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Summary

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Increasing the employment rate a prerequisite for development of social protection

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

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

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

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

Social and health care services in the focus of the draft budget for 2005

The share made up by the main division of the Ministry of Social Affairs and Health in the draft state budget comes to about € 9.9 billion. The amount is about five percent higher than in the budget for 2004. Improving the status of families and the economy of the elderly and the development of social and health care are emphasised in the draft budget. The greatest increases in appropriations are caused by added funding directed to municipalities aimed at improving social and health care, securing the availability of social and health care services, the proposed health insurance reforms and increased health insurance costs, and the raise of the level of national pension and the benefits linked to it.

Municipal economy was clearly weakened in 2003. The financing situation of municipal economy is expected to remain tight throughout 2004. The annual increase of municipalities' operating costs is estimated to be about 4 percent. The increase in costs is mainly due to an increase in wage costs and the number of staff and an increase in municipal pension contributions and employer's contributions to unemployment insurance. The increase in service demand caused by the change in population age structure is also a factor that increases municipalities' expenses. Migration also increases costs in fast-growing municipalities, while making it harder to maintain the service structure in municipalities with a diminishing population. It is estimated that beginning in 2005, the financing balance of municipal economy will be clearly improved as tax revenues and government grants increase, while the growth of expenses remains modest.

Social protection expenditure increasing slightly

After a long decline, the GDP ratio of social protection expenditure started to show a slight increase in the early 2000s. In addition to increased social protection expenditure, this was caused by a slowdown of GDP growth. Social protection expenditure has in recent years grown due to increases in costs related to old age, sickness and health. Taken together, these expenses make up over 50 percent of social protection expenditure.

The social protection expenditure in relation to GDP is in Finland on average EU level (EU15). In addition to differences in the size of social protection expenditure between EU member states, there are also differences in expense structure. In Finland, the share of total expenditure made up by service costs is smaller than in Sweden and Denmark, but higher than the EU average. International comparison of social expenditure is made difficult by the fact than in many countries considerable social tax deductions are used instead of cash benefits. In some countries, a significant part of the social security benefits paid in cash are also tax-free income. There are similar problems involved in tax rate comparisons as well.

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

The health of the Finnish population shows a primarily positive development trend in all age groups and in both genders. The health behaviour of young people has mainly moved in a positive direction, the working capacity of working-age people is relatively good, and the functional capacity of the elderly is better than before. Mortality, morbidity and the functional capacity of the elderly seem to be strongly linked to a person's socioeconomic status and lifestyle.

There are however still great differences in health between population groups, and the differences seem even to be increasing. Tobacco and alcohol explain half of the differences between population groups. The greatest threats to the positive development trend are a clear increase in obesity and alcohol use among the population. The rapid increase of obesity among the young as well as the clear increase in alcohol consumption as a result of the reduction in alcohol tax is particularly alarming. There is a danger that alcohol-related deaths will continue to increase, making the differences in mortality between population groups even greater. According to studies, regulation of the alcohol market as well as alcohol tax are the most effective means of influencing alcohol consumption and the harm caused by it.

In order to develop public health in a positive direction, it is of the utmost importance to make people aware of the effects of their own choices and lifestyle on their state of health. The foundation of a healthy adulthood and functional old age is laid in childhood and youth. The causes of many diseases can be prevented by adopting a healthier lifestyle. Focusing on prevention and health information is an inexpensive means of achieving significant savings in the years to come.

If the goal is to reduce the health gap between population groups, social policy aimed at evening out differences in people's living conditions is needed, in addition to health information. The latest research results do however indicate that health services are unequally targeted. The reduction of health differences must be adopted as an area of emphasis more clearly than is presently the case.

Positive development of working conditions

Working conditions have developed in a positive direction in recent years. According to studies, 82 percent of employees are either very satisfied or fairly satisfied with their work. Between 1997 and 2003, the employment rate of those aged 54–64 rose by about 14 percentage points. During the same period, the employment rate of total population (aged 15–64) increased by about 4 percentage points. The increase in the employment rate of elderly workers is a result of the fact that people stay on at work longer than before. The large post-war cohorts have remained at work and kept their jobs better than the cohorts before them.

Structural unemployment decreased rapidly between 1997 and 2001. After 2001, the number of those not easily employed has remained steadily at a little over 170,000 persons. The most problematic group are the long-term unemployed, about 60 percent of whom are over 50 years of age. In practice, only a small minority are able to find

employment in the open labour market without special measures. In the case of young people, long-term unemployment is a rare event, even though over 120,000 young people are unemployed for some time each year.

The belief in one's ability to continue at work seems to diminish with advancing age. This is however not just a question of deteriorating health; it is part of a larger issue. Ensuring competence, working conditions and work arrangements as well as individual life situations affect the ability to remain at work. There is no single explanatory factor. According to studies and various barometers, people do stay on and want to stay on at work longer, if there is a possibility to influence working conditions sensibly. Work calls increasingly for cooperation. Work ability and competence are not just the individual's personal concern; they are issues that concern the entire work community.

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

Both social development trends and individual factors influence the prevalence of social exclusion. It is a question of clustering of different problems and interaction between them, as a result of which the individual is excluded from the common good. Due to the complex nature of the phenomenon of social exclusion there are no definite data on trends in the number of socially excluded persons. When looking at risks of social exclusion in several risk dimensions there is no indication of a positive development trend during the last few years. Because unemployment and income problems are increasingly a long-term phenomenon, the circle of marginalisation is more difficult to break than before. Mental problems have become increasingly more common as a reason for dropping out of work. The gap between demands of working life and the working capacity of marginalised persons has widened. Long-term commitment to provide support for people with multiple problems is called for in order to break the cycle of marginalisation. In the case of long-standing problems, a person's own resources dwindle. In the case of severely marginalised persons, the use of the community-care model emphasising personal responsibility only rarely leads to desired results.

Health care expenditure at a low level internationally

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

Health care expenses as a proportion of GDP are clearly lower than the EU average. Health care costs per capita are also among the lowest within the EU. The low level of costs can be interpreted in two different ways. According to a positive view, the Finnish health care system is more effective than average, since comprehensive and high-quality

services can be provided with a small input. This interpretation can be motivated by the fact that of all EU citizens, Finns are the most satisfied with their health care services. When comparing EU member states, Finland is also one of the countries with the lowest mortality amenable to health care.

According to a more critical view, it can be questioned whether sufficient funds have been allocated to health care in Finland in recent years. This view is supported by the long waiting times to get specialised medical care in Finland compared to other European countries.

Increasing need for social and health care services

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

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

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

New production and financing models for service provision

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

Responsibility for organising service provision will remain with the public sector in the future as well. Services may be provided via private enterprises or non-profit organisations. The efficacy of service provision can be increased by making provision and commissioning of services more clear-cut. If the EU service directive currently under preparation were to be implemented in the form suggested by the commission, social and health care services would be opened up for foreign competition more extensively than is currently the case. If implemented, the directive would force private and public service provision to be more clearly differentiated than before.

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

Relative poverty remains low – the income security of long-term unemployed a problem

The relative poverty rate measuring the share of low-income population remains low in Finland compared to most other EU member states. Relative poverty has however increased in recent years. The prevalence of having a low income varies according to life stages. Having a low income is most common among young people under 30 years of age. The majority of them are students, and in their case having a low income is not a particularly permanent phenomenon. Having a low income is also more common than average among persons aged 30–64 living alone and among single parents.

The share of pensioners who only receive national pension has continued to diminish. The income of more and more pensioners is based on employment pension. About one half of unemployed persons receive labour market support. The economic situation of the long-term unemployed is still a key sore point of the income security system. Nearly half of the households receiving social assistance also receive labour market support or basic unemployment allowance. The economic situation of pensioners is more secure, and they are more seldom in need of social assistance.

Thanks to the private and public sector pension reform that will gradually enter into force from the beginning of 2005 the increase in employment pension expenditure and pension contributions is expected to remain clearly smaller than would have been the case according to current legislation. There are however differing views as to whether the pension reforms to be carried out are sufficient. A reform aimed at balancing health insurance funding is to be implemented at the beginning of 2006. According to the new system, health insurance will be divided into income security and health care insurance.

Economic incentives for accepting employment have improved as the replacement rate of benefits has decreased. When comparing different countries, it is hard to find a direct association between the level of income security of unemployed persons and the unemployment rate.

Support for families with children on the rise

The number of children born has decreased in recent years, because the age groups of childbearing age are smaller than before. Total fertility rate has however remained relatively stable. The share of the population made up of children will continue to shrink in the future as well.

Family structures have changed, and the number of cohabiting couples has risen. The number of single-parent families has also risen as a result of an increasing number of divorces and break-ups. Starting a family and having children comes later in life than before. There is also an increasing number of women who remain childless. At the moment, 15 percent of middle-aged women are childless. In the future this figure is expected to rise to 20 percent. Childlessness is most common among highly educated women.

Compared to ten years ago, there is less support today from society to families with children. To remedy the situation, the level of child allowance and partial care supplement was raised at the beginning of 2004. In 2005, the child home care allowance, private care supplement and the minimum level of parenthood allowance will be raised.

The income transfers aimed at families with children are not index-linked. This has been seen especially as weakened purchasing power of child allowance and child home care allowance, which were not raised for over ten years. Despite the raises now made, their level is still lower than in the early 1990s.

The economic situation of families with children has been improved by a positive employment trend and lighter taxation. However, the development of economy of families with children lags behind that of the rest of the population. The economic situation of single parents in particular has improved more slowly compared to other population groups. The number of families with children living below the poverty line has not been reduced. Poverty has increased especially among families with many children.

In the 1990s, the resources of mother-child clinics were cut back. The number of mother-child clinic visits, particularly periodic check-ups and home visits was reduced. In the work of the mother-child clinics, the emphasis is increasingly on supporting parenthood and promoting the psychosocial well-being of the child and the entire family. The number of school health care visits has also been reduced. There are great differences between municipalities when it comes to provision and operation of school health care services.

Childcare arrangements vary considerably depending on the age of the child. The use of child home care allowance to care for children under three at home is fairly popular. Children under one are almost exclusively cared for in the home. Forty-four percent of two-year-olds are in daycare, while over sixty percent of children over three are in daycare. Whether the number of staff in daycare centres is sufficient is an issue that has given rise to concern. The groups of children in daycare centres are often large, and the staff/child ratio varies. The high turnover of both staff and children creates an unsettled atmosphere.

The need for daycare will continue to be diminished due to a decrease in the number of babies born. According to population estimates, there will be about 13,000 fewer children of daycare age in 2010 than at present.

Advances in gender equality

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

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

In all age groups, it is more common for women aged 15–59 to have a degree after lower secondary education than men of the same age. Many fields of education are segregated according to gender, similarly to the labour market.

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

Key words: Social protection, economic dependency ratio, public health, working capacity, social exclusion, health care, social services, income security, children, gender equality

Foreword

The Ministry of Social Affairs and Health has published the report Trends in Social Protection in Finland since 1996. The reports have included special annual themes each year, but the report has mainly been based on social expenditure classification. This structure was felt to be too cumbersome in the case of an annually published report. In 2003, the structure of the report was reformed so that the report was partly based on the strategic lines of the Ministry of Social Affairs and Health.

The structure of the present report Trends in Social Protection in Finland 2004 is based on the strategic lines of the Ministry of Social Affairs and Health and the social and health care policy objectives set down in the government's strategy document. The social policy impact objectives mentioned in the government's 2004 strategy document are given at the beginning of each chapter. One of the aims of the report is to evaluate the implementation of the impact objectives as far as possible in the light of statistics and different indicators.

The possibilities of assessing the implementation of impact objectives vary considerably. In some sectors, data provision is highly developed, while in others there is still a lot of room for improvement. Statistical information is also produced with a certain delay, which means that data on the current situation are rarely available. When interpreting statistics and indicators, one must also bear in mind the complex dependencies that lie behind changes. The changes observed are affected by a number of factors. Especially when looking at social protection, the long time frame during which different measures take effect should be remembered. For example, the full impact of decisions concerning pension insurance is not felt until years later. The final effects of the decisions made must therefore be evaluated with the aid of various calculation models and by making different assumptions. This involves a lot of uncertainty.

The impact objectives themselves are also very heterogeneous in their nature. Some of the objectives are very clear, and attention has been given to the measurability of the phenomenon in question at the time the objectives were set. This is particularly true in the case of those impact objectives that have already been defined in connection with the preparation of the programmes and projects launched. Some of the impact objectives are more general in nature, and indicators offer mainly information that can be used as a basis for discussion.

The possibility of maintaining and developing social protection in the future is essentially dependent on employment trends. Employment makes up the encompassing theme of this report. Naturally, every strategic objective has its own areas of emphasis. However, together they form a larger entity, with aim to improve population welfare by raising the employment rate. Because raising the employment rate concerns all population groups, it calls for a battery of means that is as comprehensive as possible. The perspective must also be sufficiently extensive. It is not enough to take care of the economic incentives for work, if the attractiveness of working life cannot be increased. The time frame must also

be sufficiently long. The health and functional capacity of young people who enter the labour market in the future is largely dependent on the well-being of today's families with children, while a healthy and functionally capable population is a prerequisite for a high employment rate. There may also be some tension, at least in the short term, between employment and other objectives.

Kari Välimäki, Director-General

Trends in Social Protection in Finland 2004 Experts

Authors

Marja-Liisa Anttalainen, Ministerial Adviser, chapters 7.2 and 7.3
Kari Gröhn, Senior Research Officer, chapter 3
Tiina Heino, Financial Adviser, chapter 2
Ilari Keso, Senior Research Officer, chapters 1.3 and 5.2
Veli Laine, Senior Research Officer, chapter 5.1
Rolf Myhrman, Deputy Director-General, chapters 1.1 and 1.4
Juho Saari, Ministerial Adviser, chapter 1.5
Arto Salmela, Financial Adviser, chapter 1.2
Markus Seppelin, Senior Officer, chapter 4
Riitta Säntti, Senior Research Officer, chapter 6
Jouni Varanka, Senior Research Officer, chapters 7.1 and 7.4–7.9

The scenario calculations on social protection and economy were drawn up by Senior Research Officer *Pekka Sirén*. Financial Adviser *Taimi Saloheimo* and Senior Officer *Anna Väinälä* also took part in preparation of the report at different stages.

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

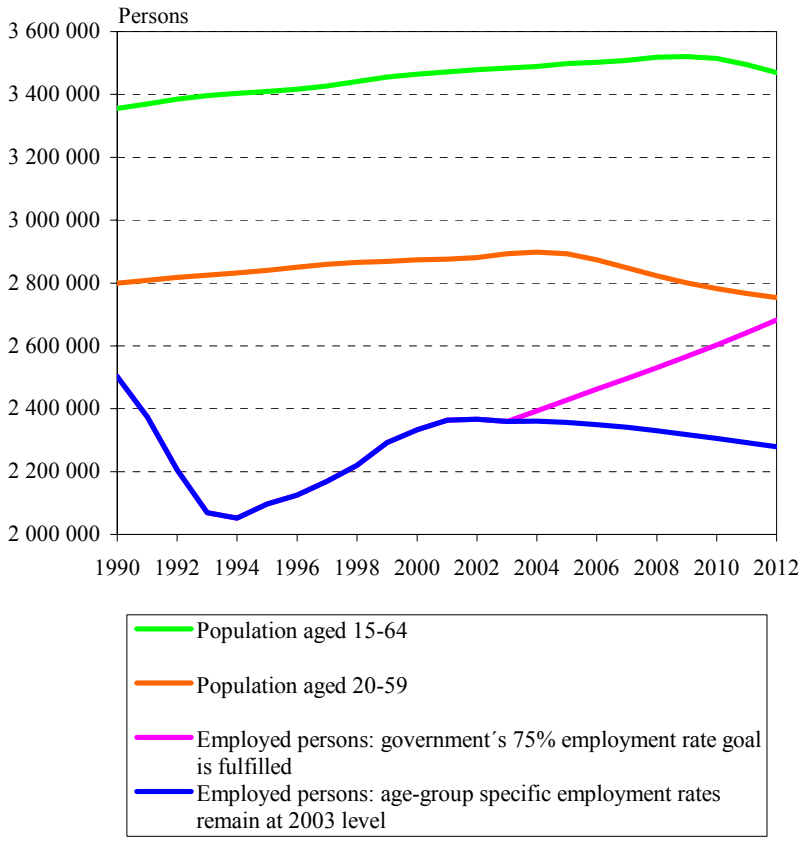
Contents

I Social protection and a changing operating environment

The fact that the baby boom generation is approaching pension age means that we must adjust to a decline in working-age population. Beginning in 2010, the number of working-age population will start to decrease. The number of population aged 20–59 will start to decrease even earlier. At the same time, the size of those age cohorts that have traditionally had a low employment rate will increase. In 2010, the number of people aged 60–64 will be fifty percent higher than in 2003.

The government's aim is to increase employment by 100,000 persons by the year 2007 and to raise the employment rate to 75 percent by 2011. This means an increase of 30,000 to 40,000 employed persons per year, or a total of 300,000 persons compared to 2003 (Figure 1).

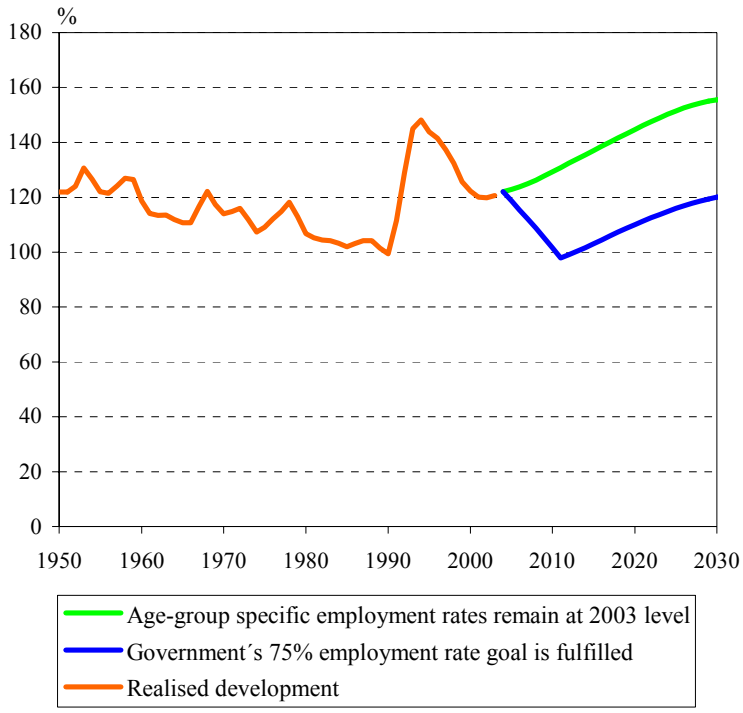
Figure 1. Working-age population and employed persons in 1990-2003 and protections until 2012 based on different assumptions



The economic dependency ratio is calculated by dividing the number of non-employed persons by the number of employed persons. The economic dependency ratio indicates how many persons are dependent on the income generated by one employed person. The

economic dependency ratio depends on both population age structure and the employment of working-age population. The full impact of the ageing of the population on the development of the economic dependency ratio will begin to be felt in the 2010s and 2020s. If the government's employment objective is fulfilled, the economic dependency ratio will be strengthened until 2011, after which it will slowly start to weaken. However, despite the ageing of the population, the economic dependency ratio would still be at the same level in 2030 as it was in the year 2000. On the other hand, if the age-group specific employment rates remain on the 2003 level, the economic dependency ratio will be weaker than during the deep economic recession in the early 1990s. (Figure 2)

Figure 2. Economic dependency ratio in 1950-2003 and projections until 2030, %



1.1 Age structure, employment and economic growth

The possibilities for developing social protection are significantly dependent on economic growth. In times of brisk economic growth, the financing of welfare services and social security benefits does not pose a similar problem as during sluggish economic growth. A positive economic trend also means better employment and fewer recipients of social security cash benefits. This creates more room for the development of welfare services. At the same time, it is easier to secure a sufficient level of cash benefits when the number of recipients is smaller.[1]

An ageing population poses a challenge for the maintenance of economic growth. The impact of the change in age structure can be illustrated by the decomposition shown in Table 1. In the decomposition, GDP growth per capita is influenced by work productivity, the share of working-age population in the total population, and the share of employed

persons in working-age population. The impact of age structure is examined using two alternative approaches. In the first alternative, the age-group specific employment rates remain at the 2003 level. In the second alternative, the employment rate increases gradually to 75 percent by 2012 in accordance with the government's employment goal. In both alternatives, the increase in productivity of work is estimated to be 1.8 percent per year between 2004 and 2020.[2] Population age structure (persons aged 15–64/total population) is also assumed to develop in a similar manner in both alternatives.

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

	Age-group specific employment rates remain at 2003 level						
Average change per annum, %	1992-95	1995-98	1998-01	2001-04	2004-07	2007-11	2011-20
Productivity of work	4.5	2.6	1.4	1.6	1.8	1.8	1.8
Share of working-age population	-0.2	0.0	0.1	-0.1	0.0	-0.2	-0.8
Employment rate	-4.9	1.7	1.9	0.2	-0.5	-0.7	-0.2
Total; GDP per capita	-0.8	4.3	3.4	1.7	1.3	0.9	0.9
	Employment rate increases to 75 percent by 2012						
Average change per annum, %	1992-95	1995-98	1998-01	2001-04	2004-07	2007-11	2011-20
Productivity of work	4.5	2.6	1.4	1.6	1.8	1.8	1.8
Share of working-age population	-0.2	0.0	0.1	-0.1	0.0	-0.2	-0.8
Employment rate	-4.9	1.7	1.9	0.2	1.1	1.6	0.3
Total; GDP per capita	-0.8	4.3	3.4	1.7	2.9	3.2	1.3

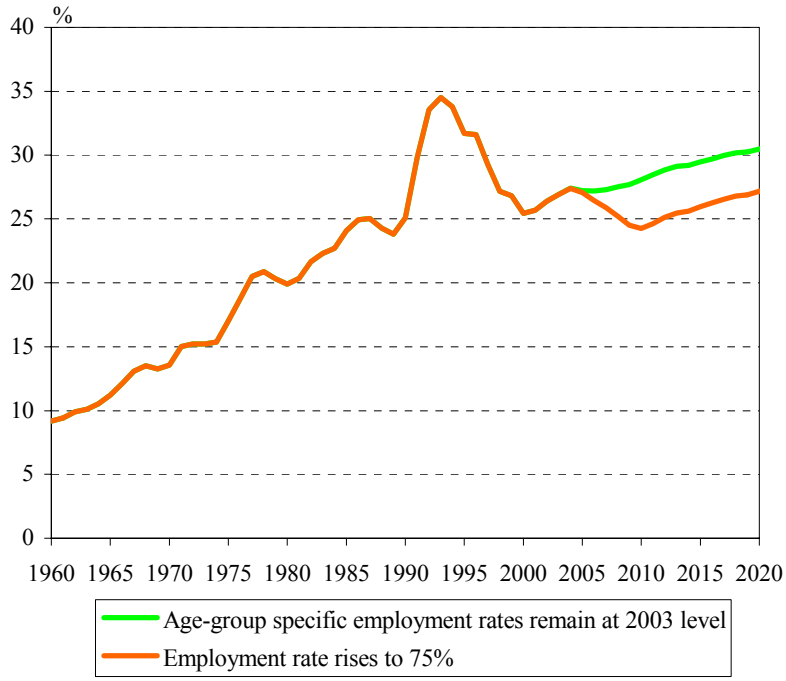
Share of working-age population = persons aged 15–64/total population
Employment rate = employed persons aged 15–64/persons aged 15–64
Productivity of work = production per employed person

The decline in the share of working-age population will weaken economic growth significantly only towards the end of the period under study, in 2011-2020 (by –0.8 percent per year). If the employment rates of different age groups remain unchanged, economic growth will be reduced earlier by the change in the age structure of working age population. An increasing number of persons of working age will belong to age groups whose employment rate is low at present. This means that ageing of working-age population would lower the employment rate. This would slow down production growth by 0.5 percent and 0.7 percent during the periods 2004–2007 and 2007–2011, respectively. During the latter period, economic growth would be slowed down by another 0.2 percent by reduction in the share of working-age population. Despite productivity growth, economic growth would remain modest. Fulfilment of the government's employment objective would change the situation considerably. In that event, economic growth would no longer be similarly slowed down by the ageing of the population. In addition to development of society's wealth, this would have a significant impact on society's ability to provide welfare services for its citizens.

Employment and social expenditure

In 2003, social protection expenditure came to 27 percent of GDP. If employment rates of different age groups remain at the 2003 level, the employment rate will go down to 65 percent in 2010. This would mean an increase by one percentage point of the GDP ratio of social protection expenditure according to current legislation. With the ageing of the population the GDP ratio of social protection expenditure would exceed 30 percent by the year 2020 (Figure 3).

Figure 3. GDP ratio of social protection expenditure in 1960–2003 and projections until 2020 based on different assumptions, %



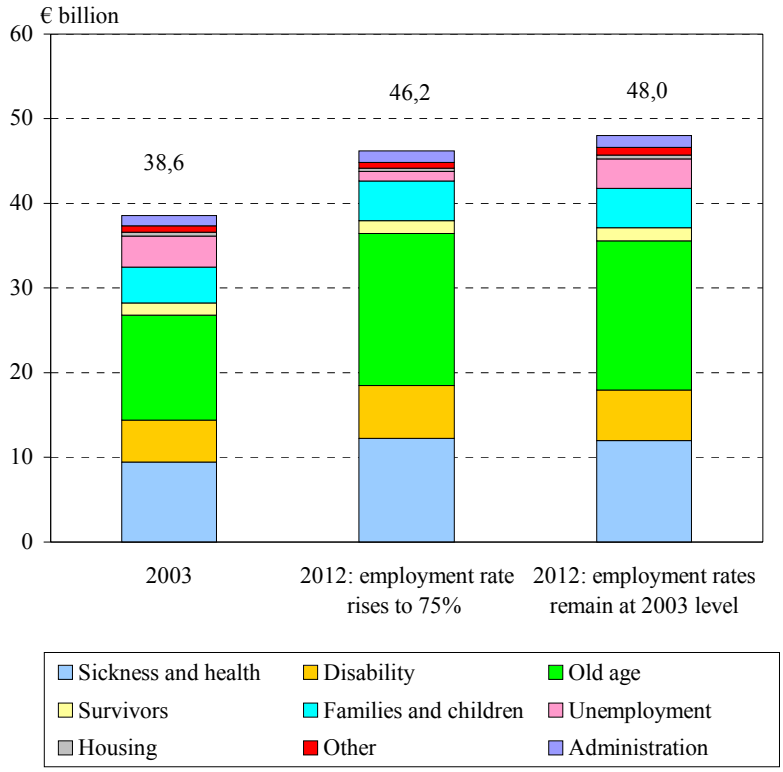
If Finland succeeded in raising the employment rate to 75 percent, the GDP ratio of social protection expenditure would go down to 24.3 percent in 2010. The high employment alternative would thus mean that the GDP ratio of social protection expenditure would be almost 4 percentage points lower than in the low employment alternative. Social protection expenditure is mainly financed through taxes and social insurance payments, meaning that the tax rate could be lower in the high employment scenario than during low employment. At the same time, a positive employment trend would ensure a positive trend in tax revenues at a lower tax rate. A positive employment trend would thus decrease social protection expenditure while increasing tax revenues. This would create leeway for tax cuts, which would help to lessen the heavy taxation of labour in Finland. Another alternative is to use the latitude in public sector economy to develop social protection. If the employment rates of different age groups remain at the 2003 level, social protection expenditure will total two billion euros more than in the high-employment alternative (Figure 4). The number of social and health care services

is assumed to be the same in both scenarios. The higher costs in the low-employment alternative are explained by unemployment and pension costs and ensuring last-resort economic assistance.

If employment rates remain at the 2003 level, we are only faced with poor alternatives. If the availability and quality of welfare services is to be maintained, the tax rate must be raised; however, higher taxation might weaken employment. It is in fact more likely that tighter international tax competition may lead to added pressure to ease taxation.

A reduction in the provision of public services means cutting back on investments supporting welfare and economic growth, which is what welfare services are by nature. Cuts in social security cash benefits will result in increased poverty and greater income differences, leading to weaker social cohesion.

Figure 4. Social protection expenditure in 2003 and projections until 2012 based on different assumptions, € billion at 2003 prices



What does attainment of the employment goal require?

Figures 5 and 6 look at employment among men and women by age group in 2003, comparing it to the government's 75 percent employment goal. In addition to the employed, the figures also show the distribution of the rest of the population by their main type of activity. The figures show clearly how challenging the employment goal is. Compared to the year 2003, attainment of the employment goal would e.g. require that nearly all unemployed and hidden unemployed, those who have given up job-seeking and those receiving unemployment pension would be employed by the year 2011. It is unlikely that this objective will be met in full.

Reaching the employment goal requires that there is a shift towards the employed in nearly all groups of the non-employed. Successful attainment of this goal calls for measures affecting nearly all age groups. Studies must progress more efficiently and study times must be made shorter. The possibilities for flexible coordination of work and family life must be improved. The working capacity of the population must be taken care of in all age groups. The possibilities and economic incentives of ageing workers to stay on at work must be ensured. The battery of means at the disposal of economic and welfare policy must be as extensive as possible.

Figure 5. Distribution of men aged 15–70 according to their main type of activity in 2003, %

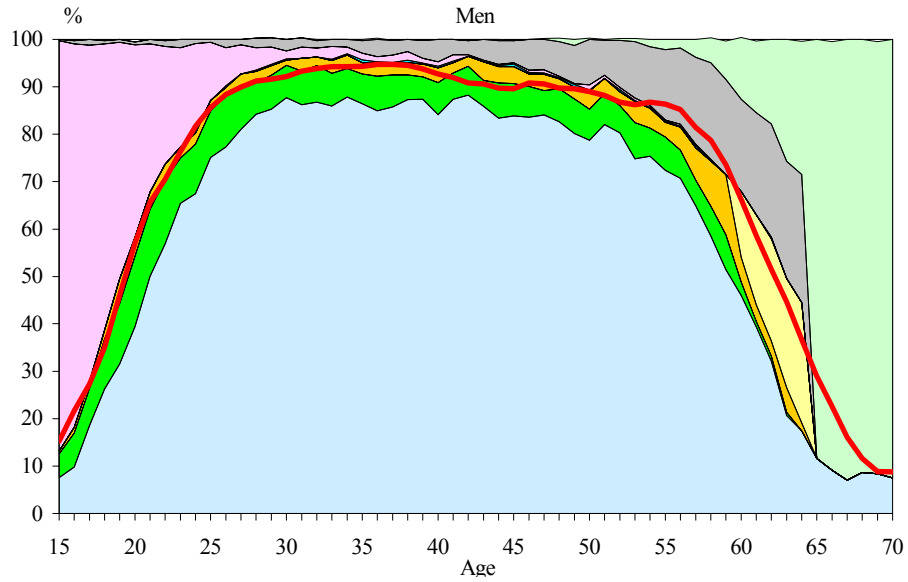
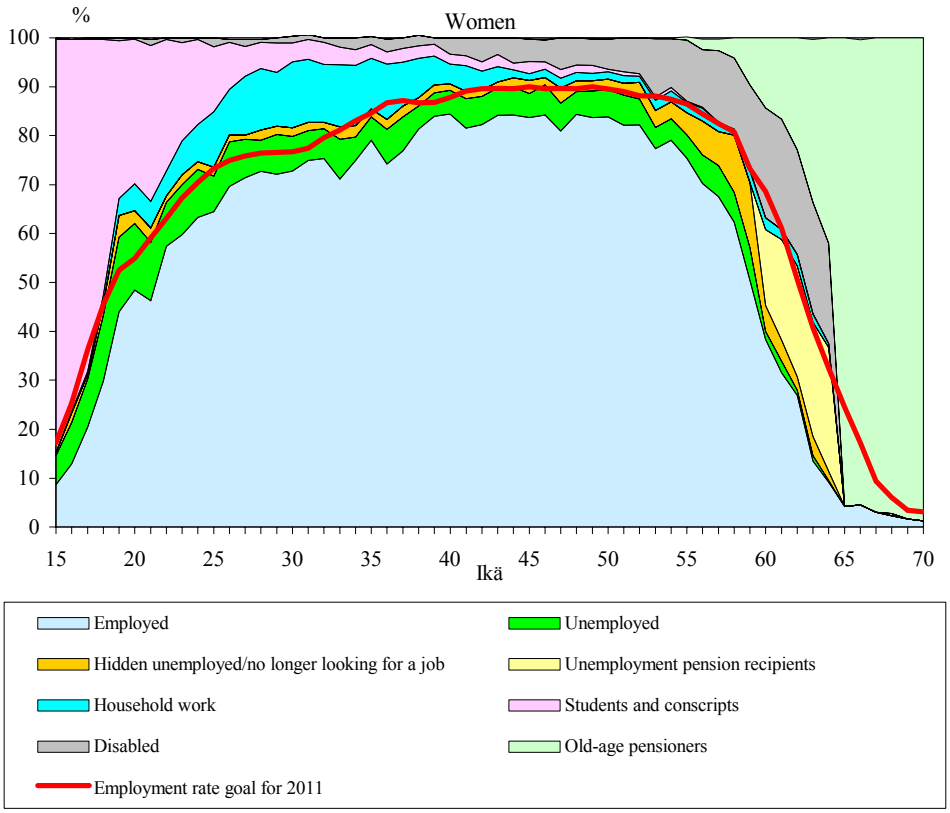


Figure 6. Distribution of women aged 15–70 according to their main type of activity in 2003, %



Source: Statistics Finland, Labour Force Survey

1.2 State budget for 2005 and municipal economy

In 2004, international economic growth was strong, but unevenly distributed. Particularly rapid growth was seen in China, India and the United States, while the growth in the Euro area remained modest. The growth in Finland has been brisker than in the Euro area on average. The Ministry of Finance estimates that during 2004, the growth of total production in Finland increased to 2.9 percent and will remain on nearly the same high level in 2005. The share of the employed in the working-age population is expected to increase somewhat in 2005. The total public economy is estimated to show a 2.2 percent surplus in 2005, which is entirely due to the surplus of employment pension institutions. In 2005, the public economy is expected to show a slight deficit. The combined deficit of the state and municipalities will increase to about –0.5 percent of the GDP.

2005 state budget

The sum total of the draft budget for 2005 comes to about € 37.6 billion. Total expenditure will increase by 1.5 percent from the 2004 budget. The main division of the Ministry of Social Affairs and Health accounts for about € 9.9 billion of the draft budget, which is some 5 percent more than in the budget for 2004. In 2005, social protection expenditure in Finland is estimated to come to about € 41.8 billion, one third of which is financed through the state budget. The main division of the Ministry of Social Affairs and

Health accounts for two thirds of the social expenditure financed through the state budget. Social expenditure is also financed through other main divisions in the budget.

Improving the status of families and the income of the elderly as well as development of social and health care are emphasised in the draft budget. The greatest increases in appropriations are caused by added funding directed to municipalities aimed at improving social and health care, securing the availability of social and health care services, the proposed health insurance reforms and increased health insurance costs, and the raise of the level of national pension and the benefits linked to it. About € 21 million more will be allocated to special benefits aimed at war veterans and invalids. Index adjustments to social security benefits will increase expenditure by about € 47 million. The minimum level of sickness and parenthood allowances will be raised by a total of € 14.8 million. The majority of the appropriations will still be used for central government grants for operating costs of municipal social and health care, pensions, child allowance and health insurance.

In the draft budget, € 3,513 million has been reserved for central government grants for operating costs of municipalities' social and health care, which is about € 194 million (5.8 percent) more than during 2004. A little over € 110 million of the increase in government grants is related to the development of municipal health care system in accordance with the National Project to Secure the Future of Health Care and development of the social service system as defined in the National Development Project for Social Services. Of this raise, € 91.7 million is reserved for increasing the central government grants to municipalities.

The minimum level of sickness allowance was raised by € 3.75 per day from 1 January 2005. This covers sickness, maternity, paternity and parenthood allowances as well as special maternity allowance. The increase also raises the minimum level of allowance in accordance with the Rehabilitation Allowance Act. As of the beginning of 2005, the minimum allowance has been € 15.20 per day, or about € 380 per month. The increases will raise state expenditure by a total of € 14.8 million. In addition, as of 1 October 2005, the criteria for defining allowance will be adjusted in the case of consecutive pregnancies within a short time period and short employment contracts. The so-called family expenses to employers has been evened out more than before by raising the annual leave reimbursement as of 1 January 2005. The adjustment will increase state expenditure by € 4 million in 2005. The child home care allowance for one child was raised by € 42 per month, and private child care allowance by € 19.60 per month from 1 January 2005. After the raise, child home care allowance and private child care allowance are € 294.28 and € 137.33 per month, respectively.

In order to ensure the minimum level of pensions, the level of national pensions was raised by € 7 per month as of 1 March 2005. This also increases other benefits linked to the level of national pensions, such as survivors' pensions, extra allowance for ex-servicemen and the special allowance for immigrants. The raise will increase state expenditure by a total of € 49 million.

Health insurance expenditure is expected to grow by 7 percent in 2005, mainly due to the increase in sickness allowances and refunds of medicine expenses. Health insurance reimbursements are estimated to total € 3.7 billion in 2005. The state will direct a total of € 3.2 billion to the national pension and health insurance funds, € 1.0 billion of which will come from the revenue of value added tax.

In municipalities belonging to the area of the Kainuu administrative experiment, social security payments by the private sector, state-owned companies and municipal employers will be abolished between 2005 and 2009. In addition, private sector and state-owned companies in Northern Finland and some communities in the archipelago are still exempted from employer's social security contributions. To make up for the deficit, the level of national pension payments levied from other employers will be raised.

Municipal economy

The municipal economy was clearly weakened in 2003 compared to the year before, when the municipalities' financing situation was good. The situation in 2003 was influenced in particular by the weak development in tax revenues. The decrease in the amount of tax revenue was caused by increases in municipal tax deductions and the municipalities' lower share of company tax revenue. The tax revenue losses to municipalities caused by increases in municipal tax deductions were however compensated by raising central government grants to municipalities.

The annual margin fell in 2003 in all types of municipalities, but the biggest decline was seen in municipalities with 20,000–40,000 inhabitants. The number of municipalities with a negative annual margin rose from 42 the year before to 75 in 2003. The financing situation of municipalities remained tight in 2004. The annual margin weakened and remained smaller than net investments. The increase in municipalities' operating costs is estimated to have been about 4 percent in 2004. The increase in costs is mainly due to an increase in wage costs and the number of staff and an increase in municipal pension contributions and employer's contributions to unemployment insurance. The increase in service demand caused by the change in population age structure is also a factor that increases municipalities' expenses. Migration also increases costs in fast-growing municipalities while making it harder to maintain the service structure in municipalities with a diminishing population.

It is estimated in the development estimate drawn up in September 2004 by the Advisory Board for Municipal Administration and Economy that starting in 2005, the financing balance of municipal economy will clearly improve. By 2007, the size of the annual margin will exceed investments. The aggregate annual margin is expected to rise to € 2.3 billion in 2008. The balancing of the economy is caused by an increase in both tax revenue and central government grants, at the same as the growth of expenses remains modest. Central government grants to municipalities will increase by about € 260 million in 2005, while the increase the year before was close to € 500 million. In 2006–2007, government grants will increase by about € 300 million per year. From 2003 to 2008, calculated central government grants together with their equalisation belonging to the system of central government grants will increase by over € 1,500 million. Of this increase, € 472 million is related to the compensation to municipalities of the increase in earned income allowance in municipal taxation, and € 358 million to adjustment of the division of expenses between municipalities and the state. The majority of the remainder of the increase in central government grants is related to development of the service system in accordance with the National Project to Secure the Future of Health Care and the National Development Project for Social Services.

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

	2002	2003	2004	2005	2006	2007	2008
Operating margin	-15.8	-16.4	-17.0	-17.6	-187.3	-18.9	-19.5
Tax revenue	14.1	13.5	13.5	14.1	14.8	15.4	15.9
Central government grants for current expenditure[1]	3.9	4.3	4.8	5.0	5.3	5.6	5.8
- of which, administered by the Ministry of Social Affairs and Health	2.5	2.9	3.3	3.5	3.8	4.1	4.3
Other expenses, net	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Annual margin	2.3	1.6	1.4	1.6	1.9	2.2	2.3
Investments, net	2.1	2.3	2.2	2.2	2.2	2.2	2.2
Total outstanding loans	4.8	5.6	6.2	6.6	6.8	6.8	6.7
Cash assets	3.3	3.3	3.0	2.9	2.8	2.8	2.8
Net liabilities (total outstanding loans – cash assets)	1.5	2.3	3.2	3.7	4.0	4.0	3.9

The figures in the table are based from 2003 onwards on preliminary data or estimates
[1]According to the municipalities' own accounts
Source: Advisory Board for Municipal Administration and Economy, 7 September 2004

Measures implemented by the state have for their part diminished the differentiation trend between municipalities, but the municipalities showing the poorest performance are still ones with a small number of inhabitants. They have trouble balancing their economy, and in many municipalities, deficits have accumulated several years in a row. According to the 2002 financial statement, 38 of the 42 municipalities with a negative annual margin had fewer than 6,000 inhabitants. In rural municipalities and in those with a population under 6,000, government grants make up about 40 percent of municipal income on average. In municipalities with more than 100,000 inhabitants, government grants constitute less than 3 percent of municipal income generation. From the viewpoint of municipal economy, the most problematic category consists of municipalities with a negative annual margin during several consecutive years and whose income financing is not sufficient to cover expenses. These municipalities typically have a small number of inhabitants, they suffer from migration loss, the municipality structure is rural, they have a high tax rate and they have a poor financing situation. The cost of service provision in these municipalities is also well above the national average.

According to a Ministry of the Interior estimate, the annual margin will improve from 2003 to 2005 in municipalities with more than 20,000 inhabitants. A weak annual margin is estimated to remain a typical feature of municipalities with fewer than 6,000 inhabitants, and especially of those with fewer than 2,000 inhabitants. There are great differences in the financing balance of municipal economy between municipalities, regions and types of municipalities. Positive development calls for active measures on the part of municipalities, in addition to readiness to implement the structural reforms required.

According to the Government Programme, the financing balance of municipalities' tasks and obligations is improved by a programme for guaranteeing the availability of social, health and educational services (basic service programme between the state and

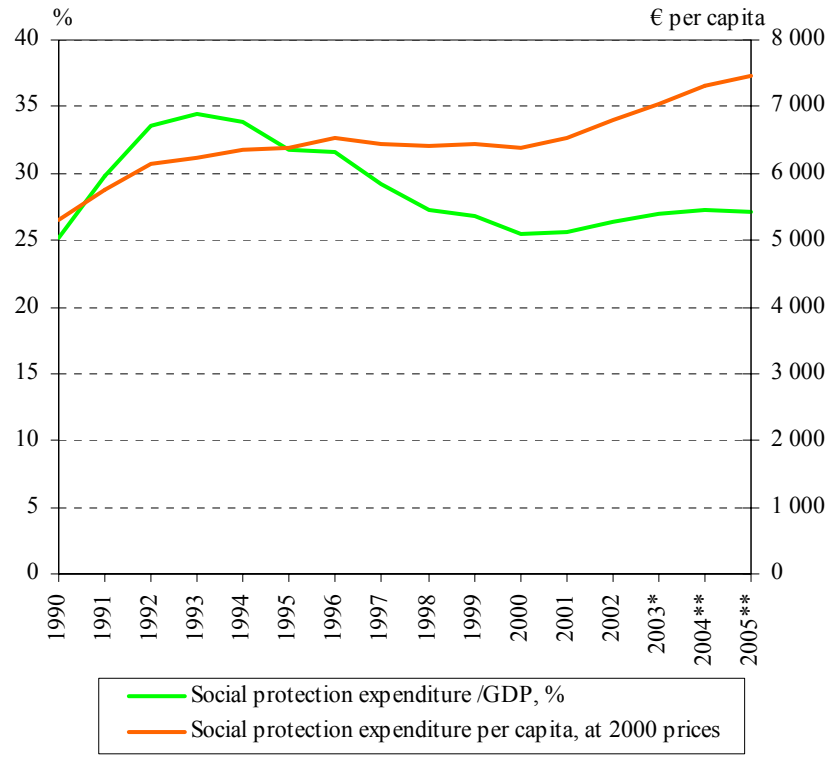
municipalities). An annual basic service budget is linked to the basic service programme. The basic service programme was drawn up for the first time in spring 2004 and it includes a summary of the availability, development and financing of services. The basic service programme is linked to the decision on central government spending limits, and the programme is evaluated annually in connection with the revision of central government spending limits. Assessment of the basic services budget covers appropriations required for the financing of social and health care, education and library services included in the system of central government grants. The aim is to assess the obligations and expenses caused by these services in relation to municipal economy as a whole. The basic services budget is used for timing and clarifying the annual implementation, costs and financing of measures in accordance with the basic service programme. The aim is to complete the preparation of the reform concerning municipal financing and government grant criteria during 2005, so that the reforms can be implemented from the beginning of 2006.

Curbing the costs of municipalities is about to face big challenges. Securing basic service calls for continuous evaluation of operating methods and the service structure on the part of municipalities, in addition to readiness for structural changes that make it possible to operate more economically and efficiently. Implementation of the National Health Care Project and the National Development Project for Social Service calls for municipalities' own input when it comes to improving their welfare services. The reforms that have been agreed, such as raising the level of child home care allowance, morning and afternoon activities for schoolchildren and subsidised school transport to pre-schoolers will increase the operating costs of municipalities. The increase in costs means that municipalities and joint municipal authorities must make decisions on service structure and cooperation between municipalities. Securing the availability and quality of basic municipal services with a reasonable tax and payment burden calls for investment in a municipal structure that is functionally capable and viable.

1.3 Social protection expenditure and its financing

After a long decline, social protection expenditure in relation to GDP started to rise slightly at the beginning of the 2000s. In addition to a rise in social protection expenditure, this was caused by a slowdown in GDP growth. The rapid growth in GDP also partly explains the decline of the GDP ratio of social expenditure in the latter part of the 1990s. Social expenditure per capita did not change appreciably during the same period (Figure 7).

Figure 7. Social protection expenditure in relation to GDP (%) and per capita (at 2000 prices) in 1990–2005



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

Social protection expenditure has increased in recent years due to a rise in expenses related to old age as well as sickness and health. These functions make up over one half of all social expenditure. Despite the increase in recent years, sickness and health-related costs still constitute a smaller share of total social protection expenditure than in the late 1980s and early 1990s (Table 3).

