reform will cause an increase in daycare fees for families of medium to high income. The fees for these families fell considerably in connection with the last reform. The daycare fees of a family with two children would go up by a maximum of FIM 200 a month.

Working group on early childhood education proposes daycare reform

A working group on early childhood education has issued a memorandum calling for a total reform of the legislation on children's daycare. The legislation currently in force does not correspond to the needs and practices of the present day. Daycare should be treated as a service which combines childrens' right to participate in early education and parents' right to receive daycare for their children. The educational aims of daycare should include active participation by both children and parents in the planning of daycare. Daycare provided in cooperation with parents promotes the healthy development of children and supports the family in bringing them up. Daycare can also contribute to children's rehabilitation and prevent problems and exclusion affecting both children and families.

The working group feels that maximum limits should be imposed on the number of children in daycare groups, a limit which it would not be permitted to exceed even by increasing the number of staff. There should also be legal provisions to cover daycare for the children of shiftworkers. In developing daycare provision for such children, the needs of the children should be taken into account and the daycare groups should be even smaller than normal. In order to improve the position of children in need of special care and education, the working group proposes that group sizes should also be reduced in these cases and that competence requirements should be introduced for the staff assisting these children. The working group further felt that municipalities should be obliged to provide afternoon care for young school children.

No great change in uptake of child home care allowance

The new child home care allowance system has been in use for over two years now. There have been no major changes in either the number of recipients or the number of children since the system was introduced. At the end of May 1999, there were 73,300 recipients of home care allowance and 116,500 children were included within the sphere of the allowance. Recipients of the

allowance had 1.6 children on average within the sphere of the allowance. The average amount of home care allowance for an individual family has been slightly higher (FIM 2,157/month) than payments under the old system. This is due to the fact that the care supplement covers a slightly wider range of incomes than the earnings-related supplement applied under the previous system. So far, 81 per cent of the recipients of child home care allowance have also received the care supplement.

Increased uptake of private child care allowance increases

A private child care allowance was introduced as a new form of support on August 1, 1997. It is paid directly to the service provider. 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 receiving private child care allowance has been growing constantly since its introduction. There were 14,200 children covered by private child care allowance at the end of May 1999. Most of these (78 %) were over three years old. About half (49 %) were in private daycare centres, while 38 % 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. This option has not been used much, however, with only 1,600 children being cared for in this way at home. The average level of private child care allowance was FIM 827 a month, against an average fee for private daycare of FIM 2,103 a month. Twenty-nine per cent of the children receiving private child care allowance also received some level of care supplement.

The parental contribution to the fees for private daycare is usually higher 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 municipal supplements varies considerably from one municipality to the next. According to Social Insurance Institution statistics, about half of the children in private daycare receive municipal supplements.

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

Pre-school teaching is a systematic form of education which bridges the gap between nursery education and primary school. The aim of pre-school teaching is to improve the learning ability of the child and help children make the transition from nursery education to primary school.

The Government programme includes the introduction of pre-school teaching free of charge for all 6-year-olds.

A legislative amendment concerning pre-school teaching is at present before Parliament. The proposal states that children would be entitled to one year of pre-school teaching free of charge prior to starting compulsory education. Pre-school teaching would be provided either in a school, a daycare facility as set down in the legislation on daycare for children, or some other suitable place as decided by the municipality. Municipalities would also have the option of procuring pre-school teaching from another public or private service provider. Regardless of where it is provided, pre-school teaching would be covered by the legislation governing basic education. If arranged in a daycare centre, it would also be subject to the legislation on children's daycare.

Participation in pre-school teaching would be voluntary, with the child's guardian making the final decision. The extent of pre-school teaching would be the same

throughout Finland: 700 hours a year, which would mean 3-4 hours a day.

A local curriculum would need to be set for pre-school teaching based on the national core curriculum set by the National Board of Education. The main responsibility for the teaching would fall on teachers with the qualification of class teacher or pre-primary teacher. During a transitional period, daycare staff with the qualification of social educator or a diploma in social sciences would also be qualified to teach pre-school. The transitional period would allow people currently employed in daycare to complete further training to acquire the competence required of pre-school teachers.

Pre-school teaching would be free of charge. Even now, the pre-school teaching provided in the comprehensive schools is free of charge. Children in pre-school teaching provided by the social services are, however, required to pay half-day daycare fees.

Municipalities would be free to choose which municipal board or administrative unit they wish to be in charge of pre-school teaching in their area. Funding would be granted for pre-school teaching per pupil in accordance with the funding system for education and cultural services departments.

The pre-school teaching reform would increase annual central government expenditure by about FIM 372 million. Central government grants for the Ministry of Education's administrative sector would increase by FIM 555 million, while those of the Ministry of Social Affairs and Health would fall by FIM 183 million. The increase in government expenditure would be caused by an increase in the number of pupils, a change in the cost structure of daycare services and the higher percentage of education spending covered by central government compared with spending on the social welfare and health care sector.

The reform would increase the Action costs of the municipalities by FIM 238 million, on top of which they would also lose revenues from daycare fees to a total of FIM 136 million. However, the increase in central government grants would leave the municipalities only needing FIM 2 million of additional funding.

The reform would be introduced in two stages. In the first year it would be voluntary for municipalities to arrange pre-school teaching. Obligatory provision and children's subjective right to pre-school teaching would enter into force at the beginning of August 2001. In autumn 2000, 80 per cent of six-year-olds are expected to take up the option of pre-school teaching, while the figure for the academic year 2001-2002 will be 90 per cent.

According to a study by the Ministry of Social Affairs and Health and the Ministry of Education, 78 per cent of children aged 6 received pre-school teaching in January 1999. The social services arranged pre-school teaching for 45,500 of these children, and the education authorities for another 6,500. In some municipalities, pre-school teaching was also provided by the local churches in the form of clubs, in which 8,000 children took part. A further 2,000 children received pre-school teaching in connection with private daycare. About 90 per cent of municipalities reported that they would be able to offer pre-school teaching to almost all applicants.

Introduction of system for redistributing the high costs of child welfare

In connection with the 1993 reform of the government grants system, the central government grants for municipal social

welfare and health care services were reorganized on the basis of estimated expenditure. This has caused problems for some municipalities in funding expensive special services which cannot be predicted in advance, e.g. long-term institutional care in child welfare cases. This problem has been particularly pronounced in municipalities with small populations, where even the cost of a single child welfare case may have a considerable impact on the municipal budget.

On the basis of a legislative proposal by the Social Affairs and Health Committee of Parliament, a system for redistributing the high costs of child welfare was approved in connection with the national budget negotiations for 1999. The purpose of this system is to redistribute the economic burden placed on an individual municipality by high child welfare costs and to channel resources in such a way that child welfare clients receive appropriate services at the appropriate time regardless of the economic situation of the municipality in question. The redistribution system has been in force since March 1, 1999.

The joint municipal boards of the special care districts are charged with implementing the cost redistribution system. The municipalities are entitled to be reimbursed through the system for 70 per cent of all costs in excess of FIM 150,000 per family per annum arising from child welfare measures entered in the welfare plan referred to in the Child Welfare Act.

The total expenditure incurred by the social services for special services for children and families comes to about FIM 2 billion a year, with expenditure on the care of children placed outside the home accounting for around FIM 1.2 billion of this sum. The total annual cost of the redistribution system has been estimated at about FIM 330 million, half of which is covered by a special earmarked allocation.

Paternity commission proposes support for parents and more time for the family

Most of the issues of combining career and family centre on the question of time and how to arrange its use. The father's commitment to the demands and timetables of working life is the main factor limiting interaction between fathers and children. The paternity commission, which submitted its report in March 1999, proposes that current legislation should be amended to meet contemporary demands and support the combination of career and family life. The commission proposes the following amendments:

– Extension of the parenthood allowance period by 25 weekdays, with the proviso that only the father would be eligible to use this extension period.

– Extension of the presumption of paternity under the Paternity Act to also cover common law marriages. In uncontested cases, the establishment of paternity could be replaced by a simple notification procedure. The parents would then have joint guardianship in the same manner as married parents.

– Amendments and adjustments to the Child Maintenance Act to improve the position of the father in the event of divorce.

The commission further proposes that, in the interest of family welfare, prenatal clinics and mother-child clinics should be developed so that they can provide more support for the parents as a couple than hitherto, while also supporting parents and especially fathers in their new roles. The commission emphasizes the importance of adequate resources in preventive health-care services.

The social problems of families with children are connected to unemployment

Unemployment is causing a lot of problems for families with children, and further social policy measures are needed to remedy this. Families' lives may be affected simultaneously by financial problems, a sense of helplessness and a lack of support as parents, and other material or psychological pressures. Unemployment, health problems and the social exclusion of the parents are also reflected in the well-being of their children. There is a danger that children will also become divided into those with the confidence to cope and those who cannot cope and become excluded. Many children are growing up in a home environment where their parents and other adults do not work. Many adolescents are also finding it difficult to begin an independent adult life due to the poor employment situation.

Over the longer term, there has been a drop in the number of children taken into care, but the number receiving various forms of community care and support has nevertheless increased. One indication of this is the number of children placed in foster families, which has been increasing throughout the 1990s. The volume of child welfare actions would be even higher if many municipalities were not avoiding the use of expensive measures. The main reasons for a child being taken into care are parental substance abuse, mental illness, or child neglect.

Although Finnish children and adolescents are generally speaking in reasonably good health, there has been a considerable increase during recent years in the occurrence of psycho-somatic symptoms including tension, exhaustion, eating disorders and anxiety. Alcohol and drug abuse among children and adolescents is an escalating problem. Smoking has become more common among young girls. The number of abortions among women under 20 is rising.

The vast majority of children and adolescents in Finland are doing well, but the minority which is suffering problems is slowly growing and their problems are becoming more serious. Adolescents with problems find it hard to discuss things with their parents and to apply themselves to schoolwork, and they may also be depressed and tired, suffer from learning difficulties and start smoking, drinking or experimenting with drugs.

2.6. Unemployment

	1997	1998*	1999**	2000**
Expenditure on main category (FIM million)	24 140	21 600	20 300	19 600
- of which cash benefits (FIM million)	22 110	19 800	18 700	18 100
% of social protection expenditure	13.0	11.5	10.6	10.1
% of GDP	3.8	3.2	2.8	2.6
Unemployment rate, %	12.7	11.4	10.3	9.3
Earnings-related allowance days as annual work year equivalent	213 780	169 400	146 200	137 400
Basic allowance days as annual work year equivalent	26 800	19 900	17 600	16 800
Labour market support days as annual work year equivalent	176 530	182 000	184 100	166 800
Training allowance days as annual work year equivalent	22 670	19 100	14 600	11 900
Recipients of unemployment pension at year end	44 860	49 400	49 400	51 000

* preliminary data
** estimate

Favourable employment trend continues

Since 1994, the unemployment rate has fallen exceptionally rapidly compared with other countries. The average unemployment rate in 1998 was 11.4 per cent, which corresponds to 285,000 unemployed. The number of people out of work has fallen because economic growth has remained rapid for some time now. Unemployment has been further reduced during the past few years by a shift in the focus of economic growth from exports to domestic demand.

The conditions for economic growth look favourable for 1999-2000, while the labour-intensive domestic sector is expected to become stronger still. New jobs will be created especially in the building industry and the service sector. During 1999, the state of the labour market has improved even further; the duration of periods of unemployment has become shorter, unemployed people with good employment potential are finding work very rapidly, and there are less labour supply bottlenecks than in 1998. The unemployment rate is expected to continue to fall rapidly, approaching the EU average. In 1999, the average unemployment rate should fall to 10.3 per cent, a cut of more than one percentage point on the previous year. The main factors causing uncertainty concerning the fall in the unemployment rate are international economic trends and domestic cost trends in Finland.

Finland's employment rate was over 70 per cent in the 1980s, which was well above the EU average. At the beginning of the 1990s, the employment rate fell by over 10 percentage points, but since the recession it has been rising steadily, regaining its position above the EU average. In 1998, the employment rate in Finland was 64.1 per cent, against an EU average of around 61 per cent.

The Government has made the improvement of the employment rate the main goal of its economic policy. The aim is to generate new jobs at a rapid pace to bring the percentage of employed people among the working age population close to

70 per cent. The Government programme states that an increase in the employment rate is the best way to guarantee the funding for welfare services and social security.

If total output were to increase by an average of over 3 per cent a year between 1999 and 2003, the employment rate would already reach 66.5 per cent in the year 2000, while an unemployment rate of under 9 per cent would be a reality in 2003. An even more favourable employment trend would require improvements to the functioning of the labour market in addition to good economic growth.

Unemployment expenditure continues to fall

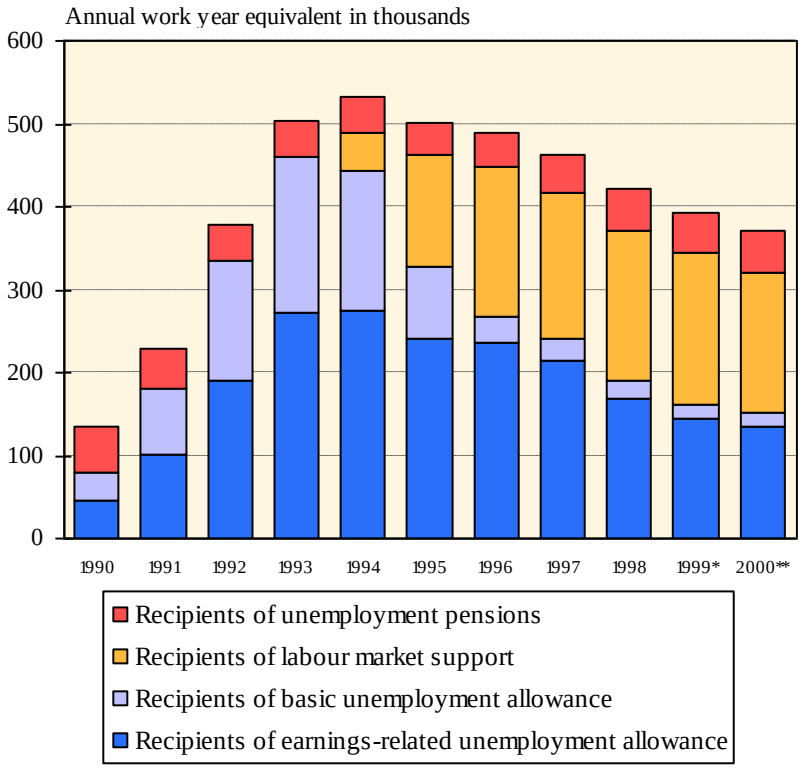
The rapid fall in the unemployment figures has allowed a reduction in unemployment expenditure. In 1999, the unemployment expenditure included in social protection expenditure is estimated at about FIM 20 billion, or about FIM 1.3 billion less than in 1998. Unemployment expenditure thus accounts for 10.6 per cent of social protection expenditure in 1999, and about 2.8 per cent of GDP. Both percentages are down on 1998, and the fall is expected to continue through 2000.