Table 3. Social expenditure by function, percentage shares in 1990 and 1995-2005, %

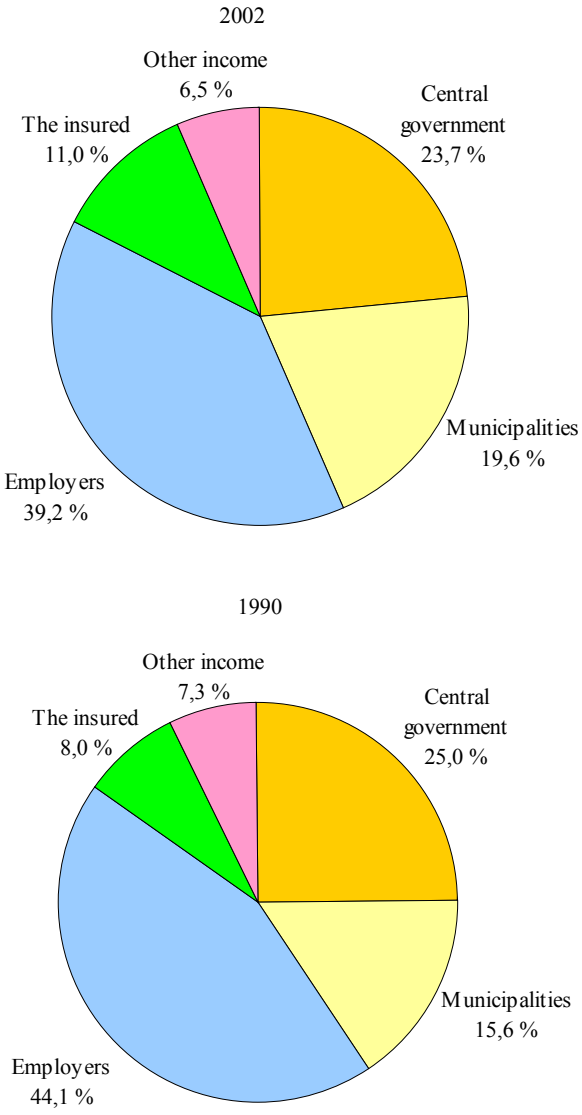
Year	Sickness and health	Dis-ability	Old age	Sur-vivors	Families and children	Unem-ployment	Hou-sing	Other social protection	Adminis-tration	Total
1990	27.5	15.0	28.6	4.0	13.0	5.9	0.7	1.8	3.5	100.0
1995	20.3	14.5	28.1	3.8	13.0	14.0	1.5	2.0	2.8	100.0
1996	20.7	14.3	29.0	3.8	12.1	13.5	1.2	2.3	3.1	100.0
1997	21.3	14.3	29.1	3.9	12.3	13.0	1.2	2.4	2.7	100.0
1998	21.9	14.0	29.6	3.8	12.4	11.6	1.4	2.1	3.1	100.0
1999	22.3	13.8	30.4	3.9	12.4	11.0	1.5	2.1	2.6	100.0
2000	23.0	13.5	30.9	3.9	12.1	10.2	1.4	2.0	3.1	100.0
2001	23.7	13.3	31.6	3.8	11.7	9.5	1.1	2.1	3.0	100.0
2002	24.1	13.0	32.0	3.8	11.3	9.5	1.1	2.1	3.2	100.0
2003*	24.4	12.8	32.2	3.7	11.0	9.5	1.1	2.1	3.2	100.0
2004**	24.5	12.4	32.9	3.6	10.8	9.5	1.0	2.1	3.2	100.0
2005**	24.6	12.4	33.2	3.6	10.6	9.3	1.0	2.0	3.2	100.0

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

Employers are the biggest financers of social protection expenditure, contributing to pensions, unemployment security and health insurance. The insured also contribute to these benefits. Basic cash benefits, such as basic unemployment allowances, child allowance, housing allowance as well as central government grants to municipalities for social welfare and health care services are mainly financed by the central government. Municipalities bear the main responsibility for financing social and health care services. Other financing comes mostly from capital income from funds (yield from funds). (Figure 8.)

The final distribution of the financing burden is hard to assess on the basis of a formal categorisation of sources of funding. Neither are the incentive effects of the different means of financing revealed using this approach. The share of both central government and municipalities is ultimately financed by tax revenue. The central government in particular gets tax revenue from a variety of sources and types of taxes. The government grants to municipalities entered under central government financing are primarily calculatory, i.e. they are not based on the actual costs of individual municipalities. Their use is not tied to a particular purpose either. The social insurance contributions paid by employers and the insured are mainly based on salaries paid, but part of the payments is based on other factors as well. For the final distribution of the payment burden, the division into contributions made by employers and the insured (employees) is not necessarily very important. The final distribution of payment shares is dependent on the impact of the changes on wage formation.[3]

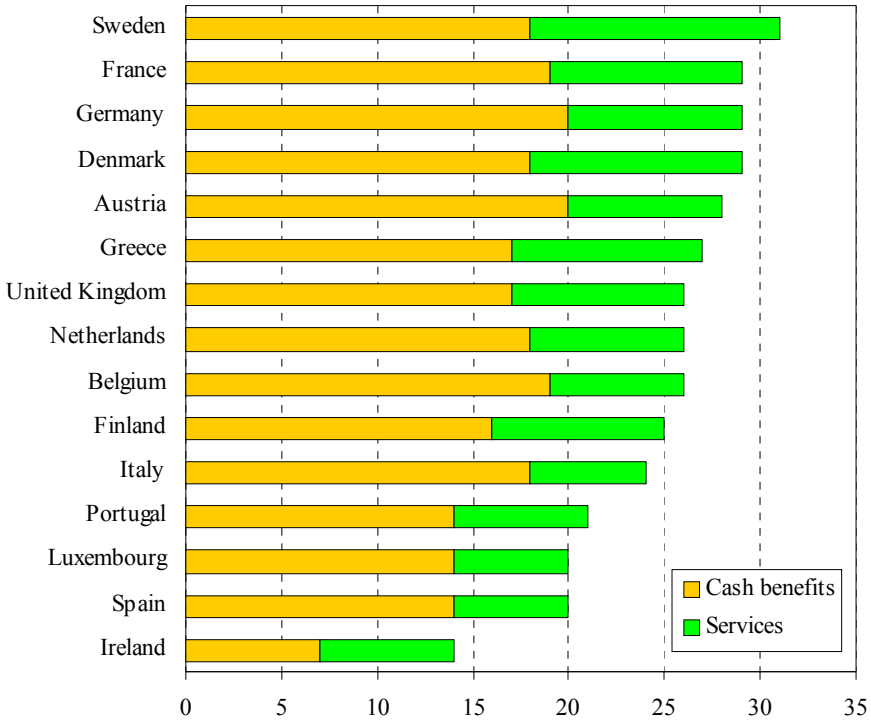
Figure 8. Financing of social protection in 1990 and 2002, %



Source: National Research and Development Centre for Welfare and Health

The GDP ratio of social protection expenditure is on average EU level in Finland (EU15). Data of the new member states that joined the EU on 1 May 2004 are not included in the comparison in Figure 9. In most of the new member states, social protection expenditure is clearly below the Finnish level.[4] In addition to the size of social expenditure, there are also differences in expenditure structure between EU member states. The large social protection expenditure in Sweden and Denmark is partly due to the high level of expenditure on services; these countries actually use even less money for cash benefits than some other EU member states. Service expenditure makes up a smaller share of total expenditure in Finland compared to Sweden and Denmark, but it is greater than the EU average.

Figure 9. Social protection expenditure in relation to GDP in some EU member states in 2001, %



Source: Eurostat

Social protection expenditure – what is actually being measured?

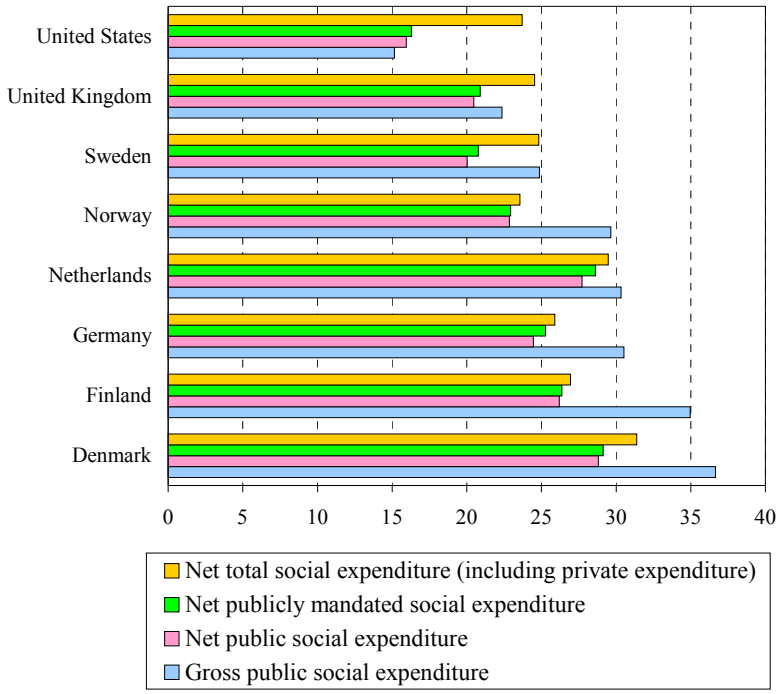
The GDP ratio of social protection expenditure is a very crude and insufficient indicator of social protection. Differences in age structure of the population or in the phase of business cycle, for example, may make it harder to make comparisons between countries or between different points in time. There may also be considerable differences in the efficiency of provision of social and health care services. Service users are mainly interested in the availability and quality of services, not in the input used to provide them.

Traditional social expenditure statistics do not take into account differences in taxation between countries. In Germany, for example, daily unemployment allowance is calculated on the basis of net salary, but it is not taxable income. In Finland and the other Nordic countries, the majority of social security benefits is taxable income, and their gross level is correspondingly higher. The significance of social tax deductions that replace social security benefits is also smaller in Nordic countries than in many other countries. In United Kingdom and the United States, families with children are granted considerable tax deductions. In traditional social expenditure statistics, this support given through the tax system is not taken into account.

The OECD has carried out comparisons of so-called net social expenditure, in which an attempt has been made to take into account differences in taxation. Measured in terms of net social expenditure, the position of some countries changes significantly in cross-

country comparisons. The changes are even greater if private-sector social spending is taken into account as well. In practice, public services financed by tax revenue and services financed by private insurance often replace each other. In countries lacking a comprehensive public health insurance or health care system, people use private insurance to be prepared for health care costs. Similarly, in countries that do not have a comprehensive statutory employment pension system, people prepare for their future retirement years through firm-level or industry-wide pension arrangements, or exclusively with the aid of private pension insurance. Statutory pension systems may also include relatively low maximum levels of pension. In such cases, especially employee groups with a strong labour market position try to improve their pensions with various supplemental pension plans.

Figure 10. Social expenditure in relation to GDP at basic prices using different definitions of social expenditure in 1999, %



Preliminary data.
Source: OECD
NB! Due to the methods used in the calculation of net social expenditure, the comparison is made with basic-price GDP instead of market-price GDP, as is normally the case (cf. Figure 2).

Taxation and tax competition

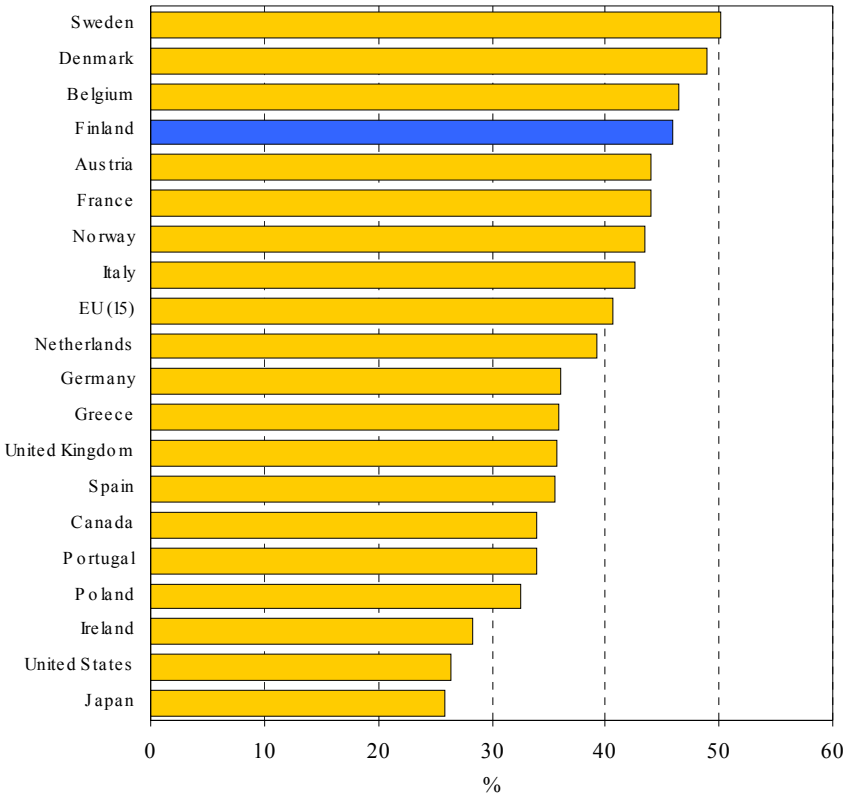
Even if the GDP ratio of social protection expenditure were not to rise significantly in the future, the financing of social expenditure may become endangered due to other reasons. The tightening of international tax competition may increase the pressure to lower taxes and social insurance contributions and thus endanger the financing of social protection. The impact is largely dependent of how the behaviour of households, enterprises and labour market organisations is affected by taxation. If households appreciate the services and benefits financed by taxes and social insurance contributions, people are more willing

to accept a somewhat higher tax burden and a lower net income level. This is not necessarily just a question of the benefits or services received by each individual household. The social cohesion guaranteed by social protection and its positive impact on the living environment may also be a value in itself. The localisation decisions of firms are also affected by a variety of factors. Taxation may provide a well-functioning infrastructure, a well-educated and healthy labour force and social stability. In such cases, minor differences in the level of taxation may not be the primary factor when localisation decisions are made.

The total tax rate in Finland is higher than the EU average. However, the tax rate in both Denmark and Sweden is clearly higher than in Finland, and the difference between Finland and e.g. France, Belgium and Austria is small. Taxation in the new EU member states in our immediate vicinity is clearly lighter than in Finland. When assessing future challenges, other EU member states may not necessarily be the only key comparison group. Many EU states are grappling with the same problems of financing social protection as we. In the global economy, the most interesting division lines when making comparisons may therefore be found between EU member states and other countries.

In addition to a high total tax rate, the heavy taxation of labour in particular has given rise to concern. One way of illustrating the taxation of labour is to calculate the wage tax wedge, i.e. employee's income tax and employee and employer social contributions as a share of total labour costs. In the case of a single person with average earnings, wage tax wedge is bigger in Finland than in most other OECD countries. However, compared to the mid-1990s, the wage tax wedge has been reduced by relaxation of income taxation.

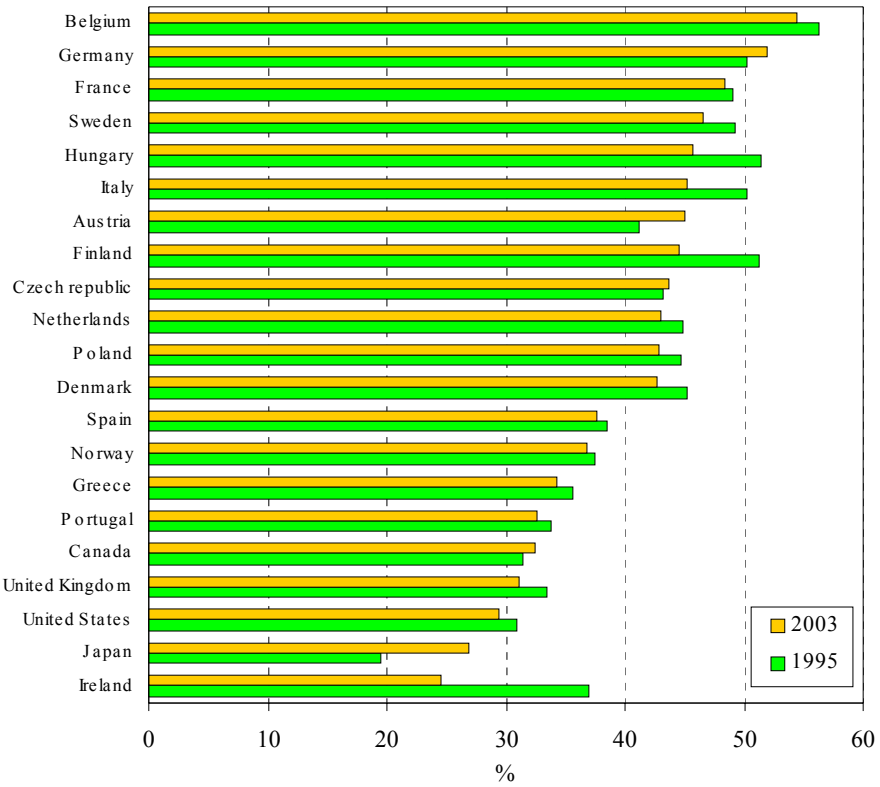
Figure 11. Total tax revenue in relation to GDP in some OECD countries in 2002, %



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

In addition to the taxes and social insurance contributions mentioned above, the total tax wedge also comprises an estimate of the indirect taxation of households' consumption. This factor is often left outside the scope of international tax wedge comparisons, because it is hard to make estimates that are comparable. This part of the total tax wedge increased somewhat towards the end of the 1990s in Finland as the level of energy taxation rose.

Figure 12. Wage tax wedge in some OECD countries in 1995 and 2003, % of labour costs. Single person with average earnings



Wage tax wedge: employee's income tax and social security contributions + employer's social security contributions, percent of labour costs. Source: OECD

On the basis of international studies, high taxation of labour seems to reduce employment to some degree. However, the link between taxation and employment seems also to dependent on how wage formation occurs in the labour market. In countries like Finland, where centralised wage negotiations are the rule, taxation has not been observed to have a significant employment impact according to the most recent studies.[5] On the other hand, it has also been suggested that centralised wage negotiations may also as such include features that weaken employment. As a result of various low-wage increments included in collective agreements and high indirect labour costs, total labour costs may constitute an obstacle for increased employment in low-productivity fields. This would concern employment in the private service sector in particular. Together with other institutions (unemployment security), centralised wage negotiations may also weaken the adaptability of the labour market to structural economic changes or various external "shocks".[6]

In addition to taxation of labour, researches also focus their attention on other factors whose impact on the employment differences between countries may be more significant than that of taxation. Such factors include differences in social security and the operation of the labour market. It is interesting to compare the view on the impact of social security on employment to a study conducted by OECD researchers, aimed at assessing the impact

of social expenditure on economic growth.[7] As a whole, it was observed that economic growth is slowed down by high social spending. It was however noteworthy that the impact of social spending on economic growth was dependent on the structure of social protection. An emphasis on "active" social protection seemed to increase economic growth, whereas increasing the share of "passive" social protection slowed down economic growth.

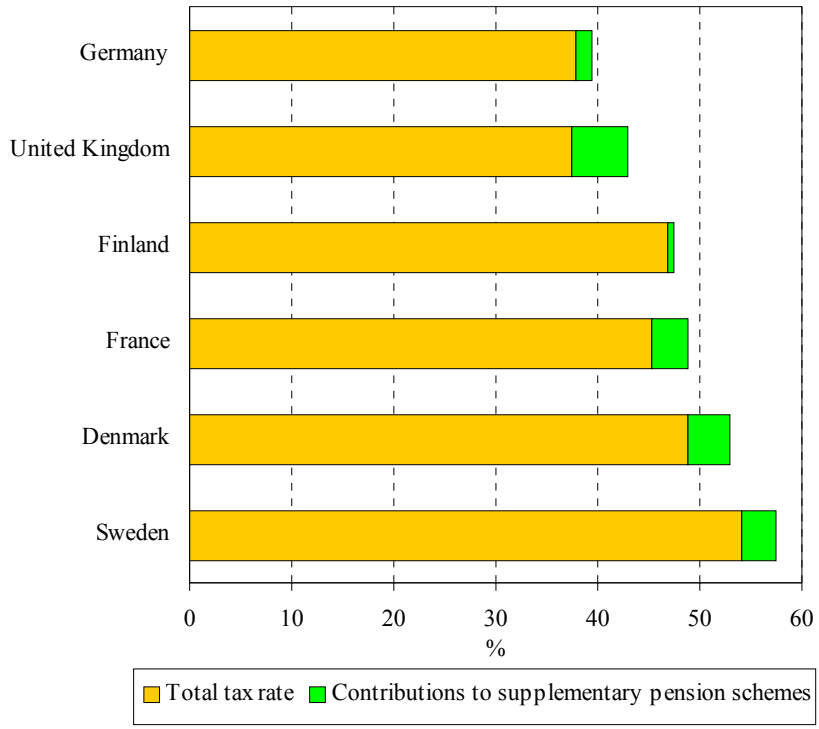
Problems associated with tax rate comparisons

The tax rate comparisons include similar problems as social expenditure comparisons. Benefits given as tax deductions lower the tax rate compared to a situation where benefits are given as direct tax-financed income transfers. If necessary, the rules for tax deductions could be defined in such a way that both the size of the benefit and various incentive effects would be nearly identical to direct income support. The Finnish child allowance system, for example, could in principle be replaced by a system where parents would be eligible to a tax credit equal in size to the current child allowance. Those families with children whose income taxes remained below the amount of deduction would be eligible for an income transfer equalling the amount of the unused tax credit (so-called non-wasteable tax credit). In 2001, only about one in ten families with children paid less income tax than they received in child allowance. As a result of the imaginary reform, both the tax rate and the GDP ratio of social protection expenditure would decrease. This would be primarily a change in accounting practice, because the net incomes or incentives of families with children would remain largely unchanged.[8]

In its tax wedge calculations, the OECD has attempted to take into account differences in the way family support is channelled in different countries by deducting "general family support" paid to households from the tax wedge, which in the case of Finland means child allowances. This adjustment does not take into account other tax-financed benefits and services affecting the income of working families with children. In Finland, for example, only a small part of municipal daycare is financed by user fees. Daycare is primarily financed through taxation. In countries without comprehensive daycare provided by the public sector or other support system reducing families' daycare payments, families with children must usually pay considerably higher daycare fees. High daycare fees as well as availability of daycare as a whole may constitute a significant threshold for mothers' work participation in particular.

It was seen above that the relative position of countries is significantly altered by inclusion of private social expenditure in social protection expenditure. What is included in taxes must also be considered when making tax rate comparisons. Taxes and statutory social protection contributions are usually included in the total tax rate, whereas contributions to supplemental pension systems agreed on in the labour market and to private pension insurances are usually left outside the scope of the tax statistics. The overall picture of the level of taxation is altered just by inclusion of insurance contributions to supplementary pension schemes based on labour market agreements or arranged by the employer. In Finland, the impact of these supplementary pension schemes is small, whereas in United Kingdom, known as a country with low taxation, the contributions to supplementary pension schemes are significant.

Figure 13. Total tax rate and insurance contributions to supplementary pension schemes based on labour market agreements or arranged by the employer, in relation to GDP in 2000, %



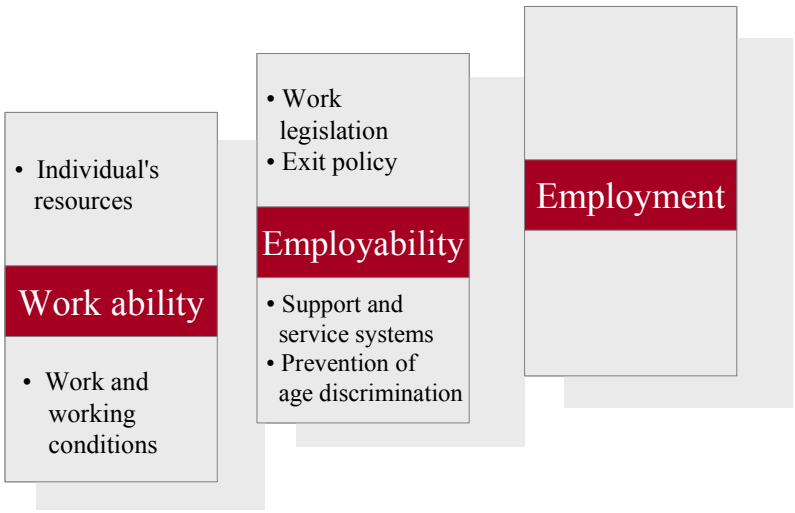
Source: Central Pension Security Institute

1.4 Productivity, employment and work ability

The overwhelming majority of the growth of welfare and economy is explained by labour force productivity. According to a survey conducted by the OECD, productivity explained at least over half of the economic growth in OECD countries in the 1990s. Productivity is largely defined through work ability. Work ability refers to the sum of factors related to both the individual and work that are important for the individual's ability to cope at work. Work ability is seen as a process where a person's resources and work interact. The employee uses and adapts his or her resources at work, but the final result is affected by the work community, the working environment and the physical and mental requirements of work.

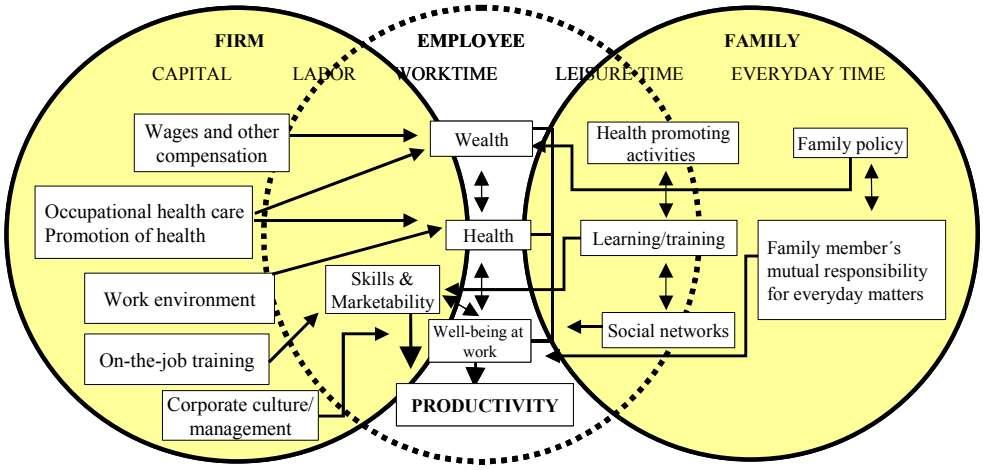
Work ability creates the foundation for employability of individuals. Employability can be promoted by different support and service systems, by employment and pension legislation as well as the values and attitudes that prevail in society. These have an impact on firms' recruitment decisions and households' labour supply decisions.

Figure 14. Work ability, employability and employment



Productivity and competitiveness of a nation are not only determined within firms; welfare policy - social and health care policy as well as education policy - has a significant impact on the success of firms operating in Finland. Figure 15 illustrates the connections between work and family life. Many of the factors affecting productivity, such as health, professional competence and well-being at work are not only determined within working life. Family policy and other forms of social policy have a significant impact on these factors crucial to productivity.

Figure 15. Reconciliation of work and family life



Corporate-level view

The productivity of a person is dependent on both the employee's characteristics and the firms' ability to make use of and develop its staff. The enterprise and its staff operate in interaction with each other. Firms invest in their staff, and correspondingly, employees'

actions influence not only the success of the firm, but its corporate culture and management strategies.

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

Well-being at work may be the single most important factor affecting productivity. Well-being at work comprises the mutual trust between the firm and its staff. Trust is shown by the way the firm adapts its operation to the challenges posed by age structure, globalisation as well as technological and economic development. This is partly influenced by pension and other social protection legislation. Job uncertainty affects employees' attitudes and motivation to look after their health and professional competence.

Social view

Well-being at work is a decisive factor when an individual makes a decision of whether to stay on at work or whether to attempt to find a way out of working life. Employees' responsibilities outside the workplace also affect decision-making. A commitment to look after one's parents or spouse, for example, may be a factor behind the decision to leave the working life.

Family policy with its daycare services for children creates the foundation for women's equal participation in work. Family members' joint responsibility for everyday matter gives rise to well-being and equality within the family, which has a direct impact on well-being at work. During their free time, individuals can pursue health-promoting activities, educate themselves and keep up their social networks. These have a direct impact on factors explaining workability, such as health and professional competence. From the viewpoint of socially sustainable development, the division between time dedicated to work, everyday chores and relaxation must be well-balanced. This balance varies during the course of a person's life.

1.5 The strategic objectives and programmes of the Ministry of Social Affairs and Health

The six strategic objectives of the Ministry of Social Affairs and Health promoting the implementation of the government programme are as follows:

- Promoting health and functional capacity
- Making work more attractive
- Prevention and combating of social exclusion
- Providing efficient services and income security
- Welfare of families with children
- Gender equality

Several programmes and projects aimed at attaining the objectives have been launched in the administrative sector of the Ministry of Social Affairs and Health. Projects elevated to government-level monitoring status are grouped under different objectives in Table 4. In addition to the projects mentioned in the table, other key projects of the administrative sector of the Ministry of Social Affairs and Health include the Social Welfare and Health Care Information Reform 2005 and development of result management within the administrative sector. The implementation of the objectives is promoted by further development of legislation as well as by traditional preparatory work related to it. Only part of this work will be carried out in connection with the programmes.

Table 4. Strategic objectives of the administrative sector of the Ministry of Social Affairs and Health and the projects supporting them

Promoting health and functional capacity	**Making work more attractive**	**Prevention and combating of social exclusion**	**Providing efficient services and income security**	**Promoting welfare of families with children**	**Promoting gender equality**
Health 2015 public health programme	VETO programme 2003-2007*	National plan against poverty and social exclusion 2003-2005	National project to secure the future of health care 2002-2007	Family policy strategy	National action programme for implementation of equality (incl. mainstreaming of equality within public administration
Alcohol programme 2004-2007	Occupational health programme 2015		National development project for social services 2003-2007, and Target and action programme for social welfare and health care 2004-2007	Family policy target and action programme	
Drug policy action programme 2004-2007					
Elderly policy action programme					

*National action programme on extending working life, coping at work and rehabilitation

The operation of the administrative sector of the Ministry of Social Affairs and Health is influenced by the government's four policy programmes, i.e. employment programme, entrepreneurship policy programme, information society programme and the civic participation policy programme. The Ministry of Social Affairs and Health participates in the first three programmes. The Veto programme included in the employment programme aimed at increasing the appeal of work is featured in this report.

The attainment of strategic objectives is also promoted by strategies and programmes of other administrative sectors. The housing policy programme for 2004–2006, which is currently being drafted by the Ministry of the Environment, forms an important part of the strategy aimed at prevention and combating of social exclusion. The Ministry of Labour's labour policy strategy for 2003–2007–2010 includes actions aimed at both increasing the appeal of work and preventing and combating social exclusion. The aim of the Ministry of Education's Noste programme is to increase the level of education of the part of the adult population with the least education. An attempt will be made to improve the balance and predictability of financing of municipalities' tasks and duties with the aid of a basic services programme between the state and municipalities, which is in force during the entire government period. This has special significance in securing the availability of social and health care services. A productivity action programme will be implemented under the direction of the Ministry of Finance as a project that is partly linked to the basic services programme. A separate productivity programme will also be launched within the administrative sector of the Ministry of Social Affairs and Health. The operation of the administrative sector of the Ministry of Social Affairs and Health will continue to be influenced by the strategic lines on competitive and trade policy that were reformed by the Ministry of Trade and Industry in 2004.

II Promoting health and functional capacity

Impact goals of promoting health and functional capacity

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

The average life expectancy has risen and the number of years with good functional capability has increased. People's state of health has primarily developed in a positive direction in all age groups and in both genders. The greatest threats to this positive trend are the clear increase in obesity and alcohol consumption. Exclusion is also becoming a major threat to the positive development trend in public health. There are still great differences in health between population groups, and they seem even to be increasing. Half of the differences are explained by tobacco and alcohol.

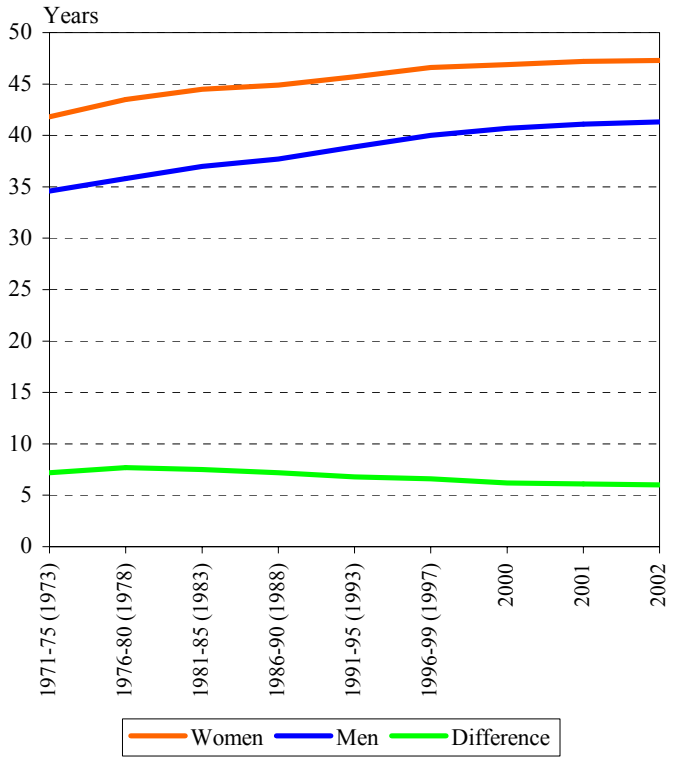
In order to develop public health in a positive direction, it is of the utmost importance to make people aware of the impact of their own choices and lifestyle on their state of health. The foundation for a healthy adulthood and functional old age is laid in childhood and youth. Many diseases can be prevented by adopting a healthier lifestyle. Focusing on prevention and health information is an inexpensive means of achieving significant savings in health-care costs in the years to come. In addition, social policy that evens out differences in people's life conditions is needed if health differences between population groups are to be reduced. The health care system must also reduce differences in health.

2.1 Health 2015 Public Health Programme

The national Finnish health policy is outlined in the government resolution on the Health 2015 Public Health Programme. The main emphasis of the strategy is on health promotion. The programme spans several administrative sectors, as public health is largely dependent on factors outside the scope of health care: lifestyle, living environment, the quality of products, as well as factors supporting and endangering health in the community. Decisions affecting the health of Finns are also increasingly made in international cooperation. The programme presents eight goals for public health:

1. In 2015, healthy life expectancy has risen by two years compared to 2000

Figure 16. Life expectancy of a 35-year-old in 1971–2002



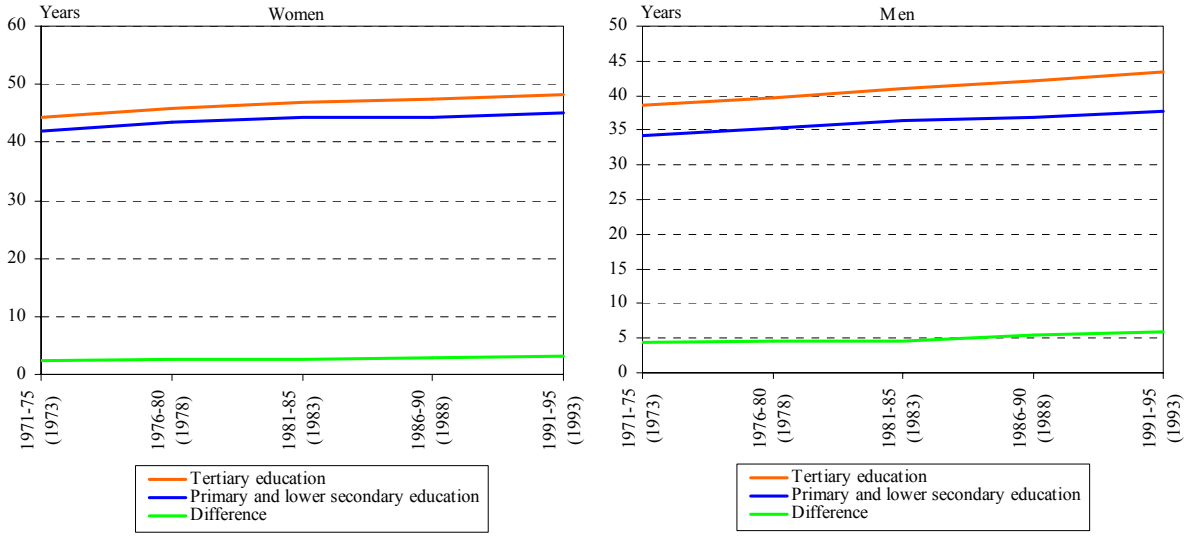
Source: Statistics Finland

The goal is expressly to increase the number of healthy years of life, not just add years to life. However, data on trends in healthy life expectancy are only available at certain intervals. That is why the increase in life expectancy is looked at in the following.

Life expectancy has continued to rise, and it seems to have increased the number of healthy years when people are functionally capable. The improvement of functional capacity among the population indicates that the goal set can be attained, or even exceeded. The gap between men and women has also narrowed somewhat, but the difference is still great in international comparison. Increasing obesity and alcohol consumption pose the most significant threat to the positive development trend.

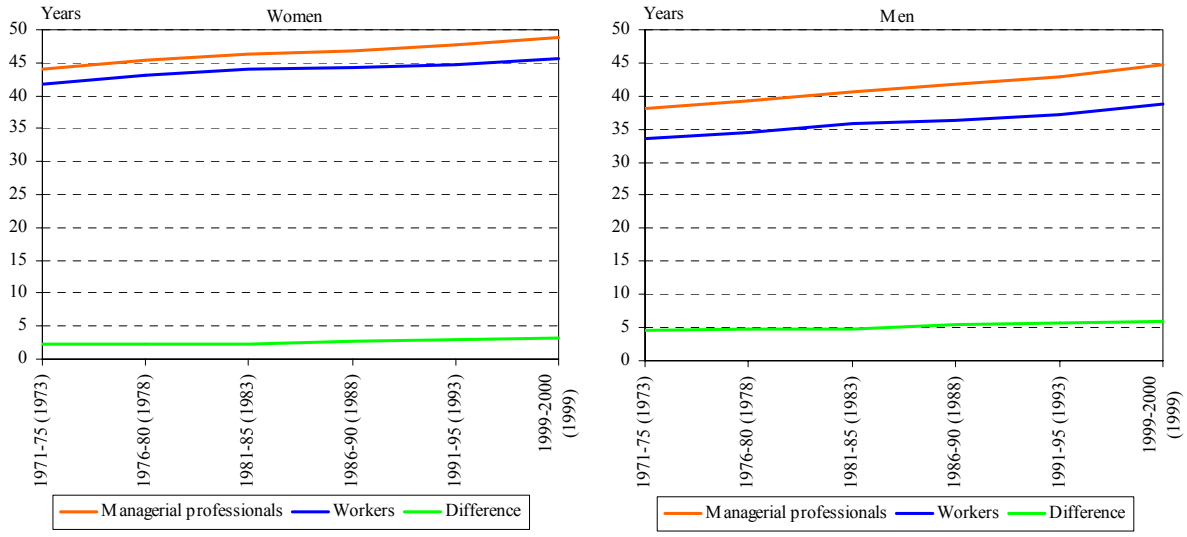
2. Reduction by one fifth of the difference in mortality between genders, people with different educational backgrounds and professional groups

Figure 17. Life expectancy of a 35-year-old according to level of education in 1971–1995



Source: National Public Health Institute and Statistics Finland

Figure 18. Life expectancy of a 35-year-old according to social group in 1971- 2000



Source: Hyvinvointikatsaus 2/2003; unpublished results of Tapani Valkonen's research group

Life expectancy has increased in all social groups among men and women alike. The difference in life expectancy between genders has shown a steady decline, whereas differences in mortality between social groups have not been reduced. The increase in life expectancy has been the greatest among managerial professionals with a tertiary education, and smaller among workers and farmers with primary and lower secondary education. Among men, the differences between social groups have even increased in recent years. The most important reason for the decrease in mortality is the rapid decline in the incidence of coronary artery disease, whereas alcohol-related mortality has increased. It is the primary cause for increased differences in mortality.

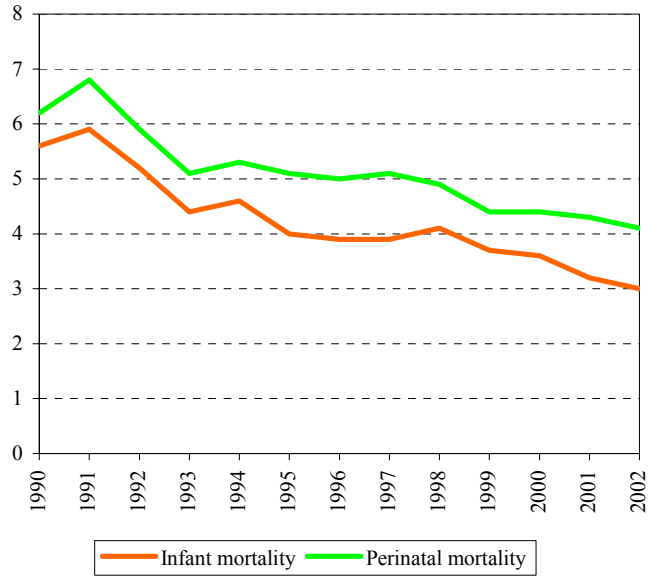
The differences in mortality are affected by lifestyle and living conditions in particular. Tobacco and alcohol account for half of the difference between population groups. The choices that individuals and communities make are important for health. There is a danger that the increased consumption of alcohol as a result of lower taxation and lower prices of alcohol beverages will increase the number of alcohol-related deaths even further, making the differences in mortality between population groups even larger.

The level of education has risen, and people are increasingly able to make use of information, which provides opportunities for health promotion. There is a lot of information available on health and factors affecting it. The challenge is to provide and present this information in such a form that both citizens and decision-makers understand the possible effects of their choices and actions on their own health and on public health. The differences in health between population groups start to develop early, in childhood; that is why it is particularly important to influence the health habits of children and young people and their parents.

Differences in mortality can be reduced by employment, education and social policy. Municipalities can have a significant impact on people’s state of health. They make important decisions related to the living environment, welfare services, education, safety and gender equality. Finns are used to trusting that differences are automatically evened out by universal services. The latest research findings do however indicate that health services are unequally targeted.

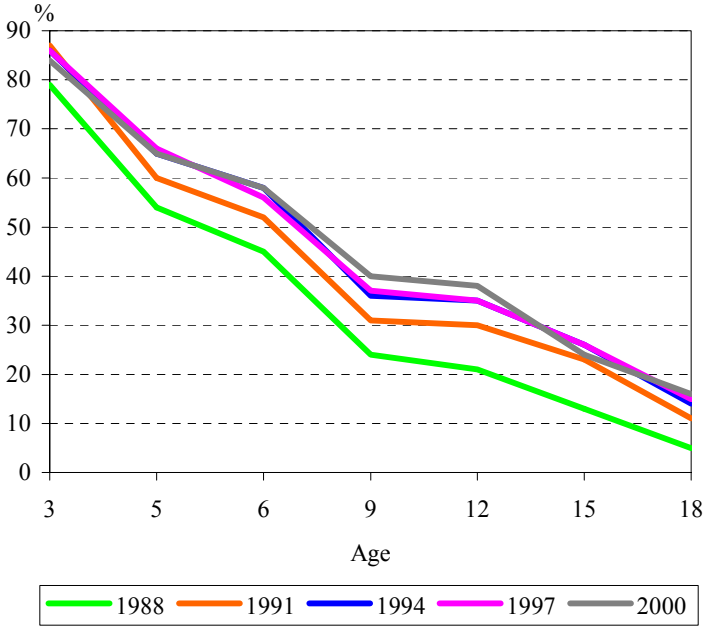
3. The well-being and health of children is improved, symptoms and illnesses caused by insecurity are significantly reduced.

Figure 19. Infant mortality*) in 1990–2002



*) Children who died under 12 months of age (excl. stillborn) per 1,000 live births according to year of birth
Source: Statistics Finland

Figure 20. Proportion of children aged 3–18 years with healthy teeth in 1988, 1991, 1994, 1997 and 2000, %



Source: Ministry of Social Affairs and Health

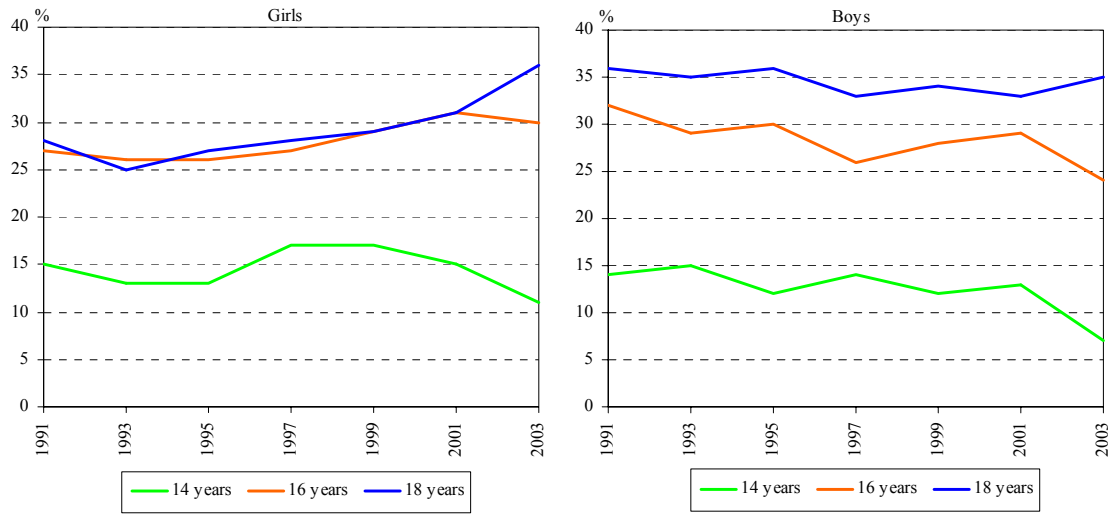
Both infant mortality and prenatal mortality have continued to decrease. The overall picture of children's state of health is fairly positive, but allergies, asthma and diabetes have become more prevalent. Children's dental health has also developed in a positive direction in the long term, but this positive trend has been halted in recent years, and the situation seems to have deteriorated somewhat. Obesity also seems to be increasing at an alarming rate among children, and it is threatening to become a major health hazard for children.

The majority of children are in good or better health than before, but the number of children who are not doing well is also on the increase. The threats to children's health include symptoms and diseases related to insecurity, such as mental health problems and disturbed social development. The foundation for children's health is laid in the womb, which is why the promotion of women's health, especially during pregnancy, is of crucial importance.

The well-being of children is looked at in more detail in the chapter Well-being of families with children/Family-policy strategy.

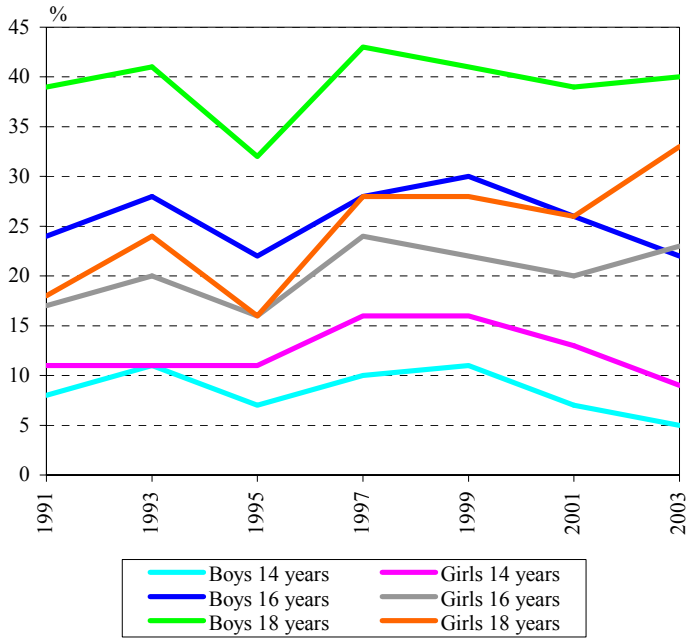
4. Smoking among young people is reduced so that less than 15 percent of those aged 16–18 smoke; alcohol- and drug-related health problems among the young can be treated with expertise, and they are not more common than in the early 1990s.

Figure 21. Proportion of daily smokers among 14- to 18-year-old girls and boys in 1991–2003, %



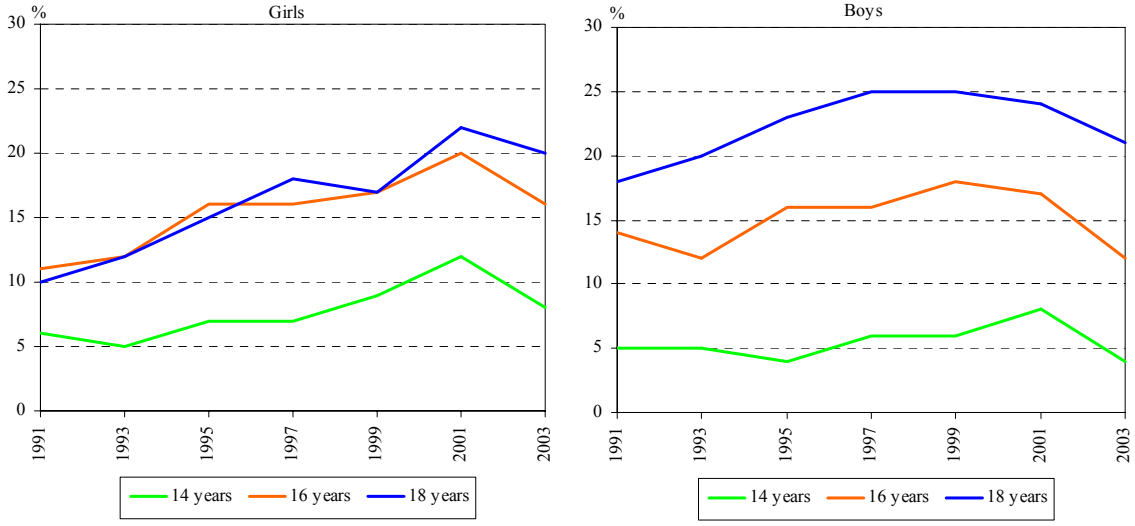
Source: Stakes

Figure 22. Proportion of 14- to 18-year-old girls and boys getting seriously drunk at least once a month in 1991–2003



Source: Stakes

Figure 23. Proportion of 14-to 18-year-old girls and boys who have been offered drugs during the past year in 1991–2003



Source: Stakes

Smoking and drunkenness-oriented alcohol use has diminished somewhat among young people in recent years. The development has been particularly positive among 14-year-old girls and 16-year-old boys, whereas both drunkenness-oriented drinking and smoking have become more common among 18-year-old girls. Among boys aged 18, drunkenness-

oriented drinking has remained common. The latest data on alcohol consumption among the young do however indicate that alcohol use started to increase again in 2004. Being offered drugs has become less common in all age groups in the past few years.

Obesity, eating disorders and psychosomatic symptoms have become more prevalent. It is alarming that compared to other age groups, obesity is at the moment increasing more rapidly among the young. A busy lifestyle has made the habit of eating snacks with a high sugar and fat content more common among the young. The change in lifestyle is also seen in the massive increase in the consumption of soft drinks and sweets. The children of overweight parents with little education as well as physically passive children are particularly susceptible to gain weight.

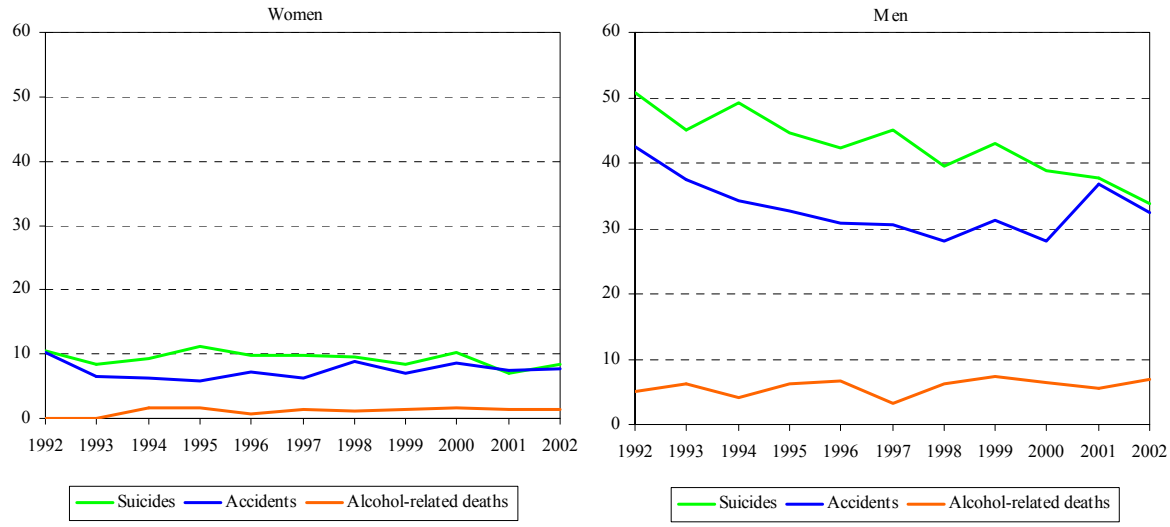
In the case of young people living in a difficult social environment with a lot of social problems, there is a greater risk that the unhealthy lifestyle will become a permanent feature.

The best way to promote the health of young people is to increase their awareness about health and the factors affecting it and to help them make health-promoting choices. Young people's health can be promoted by improving working conditions at schools, by increasing cooperation between different actors aimed at breaking the vicious cycle of exclusion and poor health, and by supporting young people's possibilities to engage in various leisure activities, sports and culture. In order to increase health awareness among the young, a new subject, health education, will be introduced in schools in 2005. Its aim is e.g. to make young people interested in health, make healthy choices and take care of themselves. This includes taking care of basic hygiene, including oral and dental health as well as health as a whole.

The school environment can also support young people by offering them healthy snacks and by avoiding the sale of sweets and soft drinks at school. The school health care quality recommendations issued in August 2004 emphasise that there must be a sufficient number of competent professionals working in school health care, that school health care services are readily available for students and their families, and that the health and well-being of students is monitored through check-ups.

5. Accidental and violent deaths among young men will be reduced by one third from the level of the late 1990s

Figure 24. Age-standardised suicide, accident and alcohol mortality among men and women aged 15–34 in 1992–2002 (per 100,000 persons)



Source: Statistics Finland

Suicide among young men poses a significant public health problem. Suicide mortality among young men has declined clearly in recent years, whereas the trend in accidental deaths shows a considerable rise since 2001, after the positive development seen in the early 1990s. The most important reason for this was road accident deaths among young men. In 2002, the number of deaths started to decline again, but mortality was still on the same level as in 1994. Among young men, the number of deaths caused by alcohol remains unaltered. Suicide, alcohol and accident mortality among young women is clearly lower compared to men, and the situation has remained largely unchanged.

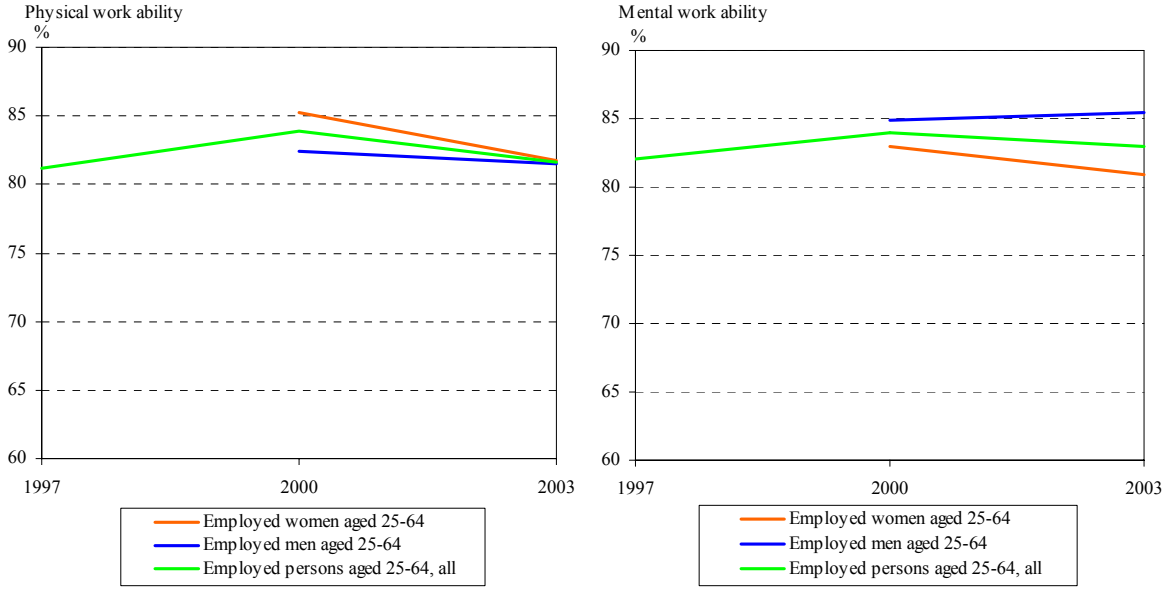
During the past few years, suicide prevention has been focused on through a number of programmes and by training nursing staff to recognise suicidal, anxious and depressed persons in time, so that they can be guided to seek treatment. Recognising young people at risk as well as treating mental disorders among the young appropriately and as early as possible are key measures. It is difficult to estimate the impact of the suicide prevention programmes on suicide mortality, but the suicide death rate has declined clearly compared to 1990. The preliminary results concerning the impact of the prevention projects are however encouraging.

A permanent reduction in the number of road accidents still calls for efficient traffic information measures aimed especially at young men. Speed limits are also an effective means of reducing the number of traffic deaths.

6. The working and functional capacity of working-age persons and working conditions improve, enabling people to cope longer at work, so that they leave work about three years later than in 2000.

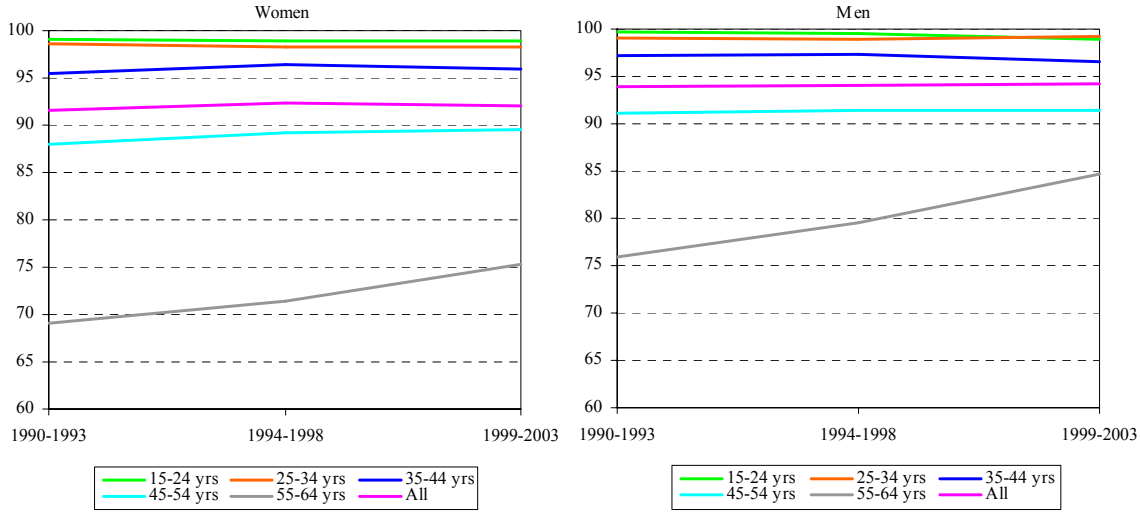
The conditions of working life and giving up work are looked at more closely in the chapter Making work more attractive.

Figure 25. Proportion of employed persons aged 25–64 with very good/fairly good physical and mental work capacity in 1997, 2000 and 2003, %



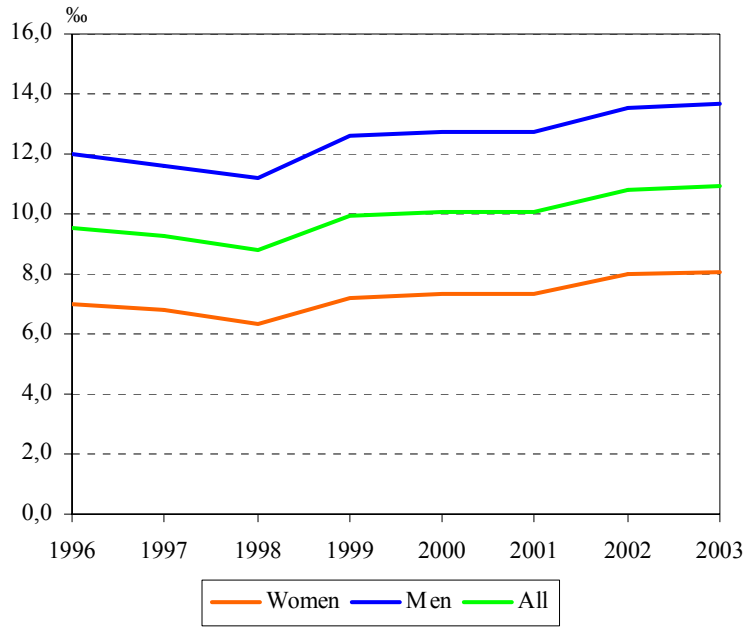
Source: Finnish Institute of Occupational Health

Figure 26. Proportion of persons aged 15–64 who are able to run 100 metres without rest in 1990–2003, %



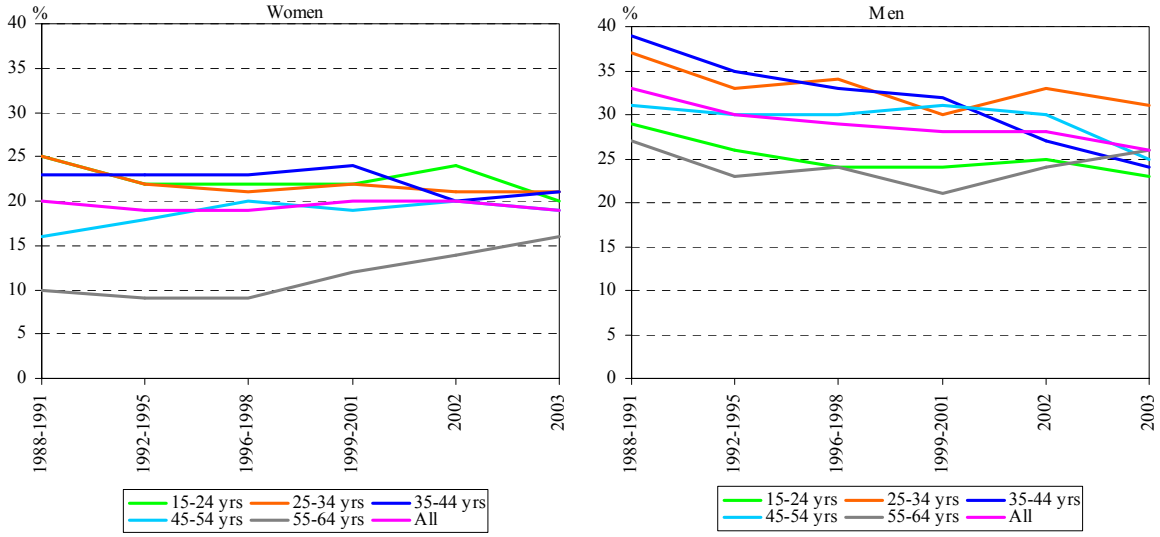
Source: National Public Health

Figure 27. New age-standardised disability pensions granted to persons aged 35–54 in 1996–2003, per 1,000 people



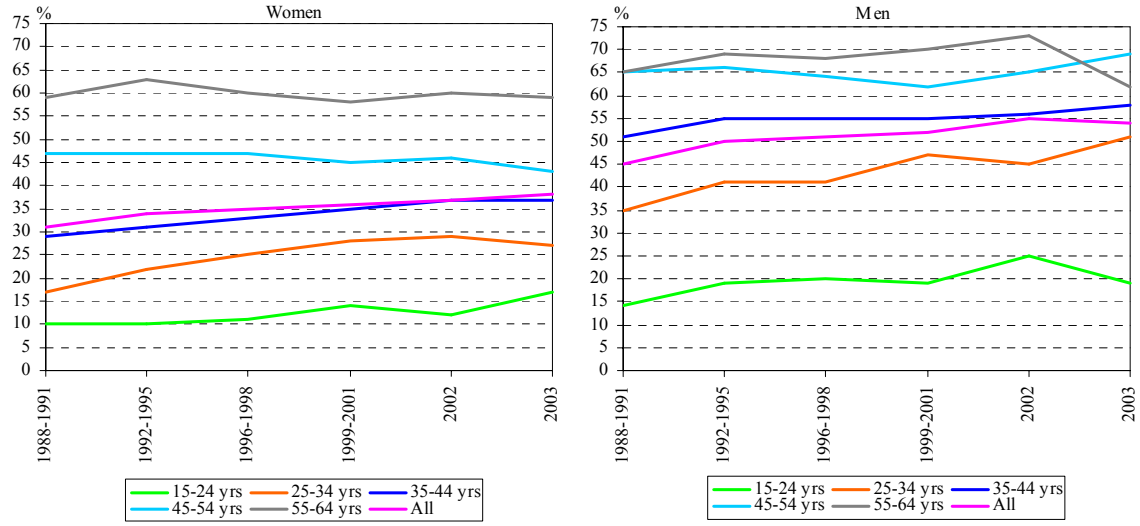
Source: Finnish Centre for Pensions

Figure 28. Proportion of adults who smoke daily, in 1988–2003, %



Source: National Public Health Institute

Figure 29. Proportion of obese[9] persons among adults in 1988-–2003



Source: National Public Health Institute

The health of working-age people has generally developed in a positive direction. Mortality due to coronary artery disease and cancer has declined significantly, and blood cholesterol levels have come down considerably. Fewer men smoke, but in age group 55–64, smoking has become clearly more common among women and men alike. Self-assessed physical and mental work ability among people of working age seems to have remained more or less unchanged, but taking up disability pension has become more common. The majority of disability pensions are granted on the grounds of mental health problems. The prevalence of disease or disability impairing work and functional capacity has declined in recent years, while the proportion of those who are able to run 100 metres without rest has increased, especially among persons aged 55–64.

Obesity is one of our biggest public health problems. It causes significant health problems: type 2 diabetes, hypertension and arthritis. A little over half of Finnish men and nearly half of the women are overweight. Obesity is most common among people with the lowest education. The differences in the prevalence of obesity between educational groups are particularly clear among women. Those with better education are more interested in their health and more receptive to health information.

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

It is important to change people's lifestyle into a healthier direction by increasing the amount of exercise and by reducing energy intake. A balanced diet, reasonable serving sizes of food and moderate alcohol consumption as well as a non-sedentary lifestyle are key factors in the battle against obesity. It is possible to attain a significant improvement

in functional capacity and health and to prevent weight-gain by increasing the amount of exercise. A weight reduction of only 5-10 percent gives considerable health benefits. The most recent exercise recommendations aimed at preventing obesity advice people to exercise at least one hour each day. The food industry has introduced a number of different light products in recent years with an energy content clearly below that of corresponding normal products. However, the same amount of the light products as of the corresponding normal products must be consumed in order to reduce the intake of energy and to lose weight. On the other hand, some light products may contain more energy than other, naturally low-calorie foods.

Thanks to persistent informing, attempts to make both consumers and the food industry reduce the use of salt have been successful. The same result must be aimed at in the prevention of obesity. Preventing obesity is emphasised in the Cardiac and circulatory diseases prevention programme, the Type 2 diabetes prevention programme of the Finnish Diabetes Association and in the action programme of the National Nutrition Council.

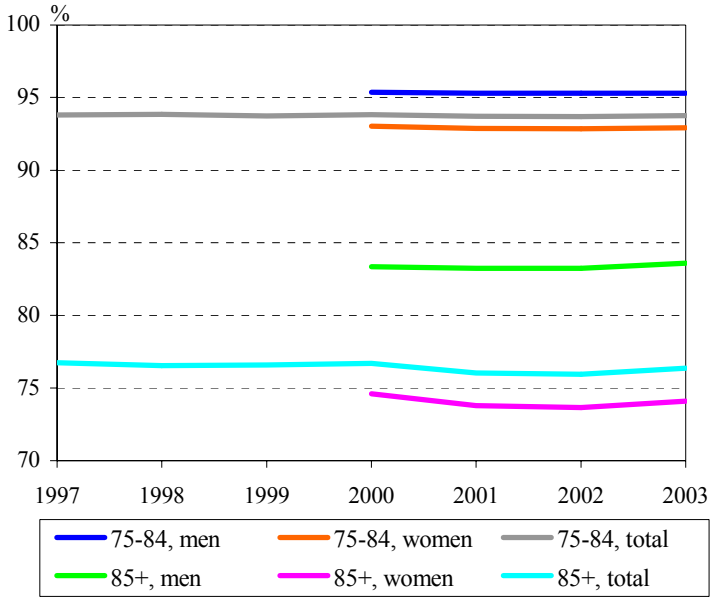
7. Average functional capacity of persons over 75 continues to improve in the same direction as during the past 20 years.

The costs of services for the elderly are reduced by improved functional capacity among the elderly and by a reduction in the need of long-term institutionalised care. Accessibility in housing and the living environment makes it possible for people to live at home and maintain their functional capacity, even as their physical condition deteriorates. Problems are also for their part prevented by well-functioning public and private services, which contribute to functional capacity and support individual initiative.

Being able to live at home as long as possible is in accordance with the wishes of elderly citizens. However, especially in the case of elderly persons living on their own whose mental and physical functional capacity is significantly reduced, safe sheltered housing and home-like institutional care is needed. Ninety-three percent of persons aged 75–84 and 76 percent of those over 85 live at home. The rest live in sheltered housing with staff on site 24 hours a day, or are in long-term institutional care in old people's homes or in hospitals. There is a significant difference between men and women over 85; a clearly greater proportion of men are able to cope at home at this age compared to women of the same age. This may be partly due to the fact that men die on average at a younger age than women. Most men who live to an old age thus have a wife at home who can help them when needed, whereas most elderly women live alone. The proportion of elderly persons living at home has remained nearly unchanged in recent years.

Good health and functional capacity among the elderly are prerequisites of initiative and participation. The functional capacity of elderly persons has improved during the past few decades, and an increasing proportion of pensioners are able to cope at home without major problems, as well as being able to move outside the home unaided. Despite the positive development trend, many elderly persons suffer from various limitations of functional capacity and need help with daily chores. Women over 85 are in particular in need of daily or almost round-the-clock assistance.

Figure 30. Proportion of elderly persons living at home by age, in 1997–2002, %



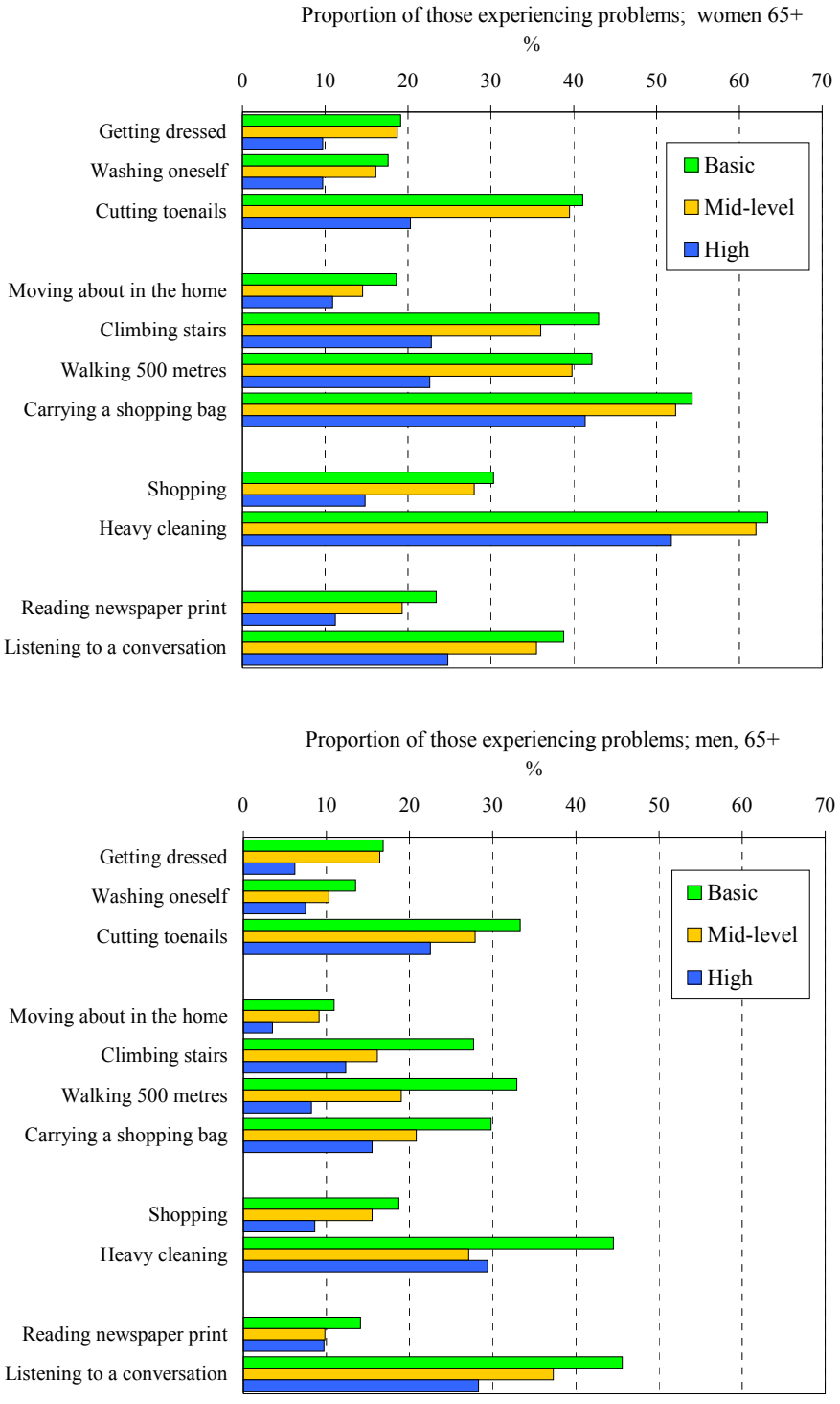
Source: Stakes

Regular exercise is absolutely essential in order for the elderly to maintain their functional capacity and mobility. In addition to exercise that they get in connection with performing daily chores, they need exercise that improves muscle strength and balance. Thanks to versatile physical exercise, elderly persons remain in good condition and are able to live at home longer. Just like mortality and morbidity, functional capacity among the elderly seems to be strongly linked to socio-economic status. The differences are probably caused by earlier life events. Differences between professional groups persist, but there is some indication among men that the differences are getting smaller.

It can be assumed that the development trend concerning health and functional capacity among the elderly will remain positive, since future pensioners have not been subjected to work that is as physically strenuous as that of earlier generations. Rehabilitation has also been focused on at an earlier stage than in the past. On the other hand, the health risks in old age caused by an increase in the prevalence of obesity and in drug and alcohol use poses a threat for the future.

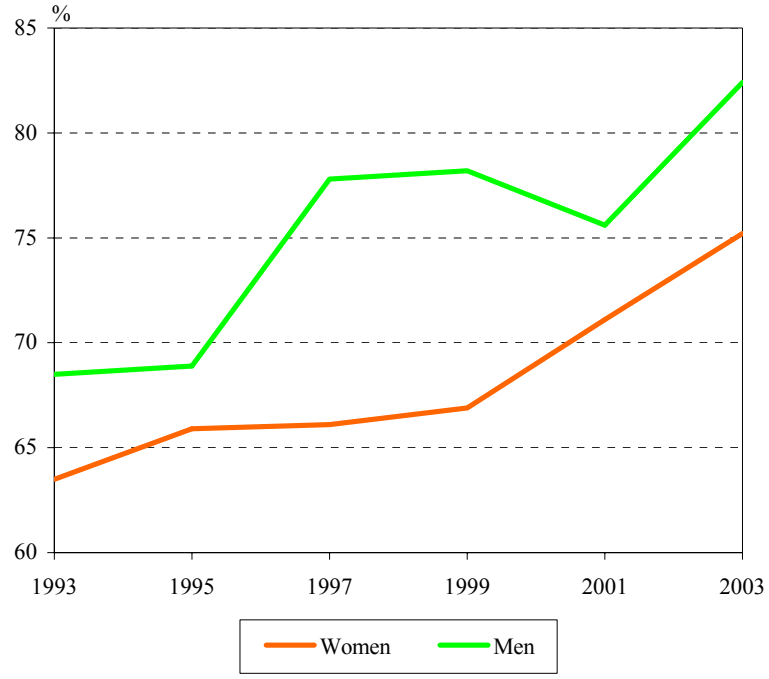
The guideline *Quality recommendations for guided exercise for the elderly* was completed in spring 2004. In the recommendations, the role of municipalities in promoting exercise among the elderly is emphasised. It is also proposed that exercise for the elderly should be included as part of municipalities' welfare policy and elderly strategy. In autumn 2004, a national programme was launched aimed at increasing awareness, particularly among elderly people living at home and their families, of the importance of strength training for the functional capacity of the musculoskeletal system. The aim is to get more elderly people to engage in exercise that increases muscle strength.

Figure 31. Age-standardised proportion of persons over 65 who had experienced problems with some activities in 2000–2001 according to level of education, %



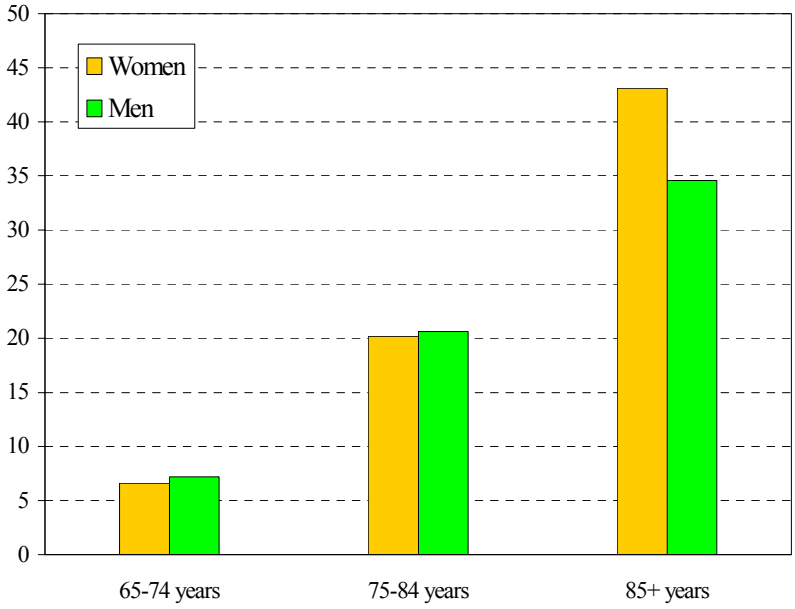
Source: National Public Health Institute (Health 2000)

Figure 32. Proportion of persons aged 75–84 able to move outside unaided in 1993–2003, %



Source: National Public Health Institute

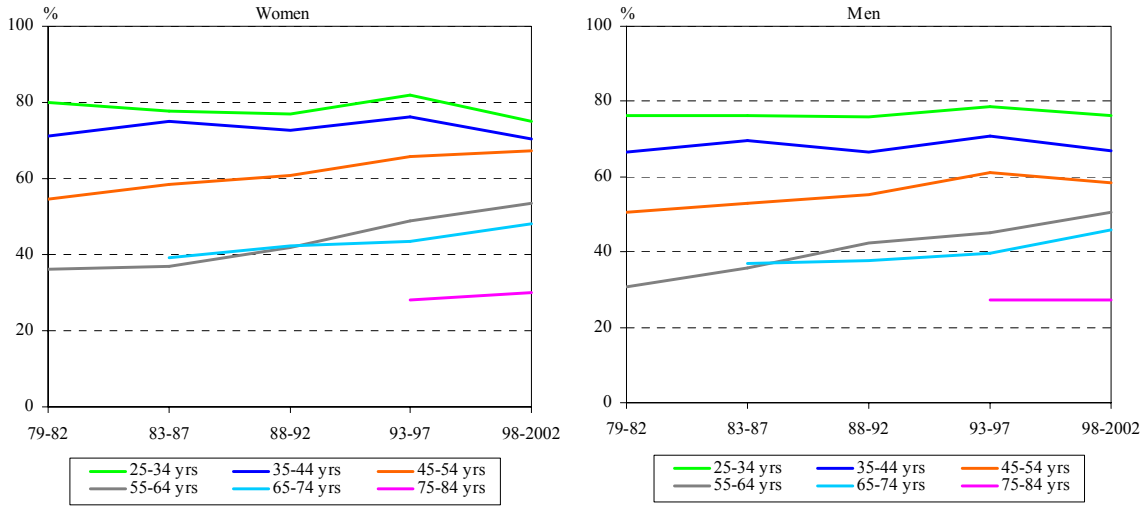
Figure 33. Prevalence of daily need for assistance among persons over 65 in 2000, %



Source: National Public Health Institute

8. Satisfaction with availability and functioning of health care services, self-experienced health and experiences of environmental impacts on one's own health remains at least on the present level

Figure 34. Proportion of those who feel their state of health to be good or fairly good by age groups in 1979–2002



Source: National Public Health Institute

Self-experienced health has for the most part developed in a positive direction. About two thirds consider that their state of health is good or fairly good. The trend has been positive in both genders in the age group 45–74, whereas a slight deterioration is seen in self-experienced health among younger women.

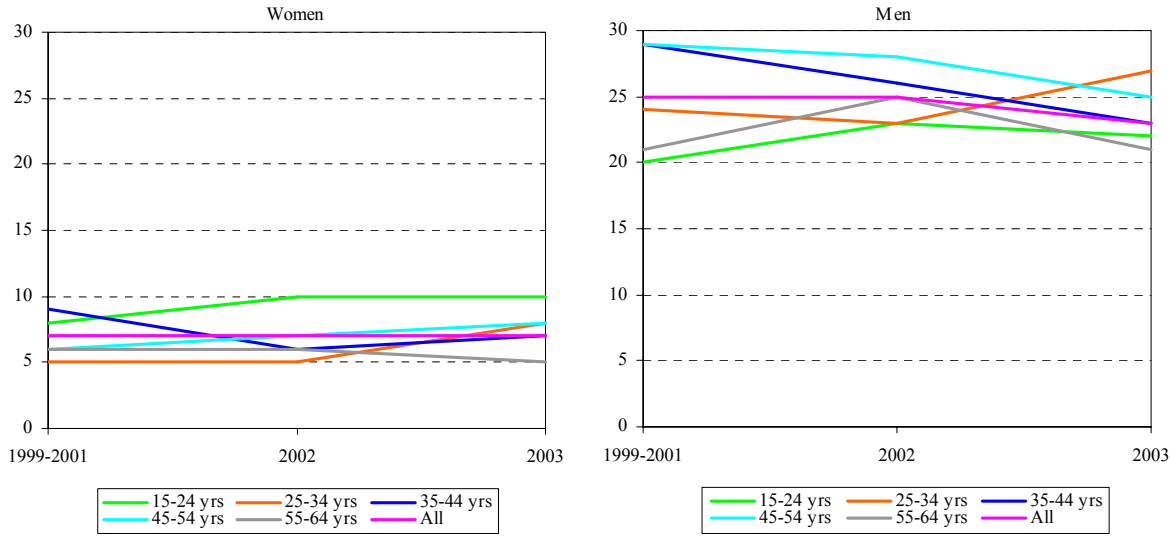
Health care services are discussed under the heading Well-functioning services/National health-care project. Finns continue to be primarily satisfied with health care services, although significant problems do exist.

2.2 Alcohol programme 2004–2007

The aim of the alcohol programme is to reduce the negative effects of alcohol use, and especially to bring about a reduction in alcohol consumption, since the negative effects are directly linked to alcohol consumption. The programme is implemented in cooperation with several administrative sectors, municipalities, churches, organisations and the business sector. The goal is to gather measures aimed at preventing and reducing the harmful effects of alcohol into a whole where the attainment of objectives is promoted by cooperation. The key objectives have been defined in the government resolution on strategies in alcohol policy.

1. A significant reduction in the harmful effects caused by alcohol to the well-being of children and families.

Figure 35. Proportion of those who drink six or more servings of alcohol at a time at least once a week in 1999–2003



Source: National Public Health Institute

Drunkenness-oriented drinking continues to be common among men; one in every four men drink regularly with the aim of getting drunk, while one in seven women do so. The proportion of drunkenness-oriented drinkers among men aged 35–54 seems to have declined slightly until the year 2003, but the latest data from the summer of 2004 show that the situation has deteriorated rapidly. Drunkenness-oriented drinking raises the incidence of domestic violence, and the increase in alcohol consumption poses a particular threat to the well-being of children and families.

About half of the cases of domestic violence occur in a situation where the perpetrator, the victim or both are under the influence of alcohol. The victim is in most cases a woman. Excessive substance abuse on the part of the parents causes considerable problems in families; children in particular feel unsafe, and they commonly experience a variety of problems. The number of children in community care interventions has doubled since 1994, and according to the latest data, the number continues to rise. About third of all child welfare cases involve parents' substance abuse.

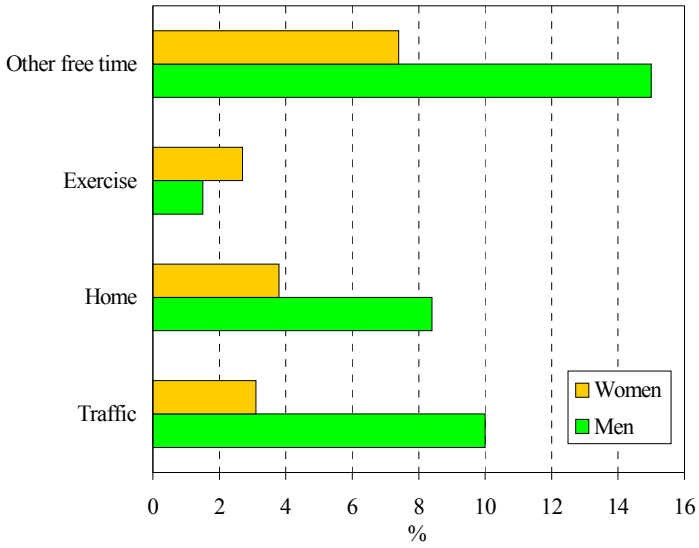
Alcohol use during pregnancy poses a significant threat to the healthy growth of the foetus and the child. It is estimated that about 6 percent of expecting mothers are substance-dependent. Each year, about 650 children suffering from alcohol damage are born in Finland. Problems with alcohol also increase the likelihood of homelessness.

The foundation for alcohol use habits is laid at an early age. Early onset of alcohol use is a severe risk factor for the development of a young person, which is why it is particularly important to prevent and intervene in drunkenness-oriented drinking among the young.

According to research, the majority of young people who use a lot of alcohol become problem-users as adults. The latest data show that drunkenness-oriented drinking has again increased among the young.

2. A significant reduction in using alcoholic beverages to a level below the risk level and the harmful effects that this causes

Figure 36. Accidents leading to physical injury under the influence of alcohol as a proportion of all accidents in 2003

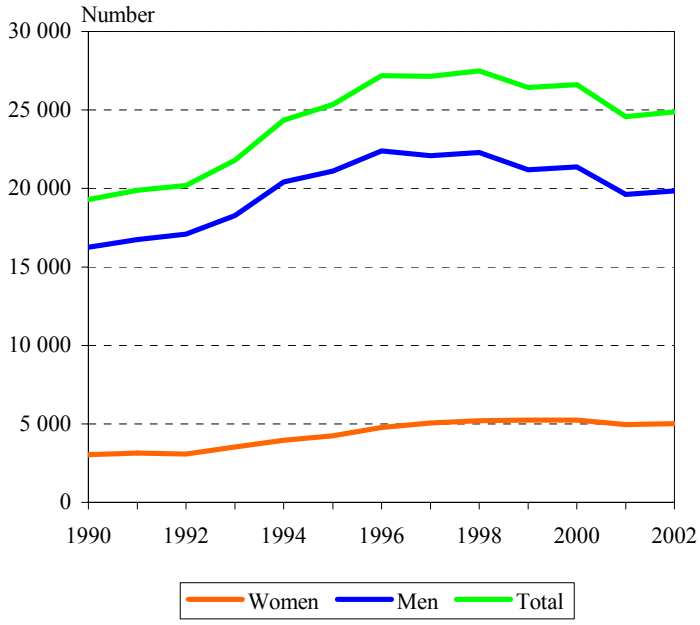


Source: Victim survey, The National Research Institute of Legal Policy

The majority of violent acts are done when drunk. In little over half of the cases, the victim is a woman. In 65 percent of all reported cases of violence, either the perpetrator, the victim or both have been under the influence of alcohol. In a typical case with a male victim, the perpetrator has been drunk, and in many cases the victim as well, whereas in cases with women as victims, the perpetrator is drunk in about half of the cases, but the victim only rarely.

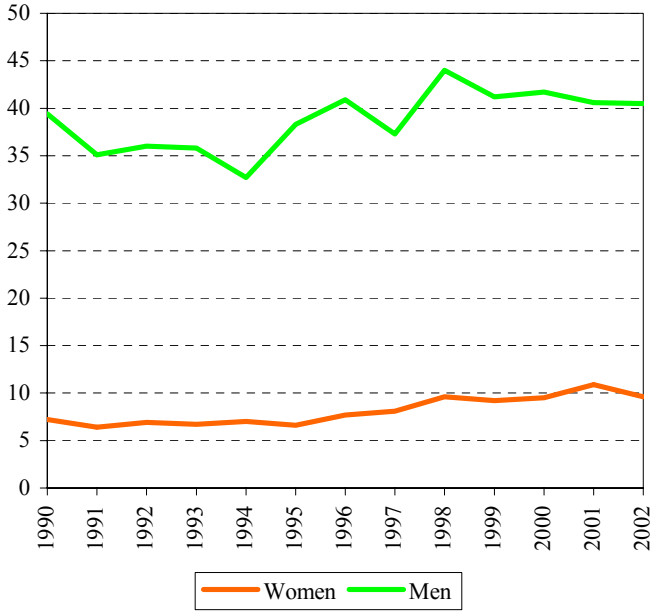
In 2003, about 42,000 alcohol-related accidents occurred in Finland. This was four percent of all accidents. In the case of men and women, 4.6 and 3.4 percent of accidents occurred while under the influence of alcohol. The situation was similar in 1997. The figures are likely to be underestimations. Among women, accidents under the influence have become more common. The majority of accidents while under the influence occur during free time. The risk of accidents is clearly increased by drunkenness-oriented alcohol use.

Figure 37. Periods of care in hospital due to alcohol-related diseases[10] in1990–2002



Source: Stakes

Figure 38. Age-standardised deaths due to alcohol-related diseases and poisoning per 100,000/ people in 1999–2002



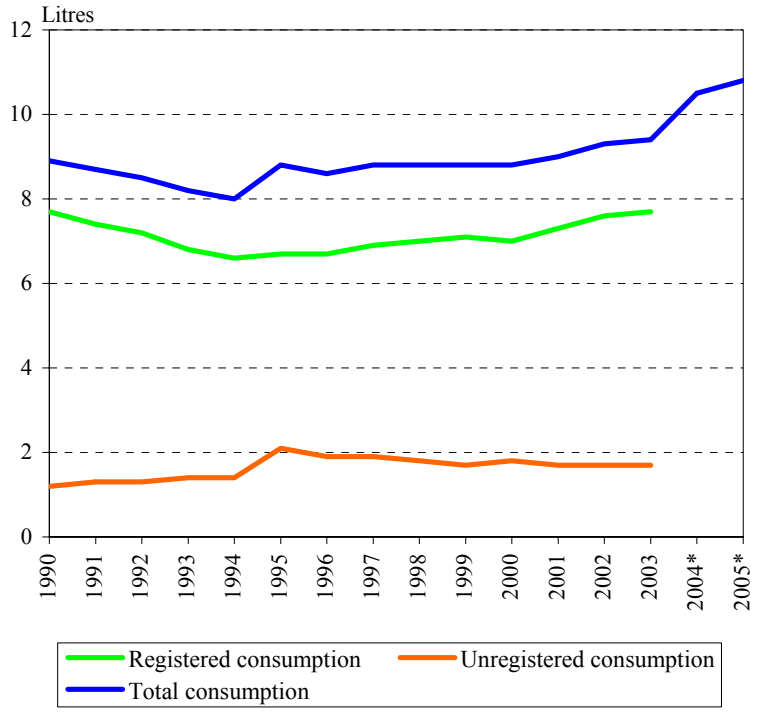
Source: Stakes

Heavy long-term alcohol use poses a serious health risk. The risk of accidents and of committing or being a victim of violent crime is significantly increased by being heavily drunk. Even a small amount of alcohol reduces functional capacity and increases the risk of accidents in traffic, at work, in the home and during free time.

The number of patients treated in hospital due to alcohol increased rapidly in the 1990s, but has been decreasing somewhat among men for a few years. The number of deaths due to alcohol has remained more or less unchanged after the rise seen in the 1990s.