The number of unemployment benefit recipients has steadily fallen, and this trend is predicted to continue in 2000. The number of people receiving earnings-related daily allowance, basic daily allowance and labour market support should also fall compared with 1998. Only the number opting to take unemployment pension has grown or remained the same. (Figure 21)

In 1998, earnings-related unemployment allowance was paid to a total of nearly 369,800 people, or more than 48,000 people less than in the previous year. The average duration of periods on earnings-related unemployment allowance shortened substantially during 1998, having remained for several years on the same level. While periods on earnings-related unemployment allowance averaged around 130 days in 1994-1997, the average period in 1998 was 118 days. Thanks to this favourable development, expenditure on earnings-related unemployment allowance has fallen consistently since the peak year in 1993. In 1998, expenditure on earnings-related unemployment allowance was about FIM 9.5 billion and is expected to fall to FIM 8.5 billion for 1999.

The number of people receiving basic unemployment allowance has fallen considerably, above all due to the introduction of labour market support. In 1998, there were only about 58,800 people still receiving the allowance, and the average duration of periods on basic unemployment allowance was 101 days.

Figure 21. Income security for the unemployed 1990-2000



A reform of the labour market support system was introduced in 1994. Labour market support carries an obligation to participate in training, work practice or other measures to promote employment. Activation measures are particularly focused on young recipients of labour market support. After the recession, the number of recipients increased until 1998, as people who had been receiving earnings-related unemployment allowance moved over to labour market support (cf. Figure 22). In 1998, a total of 322,600 people received labour market support. In 1999, the increase in recipient numbers seems to have come to a halt. It is expected to begin to fall in 2000.

The average duration of periods on unemployment allowance is much longer for older recipients than for young people. A considerable number of the older long-term unemployed receive unemployment pension until they become eligible for retirement pension. The number of recipients of unemployment pension fell from 1991 to 1995, but began to rise again in 1996. The number receiving unemployment pension is estimated at about 49,000 for 1999, and this figure is expected to rise to about 51,000 in 2000.

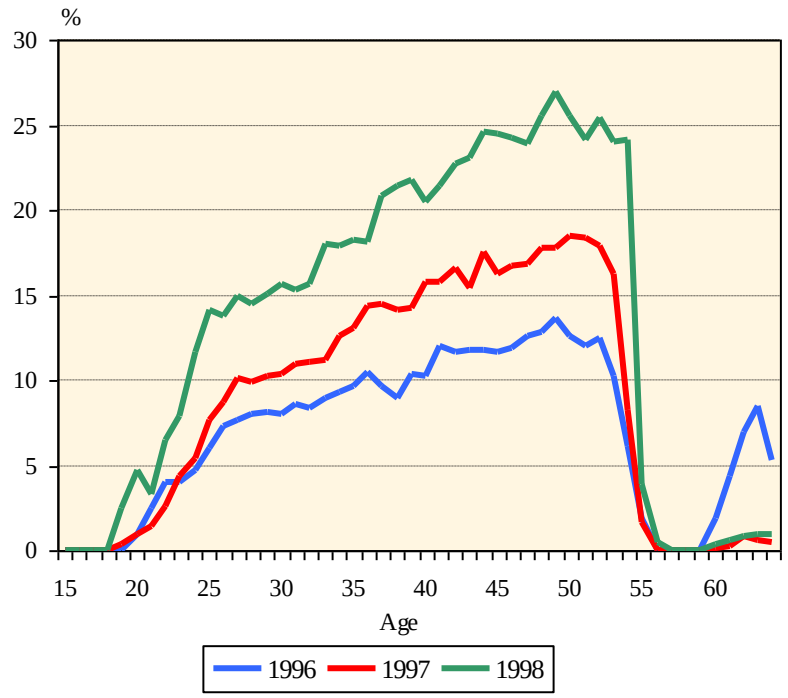
The problems of structural unemployment

As unemployment falls, its structure is brought into sharper focus. The average duration of unemployment has increased. Even ended periods of unemployment last twice as long on average as they did at the end of the 1980s. Ageing job-seekers are finding it more and more difficult to find work, and the pressure to take an unemployment pension is still great. Youth unemployment is relatively high and there are increasing regional differences in unemployment.

Unemployment has recently become much more polarized. People who have only just become unemployed may find work again

very quickly, while the labour market position of people who have difficulties finding work is steadily deteriorating. The proportion of people who have difficulties finding work and the proportion of those who end up relying on labour market support have grown in recent years (Figure 22). It is becoming increasingly obvious that unemployment is concentrated among the same people, i.e. the majority of unemployed job-seekers are people who have repeatedly been unemployed. In 1998, the average duration of all periods of unemployment was about one year, a figure which has risen slightly during 1999. Long-term unemployment has placed a considerable share of the working-age population in danger of exclusion from the labour market — in fact, many people are already excluded. Long-term unemployment increases people's dependence on welfare systems and heightens the risk of problems arising and accumulating.

Figure 22. People transferring from earnings-related unemployment allowance to labour market support from 1996 to 1998 expressed as a percentage of those receiving earnings-related unemployment allowance in the previous year and divided according to age



There is no unanimous agreement on the extent of structural unemployment in Finland, as there is no single accepted way of measuring the phenomenon. Furthermore, structural unemployment changes in accordance with economic conditions, changes in the labour market and policy measures. One way of assessing the extent of structural unemployment is to compare the relationship between vacancies and unemployment. The more efficiently the labour market functions, the better the match between supply and the demand for labour and the lower the level of structural unemployment. If labour supply bottlenecks begin to occur in a number of sectors despite high overall unemployment, this can be taken as a sign of increasing structural problems and a threat of overheating in the economy.

All the estimates of Finland's structural unemployment do, however, support the conclusion that part of the cyclical unemployment during the recession in the 1990s has become structural. In other words, structural unemployment is now higher than it was at the beginning of the 1990s. We can also get some idea of the extent of structural unemployment by examining the various categories within unemployment and establishing how many people there are who have difficulties in finding work. In 1999, there are an estimated 170,000-180,000 people who have severe difficulties in finding work; this corresponds to about 7 per cent of the labour force. This group mainly comprises people who have been receiving labour market support for a long time and ageing long-term unemployed who are in the 'retirement channel' for an unemployment pension.

As unemployment falls, an ever smaller proportion of it is cyclical unemployment, and it thus becomes increasingly difficult to reduce unemployment still further, while any measures taken are slower to take effect. The functioning of the labour market must be improved if structural unemployment is to be reduced. This means that active labour market policy must be made more effective and that structural reforms to taxation and social security must be carried out in order to create an incentive to work.

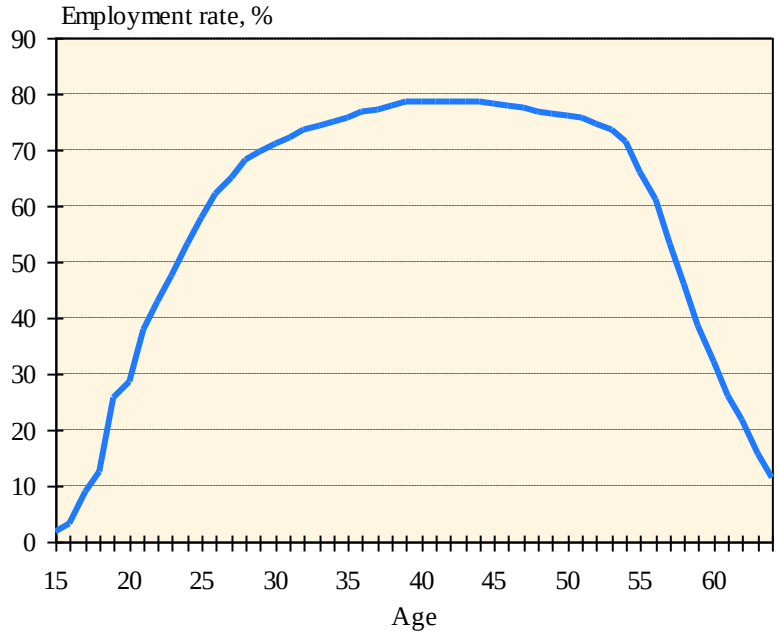
The functioning of the labour market is particularly important when there are sectoral changes in the demand for labour. During recent years, there has been a shortage of labour in high-technology sectors in particular. Managing the employment situation will be a challenging task during the next few years. There will be a need to focus simultaneously on reducing structural unemployment and preventing labour market exclusion as well as on ensuring a supply of labour for actively recruiting sectors.

Most of the long-term unemployed in danger of exclusion lack adequate training and/or are over 55 years of age. Over half of all older job-seekers are long-term unemployed, and in the 55-59 age group as many as two out of three are long-term unemployed. The unemployment periods of older people are relatively long, as people over 50 find it more difficult to return to working life should they become unemployed. During and after the recession, the chances of older job-seekers finding work have fallen more than for other age groups, and older job-seekers' own faith in their chances has not improved at the rate of that in other age groups. According to the employment statistics of Statistics Finland, only 3-5 per cent of the 55-64-year-olds who were unemployed at the end of 1996 had found work by the end of the following year. One of the reasons for this low success rate is that older job-seekers often have a relatively poor educational background. Another important reason is ageism on the labour market. This observation is supported by a recent study which showed that age undermines people's chances of finding work regardless of their training, professional or vocational category, employment sector or tendency to take sick leave.

Thanks to activation measures included in the fundamental reform of labour policy which came into effect at the beginning of 1998, long-term unemployment and unemployment among those over 50 have actually begun to fall slightly. Many older people nevertheless still leave the labour market before reaching the retirement age, which presents a challenge to attempts to raise the employment rate.

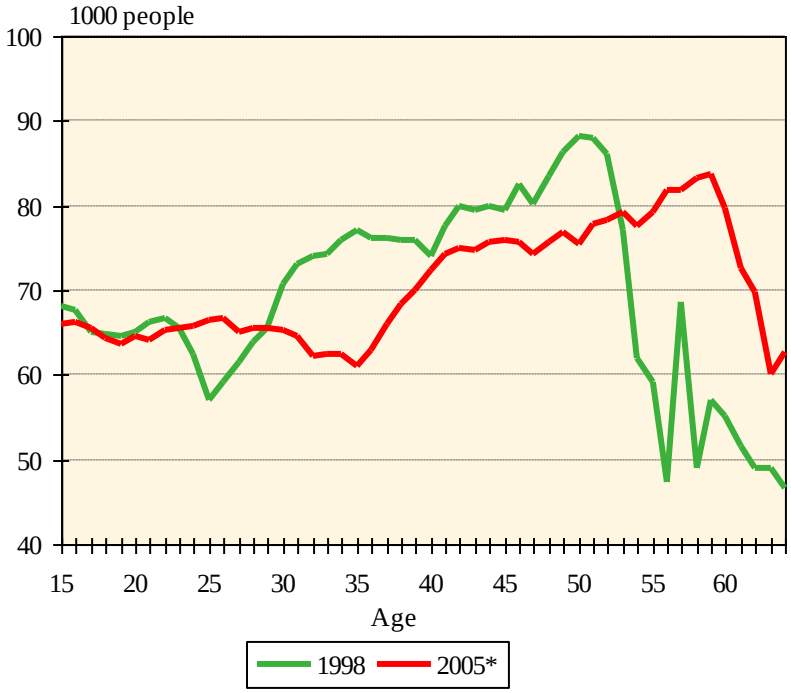
The estimate for 1999 is for an employment rate of around 65 per cent, which will leave another 5 percentage points in order to reach the 70 per cent employment rate targeted by the Government. This target will not be easy to reach. During a period of rapid economic growth from 1994 to 1998, the employment rate still rose by only four percentage points. Efforts to reach the target employment rate are further complicated by the fact that the baby-boom generation is reaching early retirement age. The employment rate takes a sharp downward turn shortly after 50 years of age. The employment rate for 55-year-olds is still close to 70 per cent, but the figure for people aged 60 or over falls to around 30 per cent. (Figure 23)

Figure 23. Employment rate by age, 1998



By 2005, the oldest age groups will be considerably larger than in 1998 (Figure 24). The changes in population structure and the low employment rate among older people are a very awkward combination as far as the target employment rate is concerned. Unless the employment rate for older people can be improved, the ageing of the baby-boom generation will hamper the achievement of the target employment rate by about 2 percentage points during the term of the present Government. This means that the target increase in the employment rate effectively rises to seven percentage points from the present five. This target is almost double the actual development during the period 1994-1998.

Figure 24. Population by age for 1998 and 2005*



*Population forecast

Unemployment among young people has fallen to half the figure during the deepest part of the recession, and the duration of young people's ended periods of unemployment is clearly less than those of other age groups. The fall in youth unemployment seems to have leveled off, however. At the beginning of 1999, there were about 40,000 unemployed people under 25. According to an estimate by the Advisory Council for Youth Affairs, about 15,000 of these are difficult to place in employment or uninterested in training. In particular, the unemployment situation for women under 20 has deteriorated since 1996, despite the improvement in the general employment situation.