3. Creating a downward trend in the overall consumption of alcohol

Figure 39. Total consumption of alcohol per capita as 100 percent alcohol in 1990–2005



Source: Stakes

An increase in alcohol consumption is directly associated with an increase in damage caused by alcohol. A rise in alcohol consumption in recent years has caused an increase in the number of the negative health and social effects of alcohol. Drinking has become increasingly common among women in particular. Lifting restrictions on the import of alcohol by passengers from countries with a lower price level and lowering the level of taxes and price of alcohol in Finland will continue to rapidly increase alcohol consumption and its negative effects. During summer 2004, a rise was seen in the incidence of drunken driving, assaults and detainment of persons under the influence. This trend will increase the need for social and welfare services and the expenses caused to municipalities.

Alcohol continues to be by far the most significant cause of substance abuse problems. The cost of the negative effects caused by alcohol is estimated to total € 3.0–5.2 billion per annum. Almost one fifth of the sum is due to direct health care, social welfare and police costs. A significant proportion consists of indirect costs due to value of loss of life and premature death. Alcohol is also a source of revenue. In 2003, the state levied a total of € 2.4 billion on alcohol in the form of taxes and other payments. A significant number of people are also employed in the manufacturing and selling of alcohol. In 2003, nearly 2,600 persons were employed by Alko, and about 17,000 and 15,000 people have full-time or part-time jobs in restaurants, respectively. In addition, restaurants also employ a considerable number of hired labour.

In order to reduce the negative effects of alcohol, the rising trend of total consumption ought to be halted, or rather reversed. Attainment of this goal calls for cooperation between administrative sectors, particularly when it comes to prevention of alcohol use among the young, prevention of danger to traffic caused by alcohol, promotion of general order and safety and prevention of crime. As providers of basic services, municipalities have a key role in the prevention and reduction of the negative effects of alcohol. This aspect is integrated in the activities of daycare, child wellness clinics, the education sector, the youth sector, student and occupational health care as well as other social and health care services.

Prevention and reduction of the harmful effects of alcohol must be included in decision-making and activities in all administrative sectors. This is also the starting premise of the quality recommendations for substance use services drawn up in 2002. In addition, what is needed is information supporting self-control of alcohol consumption as well as extensive activities aimed at moulding the public opinion. So-called mini interventions targeted at high-risk users are an efficient means of preventing alcohol-related problems. Mini-intervention refers to early information and monitoring of heavy or risk consumption of alcohol during two or three normal visits to doctor or public health nurse. Problem use of alcohol and related negative social and health effects can be reduced by sufficient, appropriately timed substance use services.

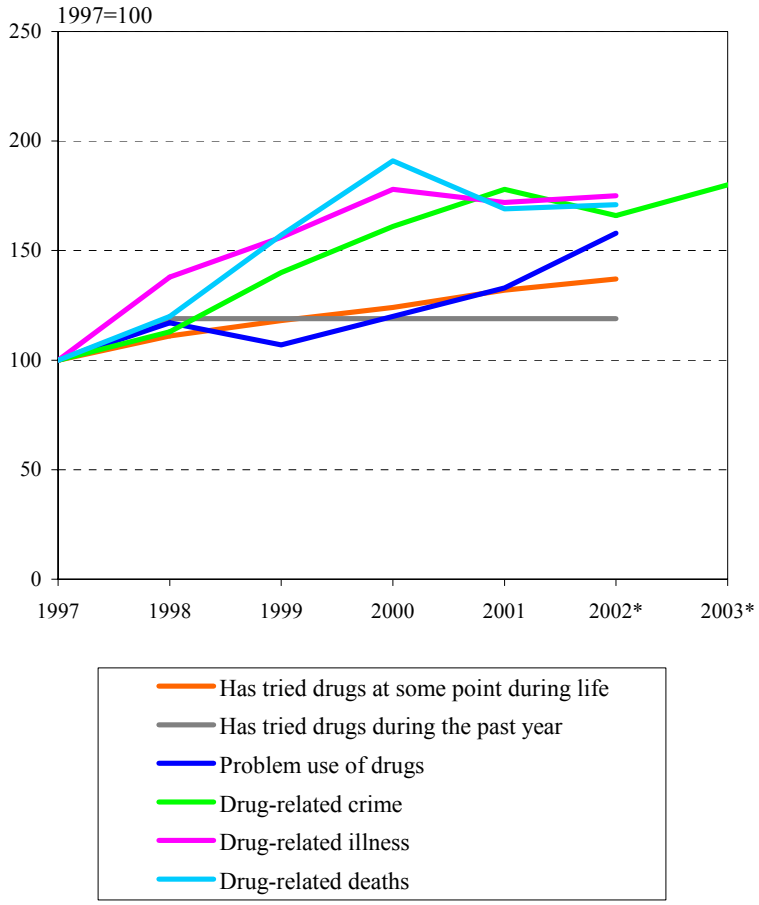
Municipalities, joint municipal authorities and organisations can apply for funding for projects related to prevention and reduction of the negative effects of alcohol from the following sources: funds reserved for the implementation of the National Healthcare Project and the National Development Project for Social Services in Finland, health-promotion funds and from Finland's Slot Machine Association (RAY). In addition, one million euros have been allocated for the implementation of the alcohol programme in 2003–2005.

Because alcohol involves extensive public health as well as business and employment policy aspects, they should all be clearly brought forward when making alcohol-policy decisions and when considering the total impact and cost of the decisions. Studies show that the regulation of the alcohol market and alcohol taxation are the most efficient means of influencing alcohol consumption and its negative effects. The tax instrument can still be utilised, even though there is less room than before for national-level decision-making.

2.3 Drug Policy Action Programme 2004–2007

The government has issued a resolution concerning a Drug Policy Action Programme for 2004–2007. The programme presents guidelines on actions aimed at preventing the negative effects of drugs. The aim is a permanent improvement of the drug situation, increased cooperation between authorities, ensuring the availability of appropriate drug treatment services and development of competence in the field of prevention and treatment of drug problems.

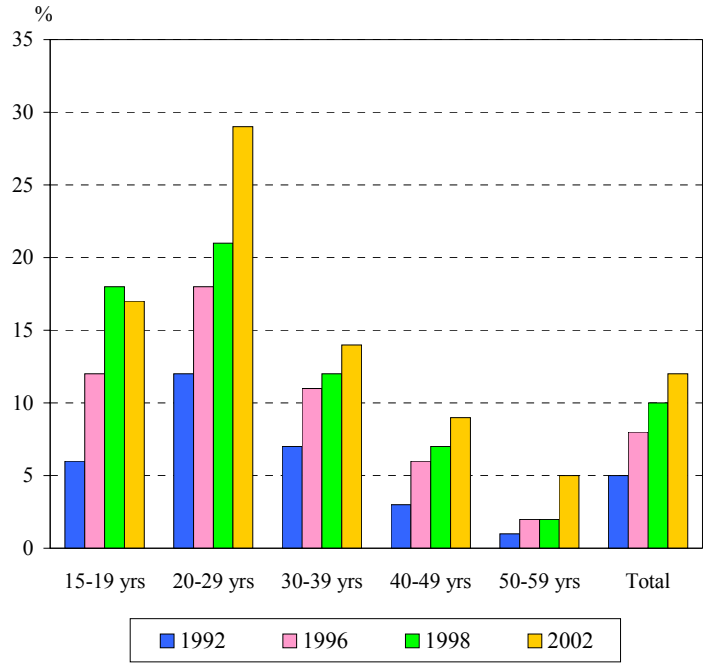
Figure 40. Drug trends



Source: Stakes

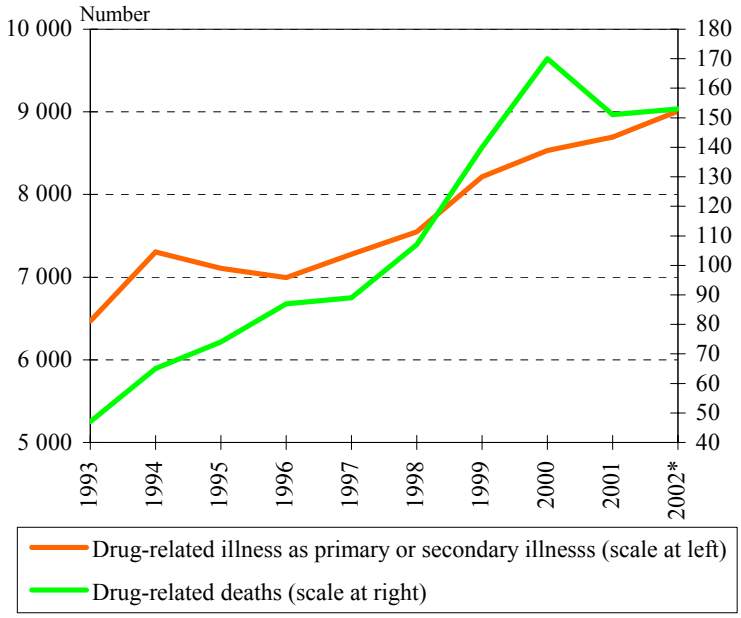
Drug experimentation and use increased significantly in the 1990s. At the turn of the 21st century, the increase seems to have levelled off, and there is even a slight decline among those under 20 of age. However, in age group 20–29 drug experimentation has continued to increase. Drugs seem to be a very prominent part of the party culture and nightlife among young people. The use of cannabis is clearly more common among students and among unmarried or cohabiting persons. Regionally, cannabis use is concentrated in the Helsinki metropolitan area and cities in southern Finland.

Figure 41. Proportion of those who have tried cannabis at some point during life in different age groups in 1992, 1996, 1998 and 2002, %



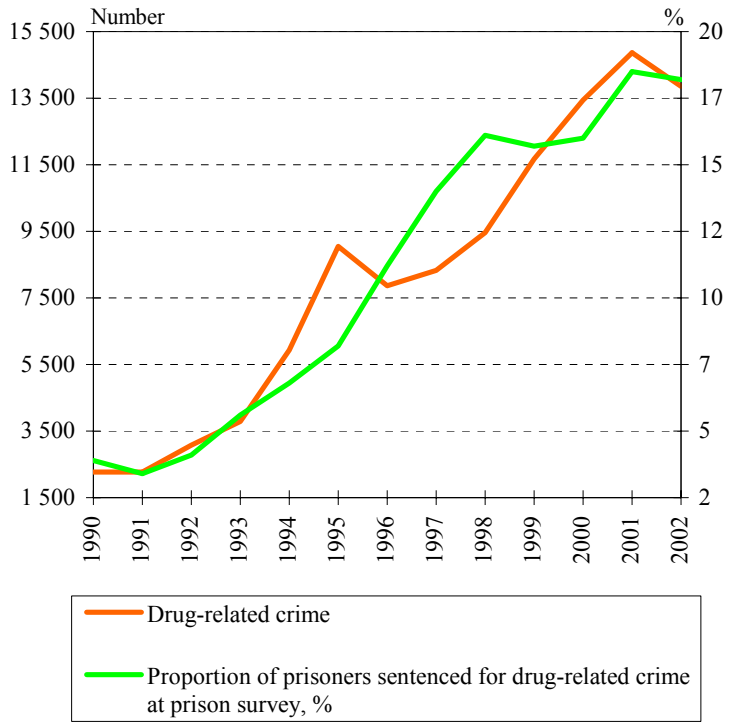
Source: Stakes

Figure 42. Periods of care due to drug-related illness at hospital and drug-related deaths in 1993–2002



Source: Stakes

Figure 43. Drug-related crime and proportion of those sentenced for drug-related offences among all prisoners in 1990-2002



Source: Stakes

The first indication of the levelling off of the rising trend in the harmful effects of drugs was seen in the number of drug-related deaths and new HIV and Hepatitis C infections in 2001. Even though it does seem that the rising trend in drug experimentation is levelling off, the negative effects continue to show an upward trend. The negative effects of problem use are seen in seeking for treatment with a delay of 3 to 5 years after first drug experiments and onset of substance use. The average age of seeking treatment is 20 years. About one fifth of those seeking treatment are women. The rise of drug-related crime also seems to have levelled off, or even declined somewhat. Nearly one in six prisoners was sentenced for a drug-related offence.

The expansion of the EU may at least initially make drugs more available. The impact of the anticipated rise in alcohol consumption may also entail an increase in drug use. In addition, the increasing use of mood medication may also encourage drug abuse.

The cost of the negative effects of drug use is high, about € 450–850 million a year. About one fourth of the sum consists of direct costs to health care, social welfare and the police. A significant proportion consists of indirect costs due to value of loss of life and premature death.

Drugs, long-term employment and exclusion are closely intertwined. The risk of exclusion from education, work and housing is clearly increased by drug use. On the other hand, long-term unemployment and exclusion easily make up a fertile ground for drug use. Mixed substance use is typical of Finnish substance users, but the attitude of the majority of Finns towards drug use is still negative.

Anti-drug work aimed at reducing drug demand involves comprehensive local, regional, national and international cooperation between various administrative sectors, authorities, organisations, citizens and the private sector. The key target of development in anti-drug work is increasing the amount of training aimed at different authorities and those involved in anti-drug work. People working in basic services should recognise problem users of drugs and guide them to appropriate treatment. It is also important to improve skills to be able to communicate with substance users and to develop early intervention models. Developing multidisciplinary preventive drug work in schools is particularly important. An extensive continuing education programme on drugs aimed at teachers was launched in 2001. In 2001–2003, a comprehensive nationwide media campaign on drugs was implemented.

The amount of drug-related health information has been increased. The emphasis of preventive work has been on the young, because the prognosis for later life is poor if young people experiment with drugs at an early age and get caught. A new subject, "health education" will be introduced in comprehensive, upper secondary and vocational schools. Issues related to drug prevention are a key area of health education. When a person under 18 is caught for the first time for using drugs, efficient intervention involving cooperation between different authorities is called for.

Services aimed at drug users have been developed on a so-called "low threshold" basis. The goal is to get those with problems to treatment as early as possible. High-quality services of different kinds must be available for those with drug problems, and they must be developed further in accordance with the quality recommendation for substance abuse problems published in autumn 2002. In order to integrate drug-addicts sentenced for drug-related offences back into society, drug treatment must be provided as part of or alternative to the penalty.

For the police and customs, the key goal is to prevent the entry of drugs into Finland. The police have also intensified their street-level activities aimed at preventing the availability of drugs. The development of the drug situation in neighbouring areas has a significant impact on the drug situation in Finland. The expansion of the EU is not only a threat – it also provides a possibility to broaden cooperation between the police, customs and Frontier Guards in Finland and the Baltic States against organised crime.

More funds than before have been directed to treatment of drug users. In 2002–2003, the central government allocated extra grants to different ministries for anti-drug work and prevention of drug-related crime and preventive drug work. In 2003, these extra grants totalled € 13.5 million. In addition, funds have been allocated yearly by the Ministry of Social Affairs and Health and RAY for health promotion and work aimed at preventing and mending drug-related problems.

III Making work more attractive

Impact goals of making work more attractive

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

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

According to estimates, municipalities will need at least 150,000 new employees by the year 2010 as a result of retirement to pension. A considerable proportion of the new employees should be in the social and health care sector. In addition to replacing staff who go into retirement, over 10,000 new employees are needed in the social and health care sector to care for ageing Finns. Correspondingly, half of all government employees, or 60,000 persons, will go into retirement during the next ten years. Besides growing pension costs, these changes will bring about a stiff competition for qualified labour. The employment needs of the private sector must not be superseded by those of the public sector as the population ages.

The Ministry of Social Affairs and Health contributes to a positive employment trend by promoting the work ability, functional capacity and professional competence of the labour force as well as occupational safety and well-being at work. In order to make work more attractive, a national action programme on extending working life, well-being at work and rehabilitation (Veto Programme 2003–2007) has been drawn up in cooperation with various ministries, labour market and entrepreneurs' organisations and research institutions.

The Veto Programme is supported by many other programmes. The aim of the four-year KESTO Programme launched by the Finnish Institute of Occupational Health is to apply research data so as to promote well-being at work and the extension of working career. One of the key aims of the Kaiku programme of the State Treasury and the Kuntatyö 2010 Project in the municipal sector is to promote job satisfaction among public-sector employees. The working life development programme (Tykes) of the Ministry of Labour supports development projects in the workplace aimed at promoting both the results of

work and the quality of working life. In cooperation with labour market organisations and the Ministry of Labour, the Ministry of Education has launched a programme (Noste) aimed at raising the education level of adults to be implemented in 2003–2007. The aim of the Noste Programme is to raise especially the level of education of adults with the least education.

3.1 Multidimensional change of working life

In little more than ten years, working life has changed in many ways. Entrepreneurship is increasingly characterised by networking, sub-contracting and externalisation. The demands of increased profitability and productivity have gained more and more emphasis as competition has become tougher. Companies are continually reforming their operations. Free movement of international capital has strengthened the globalisation process. The search for return on capital is conducted on a global scale. Functional income distribution changed clearly in the 1990s in favour of capital income.

From the viewpoint of employees, all this involves more insecurity than before. Employees must be prepared to adapt to change of job or profession when needed. Working time should adapt to changes in demand, and labour should be regionally mobile.

Finland managed to overcome the economic recession of the early 1990s thanks to moderate comprehensive income policy agreements. Labour costs did not exceed productivity growth until the beginning of the 2000s. In Finland, only the employment rate of persons with basic-level education is low, whereas that of persons with tertiary-level education exceeds the average OECD level. The education level of working-age population is rising steadily; the question of how to increase labour demand in areas of lower productivity as well is a key challenge for the 21st century.

Finland has traditionally been a country of capital-intensive production and a high investment rate. The GDP ratio of investments has varied between 25 and 30 percent. Now the GDP share of fixed investments seems to have stabilised on a clearly lower level than in the past decades. Finnish companies have more jobs than ever during their history, but an increasing number of them are abroad. Finnish companies are estimated to have more than 330,000 jobs in other countries, while the number of jobs Finnish companies have in Finland is lower than prior to the recession of the early 1990s. The reduction in investments by Finnish companies has not been replaced by direct foreign investments in Finland, which partly explains the persistently high rate of unemployment.

Figure 44. Trends in productivity of work, labour costs and employment in 1990–2005, 1990=100

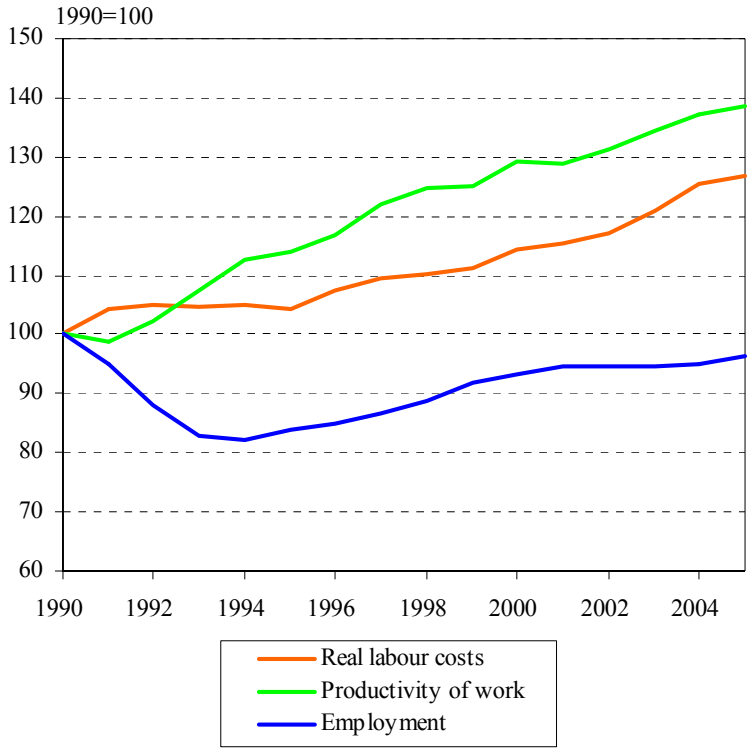
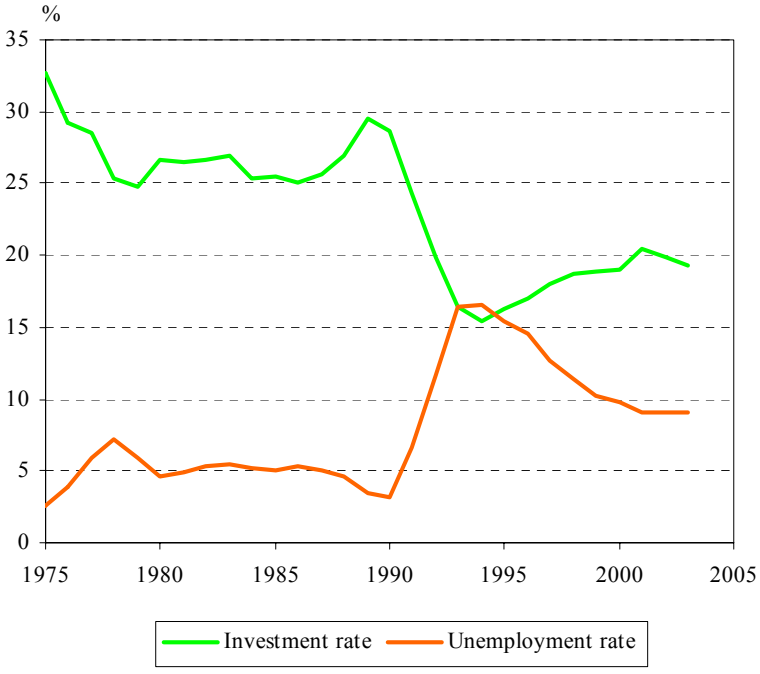


Figure 45. Investment rate and unemployment rate in 1975–2003, %

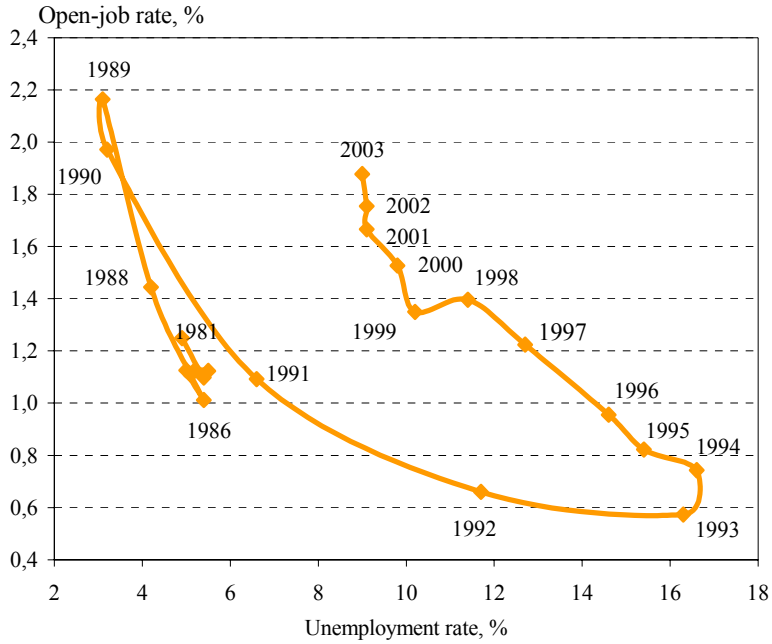


The supply of labour has exceeded the pre-recession level, but a similar increase has not been seen in labour demand. According to the definition used by Statistics Finland, the number of unemployed was 237,000 in 2002. When taking into account unemployment pension recipients and those taking part in employment policy measures, the labour reserve totalled 423,000 persons.

The development in recent years indicates that employment has become selective: some unemployed persons are able to find a job more easily than before, but the average duration of unemployment is longer. At the end of the 1980s, unemployment still resulted relatively often in employment; more than 40 percent of unemployed found a job in the open labour market within a year. When the recession was at its deepest, only 20 percent of unemployed were able to find employment within a year. The situation has not improved much after the recession.

It has been typical for the development of the Finnish labour market that growth industries and decreasing industries have been very different as to their occupational structure and skill demands. Labour has been recruited to the new fields among new age groups or among those already at work, but there has been very little recruitment among the unemployed. This partly explains the fact that open jobs and the unemployed do not match. The structural problems of the labour market can be illustrated by comparing the open-job rate and the unemployment rate. A higher than before unemployment rate corresponds to a given rate of open jobs. Structural problems have thus increased (Figure 46).

Figure 46. Open jobs and employment in 1986–2003



Open-job rate: The ratio of open jobs to sum of open jobs and number of employed.

The new cohorts entering the labour market have been better educated than their predecessors in Finland. The new growth fields have recruited labour from their ranks. As the cohorts become smaller, this old recruitment model cannot be applied on the same scale as before. Unless competent labour can be recruited among older age groups as well, there is a danger that jobs in high-productivity fields will be transferred elsewhere. Jobs in low-productivity fields will also move elsewhere if the cost level is too high. The "disappearance" of low-productivity jobs may as such be a positive phenomenon, if they are replaced by better jobs. However, a sufficient supply of well-educated labour is a prerequisite for the creation of such jobs.

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

3.2 Progress towards high employment

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

Extension of working careers

The employment rate of ageing (55-64 v.) employees rose in 1997–2003 by almost 14 percentage points, while the average employment rate grew by only about 4 percentage points during that same period. Employment among ageing workers has increased in Finland at a faster rate than in any other European country. Measured by "expected years of future employment", the indicator used in monitoring the employment programme, a 50-year-old had 7.2 years of employment left in 1997. In 2003, the expected years of future employment had risen to 8.7. However, the rise in the expected years of future employment seems to have slowed down somewhat in the last couple of years.

Table 5. Employed persons and employment rate by age group in 1997 and 2003

Age	1997		2003		Change 1997-2003	
	Em-ployed	Em-ployment rate, %	Em-ployed	Em-ployment rate, %	Em-ployment	Em-ployment rate, percentage points
15-24	212 800	33.3	250 200	38.5	37 400	5.2
25-54	1 753 800	77.5	1 774 300	81.1	20 500	3.6
55-64	187 600	35.8	320 500	49.6	132 900	13.8
15-64	2 154 200	62.9	2 345 000	67.3	190 800	4.4

Source: Statistics Finland

Despite the economic recession, members of the baby boom generation have remained at work and kept their jobs better than previous cohorts at the same age. The employment rates among ageing workers have continued to rise, unlike those among younger age groups. In the first quarter of 2004, the employment rate of those aged 55–64 was about 2 percentage points higher than the year before. There is a shift towards late exit from working life, in accordance with the goals set in the government programme.

The factors contributing to this positive development trend include restrictions in the use of early retirement and part-time work among ageing workers, which is increasingly more common thanks to the part-time pension system. The latter has helped ageing workers to cope at work. In the future, exit from working life will be postponed by changes in unemployment and pension security, decisions on which were made by the previous government. The impact of these reforms on work careers will begin to be felt in a few years' time.

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

Ensuring the availability of labour

Problems of labour availability increased during the economic boom of the 1990s. A little over one in four establishments reported having experienced recruitment problems. The situation seems to have stabilised on this level. During the first quarter of 2004, the share of establishments having recruitment problems fell to 23 percent, and that of establishments having experienced actual shortage of labour fell to 8 percent. The change is a result of a weaker demand of labour.

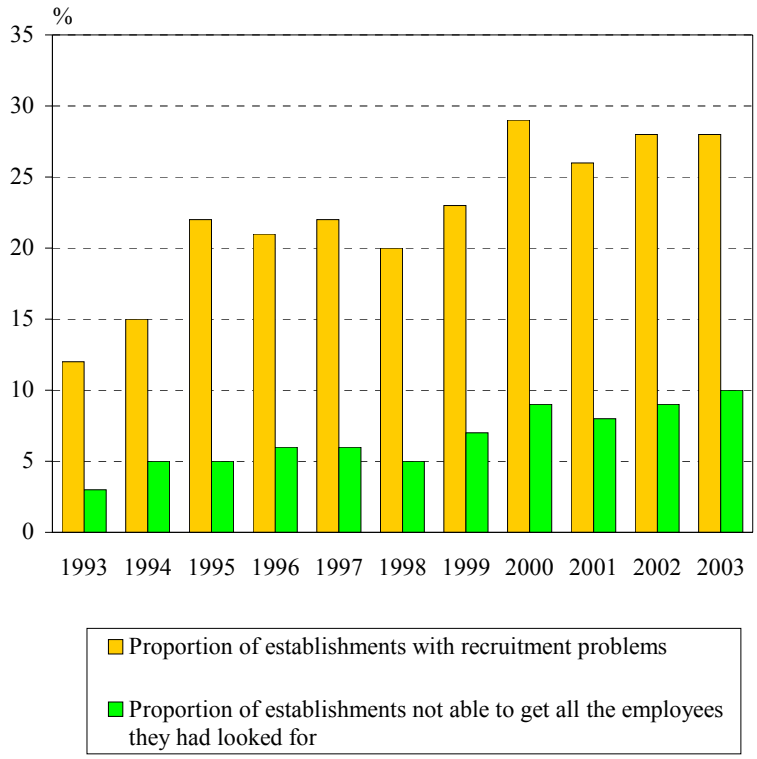
Problems of labour availability are still regarded as being relatively moderate. They may however increase in the coming few years as a result of a changing population age-structure and accelerating economic growth. Expectations of problems in the availability of labour may weaken businesses' willingness to invest in Finland. Demands to ensure the availability of competent labour are quickly strengthened once the employment situation has improved.

Attempts will be made to improve the efficiency of the labour market with the aid of the employment service reform and by the development of education policy programmes. A potential labour shortage may also be eased by keeping the labour force fit for the market during recessions.

The reduction of structural unemployment is essential in order to raise the employment rate. Structural unemployment did decline rapidly in 1997–2001, but after 2001, the number of poorly employable[11] persons has remained constantly above 170,000. This development is partly explained by the weakened impact of labour policy measures. As the demand for labour in the general labour market has declined, most of those who have completed participation in employment policy measures have either gone back to being

unemployed or are taking part in a new measure. In 2003, 52 percent of those who had completed participation in employment policy measures and 44 percent of those who had completed labour training were unemployed again after three months.

Figure 47. Proportion of establishments experiencing recruitment problems or shortage of labour in 1993–2003



Source: Ministry of Labour, Recruitment of Labour at Establishments 2003

Prevention of structural unemployment

The most problematic subgroup of structural unemployment consists of the uninterruptedly long-term unemployed. In practice, only a small minority of them are able to find employment in the open labour market without special measures. There also seems to be an upward trend in long-term unemployment: the number of new long-term unemployed grows by about 5,000 every month, while the number of those leaving this group is on the decline.

Table 6. Structural unemployment in January–December 1997, 2002 and 2003

	2003	2002	1997	2003-1997	
				change	change %
a Long-term unemployment	72400	77700	124600	-52200	-41.9
b Repeated unemployment	42700	43700	63200	-20500	-32.4
c Unemployed after measures	40400	36700	58200	-17800	-30.6
d Repeated participation in measures	18600	15600	22600	-400	-17.7
Limited structural unemployment (a+b)	115100	121400	187700	-72600	-38.7
Structural unemployment (a+b+c)	155500	158100	245900	-90400	-36.8
Extensive structural unemployment	174100	173700	268500	-94400	-35.2
(a+b+c+d)	288800	294000	409000	-120200	-29.4
Unemployed job-seekers, total	86800	79300	123400	-36600	-29.7
Measures, total	375600	3733300	532400	-156800	-29.5
Extensive unemployment, total					

Source: Ministry of Labour

About 60 percent of the long-term unemployed are over 50 years of age. Among young people, unemployment extends into long-term unemployment only rarely, even though unemployment is otherwise common among the young. More than 120,000 young people are without a job every year, i.e. nearly one in five use the services of job centres as job seekers at least once a year. Repeated unemployment is also common among young people, the number of unemployment periods among the young exceeding 200,000 per annum. There were about 1,100 young people registered as job seekers who had been unemployed for more than a year, and the number of those unemployed for more than six months was 5,000.

The aim of the government programme is to provide all young people education, practical training or a workshop position after three months' unemployment, and we are getting close to reaching this goal. Various "social guarantee for young people" measures are targeted broadly at young unemployed persons during the first stages of unemployment. In 2003, about 78 percent of young people's unemployment periods ceased within three months, and 93 percent within six months. However, about 16,000 young people exceed the limit of six months' unemployment each year, which is about 2.5 percent of all young people.

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

3.3 Working conditions and working capacity

Taking care of occupational health and safety is part of good working life. Good working capacity and high productivity are largely based on these basic matters. The quality of working life is a multidimensional phenomenon involving a lot of interaction with the world outside the sphere of work.

The barometer on working conditions drawn up each year aims also at monitoring qualitative changes in working life. Since 1999, the working capacity of employees has been measured in the working condition barometer with the aid of an index consisting of several data. According to the 2002 working condition barometer (October 2002), average working capacity had improved somewhat compared to previous years. Working capacity varies in different sectors. The best working capacity in relation to demands of work is seen among private sector and government employees, while that of industrial workers is clearly lower than in the service sector. Municipal and joint municipal authority employees have the lowest working capacity. Average working capacity decreases and differences between employees increase with advancing age. Differences in working capacity between genders are very small.

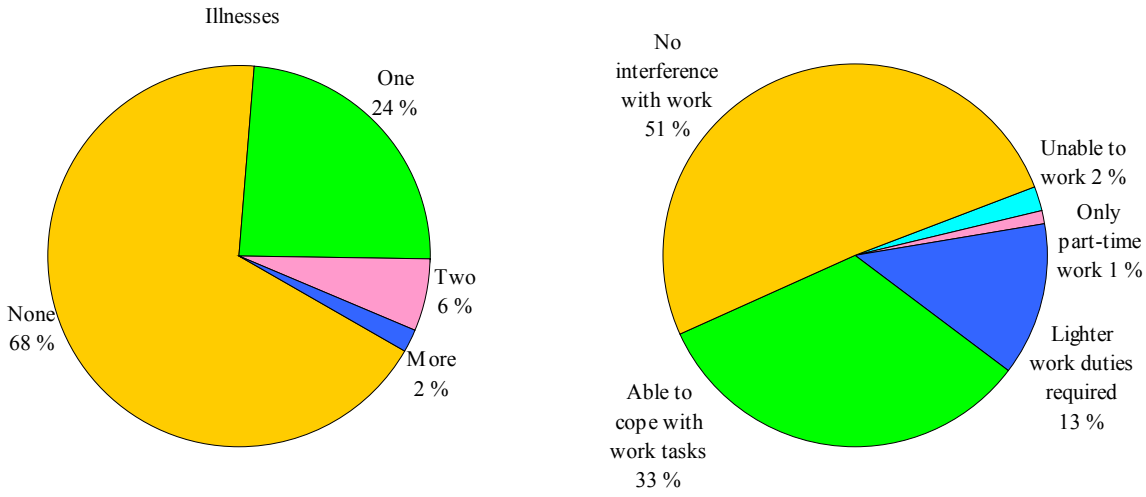
Working conditions have developed in a positive direction in recent years. According to the 2003 working condition barometer, the state of working life was satisfactory, measured by different indicators.

According to the Work and Health interview survey conducted by the Finnish Institute of Occupational Health, 82 percent of wage earners are either very or fairly satisfied with their jobs, even though employees experienced a hectic work pace and mentally taxing work relatively commonly as stressors. There seems to be have been a slight decline between 1997 and 2003 in experienced work pace and stress.

Long-term illness and coping with work tasks

Two thirds of wage earners have no chronic doctor-diagnosed illness or disability, while one third have one or several. Half of those with a long-term illness or disability did not think that it interfered with their work tasks. One third estimated that they were able to carry out their work tasks, and one in ten thought that their tasks should be made lighter. There was very little change from 2002 to 2003.

Figure 48. Long-term illnesses and their interference with work in 2003

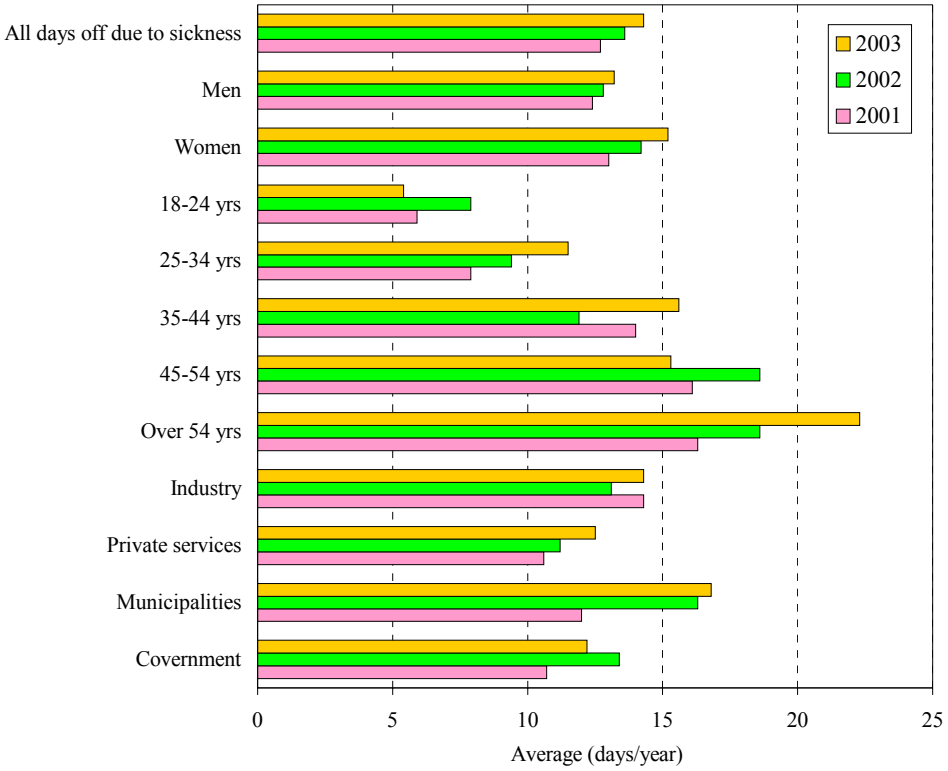


Source: Ministry of Labour, Working condition barometer 2003

Sickness absenteeism

The duration of sick leave due to own sickness lengthened in 2001–2003. In 2001, those with at least one day off due to sickness had on average 12.7 days off per year, while the corresponding figure in 2003 was 14.3. The trend was similar among both men and women. Women had slightly more days off due to sickness than men. A significant proportion of wage earners have no sickness absenteeism at all: according to the 2003 working condition barometer, about 40 percent did not miss a single day of work during the year due to sickness. The number of sickness days also varies according to sector, with the highest number in the municipal sector and the lowest among government employees.

Figure 49. Days off from work due to own sickness in 2001–2003
Only persons with sickness days included.



Ministry of Labour, Working condition barometer, 2003

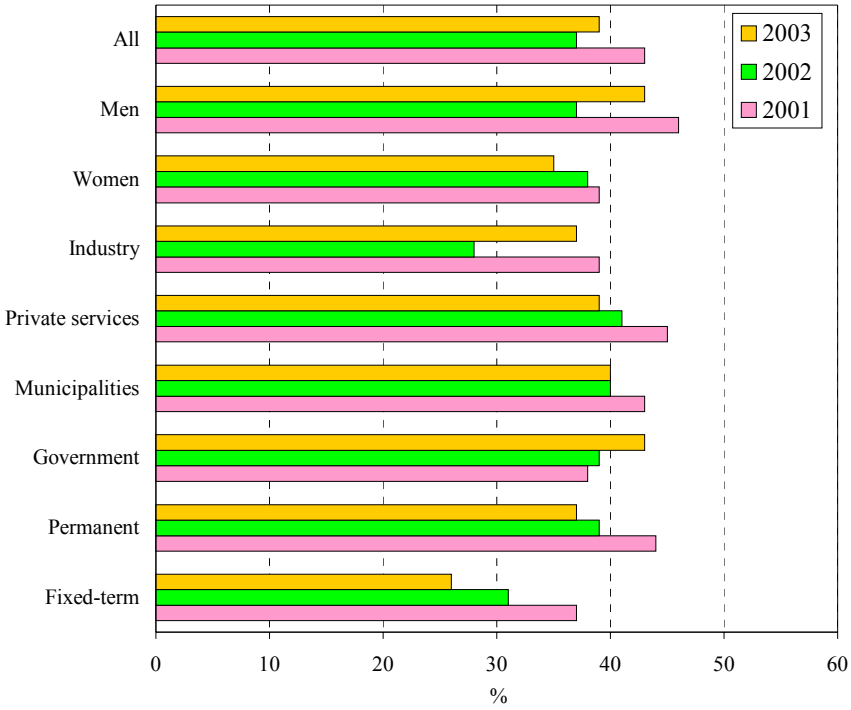
Possibilities to influence work

According to surveys, well-being at work is greatly influenced by how much employees can influence their working conditions. Good possibilities to influence improve the ability to cope with work-related stress. A good working atmosphere and management who understand its significance contribute to good everyday working conditions, and in the long term they create a positive workplace culture. This also creates a setting where

employees are well-motivated to take care of their own working capacity and to develop their competence.

On the basis of results from three years' working condition barometers, employees' possibilities to influence their own work tasks seems to have weakened. Men seem to have more possibilities to influence their work than women. Impact possibilities in permanent jobs are seen as being greater compared to fixed-term jobs. In both cases, development seems to have been negative.

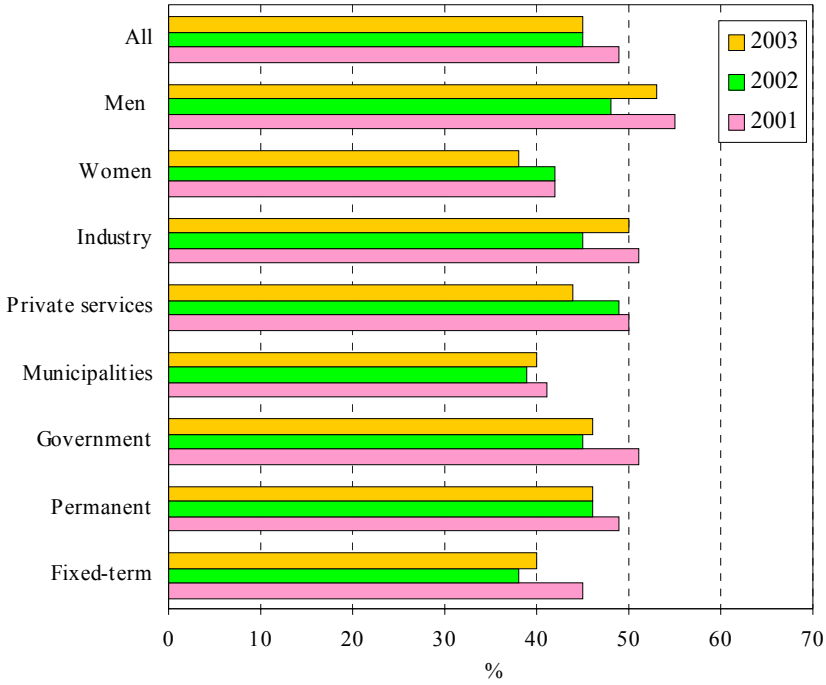
Figure 50. Possibility to influence work tasks in 2001–2003



Proportion of those able to influence their work tasks "a lot" or "to a fairly high degree"
Source: Ministry of Labour, working condition barometer 2003

Half of wage earners assessed themselves as being able to influence their work pace at least to a fairly high degree. It does however seem that possibilities to control work pace have decreased somewhat. The overall picture is not uniform, as it seems that after a slight drop, possibilities among men have improved, while those among women have deteriorated. When looking at different sectors, the situation seems to be most problematic in the municipal sector. Permanent employees have slightly better possibilities to influence their work pace than fixed-term employees.

Figure 51. Possibility to influence pace of work in 2001–2003



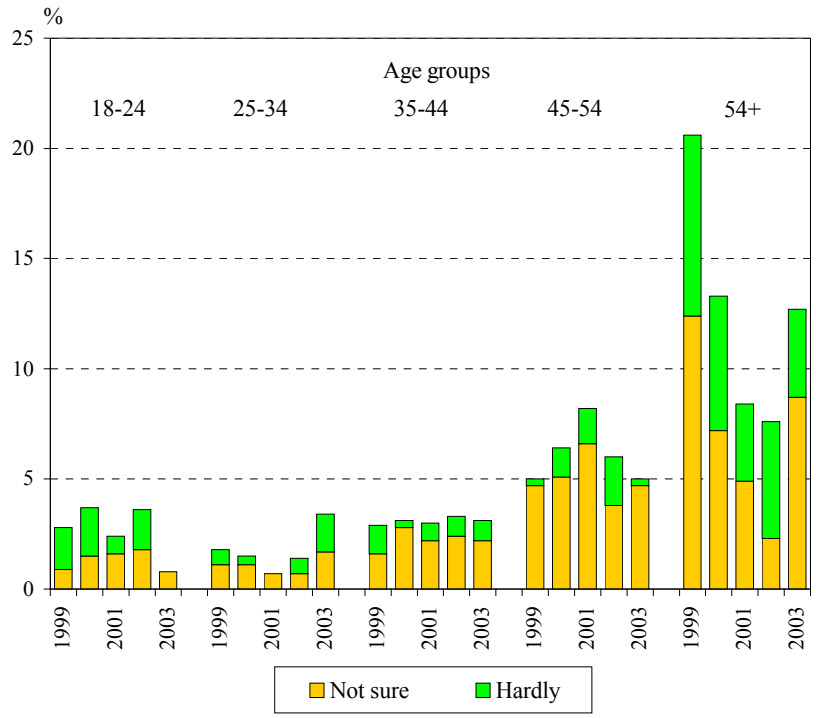
Proportion of those able to influence their work pace ”a lot” or ”to a fairly high degree”
Source: Ministry of Labour, working condition barometer 2003

Coping at work

Only four percent of wage earners doubt their ability to continue in their present profession two years from now on health grounds. As expected, uncertainty is most prevalent among the oldest age groups; however, confidence in the ability to cope at work has increased rapidly in recent years among ageing employees.

The figures indicate that there is potential for development: if the role of health aspects on coping at work is no bigger than this, it is possible to influence coping at work by developing the contents of work, management and incentives.

Figure 52. Do not believe themselves to be able to continue in their present profession two years from now



Source: Ministry of Labour, working condition barometer 2003

[1] Uninterruptedly long-term unemployed, repeatedly unemployed, unemployed after participating in measures and repeated participation in measures

IV Prevention and combating of social exclusion

Impact goals of prevention and combating of social exclusion

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

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

4.1 On the nature and the complexity of multiple problems

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

The onset of a deepening social exclusion process is often associated with either long-term unemployment, or particularly in the case of young people, with difficulty to gain entry to the normal labour market. There may be various health problems or social problems in the background. Poor ties to the labour market lead to economic problems and lack of work-related social networks. Unstable jobs and long-term unemployment have repercussions in the form of scarcity of supportive human relationship networks. Social networks based on solidarity are particularly important in job seeking. The risk of social exclusion is often exacerbated by mental health problems or substance abuse that stigmatise the individual. Cultural factors have a significant impact on what is considered to constitute a shameful failure on the part of the individual. Economic problems may also give rise to a feeling of social inferiority, leading to seclusion and alienation from normal

everyday life. In the end, the accumulating problems result in deepening social exclusion, where several negative factors are reinforced by each other, leading to an increasingly unfortunate situation.

The link between exclusion-related factors varies between different groups of people. For example, long-term unemployment has been observed to have a greater role in aggravating exclusion and cutting people off from social networks among men compared to women. The risks of social exclusion change over time. Those with learning difficulties have at present greater problems than before to find employment in the normal labour market, which may increase the risk of exclusion within this group. The increasing demands of working life raise the risk of exclusion among persons suffering from mental health problems or substance abuse. The tendency towards a reduction in the time spent with family may be reflected as disturbed behaviour and risk of exclusion among children and young people.

The Finnish standpoint towards the prevention of poverty and social exclusion is based on the operating principles of the Nordic welfare model, which include universal services and social protection. The starting point of prevention of social exclusion is strengthening of the structures of the welfare state and development of operating practices that span several sectors. Aspects that are important in the prevention of social exclusion include guaranteeing reasonable income security and well-functioning services as well as the promotion of health, which are discussed elsewhere in this report. Breaking the vicious cycle of social exclusion takes time, and the total situation of the individual in question must be taken into account. The harder the problem, the greater the cost to society of combating it. In the case of severely excluded persons, health and social problems form a tangled web, and it takes highly competent professionals from a variety of fields to solve them. That is why early prevention of social exclusion is the best and the cheapest solution from the viewpoint of both society and the individual.

4.2 Indicators describing social exclusion and its development

It is hard to form an overall picture of development among those suffering from social exclusion, because several risk factors are combined and individual data on risk accumulation is not available. Development trends in individual factors contributing to the risk of exclusion must therefore be looked at separately. This way it is possible to obtain a picture of the development of different risk factors, which may together lead into severe social exclusion. It may be assumed that certain groups of people automatically consist of large numbers of those who are in some way socially excluded. Prisoners and the homeless are examples of such groups.

When looking at the relative share of people on low income, there has been little change in recent years (for more detail, see Chapter 5), whereas long-term poverty, which has greater significance for exclusion, has increased among the population. An increasing number of people are on low income for several years. The fact that among all households receiving social assistance, a growing proportion of households is receiving uninterrupted social assistance for almost a year is also an indication of the long-term nature of economic problems.

Figure 53. Extended poverty in 1998–1999 and 2000–2002 (proportion of those below the 60% poverty line for several consecutive years)

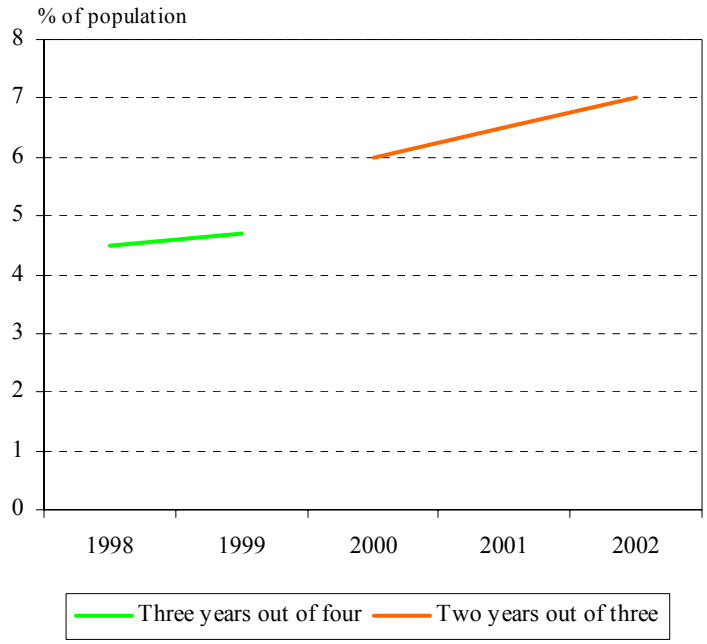
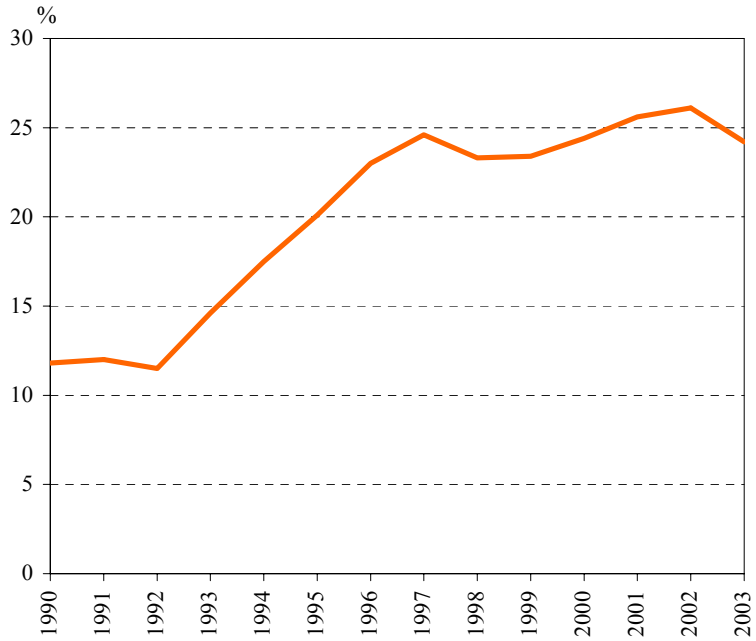


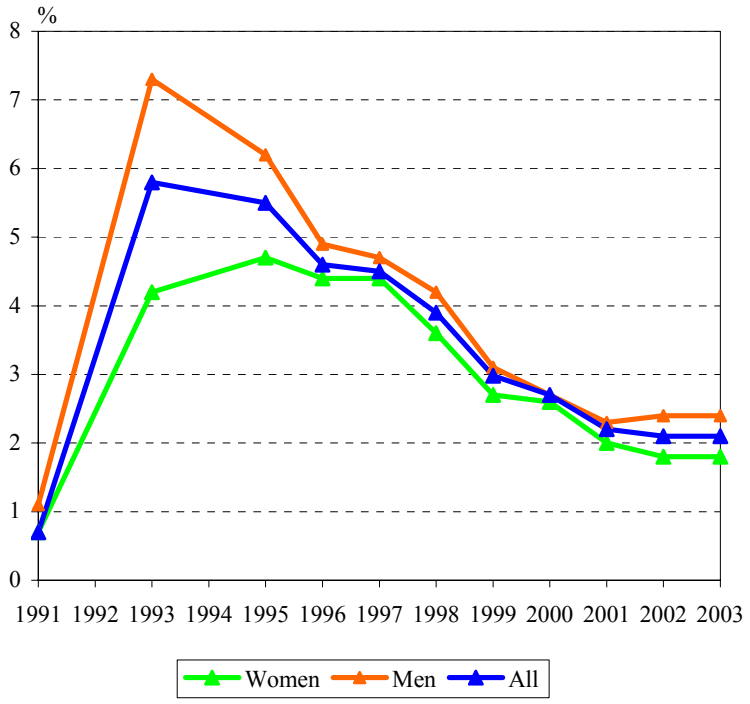
Figure 54. Proportion of households receiving social assistance for 10–12 months among all households receiving social assistance in 1990–2003



The proportion of long-term unemployed, which has a key impact on risk of social exclusion, declined significantly in the late 1990s, but the positive development trend seems to have stopped at the level of about two percentage points of the labour force after the turn of the millennium (Figure 55). The proportion of households of working age with

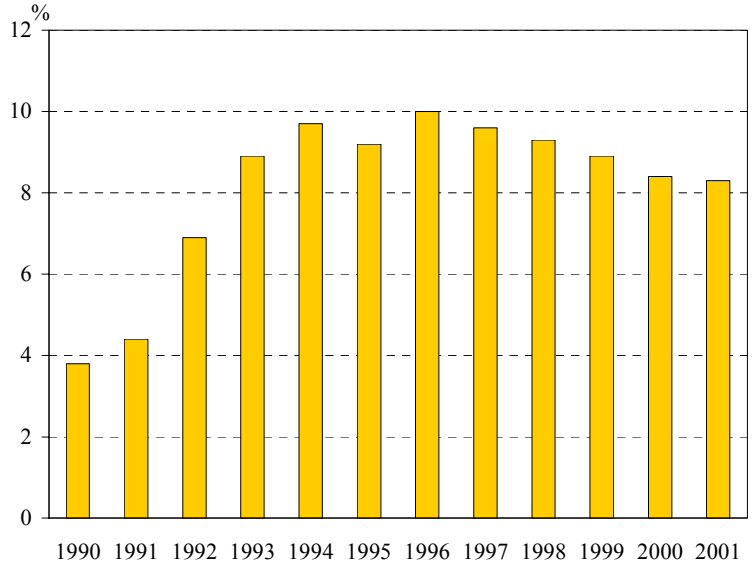
no employed persons has diminished somewhat, but it remains clearly higher than in the early 1990s (Figure 56).

Figure 55. Long-term unemployment in 1991–2003



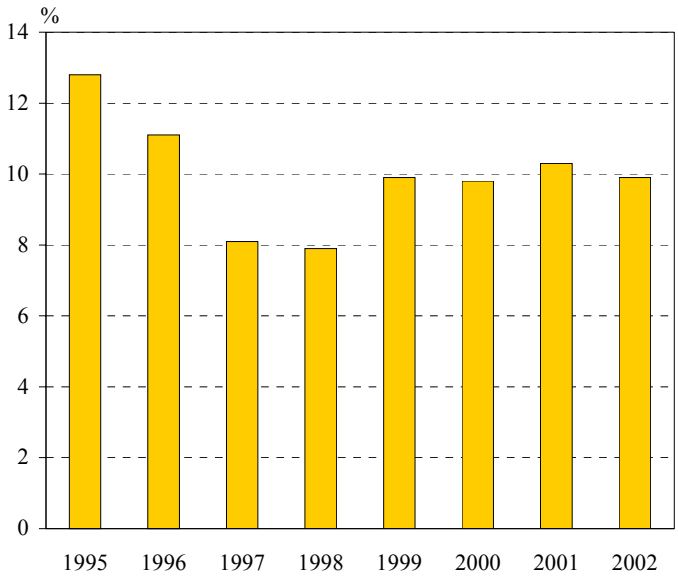
Proportion of those unemployed for over 12 months among labour force

Figure 56. Proportion of working-age households with no employed persons in 1990–2001



Definition: at least one working-age person (aged 18–59) in the household, but none employed during the year

Figure 57. Young people with low education*) as a proportion of age group 18–24 in 1995–2002



*) People aged 18–24 not taking part in any education and with only basic-level education

The number of prisoners in Finland has taken an upward turn again. The number of foreign prisoners in Finnish prisoners has increased as well. The majority of prisoners are men.

Figure 58. Average number of prisoners per year in 1990–2003

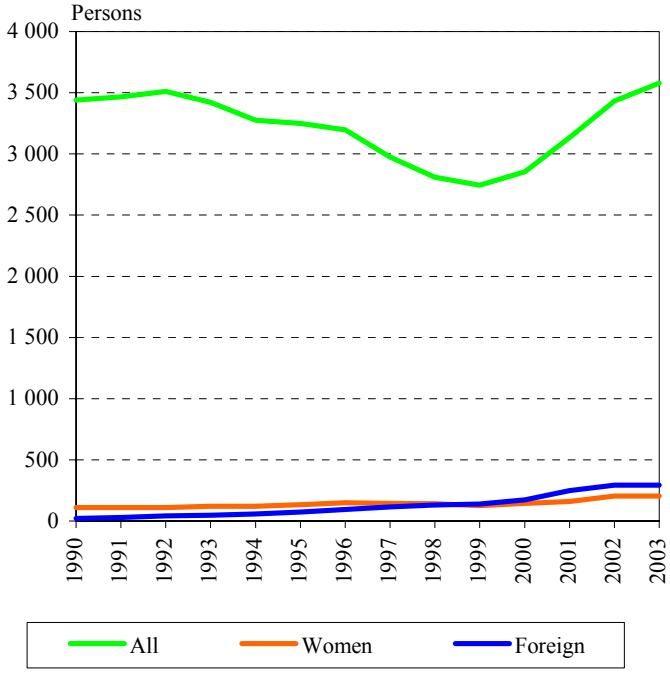
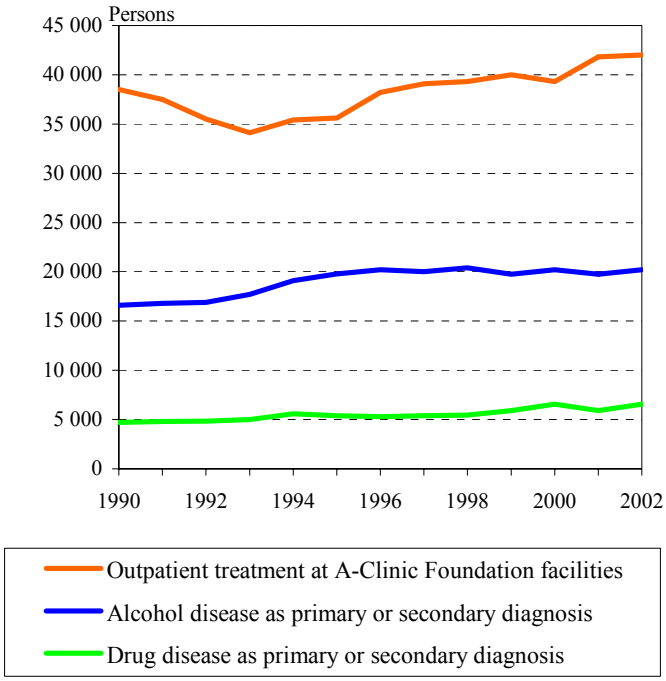
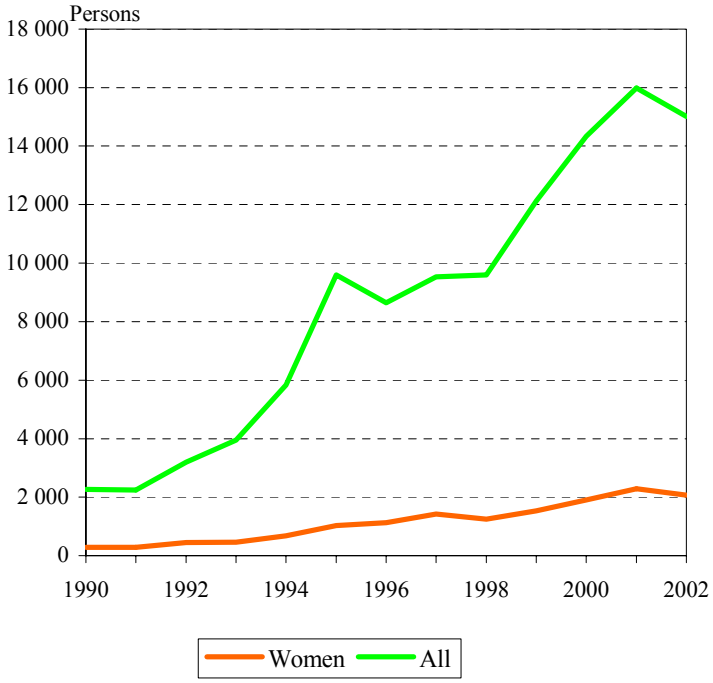


Figure 59. Persons treated in hospital for alcohol and drug diseases and persons in outpatient treatment in1990–2002



The increase in drug and alcohol use is reflected in both the number of patients treated (Figure 59) and the rise in the number of suspected drug crimes (Figure 60).

Figure 60. Trends in the number of persons suspected for drug related crimes in 1990–2002



Attempts to reduce the number of homeless have been successful. The majority of homeless are still single men.

Figure 61. Trends in the number of homeless in 1990 – 2003

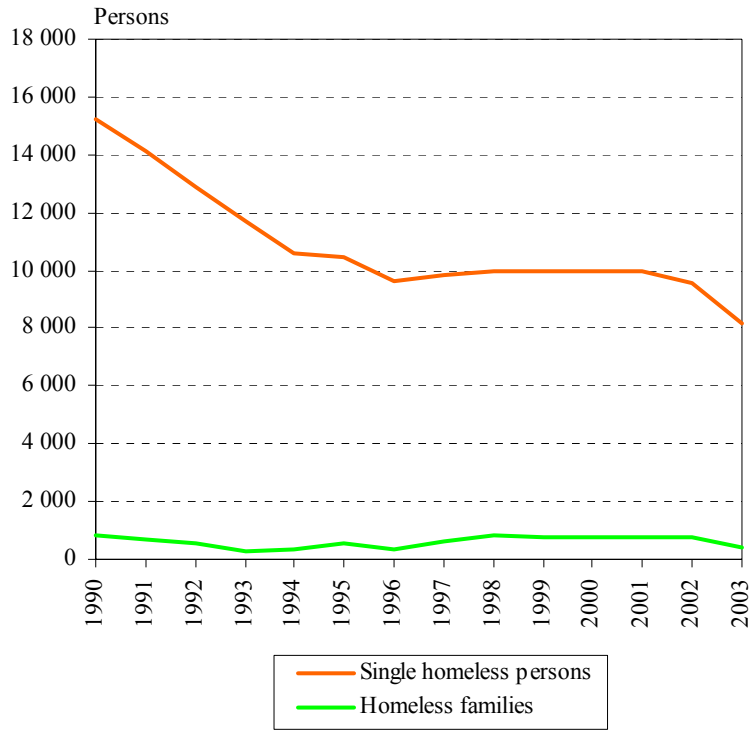


Figure 62. Children and young people placed in care outside the home 1991 –2003

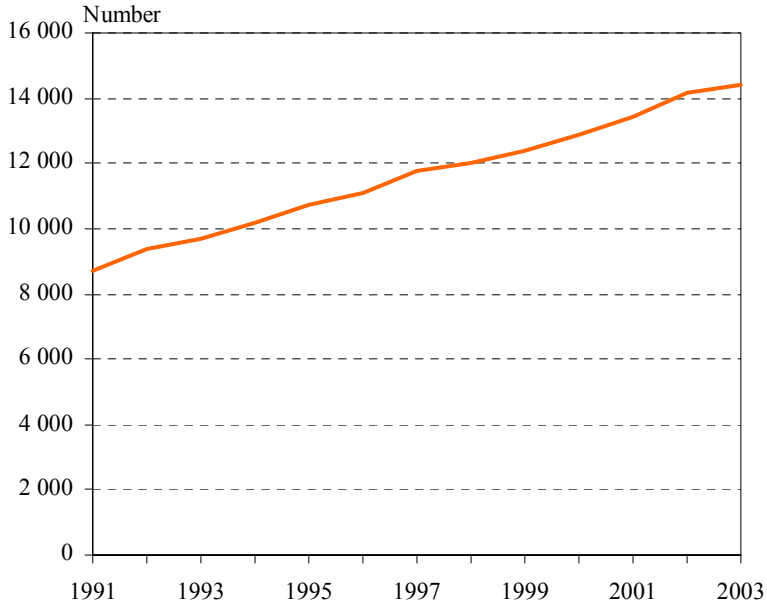
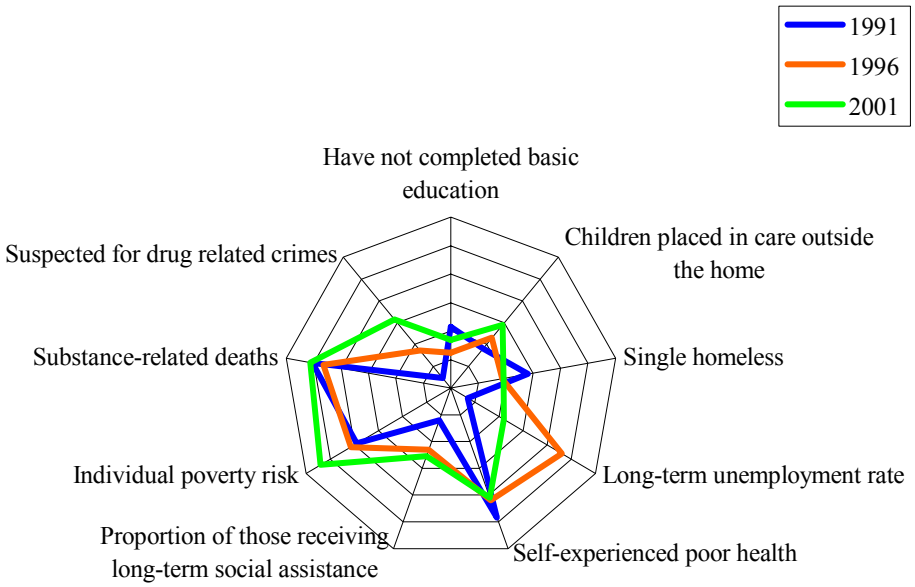


Figure 63. Development of social exclusion risk factors in Finland[12]



There have been no major changes in the various risk dimensions of social exclusion in recent years. Economic problems and unemployment have eased since the recession years of the 1990s, but the good situation of the early 1990s has not been attained since. The fact that problems of today have a tendency to persist is a worrying sign, because it increases the risk of social exclusion significantly. Some positive development has been seen in the number of homeless and the ratio of long-term unemployed, both of which have been reduced. On the other hand, exacerbation of problems due to increasing substance abuse and an increase in the number of children placed in care outside the home give rise to alarm. Exclusion risks are more prevalent among men than women. Prevention and combating of social exclusion calls for determined and close cooperation between different administrative sectors, because the phenomenon is affected by development and work carried out in several sectors. However, the results can only be assessed after a considerable period of time.

The most important programmes aimed at reducing social exclusion launched by the government are the National Project to Secure the Future of Health Care and the National Development Project for Social Services. Measures and reforms implemented to ease entry into the labour market, programmes aimed at reducing homelessness and development of measures focused on student counselling and welfare are also important. Projects with significant impact on combating exclusion include early intervention in the problems of children and young people, supporting integration of immigrants as well as projects related to implementation of national alcohol and drug programmes and crime prevention. Close cooperation and coordination between different programmes and projects is called for in order to ensure positive results. Funds from structural funds of the European Union, such as the Equal Programme, have been allocated to the implementation of projects aimed at preventing social exclusion.

In Finland, municipalities have the greatest responsibility for prevention of social exclusion and the measures required to remedy the situation. Third-sector organisations and the church also have a significant role. Cooperation between all actors is emphasised in the joint work against poverty and exclusion within the European Union. Analysis of the complex mechanisms causing exclusion, making an impact on them and monitoring the situation have proved to be challenging tasks. Prevention of social exclusion does however play a crucial role in promoting social cohesion and order in society. Good practices are in general highly situation-dependent. Besides efficiency of service systems, the rate of social inclusion in a society is in the long term also affected by changes in economy and working life.

4.3 National Action Plan against Poverty and Social Exclusion for 2003 – 2005

By the summer of 2003, member states of the European Union drew up national action plans against poverty and social exclusion for the second time. The action plans are based on the objectives of combating poverty and social exclusion agreed jointly by the member states. The four main strategic lines of the joint objectives agreed in Nice are as follows:

- to facilitate participation in employment and access by all to resources, rights, goods and services
- to prevent the risks of exclusion
- to help the most vulnerable
- to mobilise all relevant bodies.

The strategies, objectives and measures presented in Finland's National Action Plan are based on the government programme, central government budgetary guidelines for 2004 - 2007, strategies for social protection until 2010 drawn up by the Ministry of Social Affairs and Health and the programmes of various actors. The measures included in the National Action Plan against Poverty and Social Exclusion are primarily implemented in connection with the government's other programmes, projects and legislative work.

In the Finnish Action Plan against Poverty and Social Exclusion, groups at particular risk for exclusion were identified. These groups include long-term or recurrently unemployed, disabled, children living in unstable circumstances, poorly employable immigrants, chronically ill, substance abusers, children who have been subjected to violence, prostitutes, overindebted, homeless, persons convicted of crimes and Roma. The more risk groups the individual belongs to, the greater the risk of exclusion. The goals and measures aimed at preventing social exclusion of persons in risk groups are presented in the action plan. Increasingly common mental health problems and uncontrolled substance abuse are more and more often seen as background factors that increase the risk of exclusion.

Individually tailored measures and a long-term approach are emphasised in combating social exclusion. The values prevailing in society are also reflected in the cultural meaning attributed to social exclusion. In combating social exclusion, there is a clash between two views, one emphasising the responsibility and freedom of the individual, and the other stressing joint responsibility and the need of the community to interfere. Even though social exclusion is a result of the joint effect of several factors, the view of society focuses particularly on labour market status and exclusion from working life. In social debate, the significance of social networks and the immediate community is easily overshadowed by performance in the labour market. In combating social exclusion, coping in working life must be promoted in a variety of ways, but the other dimensions of exclusion also deserve attention. The well-being of people who for one reason or another have been excluded from working life can be promoted by strengthening their social networks and by helping them get attached to normal routine. Social work and social rehabilitation focusing on improvement of individual welfare and life management skills have an increasingly important role in work aimed at making excluded persons become once more fully competent members of society. It should be noted that breaking the cycle of social exclusion often calls for strong external intervention when problems occur. As problems persist, the individual's own resources to remedy the situation are exhausted. An approach emphasising community care is in such cases not a valid solution for the treatment of individual exclusion problems.

V Well-functioning services and reasonable income security

Impact goals of well-functioning services and reasonable income security

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

5.1 Well-functioning services

5.1.1 Development goals for social and health care services

The aim of the government programme is in accordance with the population's needs to ensure equal availability, quality and sufficiency of municipal services with a reasonable tax and payment burden. Municipalities are responsible for providing public social and health care services, and their financing is primarily based on government grants and municipal tax revenue. Information technology, regional cooperation and efficient division of labour and treatment chain practices must be made use of in the provision and development of sufficient high-quality services. Ways of providing new services as well as technological and product development are assessed as having a significant impact on the development of social and health care. Sufficient staffing is influenced by increasing the appeal of these fields as a career alternative.

The government's social welfare and health care target and action programme for 2004–2007 includes objectives defining the government programme more closely as well as the actions, recommendations and instructions needed. The programme is targeted especially at municipalities, and it specifies goals for development projects, preventive social and health care and multidisciplinary development of services. The areas of emphasis of social and health care policy development have been defined in the National Project to Secure the Future of Health Care and the National Development Project for Social Services. Health care services are developed jointly by the central government and municipalities, taking into account the operation of organisations and the private sector. In the action and budget plan for 2005–2008 of the administrative sector of the Ministry of Social Affairs and Health the impact goals of well-functioning services have been listed as follows:

The National Project to Secure the Future of Health Care includes proposed actions aimed at developing the health care service system. The project includes a total of 40 sub-projects, which are divided into the following categories:

- Promotion of health and preventive health care
- Securing access to treatment
- Securing availability and competence of staff
- Reforming operations and structures
- Development of operating practices in health care
- Strengthening the financing basis of health care

The goal of the National Development Project for Social Services is:

- To develop elderly care, substance abuse and disabled services and child- and family-policy benefits and services as well as social work
- To secure availability of services, development of service quality and reforming of service structures
- To secure sufficient staffing and competence
- To secure sufficient financing

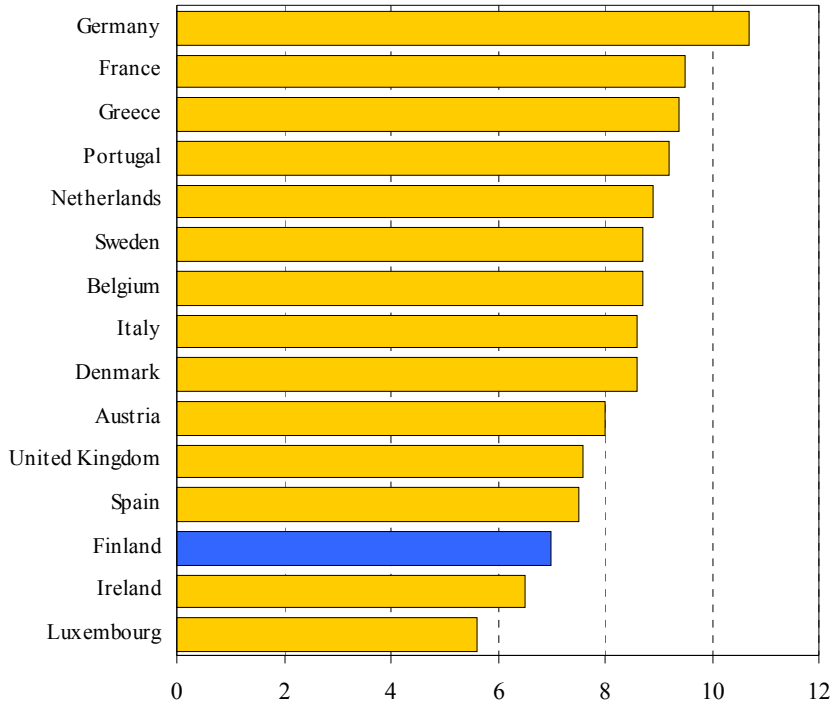
The financing balance of municipalities' tasks and obligations is improved by a basic service programme between the central government and municipalities, which is in force during the government period, and an annual basic service budget related to it. The aim of the basic service programme is to promote the availability, efficient provision and development of services and to study how sustainable and balanced financing of basic services can be secured. In addition, actions are assessed aimed at balancing the relationship between municipalities' obligations and financing, developing cooperation between ministries responsible for preparation of legislation concerning basic services and financing systems, and improving cooperation between the central government and municipalities. The main emphasis of the programme is on statutory services covered by the government grant system in the social and health care sector as well as in the education and cultural sector.

The most important impact goal and joint starting premise of social and health care services is to improve access to and quality of services. In the future, this calls most of all for securing sufficient staffing and sustainable financing of the services. These sub-goals are also included in the National Project to Secure the Future of Health Care and the National Development Project for Social Services. When looking at the development of health care and social service structure, it should be remembered that in addition to service systems, the various choices and actions of individuals, families and communities also have a significant impact on population health and well-being.

5.1.2 Development of health care expenditure

Total health care expenditure in relation to GDP came to 7.3 percent in 2002, which was 0.3 percentage points more than the previous year. The health care expenditure to GDP ratio started to rise in 2001 after a downward trend for several years. In addition to an increase in expenditure, this was caused by a clear slowdown in GDP growth. The health care expenditure to GDP ratio is clearly below the EU average. Health care expenditure per capita is also among the lowest of all EU member states.

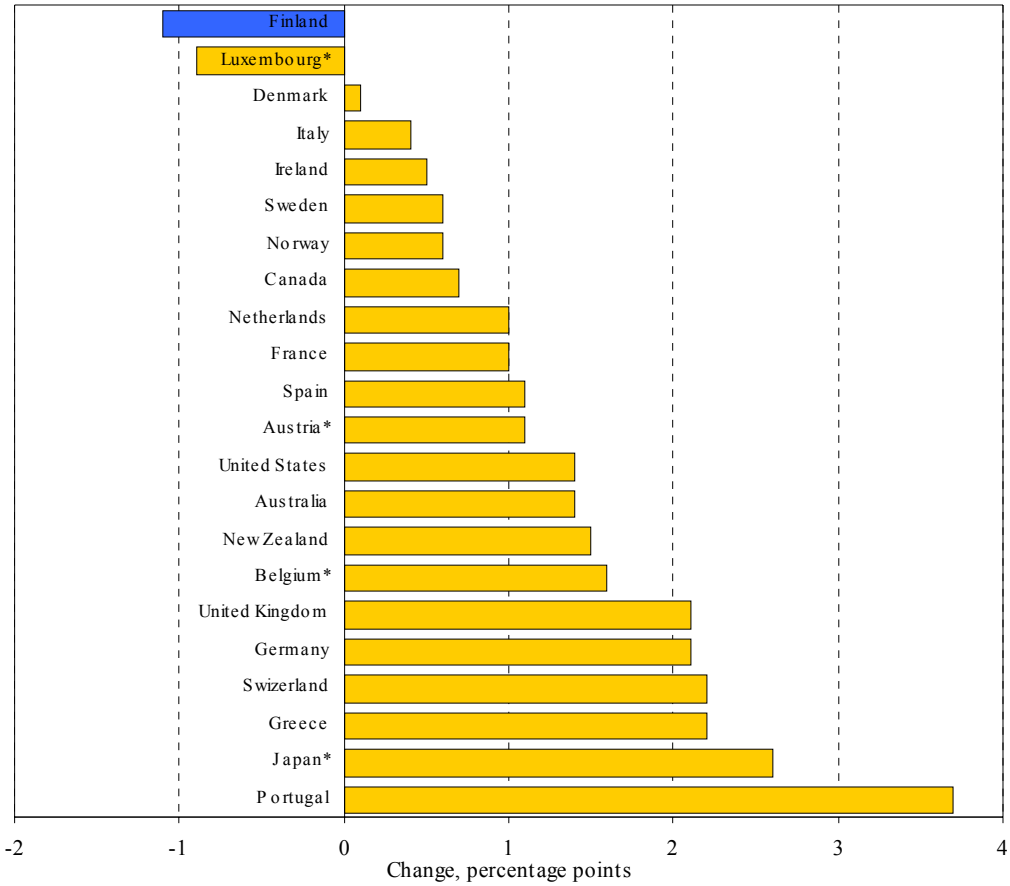
Figure 64. Health care expenditure in EU member states in 2000/2001, as a percentage of GDP



Source: OECD Health Data 2003

Even though the GDP ratio of health care expenditure has diminished compared to the beginning of the previous decade, expenditure has actually been growing since 1995. In addition, health care expenditure has grown at a faster rate than other public expenditure.

Figure 65. Change in health care expenditure to GDP ratio in 1990–2001, percentage points



*1990-2000. Source: OECD Health Data 2003

The growth of medicine expenditure has been particularly rapid; since the beginning of the previous decade, the rise of actual medicine expenditure has been around 5 percent per year. Based on the distribution of wholesale pharmaceutical sales, the distribution of medicine expenditure between medicines sold at pharmacies and those used in hospitals has not changed significantly since the beginning of the 1990s; pharmacies continue to account for about 80 percent and hospitals for about 20 percent of the total value of wholesale pharmaceutical sales.[13]

Table 7. Medicine and pharmaceutical product expenditure, change compared to previous year in 1990–2002 in 2002 constant prices, € million

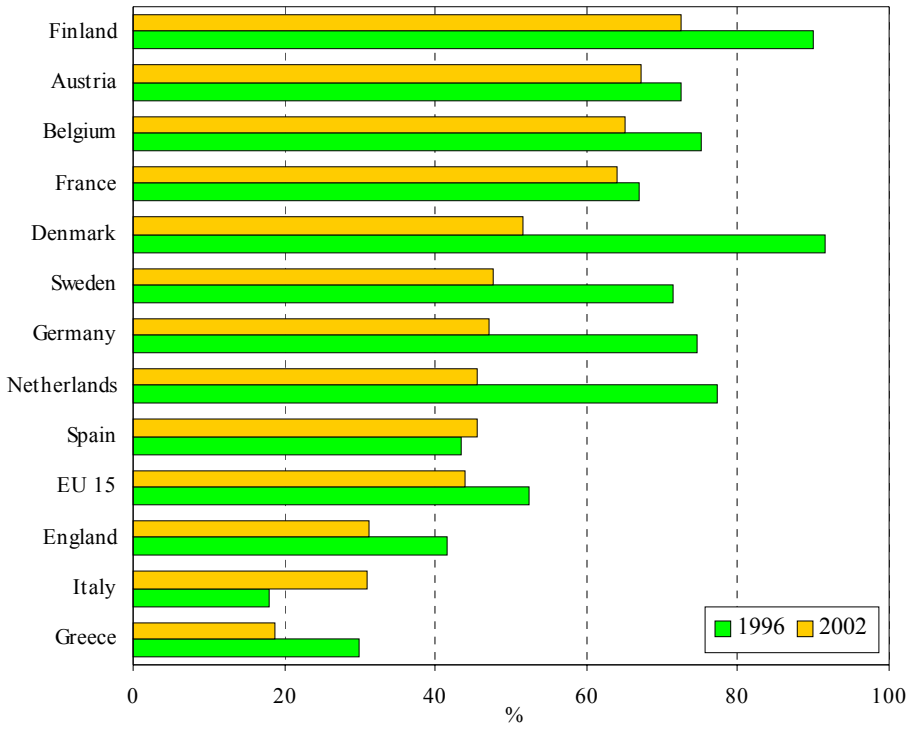
Year	Million euros	Change %
1990	931,6	
1991	991,0	6.4
1992	1 033,4	4.3
1993	1 074,6	4.0
1994	1 128,5	5.0
1995	1 203,1	6.6
1996	1 267,1	5.3
1997	1 323,1	4,4
1998	1 308,8	-1.1
1999	1 364,5	4.3
2000	1 428,1	4.7
2001	1 525,6	6.8
2002	1 620,9	6.2

Source: National Research and Development Centre for Welfare and Health 2002. Statistical report 5/2004.

5.1.3 Availability and quality of social and health care services

The low health care expenses as a proportion of GDP and per capita can be interpreted in two different ways. According to a positive view, the Finnish health care system is more effective than average, since comprehensive and high-quality services that most citizens are content with can be provided with such a small input. This interpretation can be motivated by the fact that of all EU citizens, Finns are the most satisfied with their health care services, and they do not want any major alterations to the system (Figure 66). When comparing mortality amenable to health care[14], Finland is also one of the countries with the lowest mortality rates among EU member states (Figure 67).

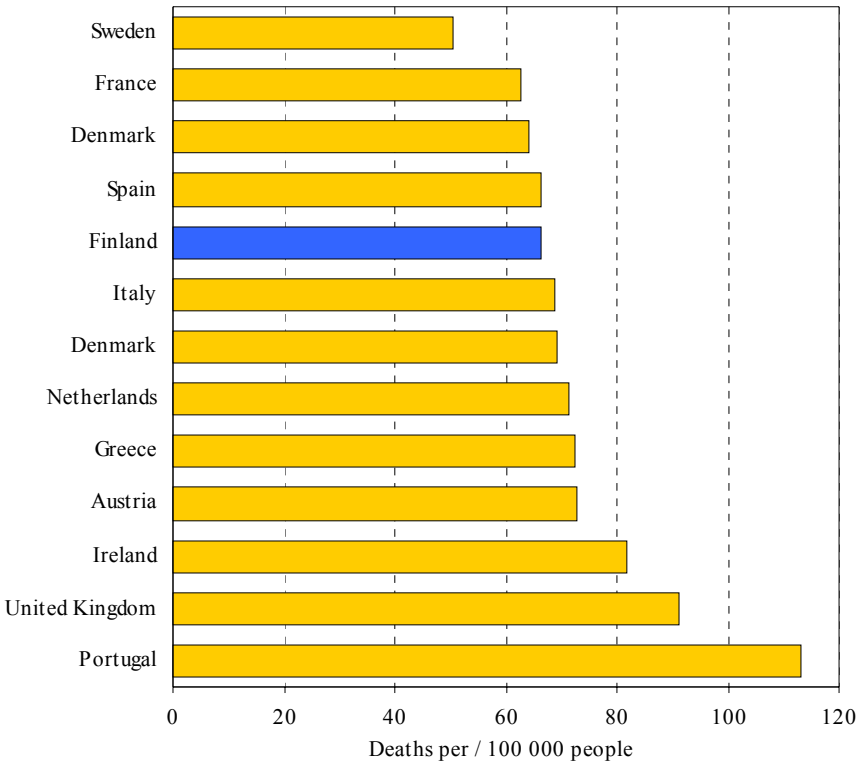
Figure 66. Citizens' views on functionality of health care services in 1996 and 2002; services work well or only minor adjustments needed, %



Source: Eurobarometer 2003. European Commission.

According to a more critical view, it can also be questioned whether sufficient funds have been allocated to health care in Finland in recent years. This view is supported by the long waiting times to get specialised medical care in Finland compared to other European countries (Table 8).[15] The increased needs have also been politically acknowledged, as the government has allocated more resources to health care within the framework of the government programme and the National Project to Secure the Future of Health Care. At any rate, the pressure towards increased health care expenditure must be recognised, so that quality and availability of services as well as sufficient resources for their implementation can be secured in the future as well.

Figure 67. Age-standardised mortality amenable to health care in some EU member states



Source: Mossialos, E. CHESS-online 1/2004, 11. National Research and Development Centre for Welfare and Health, the Centre for Health Economics - CHESS. Original source: Nolte E and McKee M. Measuring the Health of Nations: Analysis of Mortality Amenable to Health Care. BMJ Nov 2003, 327, 1129–1130

Table 8. Mean inpatient waiting times (days) of patients admitted by surgical procedure in 2000

	Hip replace-ment	Knee replace-ment	Cata-racts surgery	Varicose vain surgery	Hyster-ectomy	Prosta-tectomy	Cholecys-tectomy	Inguinal and femoral hernia	CABG	PTCA
Australia	163	201	179	216	54	69	83	87	44	
Denmark	112	112	71	99			75	73		
Finland	206	274	233	280	100	81	159	125	42	30
Norway	133	160	63	142	64	75	103	109	46	53
Netherlands	96	85	111	107	61	60	71	75		18
Spain	123	148	104	117	102	62	107	102	39	81
Sweden			199							
United Kingdom (England)	244	281	206	227	159	52	156	150	213	80

CABG = Coronary bypass, PTCA = Percutanous transluminal coronary angioplasty
Source: Siciliani, L. and Hurst, J. (2003): Explaining Waiting Times Variations for Elective Surgery across OECD Countries. OECD Health Working Papers No 7

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

In the report entitled 'Yhteistyöllä ja kilpaillen – peruspalvelut 2000/Cooperation and competition – basic services 2000' by the Government Institute for Economic Research, a good service system is defined as one providing services that 1) correspond to the needs of the population, 2) promote well-being among the population, 3) are equally available both regionally and by population groups, 4) are provided efficiently and according to high standards and 5) adapt to changing needs in terms of provision and content.

In the early stages of ageing, service needs focus mainly on community care services (Table 9). The change in elderly services structure from institutional care towards sheltered housing also affects service demand. The need for regular home-help services begins on average at the age of 76, and the need for institutional care at the age of 82 years. Fifteen percent of the population are over 65, seven percent are over 75, and 1.6 percent are over 85 years old. The ratio of women and men per cohort is such that until the age of 57 there are fewer women, and among older age groups more women than men. The proportion of elderly persons varies by region. In 2002, the highest proportion of persons over 65 was in Etelä-Savo (19.8 percent) and South Karelia (18.5 percent) and the lowest in Uusimaa (11.6 percent).

Table 9. The proportion of elderly persons receiving public elderly services in 1991 – 2002

Service recipients, % of age group	1991	1995	1997	1999	2001	2002
Home help service, 65+	18.1	11.8	11.3	11.0	10.7	10.6
Home help service, 75+	31.4	22.1	21.2	20.3	19.6	19.3
Support service, 65+	16.7	13.4	13.7	13.4	13.5	13.8
Support for informal care, 65+	1.9	1.5	1.7	1.7	2.0	2.1
Service housing, 65+, 31 Dec		1.9	2.2	2.6	2.8	2.8
Sheltered housing, 75+, 31 Dec		3.4	4.1	4.7	5.1	5.3
Residential homes, 75+, 31 Dec	7.6	6.5	5.9	5.5	5.1	5.0
Long-term care in health centre hospital, 75+, 31 Dec	3.3	3.7	3.4	3.2	3.0	2.8

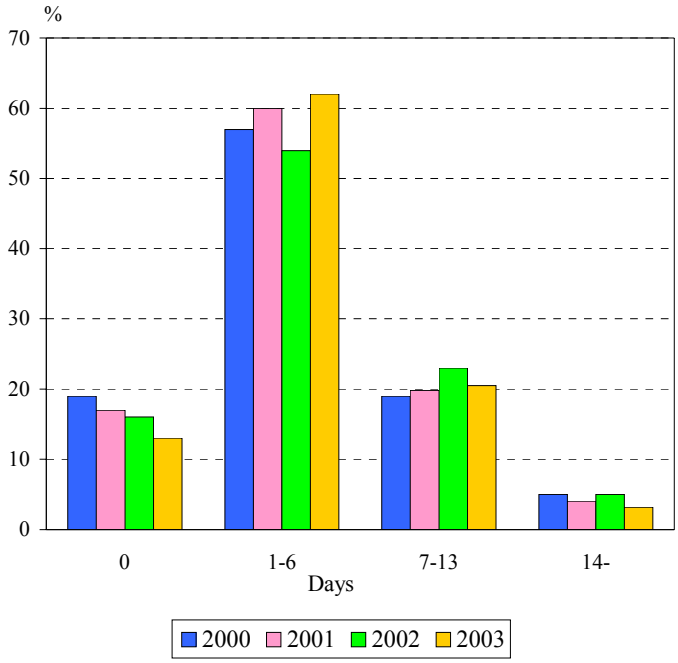
Source: Social and health care services for the elderly 2002. National Research and Development Centre for Welfare and Health, SVT Sosiaaliturva 2003:1

Welfare service providers' and organisations' views on citizens' well-being and services are charted annually by the Finnish Federation for Social Welfare and Health. In the social barometer survey, questions are asked e.g. regarding quantitative changes in public services, and the efficiency, sufficiency, availability and quality of services. In 2004, according to assessments by social services departments, the number of nearly all social services (with the exception of institutional care for the elderly and services aimed at refugees) had more often been increased than decreased during the past year. Individual public service providers' assessments concerning the efficiency, sufficiency, availability and quality of social services show a great deal of variation.

Those responding to the social barometer considered quality and efficiency of services as the strongest point, and sufficiency of services as the weakest point of social services from users' point of view. Half of the social services departments surveyed reported that people have to wait to get social services. Clients are forced to wait particularly for decisions concerning social assistance and sheltered housing and institutional care for the elderly. Eighty-two percent of health care centres reported that their clients had to wait; the corresponding figure in 2003 was 89 percent. The waiting times to see a general practitioner varied from a couple of days to two weeks. In specialised medical care, waiting times vary between two months and two years, depending on the service in question.

The waiting times to receive social assistance, which is a last-resort type of income protection, are of particular significance. By request of the Ministry of Social Affairs and Health, the National Research and Development Centre for Welfare and Health has monitored the waiting times of new social assistance clients from the beginning of 2000. In November 2003, the average waiting time of new clients was 4.3 days. This was nearly the same as in 2000. Seventy-five percent of municipalities managed to attain the maximum waiting time of one week (0–6 days) for new clients in accordance with the Ministry of Social Affairs and Health's target and action programme. The situation was worst in urban municipalities, only 36 percent of which managed to attain this goal.