The employment trend also shows regional variation. Internal migration has gathered pace towards the end of the 1990s. The population is becoming concentrated in fewer areas, notably growth centres in the southern and western parts of the country. Although all provinces show an increase in the number of jobs, close to 60 per cent of the increase during the past year has in fact occurred in the province of Southern Finland.

The ageing of the population has a tendency to slow down geographical and vocational mobility, as young people are the most likely to move. Structurally speaking, this creates two kinds of problems. In municipalities subject to net outmigration, the population structure ages rapidly, causing an increased need for welfare services while simultaneously undermining municipalities' ability to provide such services. Meanwhile, the competition for jobs in the growth centres becomes fiercer, making it harder for young people with little training to find work. This, in turn, makes the structure of youth unemployment more intractable.

Structural problems on the labour market are also caused by changes in the skills and expertise required from prospective employees. Technological development and international competition favour

training and expertise, and as a consequence people with little training or experience are more likely than others to be unemployed. The structural change in the labour market has caused an increase in the number of jobs requiring special skills, while many unskilled jobs are becoming obsolete. Learning the skills required in a new job is likely to be much more demanding today than it was even ten years ago. This also means that people must be involved in a process of lifelong learning in order to remain in working life.

Unemployment pension as a path to early retirement

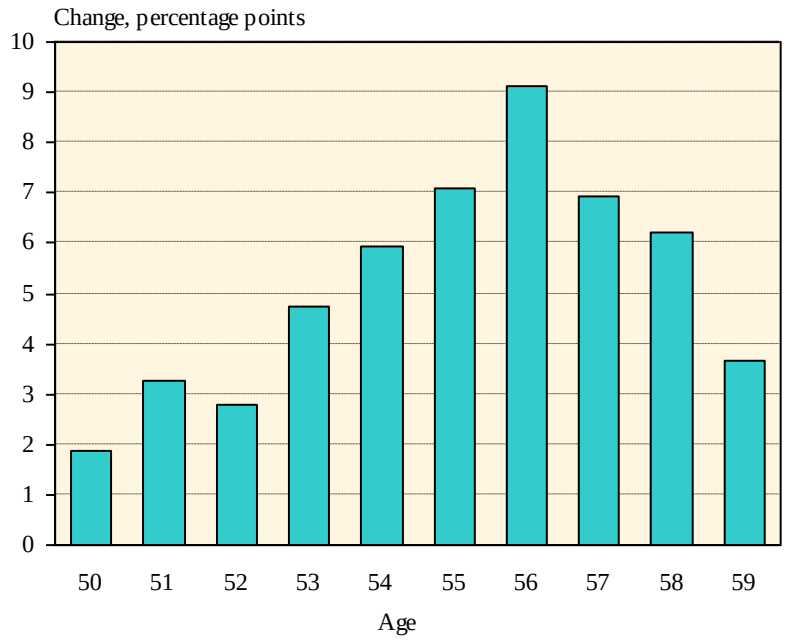
The funding of social welfare expenditure relies above all on a high employment rate. High unemployment and the popularity of early retirement lead to two related problems in this respect, causing an increase in benefit expenditure while simultaneously undermining the financing of social security.

People in the retirement channel for an unemployment pension present a particular challenge for the employment and social welfare authorities. Unless older long-term unemployed people can be successfully supported in returning to work, a possible fall in the rate of economic growth will preserve early retirement as an alternative so common as to give cause for concern.

At the beginning of 1997, the lower age limit for entry to the unemployment pension retirement channel was raised by two years, from 53 to 55 years of age. At the same time, the right to additional payment days for those unemployed before the end of 1996 was safeguarded, which meant that the increase in the age limit had a gradual effect until the end of 1998. The increased age limit and favourable economic trends appear to have improved the employment rate especially among those for whom the reform has already had time to take effect. (Figure 25)

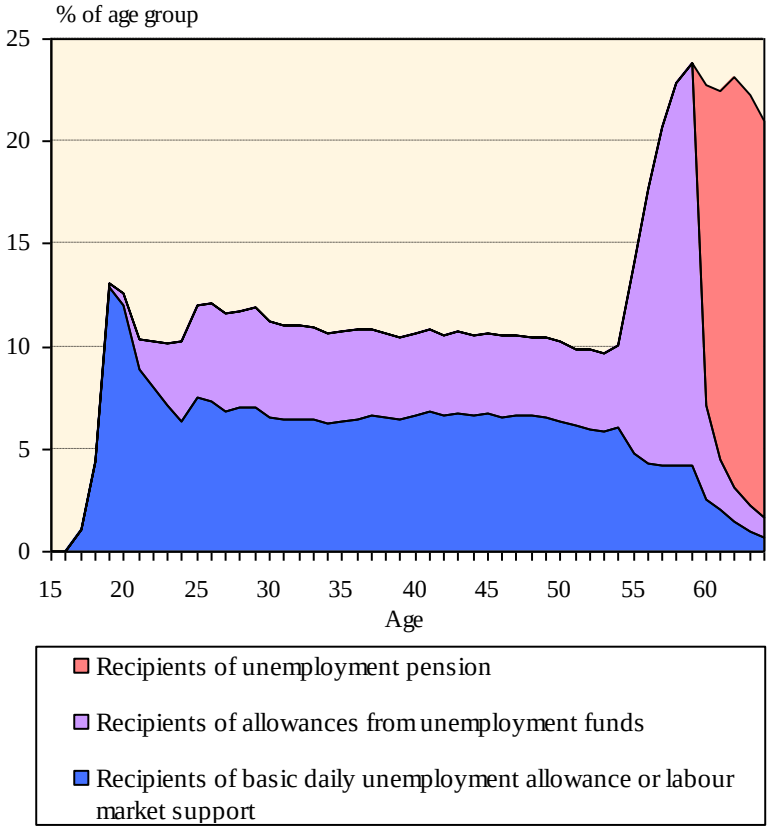
Figure 25. Changes in employment rate by age from 1995 to 1998

Employment rate in the end of the year, 1998 preliminary data



It seems clear that employers and employees can influence the increase of unemployment at the start of the retirement channel and that incentives can have a considerable impact here. The increase in unemployment with increasing age clearly also depends to a great extent on the structure of the social security system. 24 per cent of the earnings-related daily unemployment allowances paid out in 1998 went to people in the retirement channel, while the estimated figure for 2000 has risen to 30 per cent. Thus changes to the unemployment system can improve the potential for reducing unemployment. (Figure 26)

Figure 26. Recipients of unemployment benefits according to age in 1998



The increased age limits for unemployment pension or individual early retirement pension have had a clear effect in discouraging people below the age limit from take early retirement. On the other hand, the conditions for receiving unemployment pension are such that taking unemployment pension at the age of 60 has become the main route to retirement.

The baby-boom generation is approaching early retirement age in a situation where the experiences of the exceptionally deep recession are still fresh in their memory. Close to 50,000 unemployed people are in the retirement channel for unemployment pension. In addition, there are also a considerable number of employees approaching early retirement age who have returned to uncertain employment relationships or new tasks but whose sense of belonging on the labour market has never been satisfactorily re-established following periods of unemployment or lay-offs. In such a situation, even the demands of new tasks at work may drive these people to apply for disability pension.

Action needed to improve the functioning of the labour market

Improving the employment situation is a concern shared by the entire EU. The Amsterdam Treaty, which entered into force at the beginning of May 1999, added a new Title on Employment to the Treaty establishing the European Community. Under the new Title, the Member States will regard increasing the level of employment as a matter of common interest and will therefore strive to develop a common employment strategy.

The employment strategy is implemented by agreeing annually on employment guidelines and drawing up national action plans for employment. The first action plans were drawn up in 1998. The national action plans which were drawn up for the second time in 1999 comprise monitoring of the previous year's plans and new measures for the implementation of the Guidelines approved in December 1998.

The Guidelines have a four pillar structure: improving employability, promoting entrepreneurship, encouraging adaptability in businesses and their employees, and promoting equal opportunities for men and women. The national action plans take into account the promotion of equal opportunities on the mainstreaming principle.

In Finland, the key to improved employment lies in attempts to reduce the numbers of long-term unemployed and improve the employment potential of people with little training or low wages. Projects that are striving to do this include a joint project of the Ministry of Social Affairs and Health and the Ministry of Labour, where the aim is to develop the local and regional cooperation between the social welfare and health care authorities and the labour administration.

The Ministry of Social Affairs and Health also appointed two working groups in the field of benefit and taxation systems for 1999. The assignment of the working group on active social policy is to study structural and legislative measures to promote the activation and employment of long-term clients of the social welfare and health care services, and the labour administration for whom it is difficult to find employment. The assignment of the working group on social protection fraud is to investigate the extent of fraud and find ways to prevent it.

In recent years, reforms have been made to taxation, benefits and payment systems in order to eradicate employment disincentives and income traps. In 1997, the taxation of wages and entrepreneurial income was reformed to provide an incentive to low-waged or casual employment by raising the maximum earned income allowance in municipal taxation from FIM 2,000 to FIM 5,500. In 1999 this incentive was raised further to FIM 8,600. In 1998, the coordination of social assistance, housing allowance, unemployment allowance and financial aid for students was improved. According to a Ministry of Finance report from the beginning of 1999, reservation wages have fallen considerably for all types of families and incentive traps have been successfully eliminated.

In many European countries, there has been a great deal of discussion during the 1990s on whether the employment prospects of low-skill, low-paid workers can be improved by lowering employers' indirect labour costs. Reductions of employers' contributions targeted at low-wage employees have been implemented in the Netherlands, France and Belgium, amongst others.

The Ministry of Social Affairs and Health appointed a working group in May 1999 to

study whether it would be possible in Finland to reduce and progress employers' national pension and health insurance contributions in such a way as to create jobs in low-wage sectors and improve the employment potential of those in danger of exclusion from the labour market. Studies showed that small reductions in employer contributions have a negligible impact on employment. The working group therefore considered that the best job-creation impact can be achieved through measures which support each other and focus on labour demand, supply and incentives. A combination of reduced employer contributions, the earned income allowance in municipal taxation and active labour and social policy measures could therefore improve employment among low-wage groups. The working group felt that the most productive approach to lowering employer contributions would be to reduce employers' national pension contributions within the bounds of the present graduation criteria by focusing reductions on the lowest grade, at least initially.

The Government plans to reduce income tax and social security contributions during its term of office. The Government programme envisages stimulating economic growth and employment by cutting taxes and tax-related payments on personal income and indirect labour costs by a total of FIM 10-11 billion during the present Parliament.

Skills and expertise will be increasingly important in the labour market of the future. In order to ensure their availability, a training guarantee was introduced as part of the reform of unemployment security. The first two stages of the training guarantee have already been implemented, by introducing training support for the long-term unemployed and then for all unemployed people. The third stage of the training guarantee, which is intended to improve the opportunities for independent study by those already in employment, is currently being processed by the Government and the labour market organizations.

Because the average age for leaving the labour market is fairly low in Finland by international standards, the aim of Government policy is to apply pension policy measures to increase the length of people's careers. The central labour market organizations represented in the working group chaired by Kari Puro studied the options available for reducing the extent of early retirement. The working group submitted its proposals in summer 1999. It proposed that the retirement channel age limit in the private sector should be held at the present level of 55, but that the unemployment pension of 60-65-year-olds should be slightly reduced. The age limit for part-time pension should be held at 56, but the age limit for individual early retirement should be raised from 58 to 60 for people born in 1944 or later. The working group further proposed raising employer-specific contributions to unemployment pension, except if an employer hires a person over 50 years of age, then his contribution to unemployment and disability pension would be reduced. Negotiations on public sector pensions will take place at a later date. The Government presented legislation on this matter to Parliament during the autumn session.

The systems for early retirement still require further development. It should be noted, however, that raised age limits for early retirement and other stricter pension conditions will only have the desired effect if support is also provided to help older people stay on at work. If this is not the case, the ensuing pressure will take the form of unemployment or a renewed increase in disability pensions.

The employability of ageing workers was the subject of the meeting of the Informal

Council of the Ministers for Labour and Social Affairs of the European Union in Oulu in July 1999. The employment and continued participation in working life of ageing workers depends primarily on their employability. Their employability is in turn based on health and functional capacity, but also on education and experience, vocational skills, attitudes and motivation. The working environment and work community also exercise a crucial influence over individual workers' ability to draw on their strengths. If older workers are to succeed on the labour market, their own strengths will have to be supported, and working life in general must be made more suitable for people of all ages.

In order to make progress in these areas, Finland initiated a National Programme on Ageing Workers in 1997 which will continue through until 2001. Its twin aims are to promote ageing workers' opportunities to remain in working life until retirement age and to promote the return of people over 50 into working life. Recent statistics indicate that the average retirement age has gone up and that the employment rate for ageing people is also improving. The disability risk for people under 55 has been falling for some time already. If this trend continues, the baby-boom generation will be fitter and healthier than its predecessors were at the age of 55, something which will, in turn, improve the employment rate.