Figure 68. Waiting times of new social assistance clients as a percentage of municipalities responding to the survey in November, week 47/2000-2001 and week 48/2002-2003



Source: National Research and Development Centre for Welfare and Health, Statistical Report 1/2004

The provision of health care services has also for the most part increased in municipalities during the past year; only the provision of institutional psychiatric care has been decreased more often than increased. There has been a particular increase in the provision of public health nurse's and nurse's surgeries as well as home nursing and occupational health services. In 2003 and 1999, health care services were cut back in municipalities more commonly than at present. The efficiency and quality of health care services is generally assessed as being good.

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

The idea behind securing access to care and quality is to ensure that all citizens, regardless of where they live or how services are provided, have easy access to high-quality social and health care services. This objective is part of the government resolution to secure the future of health care, and its implementation has been prepared by the Access to Care and Queue Management working group at the Ministry of Social Affairs and Health.

At present, the majority of patients are admitted to care sufficiently rapidly. It is estimated that the waiting times of about 2–5 percent of patients queuing for care are too long. In some patient groups, the length of queues varies considerably, e.g. depending on when patients are placed in the queues. According to surveys, nearly 150,000 patients are currently queuing for an operation. The number has remained relatively constant in recent years, indicating that supply more or less equals demand. However, the problem is that waiting times are too long.

There are plans to include regulations on upper time limits regarding access to examination and care in the Primary Health Care Act, the Act on Special Medical Care and the Mental Health Act by 1 January 2005. The goal is that first assessment of the patient is done by a primary health care professional within three days of getting in touch with the health care facility, and a first assessment by a specialist within three weeks after referral to specialised care. Patients must access care or treatment procedure within three months, or six months at the most. Uniform national indications have been defined for placing patients into queues for medical procedures.

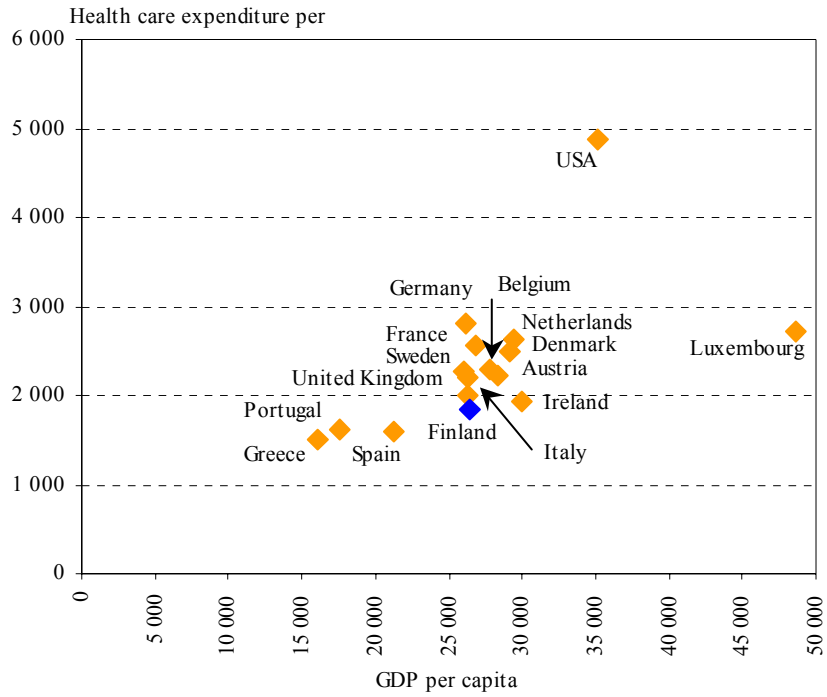
Access to care cannot be looked at solely based on operation queues and waiting times. Patients in all fields of medicine are not necessary registered in queues, even if there are problems with access to care. Insufficient service easily occurs in areas where social and health care services work in cooperation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

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

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

On the basis of international comparisons, the need of health care services has increased until the present moment along with a rise in the level of education and the general standard of living. There is however considerable variation between general living standards and health care expenditure, which is largely explained by different ways of service provision (Figure 69).

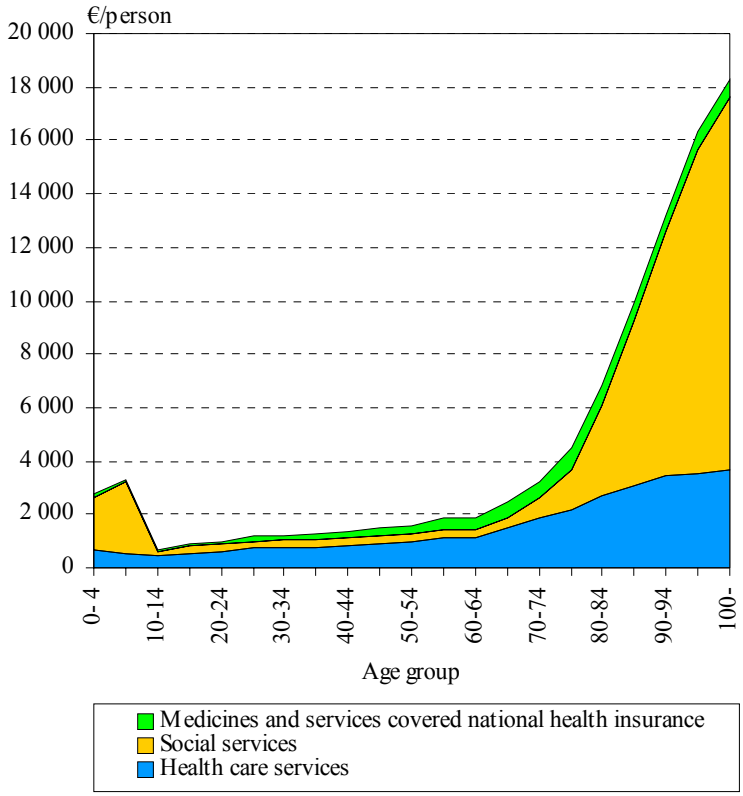
Figure 69. Health care expenditure and GDP per capita in EU member states and the US in 2001 (US$, adjusted for purchasing power)



Source: OECD Health Data 2003

Figure 70 shows average age-group specific social and health care service expenditure in 2002. An ageing population structure increases social and health care expenditure. The expenditure on older age groups – e.g. those of age group 80–84 in relation to those aged 30–34 – are fourfold in health care services as well as in medicines and services covered by health insurance. In the case of social services, the difference is twentyfold.

Figure 70. Age-group specific social and health care expenditure (including user fees and health insurance co-payments by beneficiaries) according to type of benefit in 2002, €/person



Social and health care service expenditure can be estimated to increase in the 2020s and 2030s, when there is a sharp rise in the number of very old persons. According to different studies, it seems clear that the costs of elderly care service rise more slowly and less directly than the number of old people. The state of health among the population will continue to improve in the future as well, and elderly people are able to cope independently longer than before. Despite this, at some stage there will be an increase in service need. The development of expenditure can be influenced efficiently by service provision solutions, such as the rapid adoption of new technology and reforms of service and provision structure, combined with willingness on the part of decision-makers to commit to implementation of reforms. In health care services, supply also creates demand, which is why supply has a significant impact on future costs.

5.1.5 Securing staff availability and competence

By the year 2010, about one in four of those currently working within social and health care services, or 55,000 persons, will retire to pension. In 2001, there was already a shortage of over 300 doctors in primary health care, and of about 600 doctors in specialised medical care. Table 10 shows the annual gross need of labour (sum of replacement of exit from workforce and change in total number of workforce) in 2005 – 2015[16]. It is estimated that a total of over 130,000 new employees are needed in social and health care services; the need in health care services alone is nearly 75,000 persons by the year 2015.

According to Finnish Medical Association statistics, the physician situation in health care centres has deteriorated in the 2000s. In the whole country, 12.1 percent of physician's posts and positions could not be filled in 2003. The figure is calculated using the following formula: (unfilled posts + officeholder absent) – (locums + no physician sought after). The corresponding figure in 2000 was 6.8 percent, in 2001 9.3 percent and in 2002 11.3 percent. In addition to special fields, the physician situation varies greatly by region: in 2003 the poorest situation was seen in the region of Länsi-Pohja (27.9 percent of positions remained unfilled) and in Central Ostrobothnia (27.6 percent). Physicians' posts could be best filled in Pirkanmaa (only 3.8 percent of positions remained unfilled).

Table 10. Estimation of total need of new labour in 2005 - 2015

Professional group	Basic estimate
Physicians	6,700
Nurses etc.	46,300
Other health care	20,700
Social work and recreation	59,700
Social and caring professions, total	**130,340**

Source: Report by the Committee on Estimation of Labour Demand in Social Welfare and Health Care. Ministry of Social Affairs and Health Committee Report 2001:7

As the population ages and takes up pensions, new social and health care professionals from young, smaller age groups must be persuaded to enter the field. At the same time, the workload of a reduced number of employees grows as a result of an increase in the number of clients. Finding competent staff may pose a problem in the future, and a shortage of labour may lead to a rapid rise in wage levels. In addition to development of education, the availability of competent and well-motivated staff can be secured by improving working conditions, by an adequate staff/client ratio and by supporting flexible division of labour between groups of staff. A well-functioning working community and good management improve well-being in the workplace and are also reflected in the quality of services provided. A sufficient supply of labour can also be influenced by reforms in social and health care structures and operations. Development of operational units that are larger than at present and improved cooperation between sectors (e.g. experiments to combine home nursing and home help services) may help reduce

overlapping, make division of labour more clear-cut, improve the quality of operations, secure the availability as well as efficient and flexible use of competent labour, and secure stable financing.

5.1.6 New treatment practices and technological development

Thanks to advances in medicine and treatment technology, services can be made more efficient and more versatile. Application of new technology can be made use of in health care services at an earlier stage and more extensively than before. The advances in medical technology enable new ways of treating diseases in cases where progress has so far been slow. This creates added expectations and increases service demands on the part of clients and the population.

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

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

The actual prices of care and treatment services have risen clearly in the last 25 years. Wage costs, which make up the majority of total service costs, have risen at the same rate as those of the rest of the population. Labour costs as a proportion of total health care and social service expenditure have however declined by three percentage points since 1995, to 63 percent. Input-output studies indicate that in the case of these services, labour has been replaced by medicines. If this trend were to continue in the future as well, the growth of care and treatment expenditure would slow down, because the use of increasingly expensive labour could be reduced (Parkkinen 2004).

Generic drug substitution was introduced in Finland in the beginning of April 2003. During the first year of generic drug substitution, i.e. between April 2003 and March 2004, savings came to about six percent of the total costs of the medicines substituted. Expenditure on medicine refunds increased more slowly (7 percent) in 2003 compared to 2002 (12 percent). However, it is hard to estimate the effect of generic drug substitution on medicine expenditure in the long term.

5.1.7 Health care financing

Health care financing consists primarily of municipal financing obligations supported by government grants, client fees and health insurance financing granted to private-sector services. Public financing makes up about three fourths of the total funding of health care expenditure, while the remaining one fourth comes from private financing. During the last ten years, the share of private financing has grown by about five percentage points. This has mainly occurred through a rise in the financing share of households. The twenty-percent financing share of households is among the highest in the EU. Within the public sector, the government's financing share has been almost halved, from 36 percent in the beginning of the 1990s to 17 percent in 2002. During that same time, the financing share of municipalities has increased by over eight percentage points and that of the Social Insurance Institution of Finland (SII), i.e. the health insurance system, by about five percentage points (Table 11). The health insurance system is still primarily financed through health insurance payments by the insured and employers. Client fees make up about nine percent of total public health care expenditure.

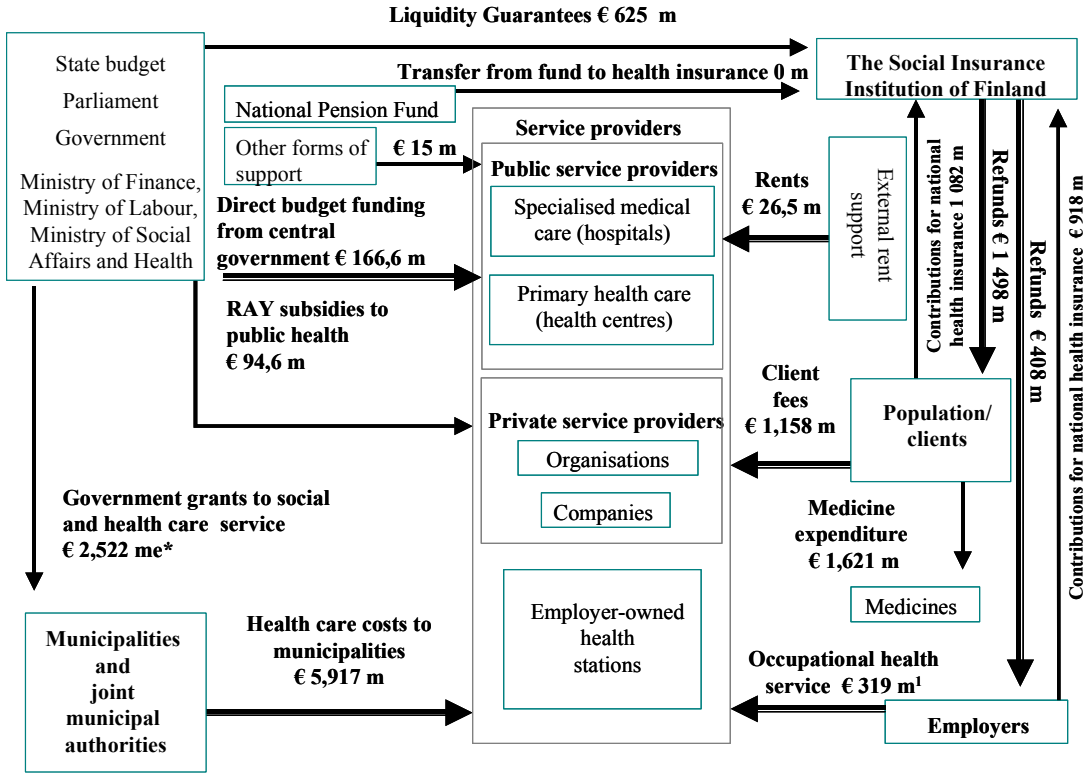
Table 11. Financing shares of total health care expenditure in 1980 – 2002

Year	Central govern ment	Munici palities	SII	Public financing, total	Emplo yers	Relief funds	Private insu- rance	House- holds	Private financing, total
1980	38.2	28.9	12.4	79.6	1.2	0.6	0.8	17.8	20.4
1985	34.0	34.7	10.2	78.9	1.3	0.7	1.2	18.0	21.1
1990	35.6	34.7	10.6	80.9	1.4	0.5	1.7	15.6	19.2
1995	28.4	33.8	13.4	75.6	1.5	0.4	2.0	20.5	24.4
1996	24.1	37.8	13.9	75.8	1.6	0.5	1.9	20.3	24.2
1997	20.6	41.2	14.2	76.0	1.6	0.5	2.2	19.7	23.9
1998	18.9	42.5	14.8	76.2	1.7	0.5	2.2	19.4	23.7
1999	18.0	42.4	14.9	75.3	1.7	0.5	2.2	20.3	24.7
2000	17.6	42.2	15.4	75.2	1.9	0.5	2.1	20.4	24.9
2001	17.1	42.8	15.6	75.5	1.9	0.5	2.0	20.2	24.5
2002	16.8	43.0	*15.9	75.7	2.0	0.5	1.9	20.0	24.3

*Includes 5.2 percent central government financing support
Source: National Research and Development Centre for Welfare and Health, Health care expenditure and financing in 2002. Statistical Summary 5/2004

The Finnish health care financing system is a combination of municipal and government financing, client fees and the private health service sector supported by health insurance. The manner of service provision or the extent or content of services is not defined in legislation; the task of assessing and implementing them has been given to municipalities. Health care financing forms a very complex whole that is difficult to manage (Figure 71).

Figure 71. Health care financing channels in 2002



*Allocated for both social and health care services
[1] Estimate from 2001

Source: Tarmo Räty / Government Institute for Economic Research

In 2002, the cost of health care services provided by municipalities came to € 5.9 billion. The operating costs of specialised medical care totalled € 3.3 billion and those of primary health care € 2.4 billion. Municipalities purchased services from private service providers to the sum of € 162 million. Municipalities make decisions on how to provide health care services, and they also have main responsibility for financing the services they provide. About 70 percent of municipal service financing comes from municipalities, while about 22 percent comes from actuarial government grants and about 9 percent from client fees. However, services provided by municipalities account only for part of total health care expenditure, and the share of total expenditure made up by municipal services has decreased during the past ten years. A significant proportion of medicines and services, such as medicine costs in outpatient care, over-the-counter medicines, part of dental care and private health care services are either paid fully by the client, or jointly by the Social Insurance Institution of Finland and the client.

The central government participates in financing health care expenditure mainly through government grants to municipal social and health care departments (€ 2.6 billion in 2002) and reimbursements to university hospitals (€ 128 million). In addition, investment and employment support to public health care service providers channelled through various ministries came to about € 40 million in 2002.

Retained profits of RAY (Finland's Slot Machine Association) are also channelled through the state budget to non-profit organisations. In 2002, a total of € 208 million was given to organisations, € 95 million of which went to public health[17]. The central government also participates in financing health care through health insurance financing support.

In health care systems based on public financing, such as the Finnish one, attempts to curb rising health care costs have been more successful than e.g. in countries where the health care system is based on health insurance. In Finland, the rise of costs has also been restricted by moderate centralised wage agreements, which have held the rise of labour costs in the field in check.

Private health insurance

Insurance-type financing may be based on either statutory social insurance or private insurance. In Finland, the role of private health insurance is minor. Private health care services are partly financed through private health insurance. In 2002, the income from private health insurance premiums was only about two percent of the total costs of statutory health insurance. However, in particular the number of private health insurance policies and the income from premiums taken by employers for their employees has risen in recent years (Table 12).

Table 12. Income from premiums and the number of private health insurance policies in 1999-2003

Million euros	1999	2000	2001	2002	2003
Health expense insurance for children	37.6	40.4	43.7	47.5	50.5
Private adult health expense insurance	22.5	24.3	25.9	28.1	29.5
Health expense insurance taken by employer	5.0	6.4	8.0	8.7	12.0
Total	65.0	71.1	77.6	84.3	92.0
Change %		9.3	9.2	8.6	9.1
1,000					
Health expense insurance for children	325.9	345.8	359.5	372.7	381.3
Private adult health expense insurance	155.7	160.5	170.2	179.3	192.7
Health expense insurance taken by employer	11.7	15.3	18.4	22.0	27.5
Total	493.2	521.6	548.1	573.9	601.5
Change %		5.8	5.1	4.7	4.8

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

In 2000, private health care expenditure totalled about € 1.4 billion, making up about 20 percent of total health care expenditure[18]. Companies contributed about 17 percent and organisations about 3 percent of total expenditure. The financing of private health care services is implemented through client fees (€ 665 million), services purchased by municipalities (€ 162 million), occupational health care paid for by employers (€ 118 million) and RAY subsidies (€ 95 million). Reimbursements from the Social Insurance Institution of Finland cover a significant proportion, over 40 percent, of private health care expenditure.

In the year 2000, the number of private health care service providers was about 10,000, with a total number of staff of nearly 26,000. Since 1996, the number of service providers has gone up by about two thousand, i.e. about one fifth, while the number of staff has only increased by two percentage points. The largest relative increase has been in the number of occupational health service providers. As a domain, the private health care service sector is dominated by small enterprises: 98 percent of the companies employed fewer than ten persons in 2000.

The majority of private health care service providers are companies. Private hospitals are an exception; a significant proportion is owned by organisations. Private health care service providers are concentrated in southern Finland and large cities. Particularly big medical centres and private hospitals are primarily located in the largest cities.

Client fee financing

Users must pay a fee for the majority of public health care services in Finland. Client fees accounted for about 7.9 percent of total public health care expenditure in 2002, and for 7.9 and 5.5 percent of primary health care and specialised medical care expenditure, respectively. In 2002, households paid a total of € 1.1 billion in various client fees to the public and private sector, and a total of € 1.7 billion in medicine costs[19]. During 2002, households received € 859 million of this sum in refunds, so the final sum paid by households totalled € 879 million. In public health care, € 218 million was paid as client fees for hospital treatment and € 275 million for primary health care. Private service providers received € 665 million in client fees.

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

Financing occupational health services

In 2002, employers' expenditure for occupational health services totalled € 319 million. Health care stations owned by employers accounted for € 130 million of the total. In 2001, the Social Insurance Institution of Finland paid employers € 141 million worth of compensations for occupational health services. In addition, the Social Insurance Institution of Finland pays occupational health care refunds for self-employed people (€ 1.3 million in 2002), state contributions to the SII administered farmers' occupational health survey(€ 0.6 million) and refunds for student health services (€ 17.8 million).

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

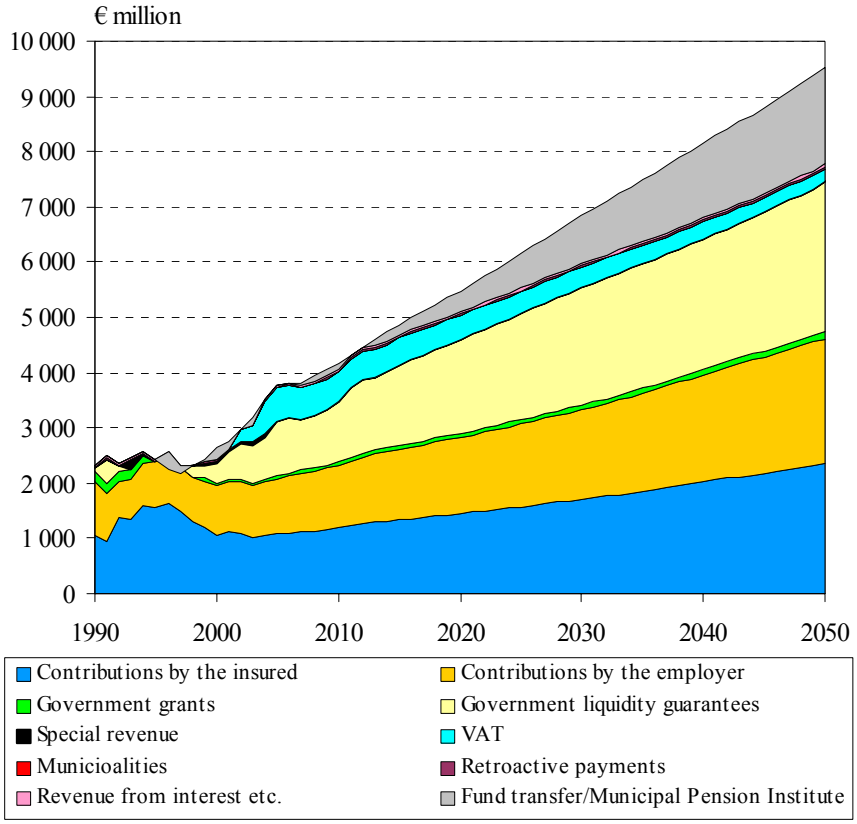
the special problems and working conditions of the domain in question. Employers can also use occupational health care as a staff policy instrument. The differences in health care service utilisation between population groups are partly explained by the fact that occupational health care focuses on employed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

5.1.8 National health insurance and its reform

In Finland, national health insurance is part of social insurance. The Finnish health insurance system is in principle financed by health insurance payments from the insured and employers. The financing structure has however changed as insurance payment grounds have been lowered[20], while health insurance expenditure, especially medicine expenditure, has increased. At the moment, health insurance is financed through health insurance contributions levied from employers and the insured, government grants towards minimum benefits, VAT revenue, the so-called full compensation payment paid by insurance companies and central government liquidity guarantees.

Until 1999, health insurance expenditure was financed almost exclusively through health insurance from employers and the insured, while only 55 percent is estimated to come from insurance contributions in 2005. It is estimated that in 2005, more than a fifth of the expenditure will be financed by central government liquidity guarantees. If the financing system is not reformed, it is estimated that this share will increase further (Figure 72).

Figure 72. Insurance-technical revenue from health insurance in 1990–2003 and projected revenue until 2050 in 2004 money, € million



In its spring 2003 memorandum, a working group looking at national pension and health insurance financing studied alternatives for balancing national health insurance financing. Dividing financing into earnings and health care insurance was suggested as one alternative. Daily allowance expenditure included in earnings insurance as well as occupational health services would be financed by contributions from employers and the insured. The part coming from the insured would be financed by a new payment levied from employees and entrepreneurs. The central government would only finance minimum daily allowance. Health insurance would include compensations for medical care in the private sector, medicine refunds and rehabilitation expenditure. The majority of health insurance expenditure would be financed by the insured, while central government would play a minor role. A health care insurance contribution replacing the current health insurance contribution would be levied from all the insured.[21] At the beginning of autumn 2003, preparation of the reform of national health insurance financing was taken up again in tripartite negotiations. Unanimity has still not been reached concerning all the principles of the reform. On the basis of the work done by the working group, a new, more precise solution model was prepared, and the government made a decision on its implementation in connection with budget negotiations in August 2004. The reform will enter into force as of the beginning of 2006. The solution model is largely in line with the suggestions of the working group memorandum. However, half of health insurance expenditure will be financed through health care insurance payments by the insured, and the other half through central government funding. In connection with the reform, improvements to some benefits were also agreed upon. The adjustment of family benefit expenditure is developed in a more balanced direction, so that the current compensation of annual leave paid to employers is raised by 55 percent as of the beginning of 2005. In the case of consecutive pregnancies within a short period of time, a better than before level of maternity and parenthood allowance is guaranteed. The position of those with short-term employment contracts is improved by adjusting the grounds daily allowances are based on. These two reforms apply in situations where daily allowance period begins on or after 1 October 2005.

The financing reform means that insurance contributions by both employers and the insured will increase. However, the aim is to ease taxation correspondingly in 2006, so that the total tax burden of employers and the insured will not increase. In addition, the aim is to compensate the increase of the contributions levied from entrepreneurs. The rise of the contributions by wage earners and entrepreneurs will be further eased by the fact that the new contribution levied to cover earnings insurance is tax-deductible. Pensioners' health insurance contributions will remain unaffected by the reform.

5.1.9 The relationship between public and private services

Securing necessary health care services is the fundamental task of the public sector. This does not however mean that the services must be provided publicly. Setting up an efficient incentive system for a public monopoly is a difficult task, whereas incentives for improved efficiency are in principle an integral part of a fully competitive market. However, purchasing services from the private sector does not as such guarantee that the solution is an effective one, but it may lead to increased cost awareness. In sparsely populated areas, this is not necessarily possible. In addition, public support forms, such as

employment and investment support, start-up money and interest support on loans may distort competition, as may letting private or third-sector enterprises have business premises below market price.

The status of the municipal sector as social and health care service provider is changing. The share of private service providers is on the increase; one fifth of social and health care services are nowadays produced by private service providers. Organisations provide a larger share of social services, whereas the majority of private health care services are produced by companies.

In 2002, municipalities and joint municipal authorities spent € 716 million on buying social services from the private sector. The sum has more than doubled in actual value since 1995. In 2002, municipalities used 12 percent of their social sector operating costs towards purchasing services from private service providers, while the corresponding share in 1995 was 6 percent.

In health care, services purchased by municipalities and joint municipal authorities play a clearly smaller role than in social services. Most health care services are bought by households, employers and the Social Insurance Institution of Finland. In 2002, municipalities and joint municipal authorities bought health care services for the sum of € 162 million, municipalities paying € 96.5 million and joint municipal authorities € 65.4 million.

In a competitive market, services must be productified, which calls for development of cost accounting in municipalities. Through more effective accounting of costs, municipalities are also able to compare the prices of services they produce themselves and the ones they purchase. In the case of hospitals, cost accounting has shown rapid progress in recent years. Service acquisition calls for expertise. For small municipalities, regional cooperation may provide sufficient resources for the acquisition of purchased services.

The use of more efficient and more client-oriented production methods can be promoted by developing competence related to service commissioning, by internal cooperation within the municipal sector and by making use of competition. Various ways of organising service provision that have proved to be effective and economically viable have already been under experimentation in Finland for a number of years.

The public sector will continue to be responsible for service provision in the future as well. Services can be provided through private companies or non-profit organisations. The efficiency of service provision can be improved by making provision and commissioning of services more explicit. If the EU service directive, which is currently being prepared, were implemented in the form suggested by the commission, social and health care services would be more open for foreign competition than before. If implemented, the directive would mean that private and public service provision would have to be segregated even more clearly than at present.

The steering relationship between central government, municipalities and service providers does not always work optimally. Steering by information is still relatively inestablished and its impact varies; systematic development is still called for. The economic incentives of various actors to provide care do not always work in the desired

manner, and legislation dates partly from a time when resource steering played a significantly larger role.

5.2 Reasonable income security

The government programme includes raises to the level of several income security benefits within the government period. Child allowances were already raised at the beginning of 2004, while income testing with respect to spouse's income was eased in the case of labour market support. In 2005, the level of national pension, child home care allowance and the minimum sickness, maternity, paternity and parenthood allowance were raised. The raise of the level of national pensions was originally not to be implemented until the beginning of 2006, but in negotiations on the 2005 budget the government agreed to implement the raise earlier, in March 2005.

Raising the level of benefits can be seen as part of the other objectives of the government programme. Raising the level of child allowance, child home care allowance and minimum parenthood allowance are a means aimed at preventing poverty and improving the economic situation of families with children and at breaking the cycle of social exclusion that spans generations. The status of families with children is featured very prominently in the government programme. The raise of the level of national pension can be seen as part of developing primary income security, aimed at reducing poverty and social exclusion. At the same time, the development of primary income security reduces the need for long-term reliance on social assistance.

Sufficient level of income security is however only one instrument in the battle against poverty and exclusion included in the government programme. The importance of employment in the prevention of poverty and exclusion is stated in very clear terms: "Successful prevention of social exclusion and poverty can only be achieved if the employment goals are attained." This link between employment and social exclusion can be looked at in two ways. A positive employment trend is necessary so that a sufficient level of benefits can be secured. If employment does not develop in a positive manner, the number of benefit recipients increases, while the amount of taxes and social insurance contributions levied to finance them decreases. Securing a sufficient level of benefits in such a situation would be very difficult. In addition to the economic link, employment is as such an instrument in the fight against social exclusion. Besides direct economic benefits, employment can be regarded as a key element of the "good life" of working-age population. If this area of life is not fulfilled, it may in the long run have negative effects in other areas as well.

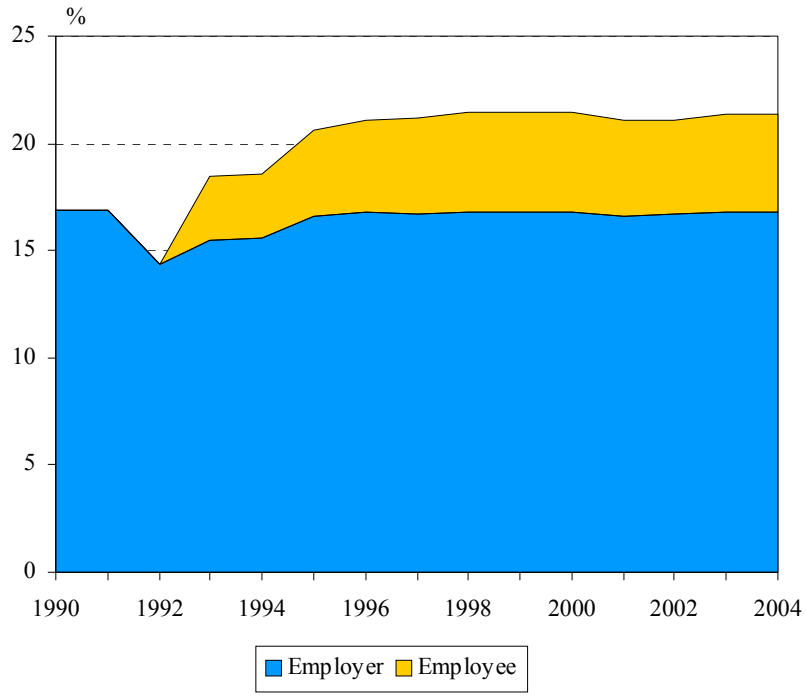
Issues related to the incentives of social security were already emphasised in the programmes of previous governments. Due to the focus on the employment objective, it is not surprising that incentives are an important theme in the current government programme as well. However, the main emphasis is now on the effect that the financing of social protection has on the demand of labour. These issues include lowering indirect labour costs of low-income jobs and large employers' disability pension deductibles.

5.2.1 Securing the financing of the pension system

Financing of employment pensions

In the 1990s, several changes were made in the employment pension systems in the private and particularly in the public sector, which slowed down the increase in pension expenditure in both the short and the longer term. This was partly the reason why e.g. the increase in pension insurance contributions within the TEL system (Employees' Pension Act) was halted in the mid-1990s (Figure 73). Despite this, employment pension funds have grown significantly. In 2003, employment pension funds showed a 2.6 percent surplus in relation to the GDP. At the end of 2003, the market value of employment pension fund investments totalled € 78,600 million, or 54.8 percent in relation to GDP.

Figure 73. Development of pension insurance contribution rate within the TEL pension system in 1990–2004



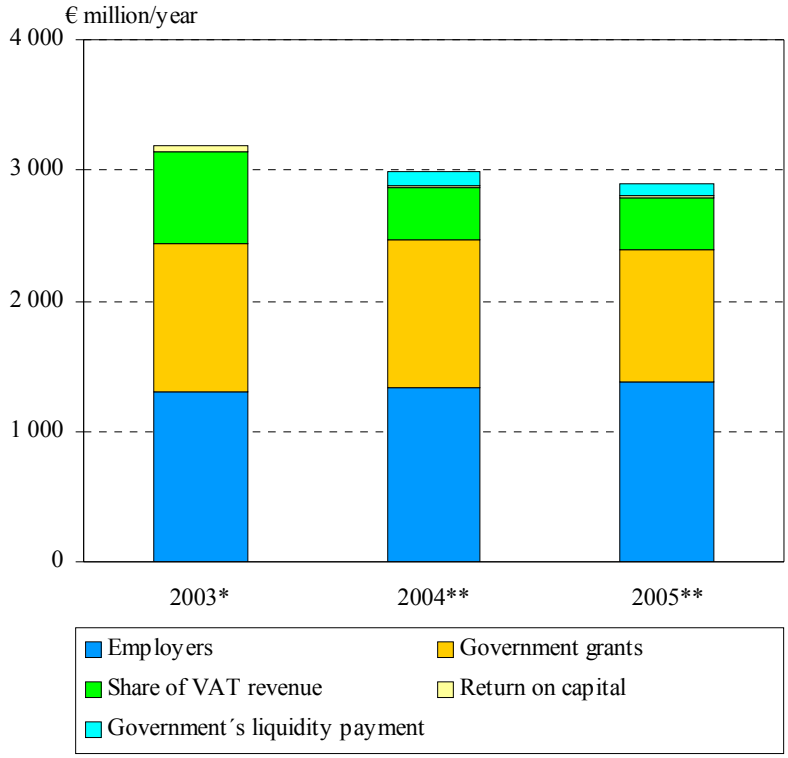
Source: The Finnish Centre for Pensions

Financing of national pensions

Employers and the central government are the primary financiers of national pension insurance. The government's financing share consists of actual government grants[22] and the part of VAT revenue that is directed to the national pension fund. In 2004 and 2005, the central government must also participate in national pension insurance funding by a liquidity guarantee payment aimed at securing a sufficient amount of the national pension fund (Figure 74). National pension insurance benefit expenditure is expected to decline fairly sharply until the early 2010s. This may create room for lowering employers'

national pension insurance contributions without endangering the financing of national pension insurance in the long term.

Figure 74. Financing structure of national pension insurance in 2003–2005

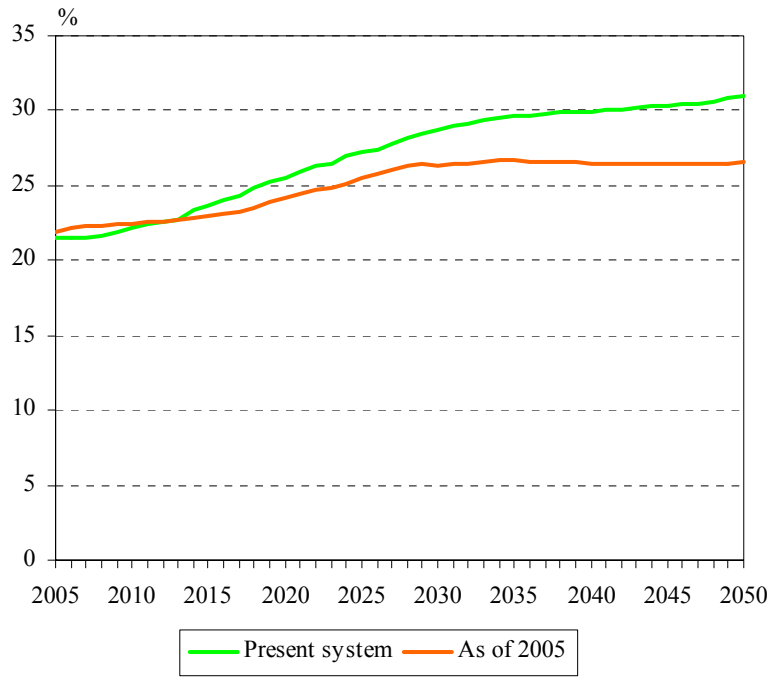


Source: Social Insurance Institution of Finland / State draft budget

Changing age structure and sustainability of the pension system

As the population ages, the proportion of persons eligible for old-age pensions will increase significantly in the next few decades. This poses a considerable challenge for the financing of employment pensions systems in particular. Without changes to the pension systems, considerable increases of employment pension contributions would have been necessary. Thanks to the reforms of the private and public sector pension systems that enter gradually into force from the beginning of 2005, both employment pension expenditure and the rise of employment pension contributions are predicted to remain at a clearly lower level than would have been the case under present legislation.[23] The Finnish Centre for Pensions estimates that employment pension contributions in the private sector will rise from the present 21 percent to about 26 percent of wages by the year 2030, and remain on that level at least until 2050. It is estimated that without the reform, by the mid-2030s the level of employment pension contributions would already be as high as 30 percent of wages (Figure 75).

Figure 75. Estimate of the effect of the 2005 pension reform on the development of TEL pension contribution rate in 2005–2050, % of wages



Source: Finnish Centre for Pensions

Long-term predictions on pension insurance naturally include various factors causing uncertainty. Development of the employment rate is a key issue for the success of the pension reform. It is assumed that the reform will raise the employment rate, especially among older age groups as retirement is postponed compared to the present situation. In the reform, attempts have been made to secure this by cutting down the number of early retirement schemes and by increasing economic incentives to extend working careers. In the new employment pension system, remaining at work after age 63 is rewarded by an annual pension accumulation rate of 4.5 percent, which is expected to encourage people to remain longer at work. Accumulation of pension continues up to age 68, and unlike in the present system, the pension percentage can exceed 60 percent.

The Finnish pension system has also been reviewed by foreign experts. In a joint EU commission and council report, the economic sustainability of the Finnish pension system was assessed as being good with some minor adjustments. At the same time, it was stated that the pension system secures sufficient income security and succeeds well in preventing the risk of poverty of pensioner households. The 2005 pension reform was seen as a step towards balancing the pension system. However, the report criticised the long implementation time of the reform, which means that baby-boomers can still take advantage of early retirement schemes. A somewhat similar view was expressed in the OECD report assessing the challenges to employment policy posed by an ageing population. The employment rate among ageing workers is low in Finland. According to the report, one reason for this is the fact that there are too many routes to early retirement available. The

changes in the pension reform were seen as pointing in the right direction, but they were suspected of being insufficient. The same view was repeated in the economic survey of Finland published by the OECD in October 2004, in which further curtailment of the early retirement schemes was recommended.

5.2.2 Sufficient basic income security and reasonable earnings-related benefits

The impact goals concerning the level of income security included in the government strategy document can be interpreted in a variety of ways. This is actually quite natural, because possibilities to develop income security are largely linked to the implementation of the other objectives of the government programme. The further we remain from the employment goal, the more limited the possibilities for developing income security. That is why a sufficient and reasonable level of income security must constantly be adjusted in relation to the changes occurring in the operating environment.

Development of benefits

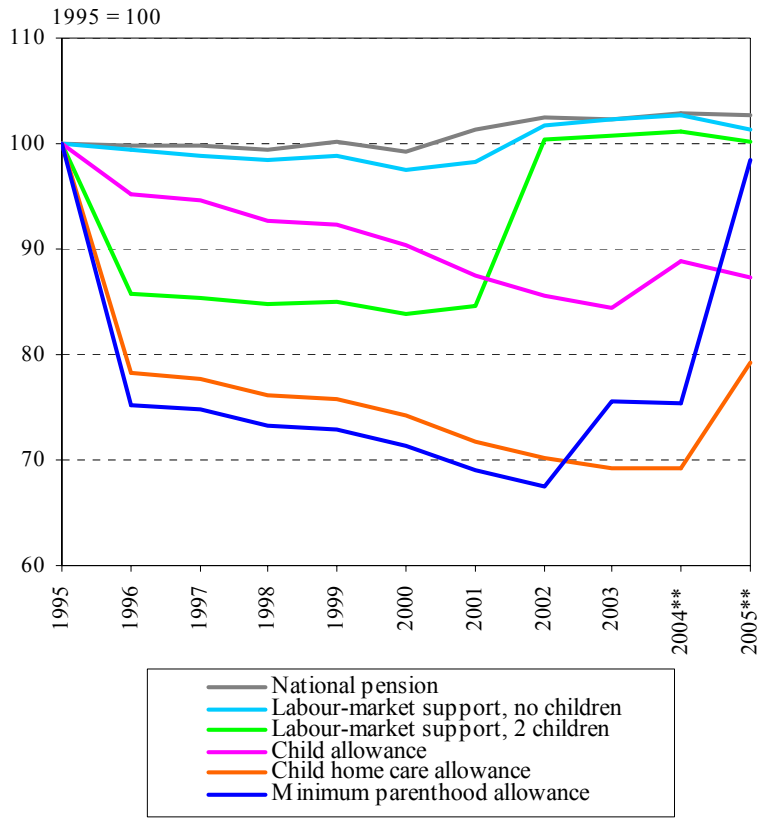
Figure 76 shows the real growth of full national pension, labour market support and some family benefits from 1995.[24] Benefits ensuring households' basic income security are primarily adjusted to changes in consumer prices, whereas adjustments of family benefits in particular are mostly made with separate decisions (child allowances, child home care allowance). Statutory index increases seem to be able to guarantee the purchasing power of benefits clearly better than separate decisions.

During the period under study, minor adjustments were made to the levels of national pensions (1 June 2001) and labour market support (1 March 2002). From the beginning of 2002, the child increments of labour market support were returned to the same level as those of earnings-related and basic unemployment allowance. At the beginning of March 2005, the level of national pensions was raised again by about € 7 per month. Despite the fact that the level of child allowance was raised at the beginning of 2004, its real value is still clearly lower than after the cut made in 1995.[25] The increases in the level of care supplement paid to recipients of child home care allowance and the minimum level of parenthood allowance made at the beginning of 2005 return their value close to the mid-1990s level.

Many of the changes affecting the size of benefits are not shown in the simplified approach used in Figure 76. Depending on family type, the total amount of child home care allowance is affected by increments based on the number of siblings and income-tested care supplement, in addition to the actual care allowance.[26] The grounds for granting these benefits were changed in August 1997. The total impact of the reform varied depending on family type and the family's other income. The net amount of labour market support and other taxable income transfers has also to a slight degree been reduced by the increase in the average municipal tax rate. The change in municipal tax rate does not affect the income of pensioners who only receive national pension, because they do not pay municipal taxes due to the pension income deduction in municipal taxation. [27] Income testing of the labour market support with regard to spouse's income became more

moderate in September 2000 and at the beginning of 2004. When looking at full labour market support, the more moderate income testing does not come out. The gross income of a family could increase by € 150 per month just as a result of the reform implemented at the beginning of 2004.

Figure 76. Real growth of some income security benefits in 1995–2005, 1995=100



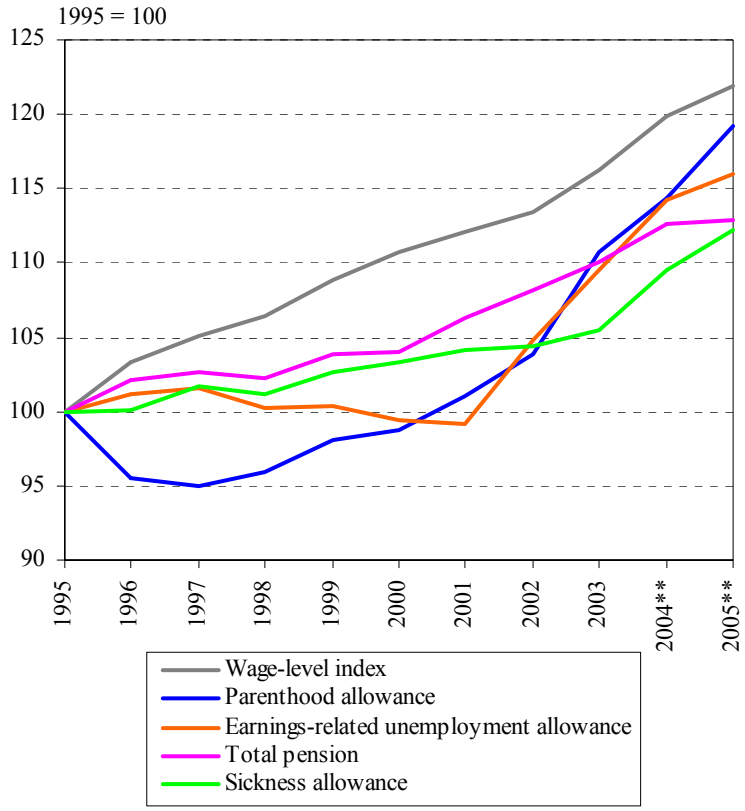
Child allowance: average per child weighted by family structure at the end of 2003
Labour-market support: full labour market support + possible child increment
National pension: full national pension, single person living in the first municipality category
Child home care allowance: excluding home care supplement and possible increments based on number of siblings, basic allowance until 1996
Weighted annual average, if the level of benefit was raised during the year

Average earnings-related daily allowances and average total pension of pension recipients have shown more positive development than basic income security and family benefits. The trend is due to the increase in the level of income that the benefits are based on, but partly also to changes in the benefit rules. Adjustments of the levels of national pension and basic unemployment allowance also increase the average level of total pension and earnings-related unemployment allowance. In connection with the increase of basic unemployment allowance on 1 March 2002, the level of compensation of the earnings-related part that had been lowered to 42 percent in the 1990s was returned to 45 percent.[28] Those left jobless after 1 January 2003 have been able to get an increased earnings-related unemployment allowance instead of severance pay, which has been discontinued. A

precondition for this is a minimum of 20 years of employment entitling to pension. After cessation of the transition period concerning severance pay, the level of average daily allowance has started to rise. The average daily sickness and parenthood allowances were increased by the adjustment to the level of minimum allowance which came into effect at the beginning of 2005.

It must be remembered particularly in the case of pension recipients that the figure does not illustrate income trends of persons receiving pensions at the beginning of the period under study. The development of average pensions and allowances is also affected by changes in group structure. The fact that pensioners' taxation was eased in the late 1990s and early 2000s is not shown either when looking at gross pensions. Despite the increase in the average level of pensions, the income tax rate of persons receiving average total pensions was about 4–5 percentage points lower in 2002 compared to 1995.

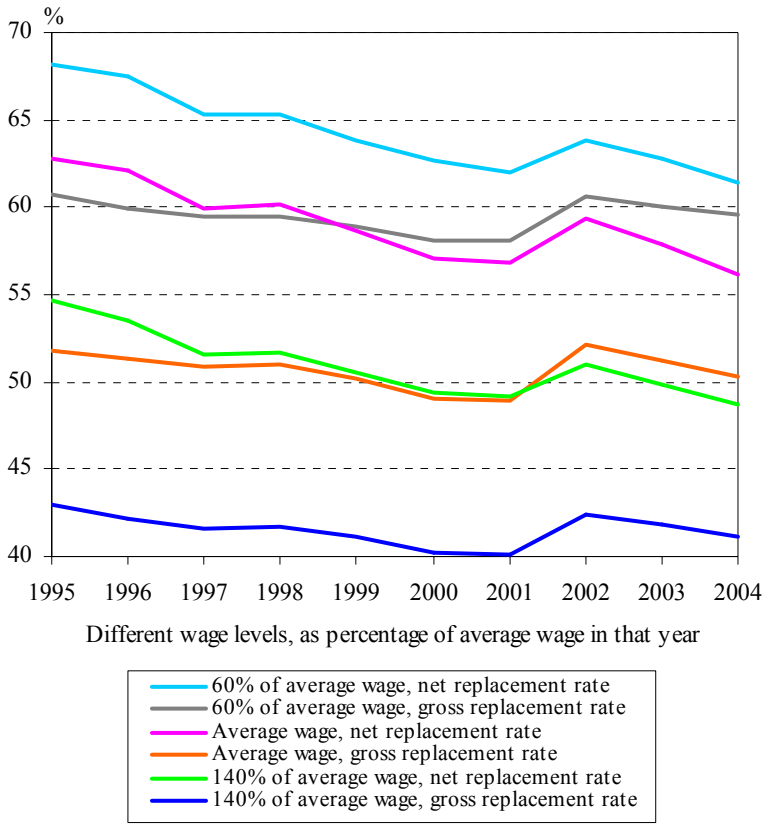
Figure 77. Real growth of average pension, average daily allowances and wage-level index in 1995–2005, 1995=100



The average level of earnings-related allowances has risen more slowly than the average wage level. Because this may be due to changes in the allowance recipients' income level and structure, it does not as such tell about the changes in replacement rates of benefit systems at different income levels. Gross replacement rate describes the relation between a benefit and the previous earnings it is based on. The gross replacement rate of earnings-related unemployment allowance has remained nearly unchanged in the case of lower-than-average wages (Figure 78). In the case of higher wages, the gross replacement rate

has decreased, because an increasing share of income only entitles to a lower compensation rate.[29] Instead of gross income, net replacement rate describes the relation of net allowance after taxes to net wages. The net replacement rate of earnings-related unemployment allowance has declined at all income levels. In addition to general changes in taxation, concerning both wages and taxable social security benefits, the net compensation rate has been lowered particularly in lower income categories by development of earned income allowance in municipal taxation. At present, only wage or entrepreneurial income qualifies for earned income tax allowance. For example, in the case of low wage earner (60 percent of average wage), the net replacement rate has decreased by nearly seven percentage points, about half of which is explained by changes in earned income allowance. One of the key aims of the earned income tax allowance has been to lower the threshold to accept low-paying work.

Figure 78. Gross and net replacement rate of earnings-related unemployment allowance at different wage levels in 1995–2004, %



Average wage: Average production wage (APW) level of OECD. The figure also includes holiday bonus, which is not taken into account when the earnings-related unemployment allowance is calculated. This lowers the replacement rate somewhat compared to calculations where holiday bonus is not included in wages during employment. Unemployment fund membership fees have not been taken into account in the calculations.

The incomes of low-income households in particular can come from many different sources. Circumstances can vary a great deal depending on life situation and family type. Even if the impact of taxation were taken into account, looking at individual social security benefits and wage income does not always give a sufficiently comprehensive picture of the combined effect of changes in income and income security. In addition to unemployment allowance and labour market support, the income of a single unemployed person living in a rented flat may be affected by taxation of the benefit, housing allowance and potential social assistance granted to supplement income. In families with children, the factors affecting income formation can be even more numerous. This is not only restricted to social security benefits. Because the need of day care of young children usually depends on whether their parents work, day care fees constitute a special expense category. The increase in income resulting from both parents being employed is counterbalanced by a new expense category, day care fees.

Coverage of income security

Being no longer covered by earnings-related income security may cause a significant drop in income for an unemployed person. From the point of view of income of the unemployed, minor changes in the benefit rules of earnings-related allowance may have less significance than how the unemployed are divided into earnings-related and basic security recipients. Correspondingly, in addition to changes in pension systems, the number of low-income pensioners depends on pension recipients' work history. The current persistent long-term unemployment may in the future be reflected as an increase in the number of pensioners with low income. In addition to the level of various cash benefits, the distribution between earnings-related and basic benefit recipients thus plays a significant role. A relatively low level of labour market support would be a clearly smaller problem if the majority of unemployed received earnings-related unemployment allowance and labour market support periods remained relatively short.

In 2003, a good 40 percent of unemployed job seekers received earnings-related unemployment allowance, while about 50 percent received labour market support. The proportion of those receiving earnings-related unemployment allowance was at its highest during the first years of the recession in the 1990s. After that there was a slow decline in the proportion of earnings-related unemployment allowance recipients, while the total number of unemployed job seekers also diminished. In 2003, a small rise was seen in the proportion of earnings-related allowance recipients. Some unemployed have retired to unemployment pension. The number of unemployment pension recipients has increased right until the last few years. (Table 13)

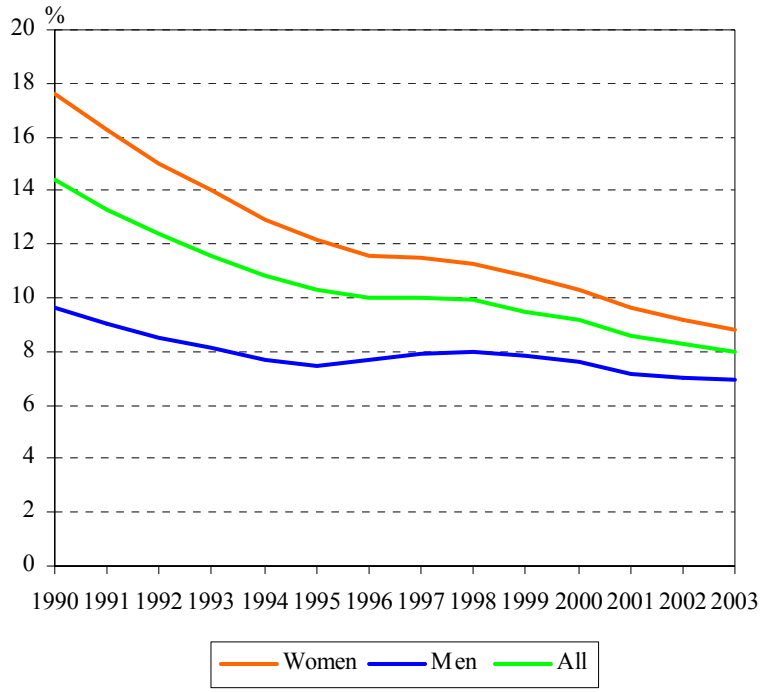
The importance of employment pension in pensioners' income formation has grown steadily. The share of pensioners receiving only national pension declined rapidly in the late 1980s and early 1990s. Their share has continued to decline after that, but at a somewhat slower rate. The share of women who only receive national pension has declined particularly rapidly. (Figure 79)

Table 13. Unemployed job seekers by type of income security and unemployment pension recipients in 1995–2003

Year	Unemployed job seekers			Unemployment pension
	Earnings-related allowance	Basic allowance	Labour-market support	
1995	238,700	76,400	142,700	39,800
1996	237,100	28,700	178,300	37,900
1997	208,500	25,500	173,300	41,100
1998	169,900	19,200	180,500	44,900
1999	150,000	16,700	175,900	48,000
2000	135,700	15,900	159,600	50,900
2001	122,400	15,800	153,500	52,700
2002	118,200	17,200	150,600	54,700
2003	121,600	19,100	144,400	53,000

On average during the year. Source: Työpoliittinen Aikakauskirja. Ministry of Labour

Figure 79. Proportion of pensioners receiving only national pension in 1990–2003



Source: Statistical Yearbook of Pensioners in Finland. Finnish Centre for Pensions/Social Insurance Institution of Finland

Trends in the proportion of those only receiving national pension do not necessarily tell much about development of income security among pension recipients, because persons with very small employment pensions are also excluded. Table 14 shows the proportion of pensioners over 65 with pension in one's own right who only receive employment pension. The basic amount of the national pension was not fully abolished until the beginning of 2001, which is why the table only includes data from 2001 onwards. In 2003, more than 40 percent of those over 65 were already only receiving employment pensions; clearly over half of all men and nearly one third of women only received

employment pensions. As women live on average longer than men, the number of women is clearly higher in older age groups (over 75), which makes it harder to compare data between men and women. This is why proportions of those only receiving employment pension have been given separately in age groups 65–69 and 70–74. [30]

Table 14. Proportion of pensioners over 65 receiving only employment pension at the end of 2001–2003, %

	2001	2002	2003
All those over 65			
All	37.9	39.3	41.4
Men	52.3	53.8	55.9
Women	28.7	30.0	31.9
65–69 yrs			
All	51.9	53.9	56.2
Men	64.6	66.6	68.6
Women	41.1	43.0	45.5
70–74 yrs			
All	40.4	42.4	45.0
Men	52.7	54.8	57.5
Women	31.3	33.1	35.5

Includes only pensioners with pension in one's own right
Source: Finnish pension recipient statistics. Finnish Centre for Pensions/Social Insurance Institution of Finland

Sickness allowance compensates loss of income due to disability. Sickness allowance is usually paid on the basis on the applicant's earnings, but in some cases the insured are entitled to minimum allowance or one below that. [31] Minimum allowance or allowances below the minimum made up 5.8 percent of all sickness allowances in 2003. The proportion of minimum allowance recipients is clearly highest among the youngest age group, 16–24 years. The minimum parenthood allowance is equal in size to minimum allowance paid on account of sickness. In 2003, minimum allowance due to low income accounted for just over one fifth of all parenthood allowances paid. The proportion of minimum parenthood allowance recipients has declined in recent years.

Social assistance as a complement to other cash benefits

As a rule, benefits granted on the basis of e.g. sickness, disability or unemployment should secure sufficient income security. The extensive need of social assistance to supplement these benefits is an indication of tensions within the income security system. The need of social assistance is closely linked to basic unemployment security. In November 2002, nearly 47 percent of all households who received social assistance had also received labour market support or basic unemployment allowance, and about 55 percent had also received housing allowance. A typical combination was labour market support and housing allowance, complemented by social assistance. One in four households receiving social assistance also received both labour market support and housing allowance.

The need for social assistance is relatively rare among pensioners; 12.4 percent of the households receiving social assistance in November 2002 had also received pension. Pensions provide long-term income security and this has been taken into account in the level of national pension. Labour market support was originally intended as a temporary support form for young job seekers entering the labour market. In defining the level of support, various incentive issues related to acceptance of low-paying work are emphasised. Labour market support is poorly suited as income security for ageing long-term unemployed. The obstacles to employment may in their case be very complex, and the impact of benefit level on employment may be small.

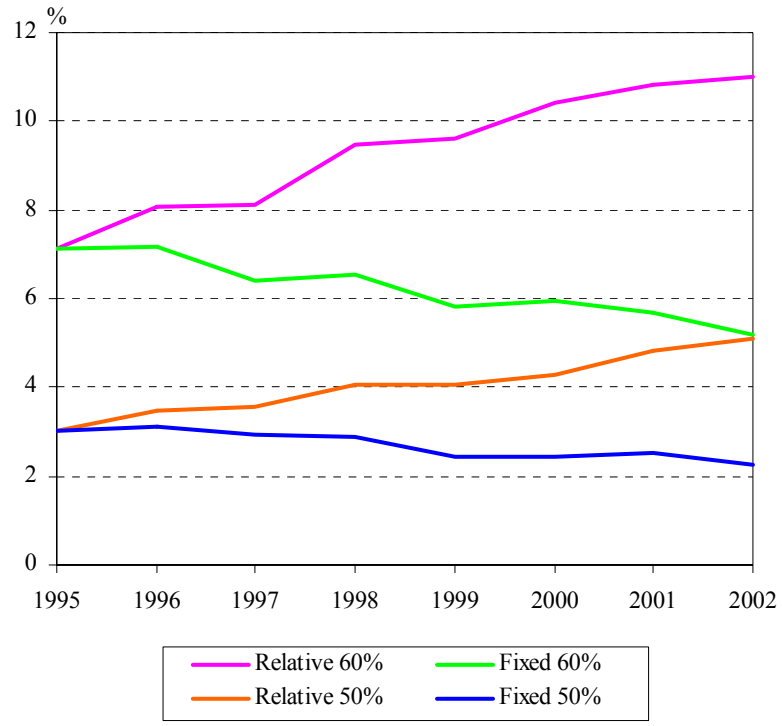
In addition to the level of primary benefits, the need for social assistance may in practice be caused by other factors that vary between households. The need for social assistance is determined per household, as the difference between the basic amount of social assistance and expenses taken separately into account and the household's income. This leads inevitably to differences compared to personal primary benefits. If the aim was to avoid the need for social assistance in nearly all situations, a considerable rise of the minimum level of primary benefits, or significant changes in the grounds for granting them would be required. An increase of the level of benefits would also be advantageous for those recipients of benefits whose income security is already reasonable. The increase in expenditure resulting from a raise in the level of benefits could be considerable, which would decrease possibilities for developing other forms of social protection. Extensive raises might also distort the economic incentives of income security.

Poverty and households on low income

One of the key aims of income security is to combat poverty and to secure sufficient income for people on low income. The prevalence of poverty and the income development of low-income population is affected by many other factors besides income security, such as changes in employment, development of earnings among low-wage earners, taxation and changes in family structure. Assessments on the sufficiency of income security through trends in poverty or income trends of households on low income must therefore be made with caution.

The indicator commonly used in measuring poverty is the proportion of population below the poverty line. Poverty line is defined in relation to the average income level of the population, and it follows changes in general income level ("relative poverty line"). Relative poverty line is most commonly set at 50 or 60 percent of households' median disposable income. Measured in this manner, the proportion of poor people has increased in recent years, which is not very surprising in light of what was said above about income security. The level of most minimum and family benefits has fallen behind general income development, while long-term unemployment remains common and many unemployed rely solely on basic unemployment security. Part of the increase in poverty can be attributed to the change in poverty line, as the poverty line has risen along with improved general income level. A different picture of recent development emerges if poverty line at the beginning of the period under study is used adjusted only with price change ("fixed poverty line"). In that case, the proportion of population below the poverty line has declined. (Figure 80)

Figure 80. Proportion of population below poverty line, calculated using relative and fixed 1995 poverty line in 1995–2002, %. Poverty line 50 or 60% of households' median income



Source: Ministry of Social Affairs and Health, Income Distribution Survey data file

Relative poverty line: relative poverty line is defined in relation to households' median disposable income each year. As the general income level rises, the relative poverty line rises correspondingly. Fixed poverty line: relative poverty line is defined in relation to households' median income at the beginning of period under study. Thereafter it has only been adjusted in relation to price changes.
Households weighted according to their size.

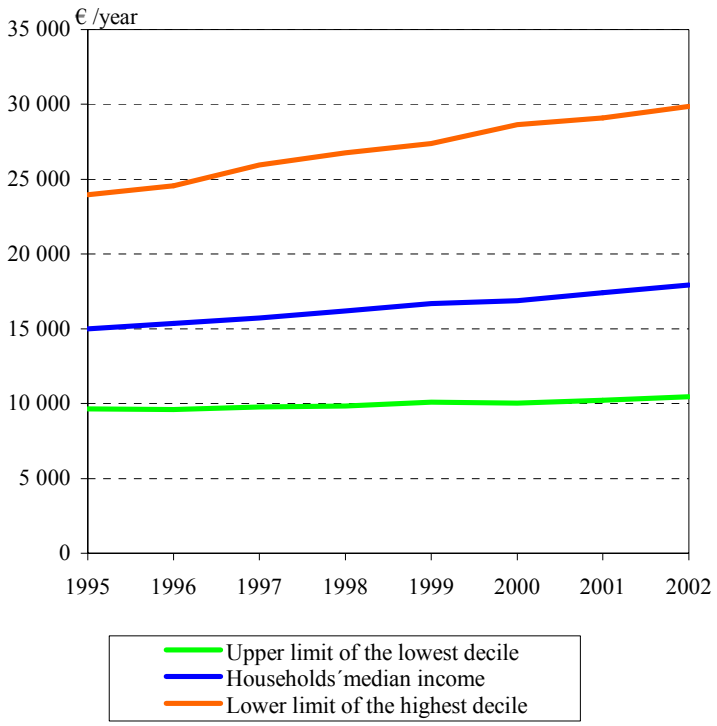
Income growth among low-income population has been clearly weaker than among middle- and high-income earners. In 1995, households' median disposable income was 56 percent higher than disposable income at the upper level of the lowest income decile. By 2002, the gap had widened to 71 percent (Table 15). Despite this, the real income of low-income households has also increased somewhat (Figure 81). About two thirds of the gross income of the lowest income decile consists of social security benefits and other income transfers, which means that their development plays a key role in the income development of this group.

Table 15. Ratios of disposable income at different points of the income distribution in 1995–2002, %

	1995	1996	1997	1998	1999	2000	2001	2002
Lower limit of the highest decile /upper limit of the lowest decile	249	256	265	272	271	286	285	285
Households' median income/ upper limit of the lowest decile	156	160	161	165	165	168	170	171

Source: Ministry of Social Affairs and Health, Income Distribution Survey data file

Figure 81. Development of households' real income per consumption unit in 1995–2002. At 2002 prices



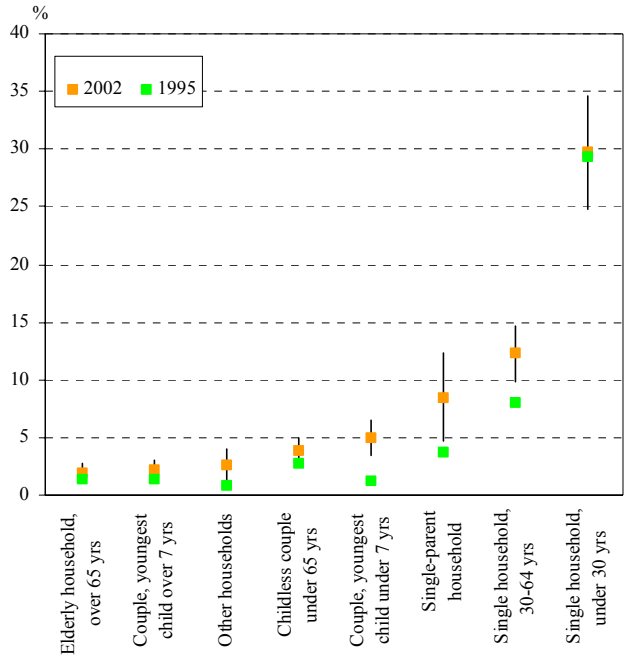
Source: Ministry of Social Affairs and Health, Income Distribution Survey data file
Modified OECD equivalence scale. Households weighted according to their size.

During times of brisk economic growth, income growth that is temporarily somewhat weaker among households on low income compared to the general trend does not necessarily constitute a major problem as far as social exclusion is concerned. What is more important is that employment improves and the real incomes of low-income households grow as well. A weaker income growth compared to others does however pose a problem when it persists over a longer period. In that case, low-income households cannot maintain a minimum level of consumption regarded as reasonable by the majority of the population. There is a danger that with time, the everyday life of people on low income diverges more and more from that of the rest of the population. From this viewpoint, securing a reasonable level of income security is a key element in the battle against social exclusion.

The prevalence of low income varies significantly according to phase of life and family type. Being on low income is particularly common among young people under 30, even if using the lower poverty line (50 percent of median income of all households). A significant proportion of these households are student households. Low income is therefore not necessarily a very permanent phenomenon; it is linked with a certain period of life. Another factor that increases the risk of having a low income is belonging to a household with only one adult. The proportion of people on low income is clearly higher than average among single persons aged 30–64 and among single parents. The proportion of people on low income has also increased in both groups during the period under study. During this period, the number of low-income two-parent families with children under school age has also increased. (Figures 82 and 83)

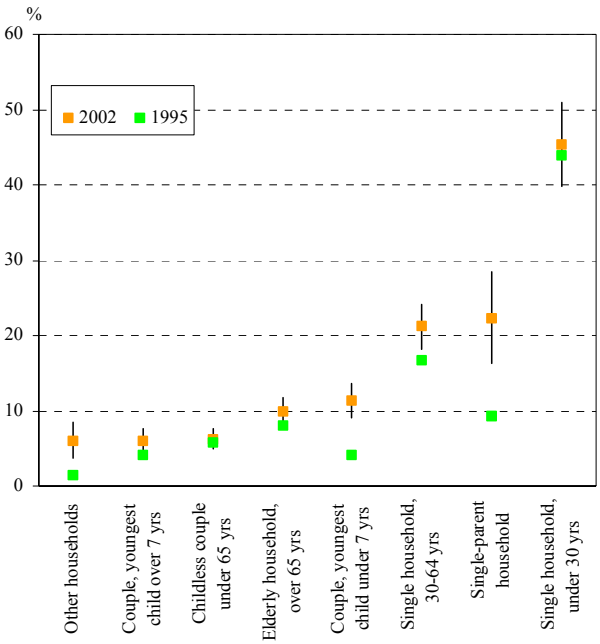
Sample-based figures include an element of uncertainty due to random variation. This is true not only of opinion polls, but of sample-based income statistics as well. This is why figures 82 and 83 include a confidence interval for the year 2002 (a vertical line), within which share of low-income population is located with 95 percent likelihood. The figure shows that the margin of error is fairly large in some groups (single parents, single households). This is why very far-reaching conclusions should not be made on the basis of small annual changes.

Figure 82. Proportion of population below poverty line by family type in 1995 and 2002, %. Poverty line: 50 percent of households' median income



Source: Ministry of Social Affairs and Health, Income Distribution Survey data file

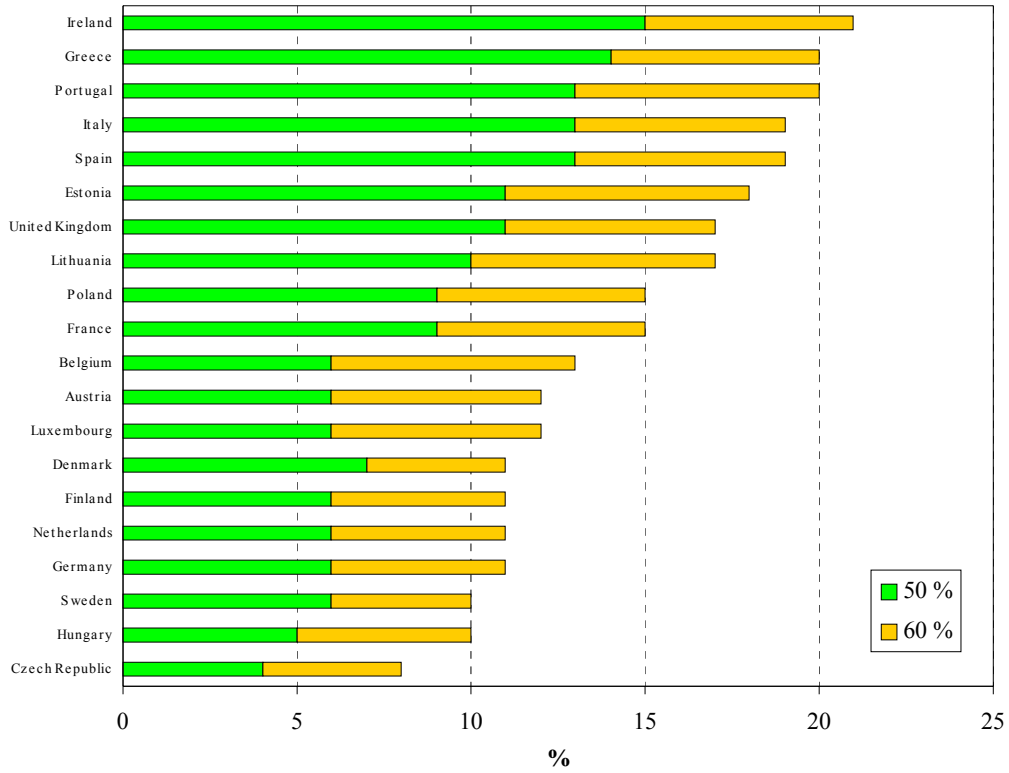
Figure 83. Proportion of population below poverty line by family type in 1995 and 2002, %.Poverty line: 60 percent of households' median income



Source: Ministry of Social Affairs and Health, Income Distribution Survey data file

Compared to most other EU member states, relative poverty is rare in Finland. The low poverty rate of new EU member states such as the Czech Republic and Hungary may seem surprising. However, poverty in each country has been defined in relation to households' median income in that country, which is why the poverty line in countries with a low income level is lower than in countries with a high level of income. [32] Poverty rates in different countries cannot therefore be used as such for comparing the income of low-income populations in different countries. Measured in terms of purchasing power, the poverty line in e.g. Finland and Sweden is clearly lower than in Denmark and Germany. (Figure 84)

Figure 84. Poverty rate in current EU member states in 2000, %. Poverty line: 50 and 60 percent of households' median disposable income in each country



Disposable income of different household types adjusted according to modified OECD-scale
Source: Eurostat, New Cronos

The working poor

A lot of attention has been focused on the group of "working poor", particularly in the United States, but in recent years increasingly in Europe as well. Among the working poor, gainful employment does not guarantee even a reasonable income level. As well as a low wage level, this may be due to irregular or part-time work. In addition, a small salary may also go towards covering the expenses of a possible spouse or children. Discussion on this phenomenon has spread to Finland as well, partly as a result of the debate on temporary jobs.

In the government programme, the close connection between a positive employment trend and combating poverty is mentioned. The connection must naturally not be solely based on employment as a way out of poverty. Thanks to an expanding financing base, a positive employment trend creates prerequisites for securing reasonable income security even for those outside working life, particularly if the size of the group remains relatively small. Whatever the interpretation, work and poverty would be a difficult combination for the objectives of the government.

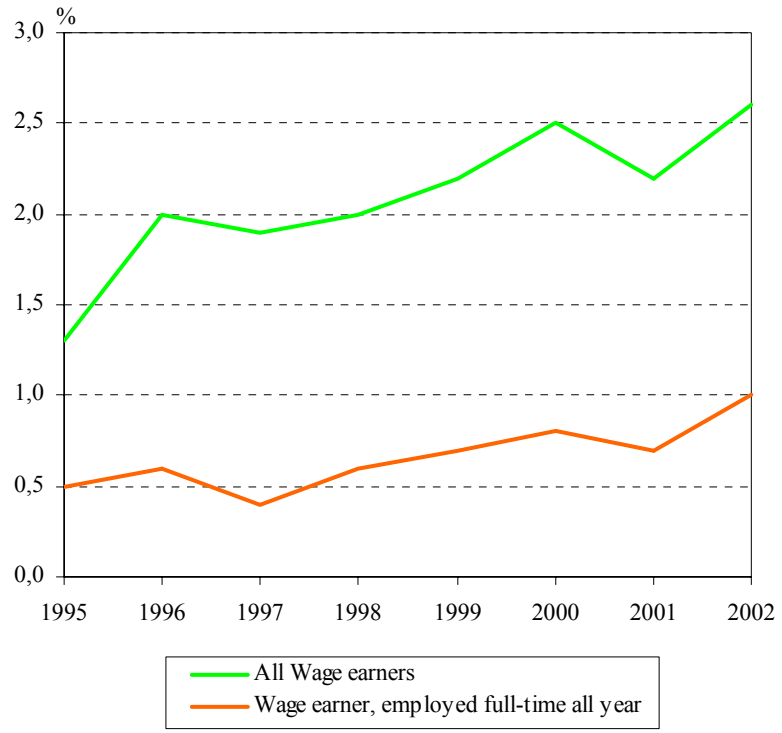
Measuring work input is a key issue when the phenomenon of the working poor is studied. In income statistics incomes are usually measured on annual basis, meaning that time at work must in some way be proportioned to this. Most people would agree that a person who has been employed full time all year but whose income is low fulfils the criteria of being poor, whereas there is room for interpretation in the case of a person who has been unemployed part of the time and employed part of the time. Another key issue is whether to measure personal income or household's income, as in done in Figure 85.[33] When using household's income, the assessment of low income is affected by the income of other members of the household, and correspondingly, the number of persons in the household supported by the income.

On the basis of Figure 85, low income (household's income) among persons employed full time does not seem to be a particularly common phenomenon in Finland. The majority of persons on low income belong to two-parent families with children, being in many cases the only employed person in the household. Due to the small size of the group, it is hard to draw conclusions concerning the increase of the proportion of people on low income.

Restricting the study only to persons with full-time employment during the entire year leaves groups with the weakest ties to the labour market outside its scope. If polarisation occurs in the labour market, so that low-wage earners are increasingly also part-time employees or have short temporary jobs, this restriction may give a misleading picture of the development. That is why the proportion of all wage earners [34] who live in low-income households is given in Figure 85. The proportion of low-income (household's income) wage earners is now clearly much higher, because the group under study also includes wage earners who have been unemployed during the year or who have had other interruptions in their work. The largest group is now made up of single households. The proportion of low-income earners has also grown during the period under study. Among wage earners only employed part of the year, average months of work have remained unchanged during the period under study; their wage development does not differ significantly from that of persons employed all year either. Activities during the year typically consisted of various combinations of part- and full-time work, study and unemployment.

The classification also has significance on the policy conclusions that can be drawn from the statistics. If poverty seems to be increasing among people employed full-time all year, adjustment of taxation and benefits given to low-wage earners could be a solution. If poverty concerns parents responsible for bringing up children in particular, the problem may be related to family benefits. On the other hand, if poverty increases among people who are working part of the year and unemployed rest of the year, the main problem may be unemployment, in which case the solutions may also be totally different.

Figure 85. Proportion of wage earners in low-income households using different wage earner definitions in 1995–2002, %
Low income line: 60 percent of households' median income



Source: Ministry of Social Affairs and Health, Income Distribution Survey data file

Income security and incentives to work

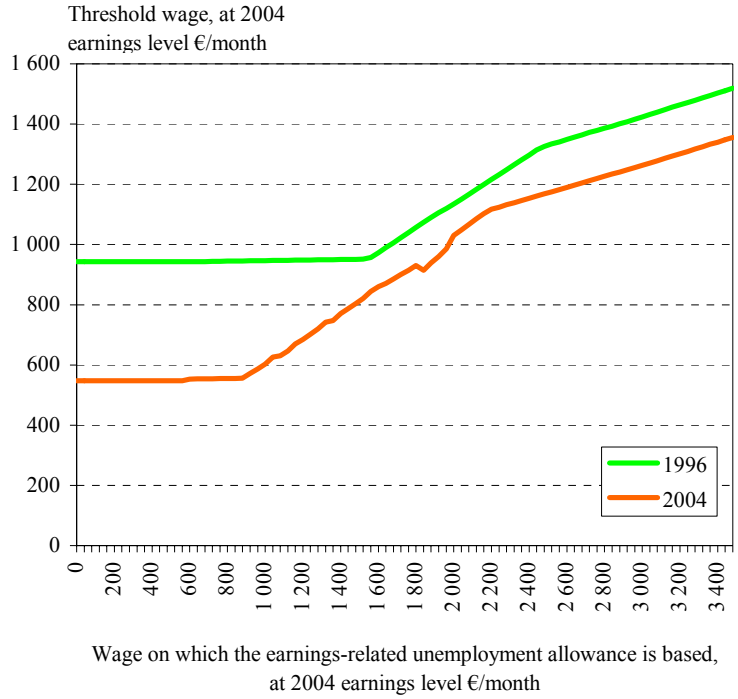
When defining a reasonable level of income security, the possible incentive impact of benefits must also be looked at. If reliance on benefits provides nearly the same level of income as work, the original intent of the benefits may be forgotten. Benefits intended as temporary security in the case of unforeseen events, such as unemployment or illness, may become a permanent source of income. Income security no longer acts as a springboard to work; in the worst-case scenario, it may even act as a hindrance to return to work.

One way of looking at income security in terms of incentives to work is to consider the gross salary with which disposable net income is the same as when relying solely on income security. The higher this threshold wage, the more likely it is that income security involves problems related to incentives to work. Figure 86 shows the threshold wage of a single unemployed person living in a rented flat at different wage levels prior to unemployment using 1996 and 2004 tax-benefit rules. In addition to changes in tax-benefit rules, the change in earnings and rent level between 1996 and 2004 is taken into account in calculating the threshold wage. The figure shows that in the example, the threshold wage has decreased, and incentives to work have improved at all levels of income. [35]

The approach using threshold salary is naturally a very simplified one. The results depend on the benefit under study, family type, housing costs and other assumptions. In addition, threshold salary only describes the level of salary that secures the same disposable income

as income security. Since work may give rise to expenses, and free time has a value of its own, threshold salary should perhaps be defined as salary level at which disposable income from earnings somewhat exceeds the level of income security.

Figure 86. Threshold wages using 1996 and 2004 tax-benefit rules, euros per month at 2004 earnings level

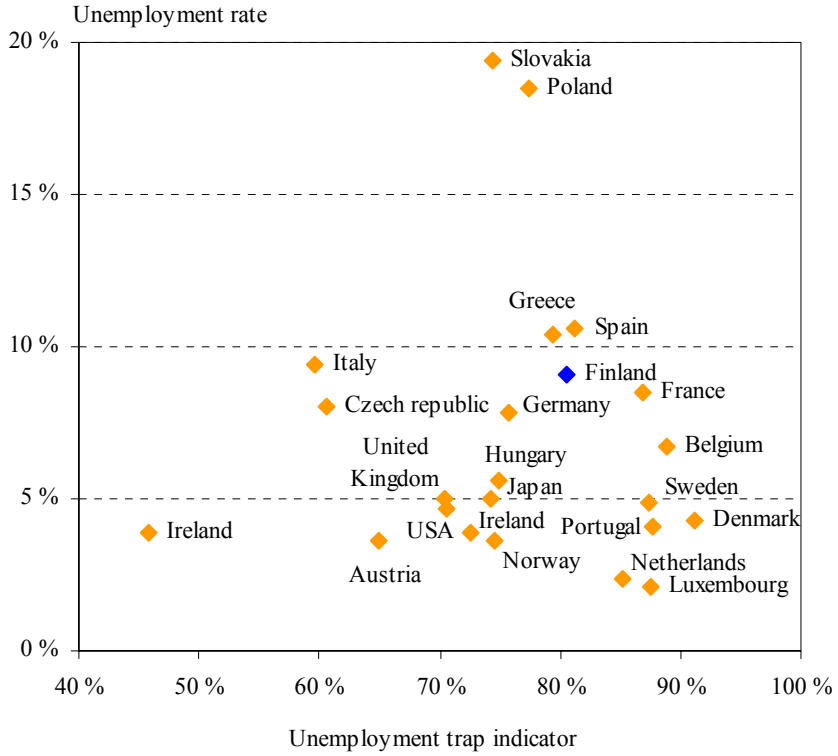


Example with figures: In 2004 a person earning € 1,600 euros per month who becomes unemployed should earn at least € 860 per month in a new job in order to attain the same disposable income as during unemployment. Earnings-related unemployment allowance, housing allowance and taxation, as well as possible social assistance during unemployment are taken into account in the calculation.

The work incentives of income security can also be studied from the viewpoint of increase of income of employed persons. In that case, the focus is on the increase in income resulting from increased earnings. Part of the increase in gross income is reduced due to taxes. The same household may also be receiving income-tested benefits (housing allowance, income-tested labour market support, care supplement for child home care allowance recipients), which are reduced as earnings rise. This may further diminish the increase in net income. In families with children, the increase in net income may be further diminished by a rise in municipal day care fees. In extreme cases, the combined effect of different systems may cause families to end up in a so-called income trap, where household's net income does not grow much. It is easy to construct hypothetical examples of such situations, but it is more difficult to study their prevalence in reality. Parpo (2004) studied the prevalence of income traps empirically using a sample representing the entire population as material. An income trap was defined as a situation where an increase in household's net income remained below 20 percent of household's increased earnings. Income traps defined in this manner were rare in wage earner households, and they seemed to be a more common problem among the unemployed. [36]

Improved calculation models and better availability of international data have increased studies on compensation levels and incentives. When comparing countries, it is hard to find a direct association between the level of income security of unemployed persons and the unemployment rate. A reasonable level of unemployment security may be linked to low unemployment and high employment. Examples of this are e.g. Denmark and Sweden (Figure 87). There is unavoidably a certain conflict between the level of income security and work incentives. Attempts can however be made to solve this conflict by other means than by lowering the level of benefits. One means is monitoring and supporting active job-seeking. Training, rehabilitation or other activities promoting employment must be available for the unemployed. Correspondingly, it can be required that benefit recipients take part in such activities. Refusal to participate may ultimately lead to benefit cuts or even total loss of benefit. The measurement and international comparison of these matters is unfortunately very complicated, which is why comparisons easily focus on measurement of benefit levels. There is a danger that these issues are forgotten when the income security is reformed so that it is better able to promote employment.

Figure 87. Unemployment rate and unemployment trap indicator in some OECD countries in 2001



Unemployment trap indicator: the greater the value, the smaller the economic incentive of the unemployed to accept work. For more details, see Carone (2003)

VI Well-being of families with children

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

In order to secure the well-being of children, the government programme of Prime Minister Vanhanen is committed to ensuring that family and child policy is stable and predictable. According to the government's strategy document, trust in the future on the part of families is improved by a long-term policy in which the well-being of children, young people and families with children is chosen as a clear social policy objective. The challenges include ageing of the population, a falling birth rate, the high average age of first-time mothers and postponement of the age of starting a family. It has been suggested in recent public debate that the present level of population growth is not sufficient to secure the financing and high level of welfare services in the decades to come.

In spring 2002, the Ministry of Social Affairs and Health published a Family Policy Strategy, which included objectives for family policy reform. The following five areas were defined as the main objectives of child and family policy:

- Social values change and the status of families with children improves, so that an increasing number of families are able to have as many children as they wish
- The home and parents have an increasingly important role in caring for and raising children
- The growing environment offers children a safe setting to develop in, and supports parents in their task to care for and raise their children
- The mental well-being of families is improved
- The material circumstances of families with children are improved

6.1 Starting a family and family formation

The age of starting a family has been increasingly postponed. The aim of the family-policy lines of the Ministry of Social Affairs and Health is to encourage young people to start a family by providing more flexible housing arrangements, by improving service and income and by supporting studies and working life. Studies take longer than before, which is why people enter working life at a later age. It is stated in the Family Policy Strategy of the Ministry of Social Affairs and Health that in order for young people to start families at a younger age, the progress of studies and starting a family should be reconciled better than is the case at present. People get married at a later age than before, very often after cohabiting with the future spouse or another partner. In 2002, the average age of women entering into their first marriage was 29.1 and that of men 31.3 years. In

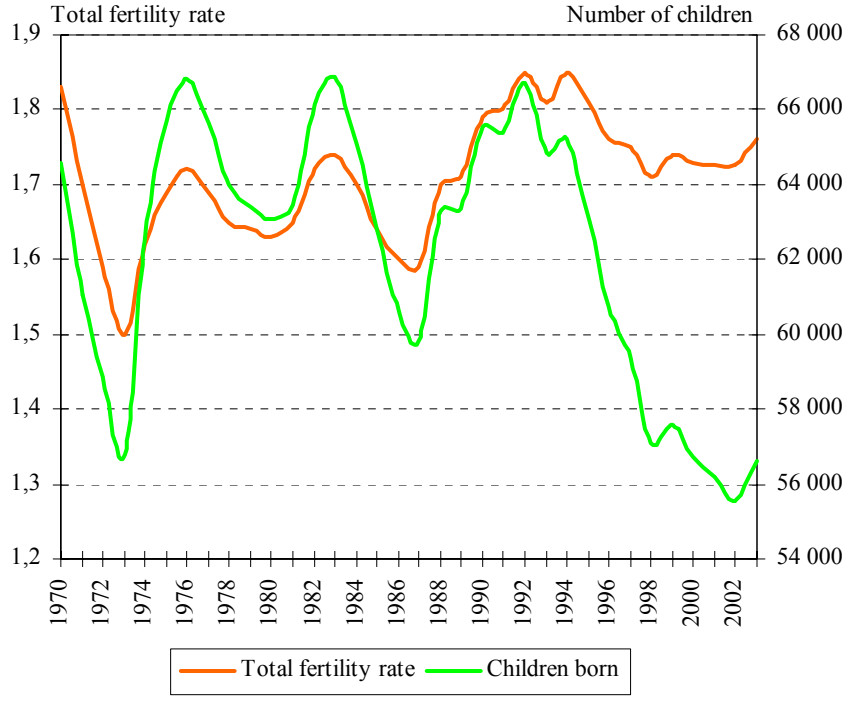
ten years, the average age when people get married for the first time has risen by more than two years.

Birth rate

In 2003, a total of 56,645 children were born, which is 8,200 less than ten years ago (Figure 88). The number of children being born has declined particularly in Kainuu and Lapland as a result of migration to large cities.

The decline in the number of children being born is primarily a result of the fact that the small cohorts of the 1970s have now reached child-bearing age. By European standards, the total fertility rate in Finland is quite high. [37] In 2003 it was 1.76, while the EU average the year before was 1.47. There have been age-group specific changes in the fertility rate in recent years. Fertility has declined among women under 25, and increased among those over 30. Fertility among women aged 25–29 has also taken a downward turn (Figure 89).

Figure 88. The number of children born and total fertility rate in 1970 – 2003



The relatively constant total fertility rate in recent years is a result of the fact that having a second or third child has been fairly common. However, the time when women have their first child has been postponed due to longer duration of studies and an increasing prevalence of short-term jobs. The average age of primiparas has risen steadily (Figure 90); in 2003 it was 27.9 years. It seems that family-policy support has made it possible for families with children to have more children. Family-policy support can influence the timing of having children, but it has no decisive impact on the number of children in the family.

Figure 89. Age-group specific fertility rates [38] in 1970–2003

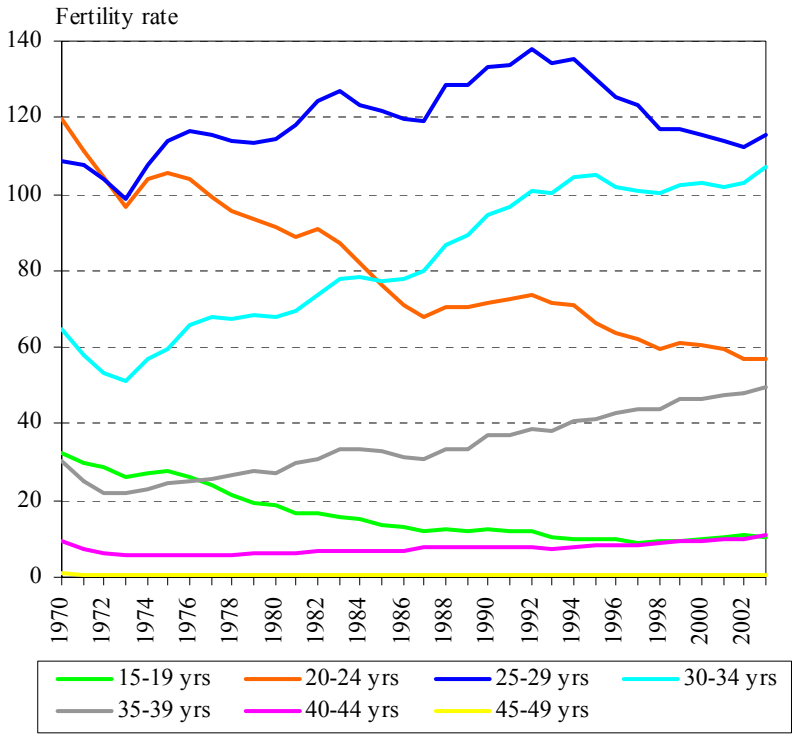
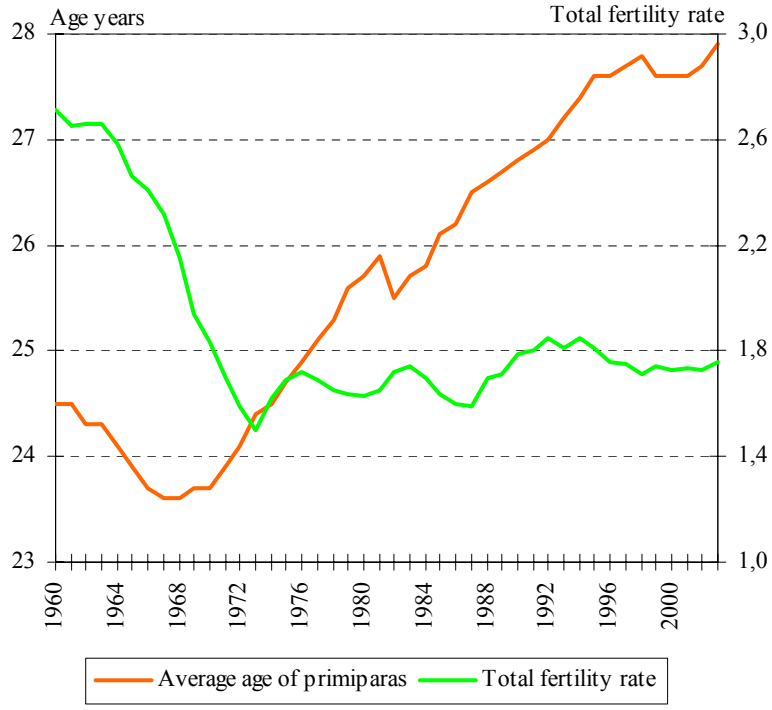


Figure 90. Average age of primiparas and total fertility rate in 1960–2003



Family structure

The number of families with children has declined steadily. At the end of 2003, there were 595,000 families with children, which was 17,600 less than in 2000. There have also been changes in family structure at the same time. The number of cohabiting families is constantly rising. Seventeen percent of families with children are cohabiting families. As many as 53 percent of first-born children are born outside of marriage; however, parents in these families often do get married later.