2.7. Housing and social assistance

	1997	1998*	1999**	2000**
Expenditure on general housing allowance (FIM million)	2 169	2 615	2 900	2 800
Recipients of general housing allowance on December 31 (no. of households)	184 600	205 600	204 000	185 000
- of which families with children	83 400	82 100	82 000	81 000
Expenditure on pensioners' housing allowance (FIM million)	1 160	1214	1 290	1 370
Recipients of pensioners' housing allowance on December 31	155 000	159 000	161 000	163 000
Expenditure on student housing supplement (FIM million)	620	615	615	730
Recipients of student housing supplement on December 31	92 000	94 000	95 000	140 000

* preliminary data
** estimate

2.7.1. Housing subsidies

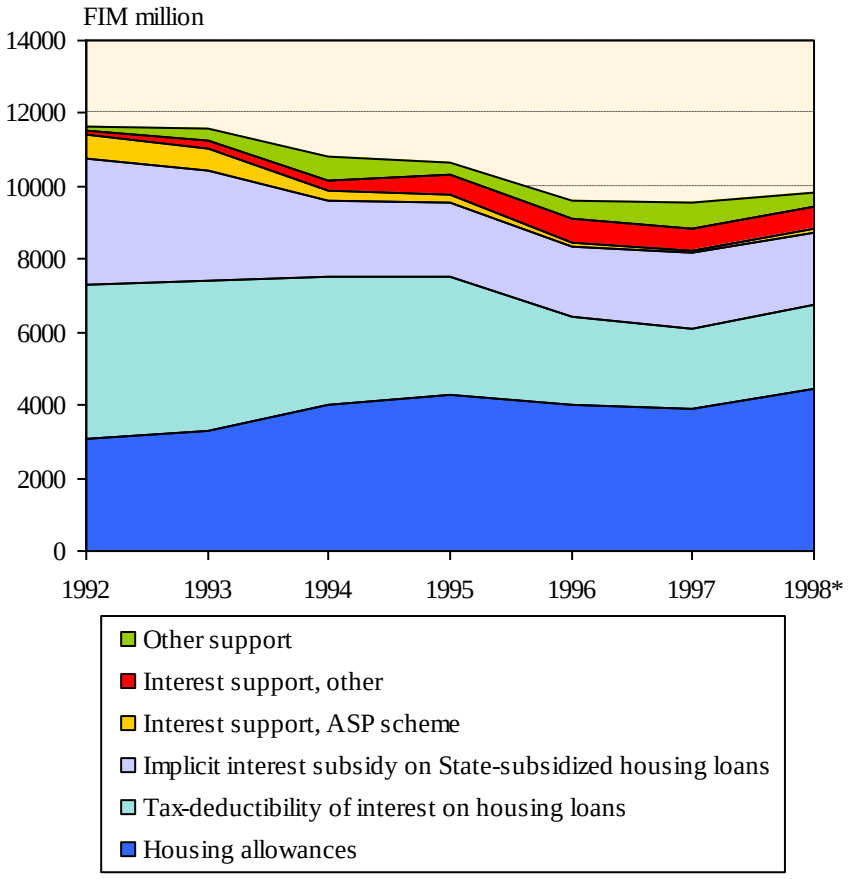
Reduced overall support for housing

In the calculation of social protection expenditure, the main category 'Housing' only includes the general housing allowance. Pensioners' housing allowance is included under pension expenditure. Student housing supplement is completely excluded from the concept of social protection expenditure. In addition to the direct housing allowance systems, housing and housing construction are also supported through interest support, grants and tax relief. The forms of interest support are the ASP scheme (government subsidy for first home purchase), State-subsidized 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.

At its peak in 1992, total expenditure on housing subsidies came to nearly FIM 12 billion, but this figure has fallen since then. In 1998, housing subsidies came to just under FIM 10 billion, and in 2000 it is estimated to have fallen even further, to FIM 9 billion. Tax relief has been considerably reduced due to an amendment to the tax-deductibility of mortgage interest in 1993 and the fall in interest rates. The same has happened to interest support. Support for housing construction and renovations has fallen slightly in line with the economic cycle. The criteria for receiving housing allowance have been changed and re-focused several times. (Figure 27)

In 1998, 72 per cent of the total expenditure on housing subsidies was made up of means-tested forms of support while 28 per cent was general allowances. The biggest individual form of support among the general allowances was the support provided through the tax-deductibility of interest on housing loans, which accounted for 23 per cent of total expenditure on housing subsidies. Among the means-tested forms of support, the main ones were housing allowances and the implicit interest subsidy on State-subsidized housing loans.

Figure 27. Total expenditure on housing subsidies, 1992-1998
FIM million at current prices



Source: Ministry of the Environment

The direct forms of housing subsidies for households, i.e. housing allowances, are subject to means testing. The 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 to a reasonable proportion of monthly gross household income. Due to the strict means testing, even a very low level of income leads to a reduction in housing allowance.

General housing allowance is meant for households on 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, to a large extent, households subsisting mainly on some form of income security. Some 57 per cent of the recipients of general housing allowance are unemployed.

General housing allowance was originally a form of support for families with children. Nowadays, only 43 per cent of recipients are families with children, while the number of recipients who live alone has risen to 44 per cent. About half of the families with children are single-parent families. In October 1999, 199,000

households received housing allowance averaging FIM 1,112. In 1998, both the number of recipients and the average allowance rose slightly, due to an increase in the levels of housing allowance. This trend continued in 1999. The increase in the housing allowance was balanced by the imposition on recipients of social assistance of an element of responsibility for their own housing costs. This reform increased housing allowance expenditure by FIM 600 million. The purpose of the reform was to support employment. There is, however, a certain delay in the effect of the improved employment situation on the employment of the long-term unemployed and other recipients of housing allowance, and thus on their need for housing allowance.

There are separate housing allowance systems for pensioners and students which differ in detail 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 rather than having to move into an institution. Thus, 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 this allowance system is its relationship with services for the elderly. At the end of 1998, there were 159,000 recipients of pensioner housing allowance, receiving an average of FIM 634 a month.

Student housing supplement is available to students who live alone in rented accommodation. The student housing supplement is part of the system of financial aid for students, the target being for the level of supplement paid to students to reflect the rent levels of student housing. At the end of 1998, there were 92,000 recipients of student housing supplement receiving an average of FIM 720 a month. Student housing supplement will be developed as a part of the system of financial aid for students, so that the grounds for receiving the supplement can be aligned with those applying to students in jointly rented accommodation. According to a Government proposal, all students other than families with children and those living in owner-occupied dwellings should be transferred from the sphere of general housing allowances to student housing supplement as of May 1, 2000. The student housing supplement would be raised at that time, but it would still not be payable during the summer months.

The housing allowance system has had to respond to rapid economic change. There has been fairly violent fluctuation in the supply and demand for housing. Although the improved employment rate has not been directly reflected in the need for housing allowance, it will improve the situation in the long term if the supply of housing remains adequate. As the employment situation and the housing market stabilize, housing allowance can be more easily tailored as part of social policy so that it takes into account the different housing markets for different population groups and different regions of the country.

Housing costs go up

During the 1990s, public support for the housing and rented accommodation market has been reduced and prices have been freed to follow the market. Rent control ended on May 1, 1995 in all tenancies for privately-financed housing. Rent for State-subsidized housing is still controlled. Rents have been rising throughout the 1990s, and from 1996 to 1999 the speed of increase was much quicker than before. From April 1998 to March 1999, rents rose in new tenancies by about 4.3 per cent. The fastest rise was in the Helsinki metropolitan area

and other centres of population growth. Rents in the Helsinki area are 30 per cent higher than in other parts of the country.

The rents of State-subsidized flats have been raised and tenancies have become much more difficult to obtain. In 1998, more than 100,000 were on the waiting-list for a State-subsidized flat; 43,000 of these families were in the Helsinki metropolitan area. The level of acceptable housing costs determined for the purposes of housing allowance has been unable to keep pace with rising rents, especially in the Helsinki area. The shortage of housing prevents people who need housing allowance from moving to cheaper or more suitable accommodation. The shortage of housing in centres of population growth may also pose an obstacle to workforce mobility and employment in general if housing of reasonable size and reasonable price cannot be found where work is available. Furthermore, the housing allowance does not cover a situation where members of the same family live in different localities. After a long period of improvement, homelessness, has begun to increase again in recent years. A new trend is the increased incidence of homelessness among women and young people.

The price of owner-occupied accommodation has been rising rapidly since 1995. In the Helsinki area, prices have been going up by over 10 per cent annually. Elsewhere in Finland, the price trend has been slightly more moderate so far. A flat in a block of flats in the Helsinki area costs FIM 11,000 per sq.m. on average. The price differential between the Helsinki area and the rest of Finland has widened with the rise in price levels, and at the moment the price per sq.m. of flats in the Helsinki area is 79 per cent higher than elsewhere in Finland. At the same time, the cost of owner-occupied accommodation has been reduced by a considerable fall in interest rates. While the nominal interest rate on new housing loans was about 13 per cent in 1993, it has now fallen below 5 per cent. In addition to the fall in interest rates, longer mortgage periods and new financing models for housing acquisition have made it easier to buy a flat. These are among the reasons why the volume of household mortgages has risen by over FIM 30 billion since 1996, reaching FIM 122 billion.

Housing costs have been rising throughout the 1990s, especially for people who live in rented accommodation. In 1990, housing costs were a maximum of 20 per cent of income for 66 per cent of households. Nowadays, only about half of all households are in this category, and these are mainly people living in debt-free owner-occupied housing.

2.7.2. Social assistance

	1997	1998*	1999**	2000**
Social assistance expenditure (FIM million) (net)	3 039	2 600	2 300	2 200
% of social protection expenditure	1,6	1,4	1,2	1,1
% of GDP	0,5	0,4	0,3	0,3
Households receiving social assistance during the year	344 700	310 400	294 200	280 400

* preliminary data
** estimate

Fewer recipients of social assistance

The number of households receiving social assistance nearly doubled in the first half of the 1990s. Numbers were highest in 1996, when about 350,000 households received social assistance. These households comprised a total of 610,000 people. In 1997, the number of households receiving social assistance began to fall slightly. In the following year, recipients of social assistance had fallen to 310,000 households. Advance information for 1999 indicates a further fall in the number of recipients. In the first half of 1999 there were 8 per cent fewer households receiving social assistance than in the corresponding period of the previous year.

Social assistance expenditure continued to grow until 1998, when it fell by 15 per cent to FIM 2.6 billion. In the first half of 1999, social assistance expenditure fell by a further 12 per cent on the corresponding period the previous year.

Both the number of recipients and social assistance expenditure per se have fallen in all parts of the country. Reliance on social assistance has fallen slightly faster in urban municipalities than in other densely populated or rural municipalities.

The average length of time on social assistance has continued to rise during the 1990s. The number of individual long-term recipients has also increased. In 1990, about 12 per cent of recipients of social assistance received it more or less throughout the year. In 1997, about one in four social assistance recipients was a long-term client. The main reason for this increase in the periods of receiving assistance is the accumulation of financial problems as a result of long-term unemployment. In 1998, both the number of long-term clients and the average period for receiving assistance fell slightly.

Monitoring the effects of the new Act on Social Assistance

The recent fall in the number of recipients of social assistance and in social assistance expenditure is partly due to amendments to social assistance and certain other benefits. The new Act on Social Assistance and its supplementary decree entered into force on March 1, 1998. Responsibility for 7 per cent of housing costs was at this time included in the costs to be covered by the basic amount of social assistance. The basic amount of social assistance for children under the age of ten was reduced by three percentage points. The basic amount for families with several children was also reduced from the second child onwards by 5-10 percentage points. The reform of social assistance was part of a more extensive package which also included e.g. improvements to housing allowances.

In approving the new legislation on social assistance, the Government stipulated that the effects of the reform will need to be

monitored. A study of the effects of the changes in 23 municipalities is underway at the National Research and Development Centre for Welfare and Health (Stakes). The data were collected during the first five months of 1998 and also during November of that year. In the municipalities monitored, the number of households receiving social assistance fell by about 13 per cent from January to November 1998. The biggest relative fall was in the number of families with several children. The number of social assistance recipients fell in all age groups with the exception of people over 65, where the number grew slightly. The monitored municipalities' social assistance expenditure also fell by about 25 per cent per month. Researchers assume that the main factor causing this fall in expenditure may, however, be the improved employment situation, rather than merely the changes to various benefits.

The study also focused on the length of time spent on social assistance and dependency on assistance. About one in four of all recipients from January, May and November received social assistance during all three months. The estimates of dependency in the monitoring study were clearly in line with the data on long-term clients in the social assistance statistics.

Under the Decree on Social Assistance, municipalities are free to consider the housing costs included in the basic amount of social assistance separately should they so wish. However, the monitoring study seems to indicate that municipalities are applying the 7 per cent provision for housing costs in a relatively straightforwardly manner. Based on the study, it seems that the maximum rent applied by the municipalities in social assistance calculations is usually slightly higher than for general housing allowance. In the Helsinki metropolitan area, the housing costs of people living alone would certainly seem to exceed the maximum amounts applicable for calculating social assistance.

3. SOCIAL SERVICES AND HEALTH CARE

3.1. Developments in social services and health care

Target and Action plan issued

The Government now defines targets and makes recommendations for social welfare and health care services for a four-year period in the Target and Action Plan for Social Welfare and Health Care. The first such plan, for 2000-2003, was issued in October 1999. The plan covers both recommendations to the municipalities and the steps to be taken by the Government in order to reach the envisaged targets. The 2000-2003 plan was drawn up in broad cooperation between the Ministry of Social Affairs and Health, other ministries, government agencies, organizations and the Association of Finnish Local and Regional Authorities.

The plan underlines the importance of preventive action. The guiding principle is to enhance interdepartmental and intermunicipal cooperation. The plan also emphasizes the importance of ensuring sufficient staff with the appropriate skills and preventing stress at work. The Government will report to Parliament on progress made with the plan every two years, in its review of social welfare and health care services. A decision on resources for the plan is made annually as part of the national budget proposal.

Several national and local development projects

In spring 1997, the Ministry of Social Affairs and Health launched a Health Care Development Project on which the advisers concerned submitted a report in February 1998. The project management group used this report to draw up an Action Programme for Health Care. Most of the measures in the programme affect actors in the municipal sector. The main responsibility for implementation rests with decision-makers and health care units in the municipalities and hospital districts. The Ministry of Social Affairs and Health has appointed five regional cooperation teams for the university hospitals' expert responsibility areas, and these will be responsible for carrying out the measures. Each cooperation team will provide information on its activities regionally and locally. The Ministry has set up a national steering group and is responsible for general information provision on the project, while also contributing to the cost of the cooperation teams' activities. The various health care units will carry out the actual work of development. The cooperation teams will compile final reports by the end of 2001.

In February 1998, the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health (Stakes) jointly launched a Dental Care Development Project to cover 1998-2000. In ten municipalities, a study is being made of ways to allocate resources more efficiently in view of both the improved oral health of children and young people and the growing need for dental care among the middle-aged in particular. As part of the project, health centres are introducing more individualized check-up periods for children and young people, and delegating check-ups and preventive care to dental nurses and hygienists. Health centre doctors are also being encouraged to send clients in need of treatment for dental care.

In accordance with the Target and Action Plan, the Ministry of Social Affairs and Health is preparing the changes in the law

needed to gradually extend publicly subsidized dental care to the entire population through the existing systems of municipal services and health insurance. These amendments will take effect in 2001. The experiences gained of the ongoing Dental Care Development Project will be utilized in drafting the legislative changes.

A project launched by the Ministry aims to improve intermunicipal cooperation in developing social services for various special groups. The Ministry is collaborating with welfare organizations as well as with the municipalities and joint municipal boards.

A regional IT experiment in social welfare and health care services is being carried out in the Satakunta area in 1998-2000. This pilot scheme incorporates the proposals made by three Ministry working groups in spring 1998. These groups had studied ways of devising seamless client-oriented service chains, the role of a client card in welfare and health care, and ways of improving data protection and security. Inter-organizational service chains based on client needs are being developed in Satakunta to help people to manage at home. New IT and telematic solutions are being tested and assessed in the region. A social services and health care client card is also being tried out.

In recent years, the municipalities have sought various solutions for the provision of primary health care. The municipality of Karjaa has decided to purchase its health care services and some of its social welfare services from Samfundet Folkhälsan. In turn, the municipality of Piippola is buying its health services from the neighbouring municipality of Haapavesi, and there are similar agreements between a number of other municipalities.

Purchaser-provider models continue to interest municipalities in various parts of Finland. The Tampere Region has gone furthest in developing its own model for agreements between the hospital district and the various municipalities within it. Some of these have formed purchasing districts, while others (primarily the largest municipalities) operate as separate units when ordering services. The principles used for invoicing services are also to be changed, making capitation a key factor in certain services; use of services exceeding or falling short of the original order is then priced at the marginal cost.

In the metropolitan area of Helsinki, efforts are being made to achieve greater efficiency and eliminate overlap in health services by reorganizing specialized medical care in the area. As of the beginning of 2000, a new hospital district (HUS) is to replace the former hospital districts of Helsinki and Uusimaa. In the first phase the change will mean reorganizing specialized medical care within the City of Helsinki.

Changes in the municipal social welfare and health care investment system

The municipalities and central government jointly finance the capital investments needed in order to provide municipal social welfare and health care services. In the 1990s, these investments were primarily aimed at developing open care services rather than constructing new institutional facilities.

The central government grant is to be reduced to 25 per cent in new social welfare and health care capital investment projects approved from the beginning of 2000 onwards. However, in the case of small projects costing FIM 2-25 million approved in 2000-2001, the grant will remain at 25-50 per cent of the total cost.

The whole system of financing new investment projects is to be overhauled gradually as of 2001, with resources allocated primarily to projects aimed at building up welfare and health care operations and improving the professional competence of staff. In the new system, building projects will only be supported in exceptional cases, when they are integral to operational improvements in social welfare and health care services. The system will be fully effective in 2003.

As of 1997, the European Investment Bank has also been contributing to the health care investments of EU Member States. By summer 1999, the Bank had provided over EUR 2 billion in such loans to four EU countries. Large loans are granted to individual applicants, but in the case of small and medium-sized projects the Bank makes framework loans to an intermediary, which then grants loans to the individual applicants. In Finland, Municipality Finance plc serves as an intermediary for EIB loans.

3.2. Private sector and NGOs important providers of social welfare and health care services

Welfare and health organizations and the private sector are important suppliers of social and health services, accounting for one fifth of the overall provision. The services provided by NGOs and private enterprise mainly supplement public services. Non-profit organizations primarily produce social services, and enterprises health services. In 1997, the value of services produced by NGOs was FIM 7.4 billion, and they employed well over 25,000 people. The turnover of private businesses was around FIM 6.1 billion and the staff figure over 18,000.

Social welfare and health care organizations rely heavily on financial assistance from the Slot Machine Association (RAY). In 1999, RAY granted nearly FIM 1.4 billion to over a thousand organizations. The EU Court of Justice decided in September 1999 that RAY's monopoly status in Finland is not contrary to EU law and that proceeds can still be used in the present manner.

Some private-sector and NGO services are provided under outsourcing agreements with municipalities. Such agreements are more common in social services than in health care. Relatively speaking, most private-sector services are purchased for the institutional care of children and young people, in family-group care homes, for instance. In health care, outsourcing agreements mainly apply to ambulance services and various examination and support services. However, some municipalities have also made substantial health care agreements with private service providers.

The number of providers of private social services has been rising in recent years. In 1998 there were nearly 2,300 units offering private social services. One third of these provided housing services, a good fifth were children's daycare centres, and 13 per cent provided home care services.

Private social services are mainly a feature of southern Finland. Half of all the country's private daycare centres are in Uusimaa. On the other hand, producers of housing and home care services are spread more evenly around the country.

The percentage of overall social welfare services accounted for by the private sector has remained stable in recent years. In 1998, 16 per cent of those employed in social services worked in the private sector.

Private social services finance their operations mainly by selling their services to municipalities. Two thirds of all units

sell at least half of their services to municipalities under either outsourcing agreements or payment commitments. One fifth of units do not sell services to the municipalities at all. These are mainly units producing private home care services which finance themselves mainly through revenues from customers.

In health care, the roles played by private services and public funding are rather different. While producers of private social services make agreements with municipalities, private health care tends to focus on services reimbursed under the national health insurance scheme. There have been no major changes in use of private health services in the last couple of years.

3.3. Ageing of welfare and health care personnel

Most people employed in social welfare and health care services work for the municipalities. The total number in the municipal sector varied throughout the 1990s. In 1998, 220,400 people worked full-time or part-time in social welfare and health care services for the municipalities or the joint municipal boards. Seventy-four per cent had permanent posts.

In the various job groupings, most people worked on hospital wards in specialized medical care (59,600), in children's daycare (50,100) and in outpatient primary health care (26,100). The number employed in children's daycare has risen rapidly in recent years.

The average age of people working in municipal social welfare and health care services rose throughout the 1990s. In 1998 there were 58,000 over the age of 50, compared with only 36,000 at the beginning of the decade. In contrast, the number of employees under 30 fell from 42,000 to 21,000 over the same period. The number of young employees has fallen particularly sharply in care for the elderly, where nearly every third worker is already over 50.

There are nearly 50,000 social welfare and health care employees in the private sector. In some specialist areas of medicine, working in the private sector has become so common that there is a shortage of doctors in the public sector, especially psychiatrists, ophthalmologists, radiologists and anaesthetists. Specialists are typically concentrated in southern Finland, while more remote regions are short of doctors. Some health centres also have difficulty finding doctors.

Although there is currently some unemployment in social services and health care, there is soon likely to be a labour shortage, especially in the municipal sector. According to calculations by the Association of Local and Regional Authorities, some 125,000-140,000 municipal employees will be retiring by 2010. At the same time, changes in the population structure will result in a growing need for social welfare and health care services.

The central issues in the Target and Action Plan for Social Welfare and Health Care for 2000-2003, as approved by the Government, are to ensure the availability of sufficient well-qualified social welfare and health care personnel and prevent the occurrence of stress at work within the sector. Its recommendations underline the importance of drawing up a national estimate of the future need for welfare and health care personnel, and the importance of supplementary training, of maintaining the professional skills of the young professionals trained over the next few years, and of drawing up a programme of research and action on the prevention of stress at work. The recommendations also propose wider use of personnel accounting

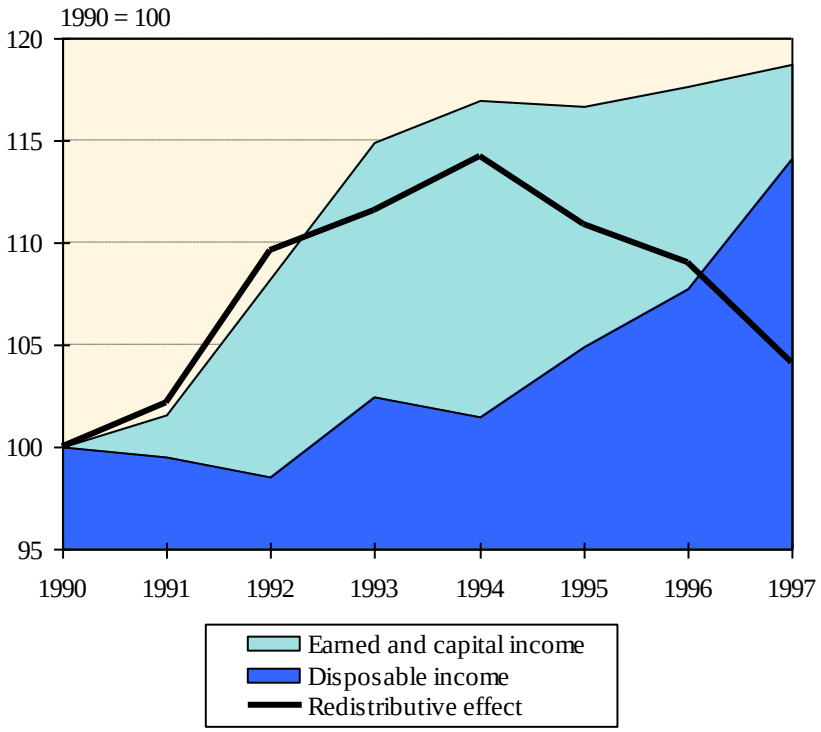
by municipalities and joint municipal boards. Such accounts supplement the normal annual report and accounts, and can provide useful guidelines for the next year's planning. They are also helpful in studying the link between services and the staff who produce them.

4. INCOME DISTRIBUTION

The growth of income differentials continues

Household income differentials increased in the 1990s. As mass unemployment became more prevalent in the early 1990s, income differentials between households, measured by earnings and capital income, started to grow. However, income transfer systems and moderate wage increases among the working population kept the growth of income differentials quite small in terms of disposable income. By the mid-90s, however, income differentials had also started to grow in terms disposable income. Especially the top tenth with highest incomes has increased its share of total income. Income differentials have been aggravated by rising capital incomes, persistently high unemployment even as the economy recovered, and cuts in various social transfers. The equalizing effect of income transfers and taxation has weakened since the mid-90s (Figure 28).

Figure 28. Trends in income differentials and redistributive effect of income transfers, 1990-1997



Income differentials: Gini coefficient, the higher the figure, the greater the income differentials, 1990=100. Income/OECD consumption unit. Redistributive effect (Kakwani): effective reduction of income differentials by income transfers received and paid, 1990=100.

Trends in household income differentials can also be studied using consumption expenditure. The effects of the overindebtedness prevalent at the beginning of the 1990s, for instance, are not always visible if one merely examines income statistics. Household consumption expenditure in the mid-90s was actually distributed rather more evenly than in 1990. The most recent data, on 1996, seem

to indicate that differences in expenditure have also started to increase. The proportion of household consumption expenditure accounted for by housing costs rose sharply in the 1990s. This also applied to the lowest income groups, where housing costs represent a larger than average proportion of expenditure. The money spent by households on consumption other than housing costs was less evenly distributed in 1996 than at the beginning of the decade.

When we examine trends in income differentials, we should remember that the latter illustrate the relative income level of households. Between 1991 and 1994, the average disposable real income of households decreased by over 10 per cent. This meant that low-income households also suffered from loss of income. Household indebtedness in the early 1990s aggravated the economic problems caused by declining incomes. Similarly, the declining share of income going to low-income households between 1995 and 1997 did not reflect a similar fall in real incomes, because the average real incomes of households have actually risen.

The latest income distribution data date from 1997. Since then, the employment situation has improved, although the number of people receiving basic unemployment security has remained almost unchanged. As a result, higher employment could well have had less effect in reducing income differentials than hoped. The Government programme underlines the importance of employment in preventing impoverishment and marginalization. The effect of general taxation and social protection measures on employment could well be limited in the case of the long-term unemployed. Accordingly, labour policy measures will be primarily focused on this group.

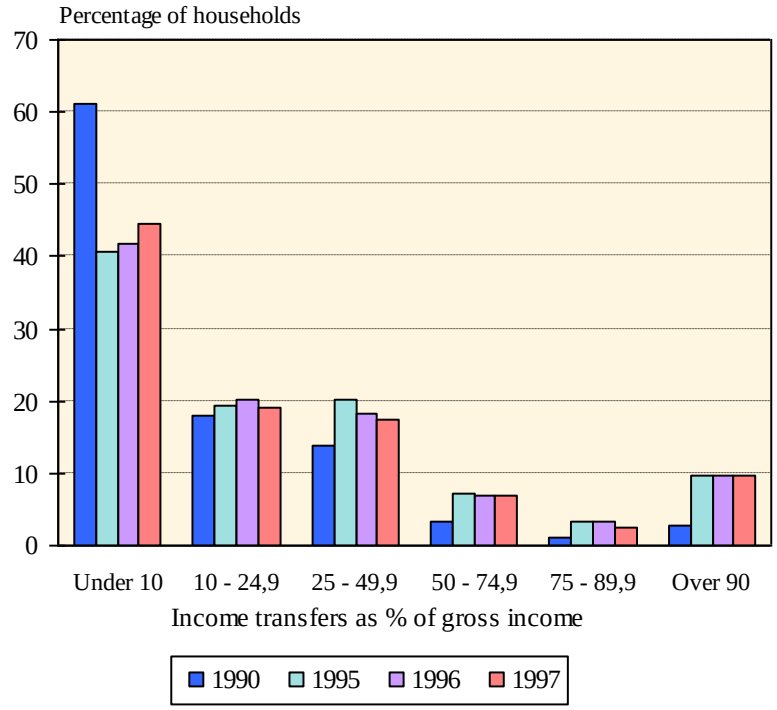
The role played by capital income in household income formation has grown. This mainly affects high-income households, so the trend is likely to increase income differentials. The Government programme aims to raise the tax rate applied to capital, corporate and interest income by one percentage point, to 29 per cent, from 2000 onwards up to the next elections.

Some changes have taken place in income transfers since 1997 that may have affected the standing of households dependent on them. The reform of housing and social assistance systems during 1998 extended the income bracket entitled to general housing allowance, ensuring better coverage for households living on a small earned income. The changes made in social assistance at the same time, however, undermined the financial position of households forced to rely on it, especially if they had several children. The final effects of these changes, too, will largely depend on whether people living in such households can manage to find a job.

Dependence on income transfers still great

Household dependence on income transfers grew in the first half of the 1990s. More and more households have come to rely largely on various income transfers, even in the case of people of working age. As the employment situation has improved, dependency on income transfers has decreased somewhat, but the number of households relying almost totally on income transfers looks likely to remain higher than before (Figure 29).

Figure 29. Income transfers as a percentage of gross income in households where the reference person is aged 25-54



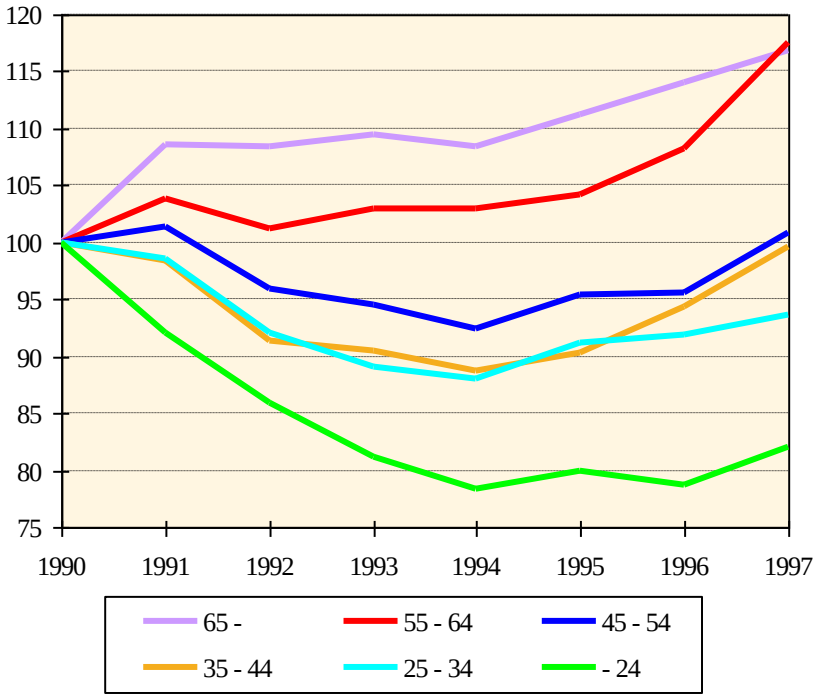
Income transfers as % of gross income
Income transfers received as % of gross cash income. Income transfers also include transfers between households. The reference person is generally the member of the household with the highest income.

Income trends in different age groups and household types

The financial standing of young people, especially, deteriorated in the early '90s. Older age groups were less affected by the recession than households made up of people of working age. Since then, however, such differences in income trends have levelled out.

When we interpret income trends in older households, we should remember that the retirement of new age groups receiving better employment pensions has raised the average income of the group as a whole. This rise in income does not reflect the average income trend of households already in the group at the beginning of the period surveyed. Exemplar case calculations indicate that the real incomes of pensioner households at certain income levels in fact fell slightly in the '90s. Assessment of income trends should also take into account the fact that Figure 30 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* in the various age groups do not come out.

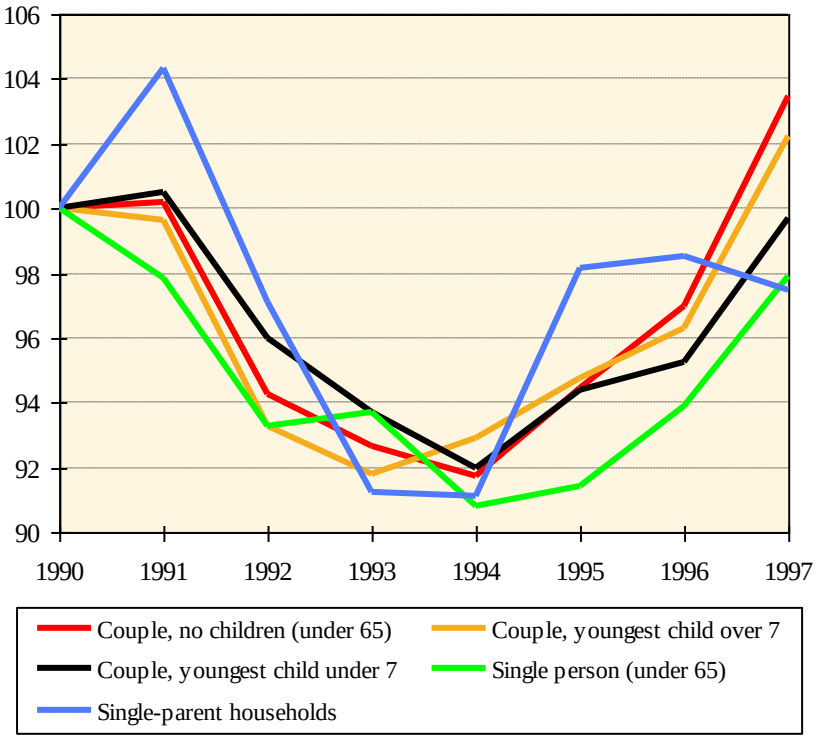
Figure 30. Trends in average real incomes of households by age group, 1990-1997



Real disposable income, 1990=100.

In the recession years at the beginning of the 1990s, the real average income of the working-age population fell in all family types (Figure 31). It was not until the second half of the decade that incomes again started to reach the pre-recession level. The average trend was roughly the same for all family types, although the income of single parents does not seem to have risen very much in recent years, unlike the other groups. The categories used in Figure 31 are fairly rough, especially in the case of one-person households and childless couples. Within these categories, income trends among the older age groups have been better than for younger groups. Income differentials between family types have increased somewhat since the mid-1990s. Most of the growing gap is due to rising income differentials within family types, however. The share of within-group differentials in overall income differentials was much greater in 1997 than at the beginning of the 1990s.

Figure 31. Trends in real incomes of households of working age in different household types, 1990-1997



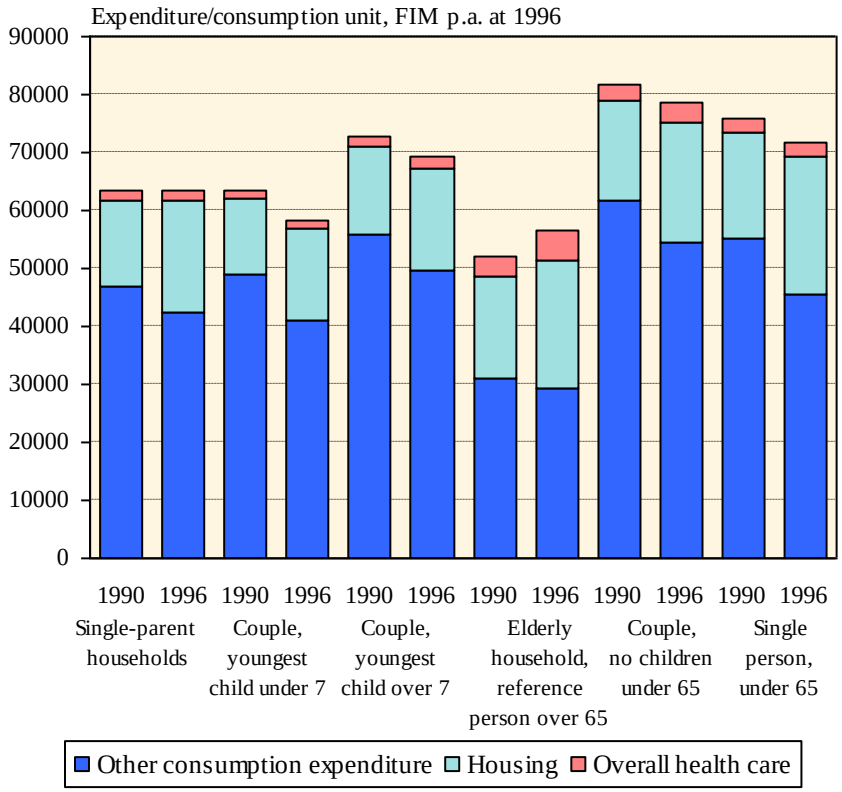
Real disposable income, 1900=100.
NB: Random variation in the sample data may result in over-estimation of annual income changes, especially in categories with rather small sample sizes (e.g. single parents).

Changes in the prices of various commodities and services showed quite considerable variation in the early 1990s. The prices of foodstuffs fell as a result of EU membership, while the cost of overall health care rose more than average. Living in rented accommodation also became more common in the first half of the 1990s. Partly as a result of these factors, the structure of household consumption has changed.

Figure 32 examines the change in household consumption expenditure and its structure in different family types. In most cases, real consumption expenditure was somewhat lower in 1996 than in 1990. The exception was elderly households, whose consumption expenditure rose. The role of housing costs had risen in all age groups. Elderly households spent far more than others on overall health care. In addition, the share of health care in the total expenditure of elderly households increased throughout the survey period. By 1996, it accounted for a good 9 per cent. In all family types the share of other consumption expenditure declined. At the same time, the amount of money spent on other expenditure decreased in real terms.[4]

4 Changes in price levels have been measured using the total index of change in living costs, which does not necessarily measure price changes in different consumption categories very well. However, if the index is made up using a weighting appropriate for 'other consumption', the result remains essentially unchanged.

Figure 32. Household consumption expenditure, 1990 and 1996

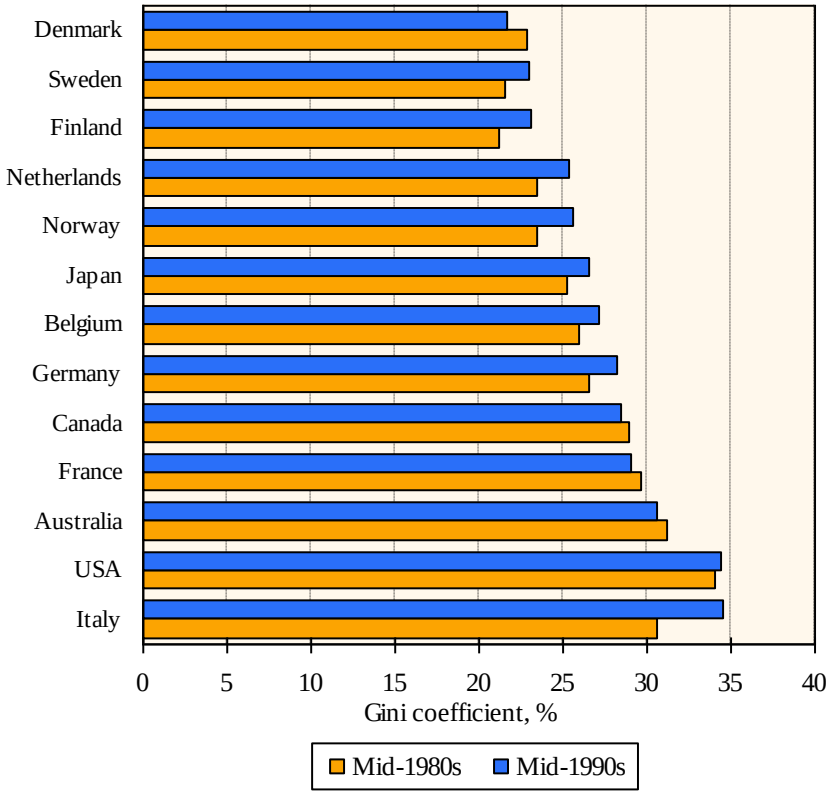


Income differentials also growing in other countries

Various surveys have been conducted by the OECD in recent years to compare income differentials and trends in various countries. In most of the countries surveyed, including Finland, income differentials were greater in the mid-1990s than in the mid-1980s (Figure 33). Similarly, the rising income differentials in Finland since the mid-1990s do not necessarily run counter to trends elsewhere. National statistics — for instance in Sweden and Norway — indicate that income differentials are still growing.

In Finland and the other Nordic countries, differentials are still relatively small compared with most other OECD countries. This is largely thanks to the equalizing effect of social security benefits and taxation. Measured by earnings and capital income, income differentials are roughly in the same class as in many other OECD countries.

Figure 33. Income differentials and trends in certain OECD countries
Disposable income



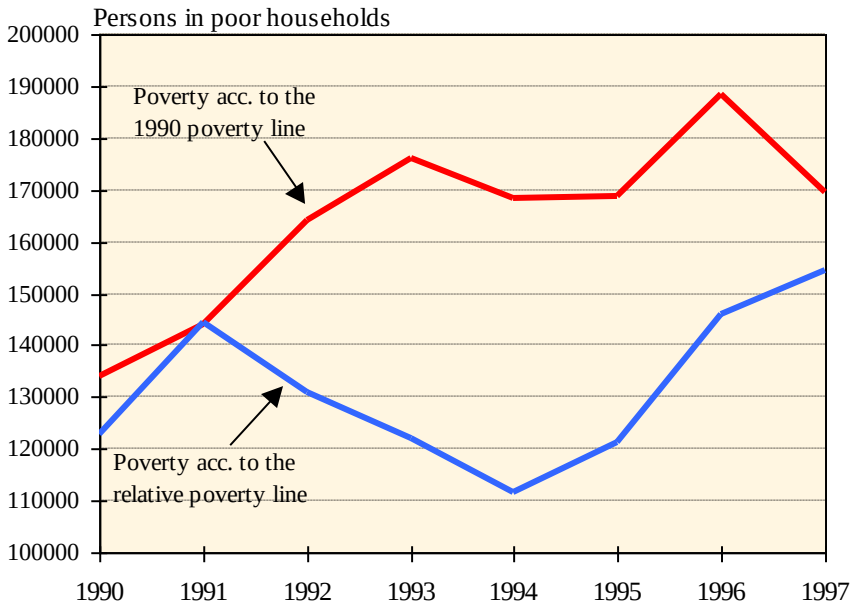
Source: OECD

Increase in relative poverty among the young

In an income distribution comparison, relative poverty is often defined as a situation in which a household's disposable income is less than half of the median for all households. Such comparison endeavours to take account of differences in household size and family type. Measured in this way, relative poverty did not rise in the early '90s, despite growing unemployment. This was largely because the fall in average real household incomes resulted in a fall in the relative poverty line. In the mid-90s, however, the relative poverty rate started to rise. Increasing incomes among the working population and the better general employment situation raised the average household income and thus also the poverty line. At the same time, several benefits important to those on small incomes either suffered direct cuts or the abandonment of index-based increases.

A different picture emerges of trends in the 1990s if the 1990 poverty line is used. Based on a fixed poverty line, the poverty rate rose appreciably during the recession. In the latter half of the decade, however, this rise seems to have halted, a development reminiscent of changes in the number of recipients of social assistance. (Figure 34)

Figure 34. Poverty using a fixed and a relative poverty line, 1990-1997



The figures based on a relative and a fixed 1990 poverty line are different for 1990 itself, as an adjustment was made to the 1990-1993 figures due to a change in the definition of 'income'.

In 1997, about 155,000 people, or some 3 per cent of the population, lived in households where income fell below the relative poverty line. Estimates of the scale of poverty depend greatly on the income threshold or other definitions used. If the poverty line is put at 60 rather than 50 per cent of the median income of all households, this doubles the poverty rate. The picture also changes if household consumer data or households' own information about their financial problems are used instead of income data. In addition, the most poorly off and socially excluded members of the population tend to slip through the survey net. This problem could well have grown in recent years, with rising non-response rates.

Table 3 shows the relative poverty rate in different household types in 1990 and 1997. In order to illustrate the effect of calculation assumptions, the figures have been calculated using two different 'consumption unit' figures. The income of households of different sizes and types are made as comparable as possible by dividing their incomes by the total number of consumption units. The consumption unit scale chosen has quite a considerable effect on the impression we get of the prevalence of poverty among the various household types. In some cases, the choice even seems to affect the direction taken by the change in the poverty rate. However, the poverty rate among young households rose during the 1990s in both options. By contrast, the poverty rate of elderly households would seem to have fallen. There is every reason to be fairly cautious in interpreting the findings. Many young households that fall below the poverty line are made up of students. These households actually study for rather a short period of their lives, after which point their income level usually rises. In addition, study loans are not included in the income definition. The limitations of income analysis also apply to elderly households. As noted earlier, these spend more on overall health care than other groups. In some cases, such spending may be so large as to make what is otherwise a reasonable income level inadequate.

Table 3. Relative poverty rate in different household types, 1990 and 1997

	Eurostat consumption units[1], 50 % of median income			OECD consumption units[2], 50 % of median income		
	1990	1997	Change, % points	1990	1997	Change, % points
Single-parent households	5,5	3,7	-1,8	5,6	5,8	0,2
Couple, youngest child under 7	1,1	2,3	1,2	2,3	3,7	1,4
Couple, youngest child over 7	1,3	1,4	0,1	1,4	1,6	0,2
Elderly household (over 65)	10,3	2,0	-8,3	2,5	1,4	-1,1
Couple under 30, no children	4,2	7,8	3,6	3,6	5,7	2,1
Couple over 30, no children	1,2	1,0	-0,2	1,1	0,9	-0,2
One-person household, under 30	19,4	30,3	10,9	12,8	20,5	7,7
One-person household, over 30	8,5	8,5	0,0	3,5	3,0	-0,5
Other households	1,7	1,5	-0,2	2,4	1,4	-1,0
All households	**3,3**	**3,6**	**0,3**	**2,6**	**3,0**	**0,5**

Percentage of people below the poverty line in each household type.
Because of rounding, the difference between poverty rates in 1990 and 1997 may not correspond with the indicated change.
1990 rates adjusted due to a change in the definition of 'disposable income'. In some cases this may overemphasize the change in the poverty rate.

[1] Consumption unit scale used in the Eurostat ECHP survey
[2] 'Old' OECD consumption unit scale used by Statistics Finland

Overindebted households are one group suffering from serious financial problems that normal poverty analysis does not bring out. Like poverty, overindebtedness is very difficult to measure. Evaluations of the number of people in excessive debt, and changes in it, vary, depending on the method used. One way of solving the issue is to use households' own views of their indebtedness. Measured in this way, the volume of indebtedness rose throughout the 1990s. At the beginning of 1998, around 130,000 households considered that they were excessively in debt. Statistics on various household payment defaults, however, indicate that the situation began to improve soon after the mid-90s. A comparison of household income and debt also shows that the problem was easing by then. By 1997, the number of households whose debts were over double their net annual income had fallen by a third from the peak level in the early years of the decade.

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APPENDIX 1

SOCIAL PROTECTION INDICATORS

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
I Social protection expenditure and financing											
Social protection expenditure											
Social protection expenditure, FIM million	131 369	148 924	163 622	170 463	176 589	179 654	185 272	186 033	187 700	190 300	194 500
GDP	521 021	499 357	486 923	492 609	522 309	564 566	585 865	635 532	686 742	718 029	757 400
Social protection expenditure/GDP	25.2	29.8	33.6	34.6	33.8	31.8	31.6	29.3	27.3	26.5	25.7
Social protection expenditure, FIM/inhibitant at 1999 prices	30 734	33 244	35 438	35 996	36 733	36 845	37 684	37 274	37 000	36 800	37 000
Social protection expenditure by target group:											
- sickness and health care	27.5	25.9	22.7	20.7	19.7	20.3	20.7	21.3	22.1	22.8	23.5
- disability	15.0	14.8	14.7	14.7	14.5	14.5	14.3	14.3	13.6	13.4	13.2
- old age	28.6	27.8	27.3	27.5	27.3	28.1	29.0	29.1	30.0	30.3	30.7
- survivors	4.0	3.9	3.9	3.9	3.8	3.8	3.8	3.9	3.9	4.1	4.2
- families and children	13.0	12.9	12.5	11.8	13.3	13.0	12.1	12.3	12.5	12.5	12.3
- unemployment	5.9	8.5	12.8	15.6	15.2	14.0	13.5	13.0	11.5	10.6	10.1
- housing	0.7	0.9	1.1	1.1	1.4	1.5	1.2	1.2	1.4	1.5	1.5
- other	1.8	2.1	2.2	2.0	2.0	2.0	2.3	2.4	2.1	1.9	1.9
- administration	3.5	3.0	2.8	2.6	2.8	2.8	3.1	2.7	3.0	2.7	2.7
- total	100	100	100	100	100	100	100	100	100	100	100
Contributions to the financing of social protection expenditure											
- State	25	28.9	29.4	30.4	30.6	29.5	28.8	27.4	26.8	25.7	25.4
- local authories	15.6	15.3	15.2	15.1	15.8	16.6	16.1	17.2	17.5	17.8	17.3
- employers	44.1	41	36.7	34.7	33	33.5	35	35.2	36.4	37.2	37.8
- the insured	8.0	7.2	10.4	12.3	14.3	13.6	13.0	13.3	12.9	12.5	12.3
- property income	7.3	7.7	8.2	7.6	6.3	6.8	7.1	6.8	6.4	6.8	7.3
- total	100	100	100	100	100	100	100	100	100	100	100
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, FIM million	38 961	51 775	53 858	53 814	53 541	49 027	47 983	45 124	44 998	43 513	42 992
Government subsidies for Action costs of social services and health care, FIM million	19 498	21 387	21 133	20 568	18 409	17 942	15 945	13 557	12 857	12 690	13 035
Ministry of Social Affairs and Health's main division expenditure as a percentage of total government expenditure	27.7	30.8	28.9	26.6	27.0	24.7	24.1	24.1	22.1	23.1	21.6

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
Municipal expenditure											
Municipal Action costs on health care and social services, FIM million	41 099	45 632	47 486	50 010	50 358	52 746	55 448	57 712	58 872	60 000	62 000
Staff in the municipal social services and health care sector											
Social services and health care staff	206 700	213 650	212 700	202 700	205 700	205 100	216 050	220 400	220 450	220 400	219 000
Government debt											
Government debt, % of GPP	11	18	34	53	59	64	67	66	61	60	57
II SICKNESS AND HEALTH CARE											
Main categories of sickness and health care expenditure											
Sickness and health care expenditure (net), FIM million	36 123	38 639	37 204	35 372	34 867	36 529	38 422	39 695	41 500	43 400	45 700
Cash benefits	7 949	8 248	7 659	6 953	6 809	7 142	7 261	7 493	8 000	8 400	9 000
- daily sickness allowance	3 063	3 341	3 172	2 683	2 620	2 523	2 373	2 384	2 500	2 600	2 800
- sick pay	4 100	4 100	3 700	3 600	3 500	3 900	4 200	4 400	4 700	5 000	5 350
Services (net)	28 174	30 391	29 545	28 419	28 058	29 387	31 161	32 202	33 500	35 000	36 700
- primary health care	11 178	12 149	11 887	9 161	9 347	9 660	10 153	9 887	10 600	11 200	11 800
- specialized health care	12 266	12 940	12 083	13 546	12 945	13 631	14 459	15 154	15 400	15 900	16 700
- sickness insurance	2 893	3 264	3 240	3 292	3 560	3 910	4 346	4 681	5 000	5 300	5 600
Life expectancy and infant mortality											
Life expectancy											
- men	70.9	71.3	71.7	72.1	72.8	72.8	73.0	73.4	73.5	73.7	73.8
- women	78.9	79.3	79.4	79.5	80.2	80.2	80.5	80.5	80.8	80.8	80.9
Infant mortality (1/1000)	5.6	5.9	5.2	4.4	4.7	3.9	4.0	3.9	4.2		
Morbidity											
Recipients of daily sickness allowance	397 900	385 100	355 100	293 300	283 200	284 400	275 000	271 800	278 100	289 000	300 500
Absences due to sickness as percentage of total working days, %	3.8	3.7	3.4	3.8	3.5	3.5	3.4	3.4	3.4	3.5	3.5
Number of persons got an occupational disease	9 100	8 800	8 000	7 000	6 700	5 800	5 700	5 000	4 800	4 700	4 500
Prescriptions/inhabitant	6.1	6.3	6.0	5.9	5.7	6.0	6.3	6.4	6.6	6.7	6.8

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
Bed-days and discharges of health care											
Primary health care, wards											
- discharges/1,000 inhabitants	51	42	46	48	51	51	56	56	58	59	59
- bed days/1,000 inhabitants	1 676	1 538	1 544	1 525	1 542	1 577	1 624	1 574	1 578	1 580	1 580
Specialized health care, wards											
- discharges/1,000 inhabitants	162	173	179	182	183	181	184	181	176	173	170
- bed days/1,000 inhabitants	1 552	1 578	1 464	1 359	1 294	1 235	1 183	1 145	1 078	1 050	1 030
Reimbursements of National health insurance											
Number of refunds											
- medicines	16 161	16 999	16 389	16 167	15 590	16 045	16 813	17 314	17 684	18 200	18 600
- private doctors' services	3 903	3 879	3 499	3 451	3 161	3 228	3 310	3 264	3 316	3 340	3 370
- private dentists' services	517	641	651	752	778	817	860	980	1 324	1 370	1 420
- private examinations and treatments	1 327	1 319	1 097	1 017	920	933	992	1 016	1 083	1 120	1 150
- transportation sevices	3 550	3 706	3 142	2 520	2 503	2 597	2 883	2 954	3 030	3 080	3 110
Share of refund of total costs											
- medicines	37.3	38.0	38.0	29.4	35.1	38.2	38.9	39.7	40.0		
- private doctors' services	37.5	35.8	35.8	35.6	36.1	38.0	40.1	39.1	38.2		
- private dentists' services	57.1	53.9	53.9	56.6	55.6	53.1	49.9	49.0	48.9		
- private examinations and treatments	39.7	38.1	38.1	37.8	39.7	41.5	43.2	42.8	43.1		
- transportation sevices	81.8	83.0	83.0	82.0	83.9	84.8	85.1	85.5	85.8		
III DISABILITY											
Main categories of expenditure related to disability											
Expenditure on disability, FIM million	19 691	22 090	24 033	25 030	25 582	26 124	26 440	26 554	25 500	25 500	25 700
Cash benefits	16 461	18 435	20 370	21 246	21 470	21 783	21 792	21 648	20 300	20 200	20 200
- disability pensions	11 113	11 961	12 702	13 125	13 166	13 422	13 633	13 925	13 100	13 200	13 300
- individual early retirement pensions	2 089	2 834	3 424	3 814	4 078	4 242	4 050	2 624	3 200	3 000	2 900
- military injuries indemnities	1 740	1 976	2 138	2 024	1 779	1 756	1 712	1 699	1 560	1 500	1 400
Services (net)	3 230	3 655	3 663	3 784	4 112	4 341	4 648	4 906	5 200	5 300	5 500
- institutional care for the disabled	896	966	927	944	892	801	780	789	800	800	800
- services for the disabled	1 021	1 207	1 250	1 306	1 566	1 765	2 164	2 454	2 700	2 800	2 900
- rehabilitation	829	956	948	1 084	1 173	1 191	1 104	1 132	1 150	1 200	1 200

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
Disability pensions											
Total recipients of disability pensions on December 31.	300 930	305 410	308 540	309 730	310 630	309 510	301 780	294 990	288 050	289 200	282 800
Services for the disabled											
Disabled persons in institutional care on December 31.	4 390	4 850	4 870	3 630	4 000	3 770	3 650	3 370	3 200	3 000	2 800
Disabled households receiving home help services during the year	7 920	6 780	7 090	6 120	6 210	7 000	6 950	6 615	6 300	6 300	6 300
IV OLD AGE											
Main categories of expenditure on old age											
Expenditure on old age, FIM million	37 529	41 472	44 683	46 856	48 153	50 420	53 697	54 081	56 300	57 800	59 600
Cash benefits	33 547	37 217	40 480	42 463	43 660	45 472	48 321	48 771	50 700	52 000	53 800
- old age pensions	31 790	35 199	38 339	40 138	41 425	43 240	45 169	46 617	48 500	49 900	51 600
Services (net)	3 982	4 255	4 203	4 393	4 493	4 948	5 376	5 310	5 600	5 700	5 800
- institutional care for the elderly	2 431	2 611	2 530	2 671	2 667	2 865	2 888	2 701	2 800	2 800	2 800
- open care of the elderly	1 551	1 644	1 673	1 722	1 826	2 083	2 488	2 609	2 800	2 900	3 000
Pensioners											
Recipients of old age pensions, December 31.	737 150	750 900	762 570	776 810	789 390	804 060	822 520	836 700	843 900	851 100	860 800
Recipients of part-time pensions, December 31.	430	700	1 210	2 260	4 470	5 440	6 100	6 930	10 920	13 200	16 100
Services for the elderly											
Persons in old people's homes on December 31.	26 620	25 820	25 350	24 210	23 410	22 950	22 910	22 270	21 420	21 200	21 000
Elderly households receiving home-help services	124 010	122 720	103 780	99 100	91 680	86 750	87 410	85 400	84 820	85 500	86 500
Elderly clients receiving auxiliary services during the year	200 170	113 910	128 000	109 720	93 950	97 970	99 210	103 300	105 620	107 700	109 800
V SURVIVORS											
Main categories of expenditure on survivors											
Expenditure, FIM million	5 291	5 854	6 345	6 648	6 720	6 800	6 984	7 181	7 400	7 800	8 200
- survivors' pensions	4 994	5 534	6 003	6 337	6 438	6 528	6 754	6 941	7 150	7 550	7 900
Recipients of survivors' pensions on December 31.											
- widows' and widowers' pensions	194 780	203 720	212 430	220 040	225 050	230 830	238 380	243 450	247 550	258 600	266 100
- children's pensions	28 430	28 740	29 080	29 530	29 630	29 340	29 250	29 340	28 880	28 900	28 900

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
VI FAMILIES AND CHILDREN											
Main categories of expenditure on families and children											
Expenditure on families and children, FIM million	17 118	19 268	20 445	20 086	23 441	23 307	22 448	22 808	23 400	23 700	23 900
Cash benefits	9 930	11 538	13 106	12 838	16 204	15 549	13 924	13 874	14 000	13 900	14 000
- parents' allowance	3 314	3 585	3 774	3 416	3 130	3 016	2 773	2 733	2 700	2 800	2 800
- home care allowances	2 234	2 650	3 212	3 229	3 274	3 053	2 042	2 076	2 200	2 200	2 150
- child allowance	4 094	4 791	5 549	5 539	9 101	8 768	8 398	8 384	8 350	8 300	8 250
Services (net)	7 188	7 730	7 339	7 248	7 237	7 758	8 524	8 934	9 400	9 800	9 900
- child day care	5 872	6 292	5 895	5 553	5 527	5 946	6 589	6 894	7 200	7 500	7 500
Recipients of parents' allowance during the year											
- mothers	54 910	56 320	57 660	57 070	55 210	53 340	51 570	49 870	48 430	48 400	48 200
- fathers	1 300	1 870	1 850	2 050	2 210	1 930	2 210	2 030	2 190	2 200	2 200
Families receiving home care allowance on December 31.	81 210	85 210	92 570	95 820	95 380	84 480	73 980	75 490	74 360	72 000	71 500
Children in municipal daycare on December 31.	200 200	195 500	182 300	174 300	180 800	189 900	217 300	219 700	218 500	220 000	218 000
VII UNEMPLOYMENT											
Main categories of unemployment expenditure											
Unemployment expenditure, FIM million	7 723	12 724	20 973	26 611	26 892	25 093	25 099	24 143	21 600	20 300	19 600
Cash benefits	6 559	11 398	19 388	25 047	25 095	25 549	23 186	22 111	19 800	18 700	18 100
- basic daily allowance	860	2 321	4 464	5 789	5 133	2 703	939	818	600	550	500
- earnings-related daily allowance	2 231	5 698	10 897	15 177	14 855	13 001	12 958	11 847	9 460	8 500	8 300
- labour market support	0	0	0	0	1 307	4 089	5 327	5 117	5 360	5 400	5 100
- unemployment pensions	2 644	2 481	2 329	2 313	2 373	2 432	2 397	2 683	3 000	3 000	3 200
- labour market training benefits	739	671	1 142	1 274	1 108	1 130	1 308	1 327	1 130	900	800
Services	1 164	1 326	1 585	1 564	1 797	1 544	1 913	2 032	1 800	1 600	1 500
- labour market training for adults	703	778	1 040	1 026	1 217	937	1 283	1 381	1 100	900	800
Unemployment rate											
Unemployment rate, %	3.1	6.8	11.7	16	16.6	15.4	14.6	12.7	11.4	10.3	9.3
Long-term unemployed as a percentage of all unemployed	3	3	8	18	27	30	30	30	30	33	33

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
Recipients of daily unemployment allowances											
Recipients of earnings-related daily unemployment allowance as annual workyear equivalent	46 340	101 910	190 020	272 120	275 790	240 650	235 880	213 780	169 450	146 200	137 400
Recipients of basic daily unemployment allowance as annual workyear equivalent	32 810	78 290	144 390	188 930	167 470	87 110	30 450	26 800	19 920	17 600	16 800
Recipients of labour market support as annual workyear equivalent	0	0	0	0	45 980	133 970	181 660	176 530	181 970	184 100	166 800
Unemployment pensions											
Recipients of unemployment pensions on December 31.	55 490	47 780	43 720	42 790	42 960	39 150	41 410	44 860	49 400	49 400	51 000
VIII HOUSING											
Expenditure on general housing allowance, FIM million	957	1 280	1 862	1 900	2 444	2 623	2 299	2 169	2 615	2 900	2 800
Recipients of general housing allowance (on December 31., households)	110 490	146 270	192 830	182 370	227 560	213 820	191 880	184 640	205 600	204 200	185 000
IX OTHER											
Main categories of other expenditure											
Expenditure, FIM million	2 387	3 142	3 571	3 457	3 515	3 658	4 220	4 443	3 900	3 650	3 650
Cash benefits	1 238	1 745	2 127	2 375	2 467	2 614	3 072	3 213	2 700	2 400	2 350
- social assistance (net)	1 085	1 413	1 665	2 005	2 308	2 493	2 906	3 039	2 600	2 300	2 200
Services (net)	1 149	1 397	1 444	1 082	1 048	1 044	1 148	1 230	1 200	1 250	1 300
- care for alcoholics and drug abusers	448	505	403	362	387	408	437	452	420	430	450
Social assistance											
Households receiving social assistance during the year	181 600	222 700	258 900	292 600	329 400	339 000	349 600	344 700	313 400	294 200	280 400
Average duration, months	3.9	3.9	3.9	4.3	4.8	5.1	5.4	5.6	5.7	5.8	5.8

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
Alcohol, tobacco, drugs											
Daily smokers, percentage of 15-64 year-olds											
- men	33	33	33	29	29	28	28	30	30		
- women	20	21	21	19	19	19	19	20	20		
Alcohol consumption, l/inhabitant											
- in official statistics	7.7	7.4	7.2	6.8	6.6	6.7	6.7	6.9	7.1		
- illicit	1.2	1.3	1.3	1.4	1.4	2.1	2.1	2.0	1.9		
- total	8.9	8.7	8.5	8.2	8.0	8.8	8.8	8.9	9.0		
Drug-related crimes	2 500	2 500	3 300	4 000	5 700	9 100	7 900	8 300	9 500	11 500	
X POPULATION AND INCOME											
Income											
Disposable income per capita, FIM at 1999 prices	64 200	64 800	63 100	59 100	57 100	61 700	61 300	64 000	67 300	70 000	
Income differentials											
(Gini coefficient, the higher the figure the greater the differential, 1990=100)											
Factor income (earned income + capital income)	100	102	108	115	117	117	118	119			
Gross income (factor income + income transfers received)	100	98	99	102	101	104	106	110			
Disposable income (gross income - taxes)	100	100	99	102	101	105	108	114			
Disposable real income, 1990=100											
Single parents	100	104	97	91	91	98	99	97			
Other families with children (youngest child under 7)	100	101	96	94	92	94	95	100			
Other families with children (youngest child over 7)	100	100	93	92	93	95	96	102			
Elderly households (over 65)	100	109	109	110	108	111	114	117			
Childless couples (under 65)	100	100	94	93	92	94	97	103			
Single persons (under 65)	100	98	93	94	91	91	94	98			
Others	100	102	97	95	95	98	100	105			
Poverty rate											
(Percentage of households whose disposable income is less than 50% of the average disposable income for all households)											
Poverty rate	2.5	2.9	2.6	2.4	2.2	2.4	2.9	3.0			

	1990	1991	1992	1993	1994	1995	1996	1997	1998*	1999**	2000**
XI SOCIAL INSECURITY											
Suicides, accidental deaths and violent crimes											
(Average per 100,000 people; violent crimes include murders, manslaughters and assaults)											
Suicides	30.3	29.8	28.8	27.6	27.3	27.2	24.3	25.7			
Accidental dealths	56.5	55.7	53.7	50.8	50.8	51.8	50.3	53.1			
Violent crimes	3.2	3.1	3.4	3.3	3.2	2.9	3.3	2.8			
Divorce and abortions											
(Divorces per 1,000 married women; abortions per 1,000 women aged 15-49)											
Divorces	12.6	12.3	12.5	12.4	13.4	13.9	13.6	13.4	13.8		
Legal abortions	9.7	9.3	8.7	8.1	7.9	7.8	8.3	8.2	8.7	8.9	
Children and young people placed outside the home and in open-care											
Placements outside the home											
- total	,,	8 720	9 410	9 670	10 210	10 700	11 120	11 760	12 130		
- of which taken into custody	,,	6 203	6 382	6 393	6 403	6 478	6 474	6 803	7 144		
Children and young people in open-care											
- total	,,	,,	,,	24 690	27 820	30 690	33 270	35 810	38 630		
Recipients of maintenance support											
Children receiving maintenance support	73 090	78 730	85 580	92 590	98 480	103 100	106 810	107 900	107 720	107 350	107 000

*) forecast/estimate

Sources: Ministry of Social Affairs and Health
Statistics Finland
SOTKA database
National Research and Development Centre for Welfare and Health (Stakes)
Institute of Occupational Health
Central Pension Security Institute
Social Insurance Institution

APPENDIX 2

Average social insurance contributions[1]

	1992	*1993*	*1994*	*1995*	*1996*	*1997*	*1998**	*1999**	*2000***
EMPLOYERS									
National pension insurance (2)	2,94	3,20	3,41	3,39	3,45	3,24	3,25	3,22	3,21
Sickness insurance (2)	1,56	1,90	1,91	2,05	2,05	1,74	1,74	1,70	1,70
Unemployment insurance (2),(3)	3,70	5,60	5,40	4,50	2,90	2,90	2,78	2,75	2,40
Employment pension insurance (4)	14,40	15,50	15,60	16,60	16,80	16,70	16,80	16,80	16,80
Municipal pension insurance	19,10	17,20	18,90	20,30	21,00	20,80	21,10	21,40	21,70
INSURED GROUPS									
Wage-earners	**5,25**	**6,90**	**8,32**	**8,32**	**7,70**	**7,90**	**7,60**	**7,55**	**7,20**
National pension insurance	3,05	1,80	1,55	0,55	0,00	0,00	0,00	0,00	0,00
Sickness insurance (5)	2,20	1,90	1,90	1,90	1,90	1,90	1,50	1,50	1,50
Unemployment insurance	0,00	0,20	1,87	1,87	1,50	1,50	1,40	1,35	1,00
Employment pension insurance	0,00	3,00	3,00	4,00	4,30	4,50	4,70	4,70	4,70
Retired persons	**5,25**	**6,70**	**7,45**	**6,45**	**4,90**	**4,90**	**4,20**	**3,90**	**3,20**
National pension insurance	3,05	2,80	2,55	1,55	0,00	0,00	0,00	0,00	0,00
Sickness insurance (5)	2,20	3,90	4,90	4,90	4,90	4,90	4,20	3,90	3,20

(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 the number of pennies out of each tax unit.

(2) The average weighted with the total payroll of the various payment categories.

(3) The progressive employers' unemployment insurance contribution introduced during 1993. In 1993 the level was 3.75 % of the salary if the annual total payroll was less than FIM 1 million; for larger amounts the contribution was 6 % of the total. The contributions for 1994-1999 were as follows:

- In 1994, the contribution was 3 % for the first FIM 1 million total payroll, otherwise 6.3 %.
- In 1995, the contribution was 2 % for the first FIM 5 million total payroll, otherwise 6.1 %.
- In 1996-97, the contribution was 1 % for the first FIM 5 million total payroll, otherwise 4 %.
- In 1998, the contribution was 0.9 % for the first FIM 5 million total payroll, otherwise 3.9 %.
- In 1999, the contribution is 0.9 % for the first FIM 5 million total payroll, otherwise 3.85 %.
- In 2000, the contribution is 0.9 % for the first FIM 5 million total payroll, otherwise 3.45 %.

(4) Employment pension contribution

(5) Contribution percentage in the table up to 80,000 tax units. A surcharge was levied on amounts in excess of 80,000; the contributions were as follows in 1992-99: 1.5 %/1992-93, 1.9 %/1994-95, 1.45 %/1996 and 0.45 %/1997-98. The surcharge will no longer be in effect after the beginning of 1999.