Table 16. Types of families with children 1970 – 2003

	Married couple with children, %	Cohabiting couple with children, %	Mother/father with children, %	Families
1970	88.9	0.9	10.2	677,035
1980	83.1	4.7	12.3	688,732
1990	76.6	9,4	14.0	659,052
1995	70.2	12.3	17.5	640,637
2000	65.1	15.5	19.4	612,627
2003	63.0	17.1	19.9	595,027

Source: Statistics Finland

Due to the increasing prevalence of divorce, the number of single-parent families grew in the 1990s. At the end of 2003, 20 percent of all families with children were single-parent families. The number of reconstituted families has also increased somewhat in recent years; about eight percent of families with children are reconstituted families.

Table 17. Number of children in families with children in 1990 – 2003, %

	Number of children in the family			
	1	2	3	4-
1990	44.7	39.1	12.7	3.5
1995	44.5	37.8	13.4	4.2
2000	43.8	37.7	13.9	4.6
2003	43.3	38.0	14.0	4.7

Source: Statistics Finland

In the last few years, the number of one-child families has declined, while that of families with three or four children has grown. There are two trends in evidence in family formation. The number of children in families is showing a slight increase, but on the other hand, a growing number of women remain childless. According to the latest statistics, about 15 percent of women aged 50–54 have no children. Childlessness is most common among highly educated women; 23 percent of middle-aged women with a high education are childless, while the corresponding figure among women with no vocational training is only 14 percent. According to preliminary estimates, the proportion of childless women may rise to 20 percent in the future.

6.2 Evening out costs due to children

The starting premise of family policy has been to even out costs to parents caused by children. In recent years, the emphasis of family policy has been on the development of services aimed at families with children. Raising the level of many family-policy benefits is included in the government programme. Support from society to families with children is smaller than ten years ago. In 2003, family-policy support totalled € 4.6 billion, or about 3.2 percent of GDP. Child allowance and child day care are the most important forms of support aimed at families with children (Figures 91 and 92).

Figure 91. Development of family-policy support in 1990 – 2003 at 2003 prices, million euros

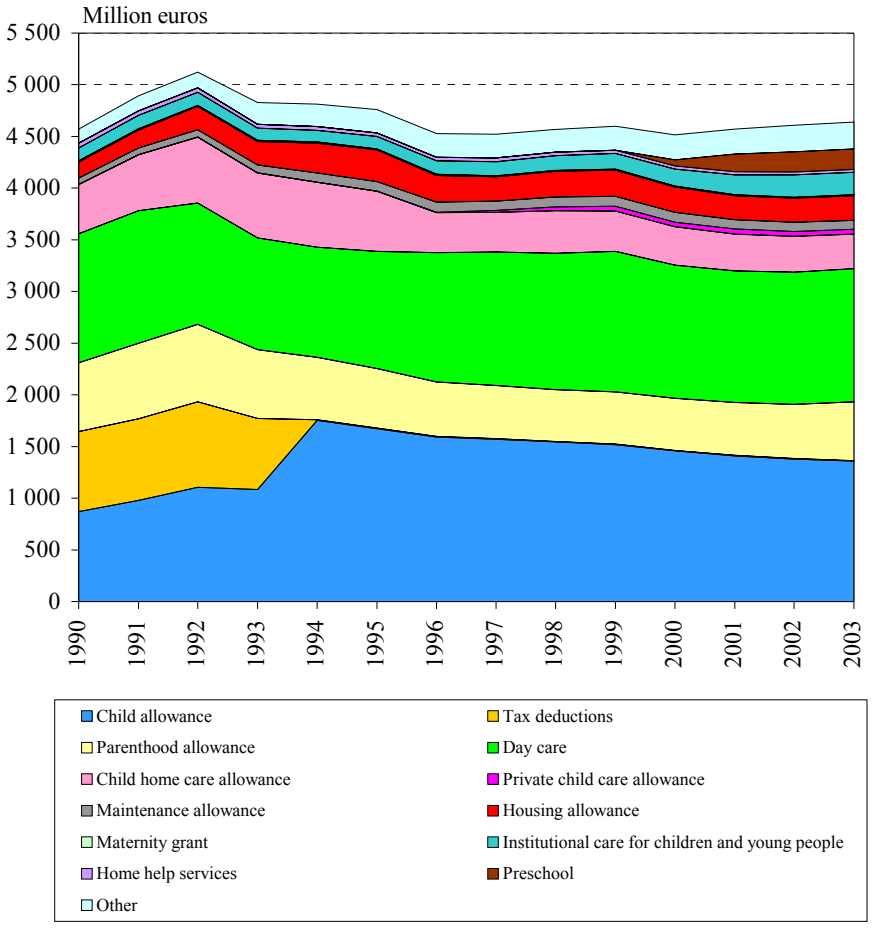
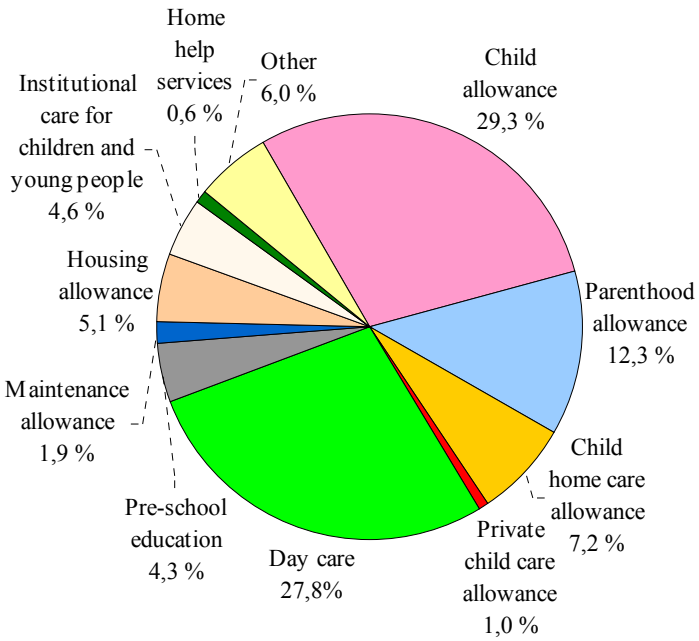
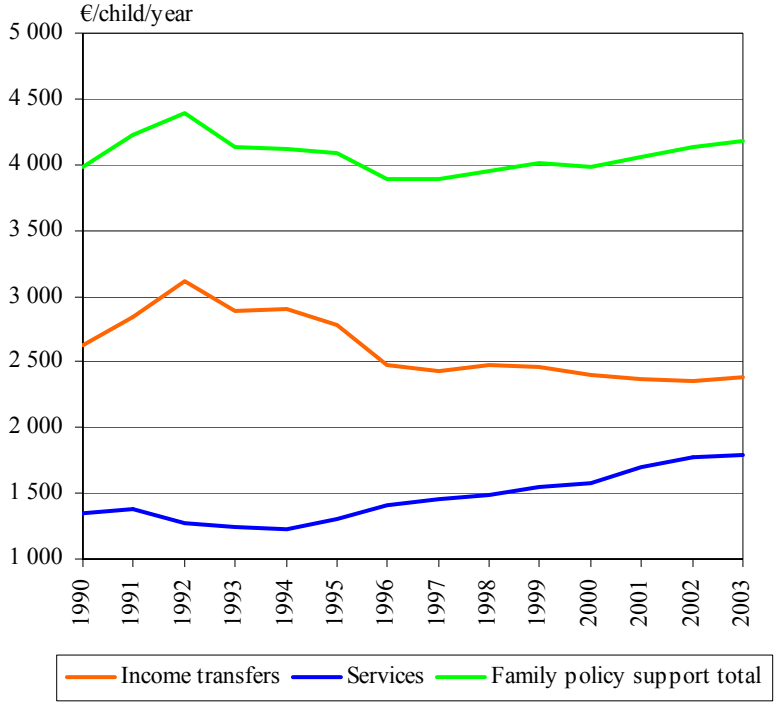


Figure 92. Distribution of family policy support [39] in 2003



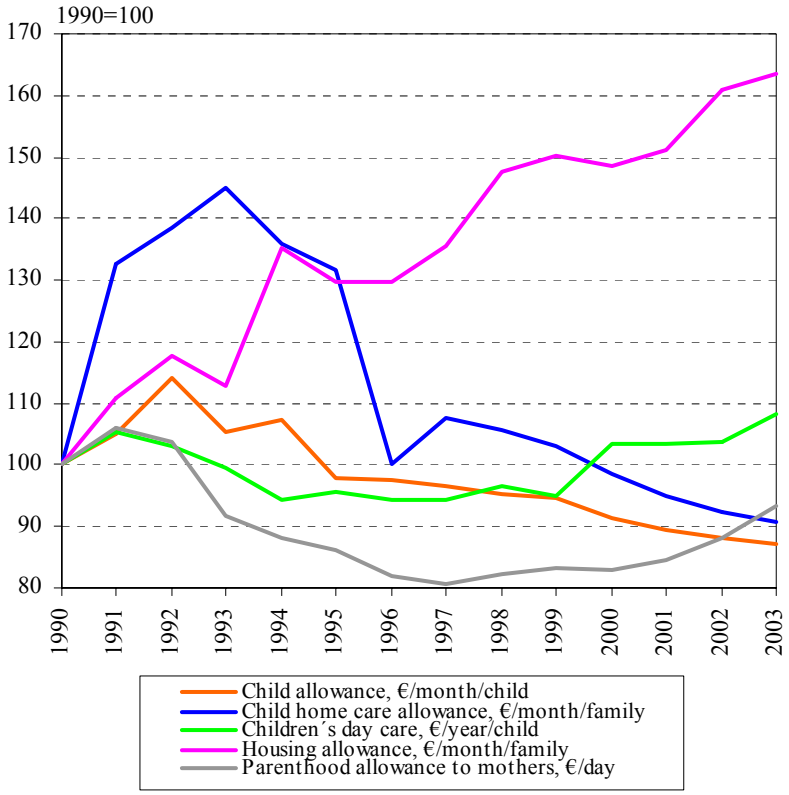
Family policy support per child is about five percentage points smaller than in 1992. However, there has been a small increase in the amount of support in recent years (Figure 93). The support provided by society to families with children has increased since 1996 following the increased entitlement to day care and the pre-school reform, whereas income transfers to families with children have decreased since 1992. Income transfers to families with children were cut in 1995 and 1996 in order to balance the public economy. At the beginning of 2004, the level of child allowance and partial child care allowance was raised, and child home care allowance, private child care allowance and the minimum level of parenthood allowance will be raised in 2005. The scope of partial care supplement was extended in August 2004 to cover parents of children in grades 1 and 2 in comprehensive schools.

Figure 93. Family policy support in 1990 – 2003, euros/child/year at 2003 prices



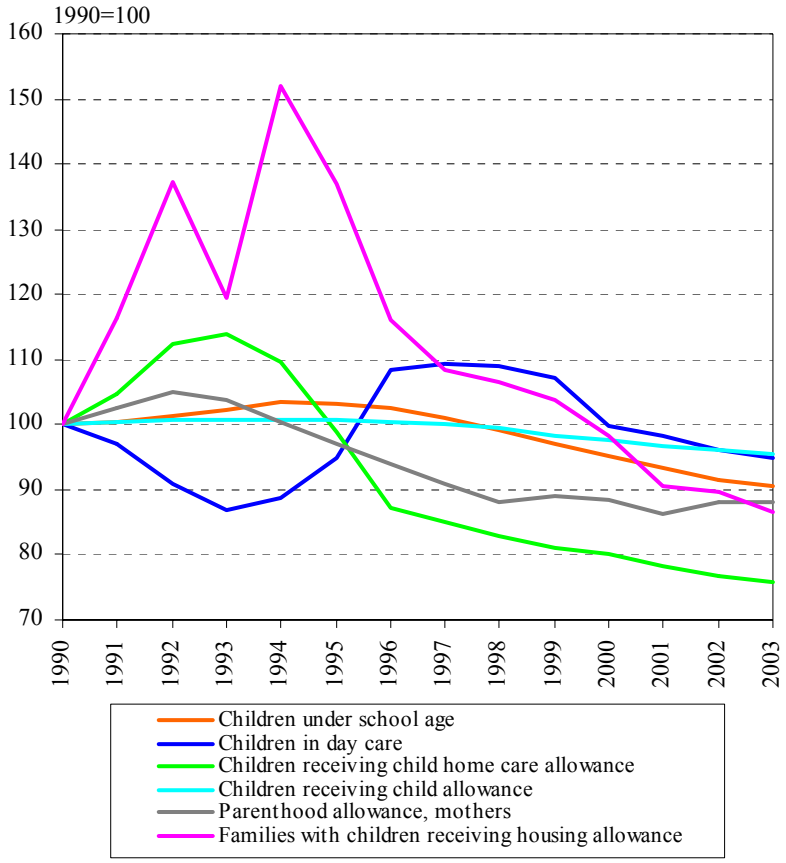
The income transfers aimed at families with children are not index-linked. This has been reflected particularly in the deterioration of the purchasing power of child allowance and child home care allowance, which were not raised for over ten years (Figure 94). At the beginning of 2004, child allowances were raised on average by € 6 per child by the adjustment implemented. One-parent families benefited the most from the adjustment. The level of child allowance is still about 14 percent lower than ten years ago. The level of child home care supplement will be raised by about 16 percent in 2005, and private child care allowance will be raised correspondingly. The minimum level of maternity, paternity and parenthood allowance will also be raised in 2005. The proportion of those receiving the minimum allowance has decreased; in 2005, about 21 percent of mothers received minimum parenthood allowance.

Figure 94. Real growth of some forms of family policy support in 1990 – 2003, 1990=100



The number of recipients of family policy benefits has fallen in recent years (Figure 95). The impact of a falling birth rate has been seen especially as decreased child allowance expenditure and a diminished need of day care. This trend is expected to persist.

Figure 95. Trends in the number of family policy benefit recipients in 1990 – 2003 (31 Dec)

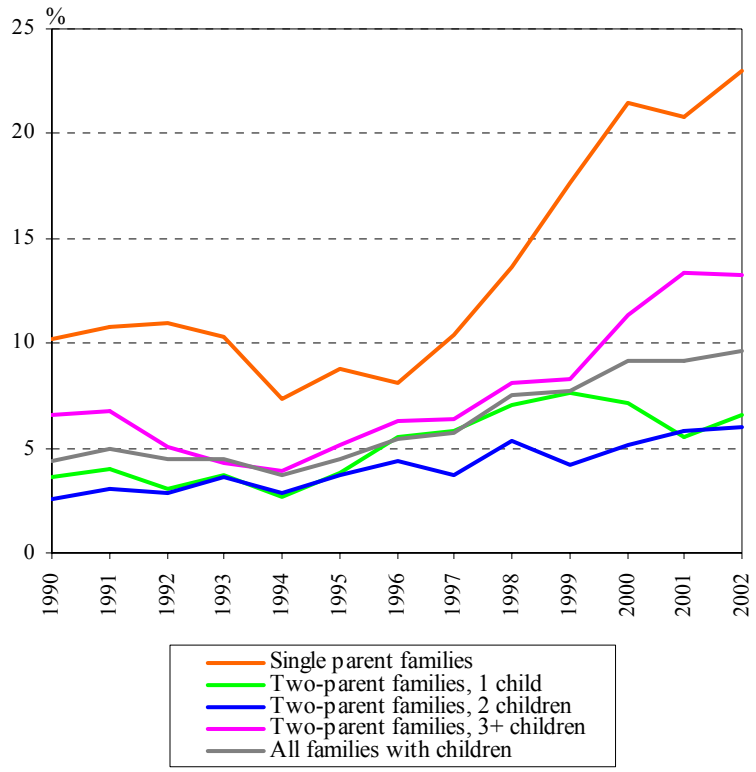


Economy of families with children

A positive employment trend and lighter taxation has improved the economic position of families with children. However, the development of the economy of families with children lags behind that of the rest of the population. The economy of single parents in particular has improved more slowly compared to the rest of the population. The primary reason for this is higher unemployment among single parents. In recent years, the income of single parents has also taken an upward turn.

The number of families with children living below the poverty line has not decreased. Poverty has increased particularly among families with several children (Figure 96). In 2002, 22 percent of single-parent families and 6 percent of two-parent families lived below the poverty line. There were 123,000 children in low-income families. About 11 percent of all children below 18 belong to families living below the poverty line.

Figure 96. Families with children below low-income line 1990 – 2002. Low-income line: 60 percent of median income



Source: Statistics Finland

6.3 Supporting parenthood

Parents have the primary responsibility for the welfare and upbringing of their children. The parenthood of mothers and fathers must be supported so that the well-being of families and children is improved. Parenthood must be supported not only when problems occur, but also in an attempt to prevent problems and to increase parents' material and mental resources. In addition to closeness, care and parental guidance, securing the economy and seeing to material needs are an integral part of parenthood.

Working life

Lack of time for children on the part of adults has come up in several surveys charting children's views and concerns. The possibility of reconciling work and family life is a key factor in supporting parenthood. Current legislation gives families with young children several alternatives enabling flexible reconciliation of work and family life. The starting premise has been to provide various options to reconcile work and child care with the aid of different support and service systems.

Employment is more common among families with children than in other households. Since the early 1990s, unemployment among parents with children has decreased. In more than half of all families with children, both parents work outside the home. After the recession, unemployment has diminished more slowly among single mothers compared to other mothers (Table 18).

Table 18. Employment and unemployment among mothers in 1989 – 2002, %

	1989	1992	1994	1996	1998	2000	2002
Employment rate							
Single-parent families	87.3	74.3	64.1	62.6	68.5	66.0	67.0
Two-parent families	83.0	75.3	69.9	70.1	71.6	74.7	77.4
Unemployment rate							
Single-parent families	3.0	12.4	23.5	21.1	16.7	14.3	11.8
Two-parent families	2.0	7.0	13.7	12.0	9.7	7.5	6.1

Source: TASTY database/ Statistics Finland, Labour Force Survey

The number of people with atypical employment (part-time or fixed-term jobs) has increased in recent years. Fixed-term employment contracts are especially typical at the early stages of career of highly educated women. Fixed-term contracts are relatively more common in the public sector compared to the private sector. It has been suggested that fixed-term jobs among young women are linked to the fall in the birth rate.

Family leave

Family leave is still prevalently used by women. All women make use of maternity leave, and nearly all take the parenthood leave following maternity leave. The popularity of paternity leave has been growing steadily (Table 19); about two out of three fathers take paternity leave. Only few fathers have taken advantage of parenthood leave available to fathers. In 2003, only 5.6 percent of fathers took parenthood leave, the figure was however more than twice as high as the year before. The two-fold increase in the proportion of fathers taking advantage of parenthood leave was due to the system known as bonus leave aimed at fathers. As of the beginning of 2003, the 18-day paternity leave for fathers was extended by 12 week days, if the father takes a minimum of 12 week days of his paternity leave at the end of the parenthood allowance period and the extended paternity leave immediately afterwards. Despite the increase in the proportion of fathers making use of parenthood allowance, the popularity of the new system has remained more modest than was expected. This may be due to the time limit included in the use of the extended leave. Taking paternal leave in a situation when the mother intends to take child care leave may be problematic, because in order for the father to be given paternal leave, the mother must return to work for one month's time. In 2003, a total of 2,105 fathers took advantage of the new system.

Table 19. Fathers receiving paternity and parenthood allowance in 1990 – 2003, percent per completed period

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Paternity allowance	44.7	51.5	45.7	52.6	53.5	54.6	55.7	58.5	61.1	62.9	64.7	67.4	68.2
Parenthood allowance	3.5	3.3	2.9	2.6	1.4	2.1	2.4	2.2	2.3	2.2	2.2	2.6	5.6

Breaking up of families

The number of divorces grew rapidly in the 1970s and 1980s. According to the latest statistics, the increase in the number of divorces seems to have stopped. In 2003, 13,500 marriages ended in divorce (Table 20). The total number of children in these families was 19,000. Separations between cohabiting couples are not shown in divorce statistics. Compared to married couples, separation is almost twice as common among cohabiting couples. As the divorce rate increases, the number of single-parent families grows. In 2003, there were 184,300 children in single-parent families, which is 56,600 more than at the beginning of the 1990s.

Table 20. Divorces and the number of children living in single-parent families in 1970–2003

	Divorces	Children in single-parent families
1970	6,044	
1980	9,464	
1990	13,127	127,667
1995	14,025	167,085
2000	13,913	182,829
2002	13,336	183,690
2003	13,475	184,309

Supporting parenthood as part of the services provided by municipalities

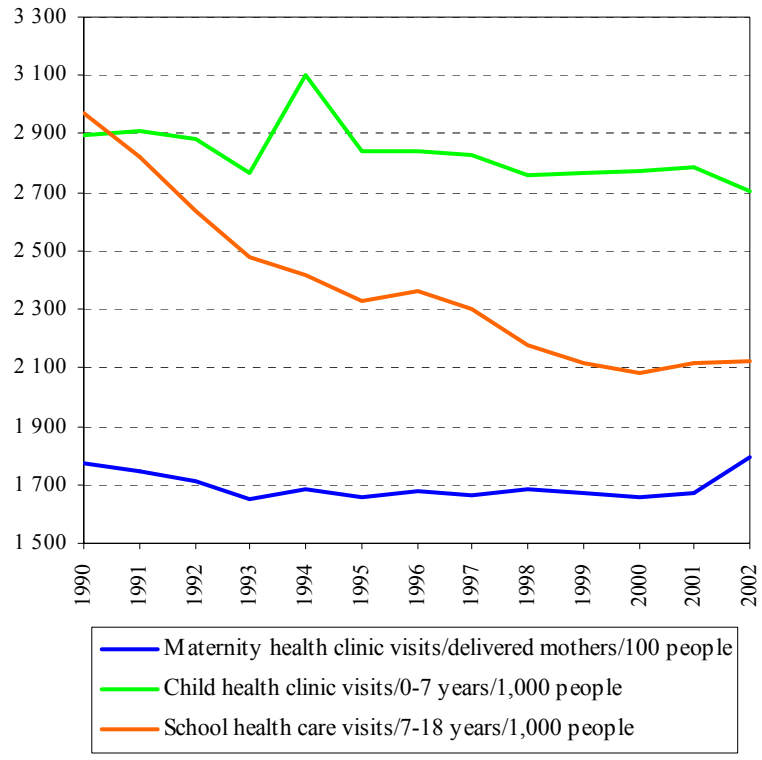
The task of maternity and child health clinics is to promote health and well-being of expectant mothers and families with children under school age. In the 1990s, the resources of maternity and child health clinics were cut, so that the number of visits was reduced, particularly in the case of periodic check-ups and home visits by clinic staff (Figure 97). In autumn 2004, a child health clinic guide book was completed at the Ministry of Social Affairs and Health, containing guidelines for municipalities concerning the development of the operation of maternity and child health clinics as part of basic municipal service. The work of maternity and child health clinics focuses increasingly on supporting parenthood and on promoting the psychosocial well-being of the child and the family as a whole. This calls for cooperation between actors engaged in work with families with children, and it is suggested that this cooperation be made more effective by

setting up a municipal family service network. Periodic monitoring and screening as well as provision of related counselling and support still make up the core of the work of maternity and child health clinics. Parenthood is also supported through various parents' groups.

The most significant reduction in the number of visits has been seen in school health care (Figure 97). There are considerable differences between municipalities in the provision and operating practices of school health services. The number of public health nurses and doctors for school health care is not sufficient at the moment at all health care centres.

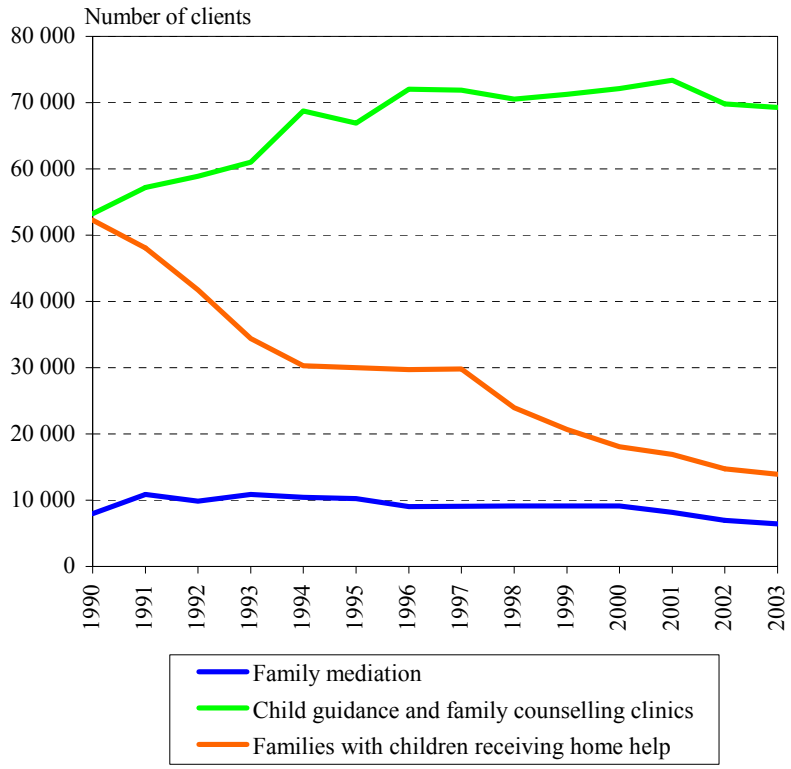
The aim of school health care is to promote students' health and the well-being of the entire school community, and to support healthy growth and development in cooperation with students, their parents, teachers, student counsellors and other school staff. The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities have issued a joint quality recommendation for school health care. The aim of the quality recommendation is to guide and support municipalities so that students receive high-quality school health-care regardless of where they live.

Figure 97. Visits to maternity and child health clinics and school health care in 1990–2002



The possibilities of families with children to receive municipal home help have diminished considerably. In ten years, the number of families with children receiving home help decreased by over 30,000 (Figure 98). At the same time, the number of clients at child guidance and family counselling clinics increased, whereas the number of clients taking part in family mediation has decreased somewhat in recent years.

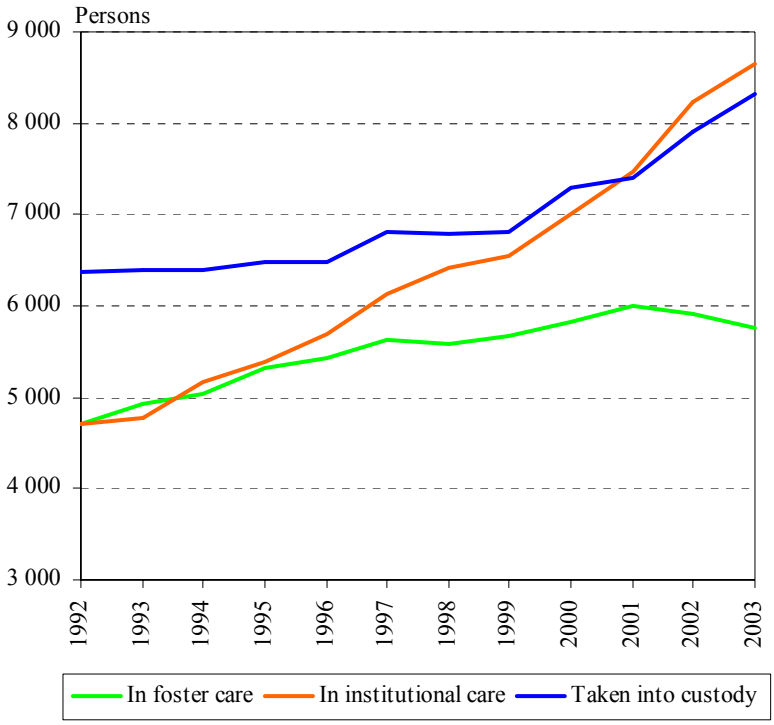
Figure 98. Special services for families with children in 1990 – 2003



Child welfare

The number of children placed outside their own home increased throughout the 1990s (Figure 99). In 2003, the total number of children and young people placed outside own home was 14,392, or 1.0 percent of the age group. Sixty percent of these children were in institutional care of some kind, and 40 percent were placed in foster care. The number of children and young people taken into custody was 8,325. The majority of children are taken into custody with the consent of the parties involved; however, the number of urgent decisions to take children into care against the will of those involved has increased. The most common reasons for placing children outside the home include parents' substance abuse and mental health problems, which often lead to child neglect and domestic violence. Today, more and more decisions to place children outside the home are based on the fact that the child is displaying symptoms such as school difficulties, criminal behaviour or drug use.

Figure 99. Children and young people placed outside own home and those taken into custody in 1992–2003



The number of cases where children are placed outside their own homes for a short while without being taken into custody has increased. It is increasingly common for one child to be placed repeatedly outside the home. As we entered the 2000s, the shortage of institutional child protection grew. Municipal units have been closed, but the number of places available at private units has risen. Staff workload has increased.

In the last few years, the number of children receiving child protection services in community care has grown, and there are more and more long-term clients. However, the number of those using various social services aimed at helping families cope has decreased. In 2003, 56,379 children and young people were clients of child protection community care, which was about 2,000 more than the previous year.

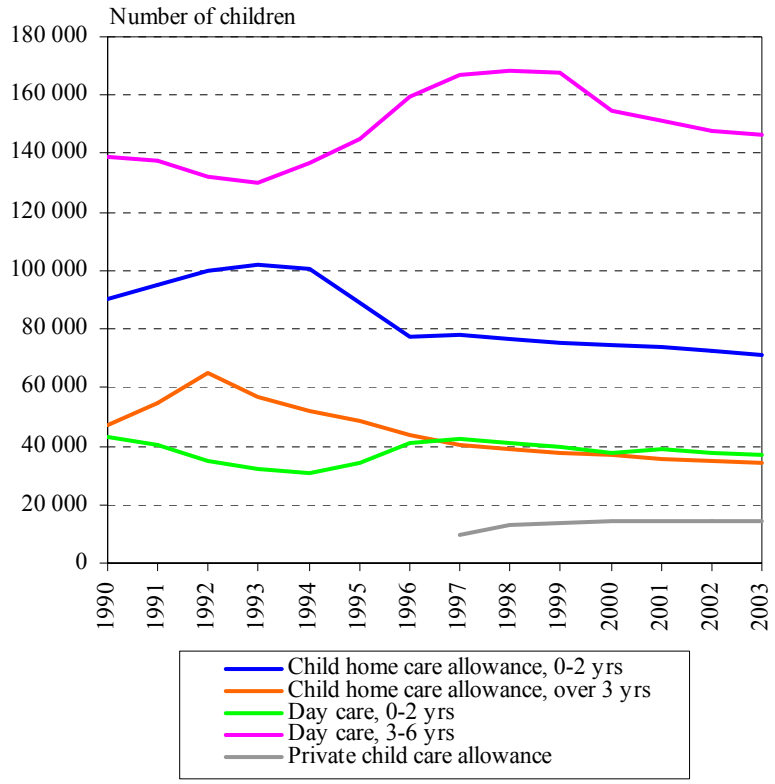
6.4 The environment in which children grow and develop

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

Child day care

The number of children in day care has decreased in recent years, due to a falling birth rate and the pre-school reform. In 2003, there were 190,650 children in municipal day care. The number of children cared for with child home care allowance has diminished somewhat (Figure 100). The share of family daycare of all daycare provided has diminished, and it has been partly replaced by group family daycare. However, family daycare in the home of the daycare provider is often the parents' primary choice, especially in the case of very young children. The popularity of privately provided day care has increased somewhat in recent years.

Figure 100. Children in municipal day care and children cared for with child home care allowance and private child care allowance in 1990 – 2003



Child care arrangements vary considerably according to the age of the child (Table 21 and Figure 101). Nearly half of all children under school age are in day care, whereas children under one are almost exclusively cared for at home. Forty-four percent of two-year-olds are in day care, while over 60 percent of children over three are in day care.

Table 21. Children under school age cared for outside the home* in 1998 – 2003, proportion of age group, %

	Child's age, years							
	0	1	2	3	4	5	6	Total
1998	1.8	29.2	42.2	59.2	64.9	69.7	79.8	50.9
1999	1.6	28.5	43.1	60.1	67.1	71.2	81.5	51.7
2000	1.6	28.0	42.6	60.5	67.1	71.5	66.9	49.3
2001	1.7	28.6	43.6	61.1	67.7	72.4	67.5	49.7
2002	1.3	27.9	44.0	61.4	68.2	72.3	67.9	49.6
2003	1.4	27.5	43.9	62.3	68.5	73.0	67.6	49.5

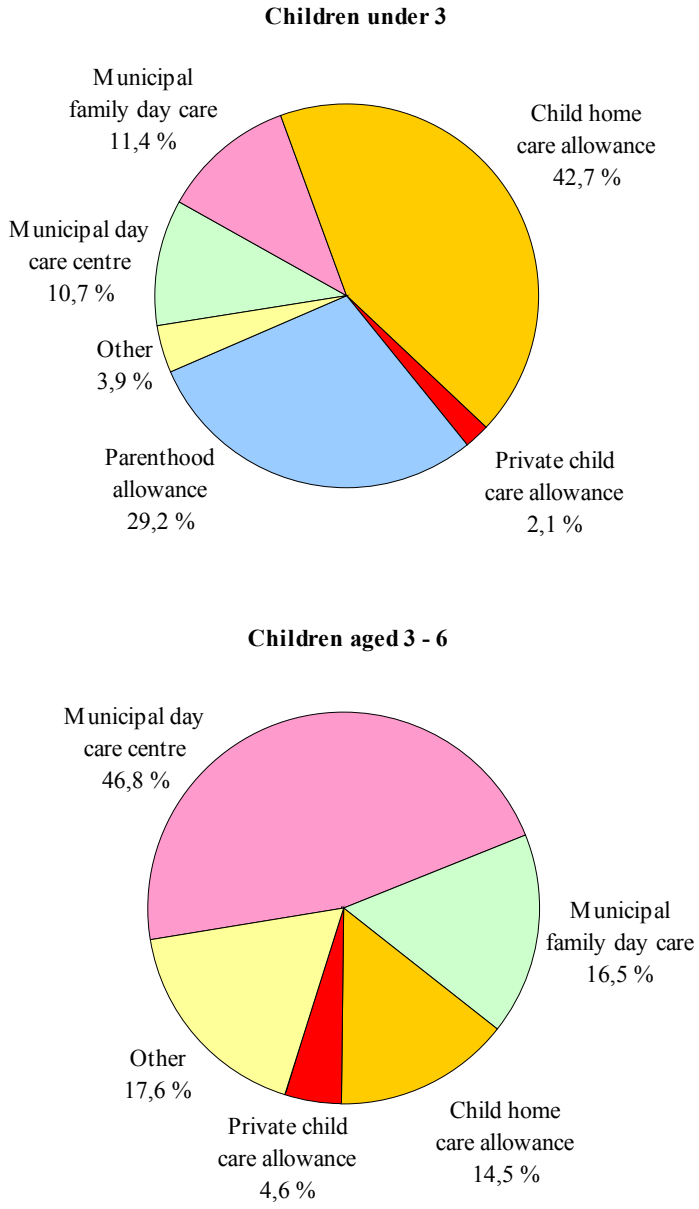
* Children in municipal day care and children cared for with private child care allowance
Source: SOTKA database and Social Insurance Institution of Finland

Whether the staff-client ratio in day care centres is sufficient has become a major cause for concern. The groups of children are often very big, and the sufficiency of staff in relation to the number of children varies. High turnover among both staff and children also contributes towards a restless atmosphere.

There has been lively public debate lately on whether all children should be entitled to day care provided by the municipality, particularly if at least one of the parents is at home. According to a survey conducted by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities, one child in ten in municipal day care has at least one parent at home. Three percent of the children in full-time day care had parents on parenthood leave or child care leave; two percent of children in full-time day care had at least one parent at home due to unemployment. Other reasons why children of parents at home were in day care included child protection measures, the need of special day care or immigrant background.

The demand for day care continues to fall due to a smaller number of children being born. According to population estimates, in 2010 there will be about 13,000 fewer children of day care age than at the moment. On the other hand, the need for afternoon care for school children will grow.

Figure 101. Care arrangements for young children on 31 December 2003



Morning and afternoon activities for schoolchildren

As of the beginning of August 2004, municipalities must provide morning and afternoon activities for pupils in grades 1 and 2 of comprehensive schools. A total of 570 hours of morning and afternoon activities must be provided during the school year. Participation in the activities is voluntary for the children. The aim of the activities is to support homes and the school in their educational task as part of early education. The children taking part in morning and afternoon activities should have the right to a safe operational

environment. Municipalities are obliged to ensure that the facilities and equipment used in morning and afternoon activities for schoolchildren are safe, and to make sure that the children are not exposed to violence or other forms of bullying.

In autumn 2004, 358 municipalities provided morning and afternoon activities for schoolchildren; 38 percent of pupils in grades 1 and two took part in the activities. The municipality makes the decision concerning the size of the fee charged for participation, which may not exceed € 60/month. The maximum fee only applies in situations where the child participates in the activities for three hours a day at the most. In the case of most children, more than three hours a day is needed, in which case the monthly fee may exceed € 60. The fees charged varied considerably between municipalities in autumn 2004. In some municipalities, no fee was charged. Most municipalities charged a fee that was clearly higher than € 100 per month.

VII Promoting gender equality

Impact goals of promoting gender equality

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

Measures aimed at promoting gender equality have long focused on working life and the public life sphere, and they have primarily attempted to improve the status of women in these areas. During the past ten years, the following have emerged as new gender equality themes: reconciliation of work and family life, uneven distribution of family leave costs, violence against women, pornographisation of public space, and the relation of men and gender equality.

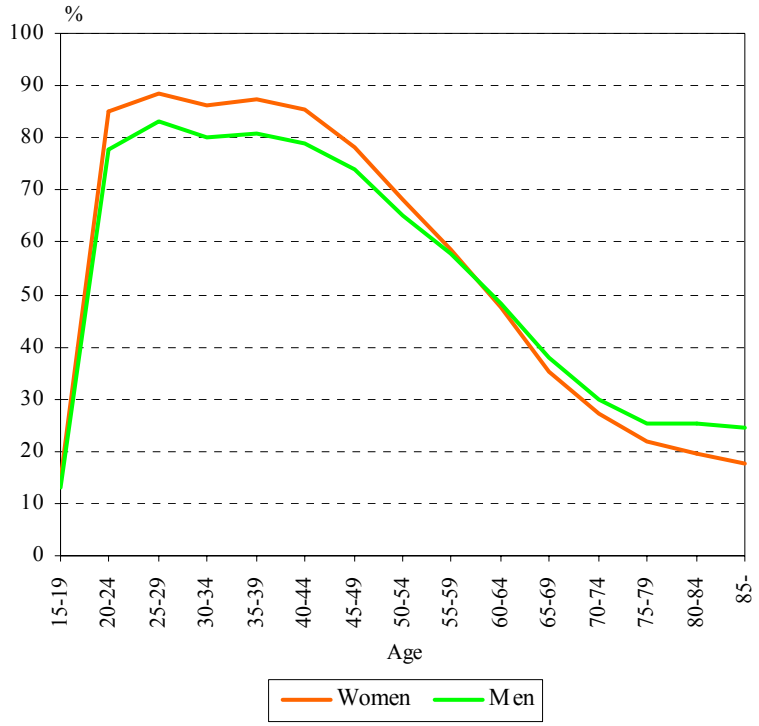
The government's gender equality objectives are implemented by the government's gender equality programme completed in autumn 2004. The programme includes both joint measures aimed at all ministries, such as mainstreaming of gender equality, and actions focusing specifically at the ministries' own administrative sectors. The government's gender equality programme gathers together, coordinates and launches projects promoting gender quality in central government administration. No separate funding has been reserved for the preparation and implementation of the programme. The programme includes various projects focusing e.g. on legislation, education and development.

The government proposal concerning total reform of the Act on Equality between Women and Men was given to the Parliament in October 2004. The aim of the total reform is to strengthen the obligation decreed in law to promote gender equality and to abolish discrimination. It also defines more clearly the regulations concerning gender equality planning. Among other things, a gender equality plan must include charting of men's and women's wages and wage differences. In the future, an employer who has neglected to draw up a gender equality plan can be subjected to sanctions.

7.1 Education and gender

In 2002, the number of persons with a degree after basic (primary and lower secondary) education totalled 2.6 million. Among those aged 15–59, women have completed a degree more often than men in all age groups. The difference is greatest, 6 to 7 percentage points, among those aged 20–44, depending on age group. Among the oldest age groups over 60, men have completed a degree more often than women.

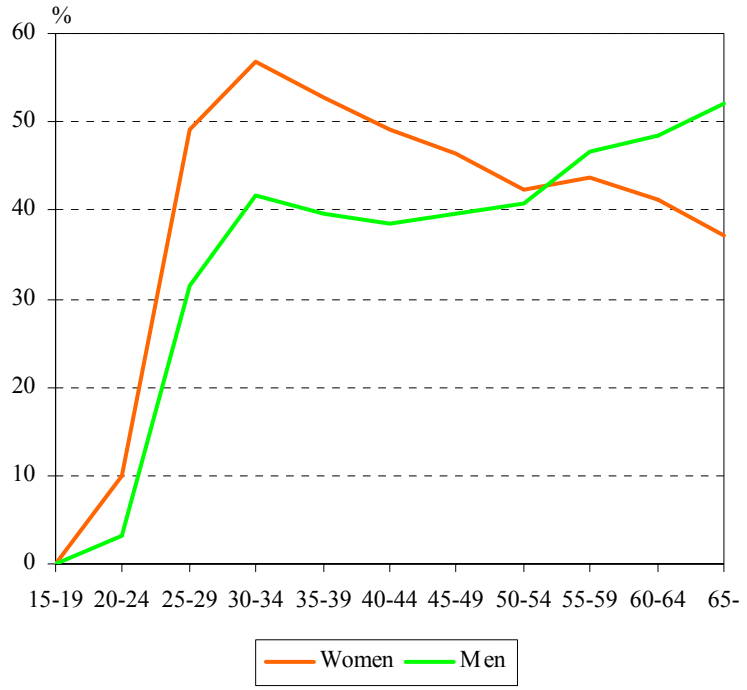
Figure 102. Proportion of people with a degree after basic education according to age and gender in 2002, %



Source: Statistics Finland

Women also pursue their studies longer than men. Among those with a degree after basic education, the proportion of women with a tertiary-level degree is higher up to age group 50–54 years.

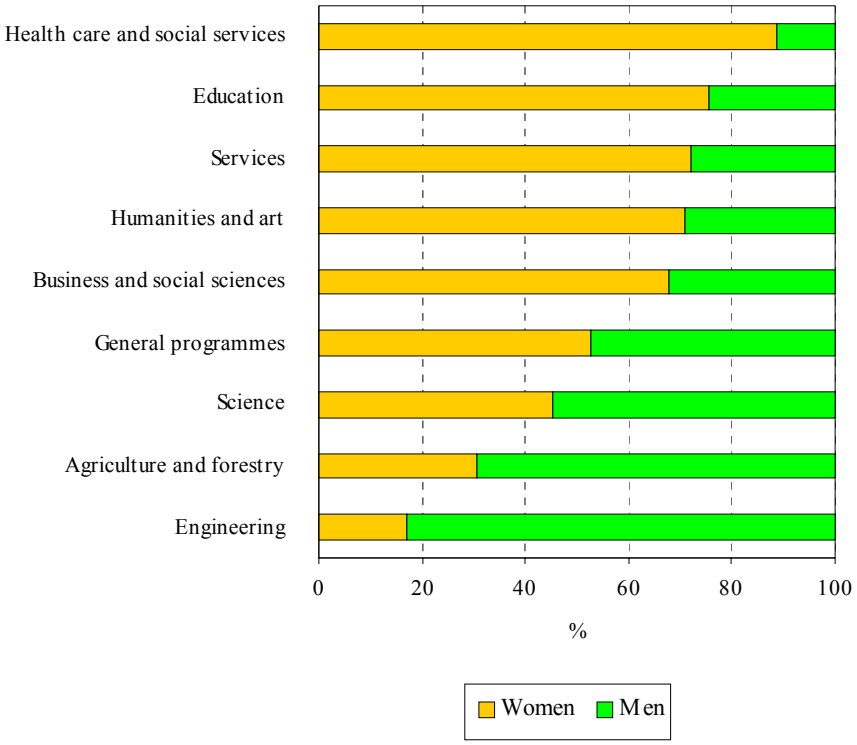
Figure 103. Proportion of those with a tertiary-level degree among those with a degree after basic education in 2002, %



Source: Statistics Finland

Many fields of education are segregated by gender. Health and social sector is the field of education with the highest percentage of women. Nearly 90 percent of those with a degree in health care and social services sector are women, while over 80 percent of those with a degree in technology or engineering are men. Men primarily study technology- and engineering-related subjects; over half of all degrees completed by men are in the field of technology and engineering.

Figure 104. Population with a degree by field of study in 2002



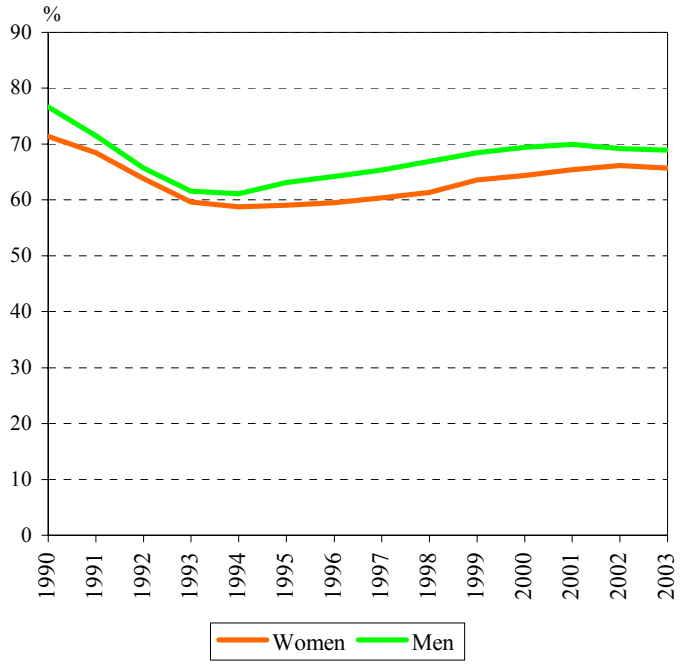
Source: Statistics Finland

7.2 Women and men in the labour market

The employment rate among women is nearly as high as that among men, and almost half of all employed are women. Because women and men work in different sectors and industries in the labour market, the effects of economic fluctuations on the employment and unemployment rates of the genders have been felt with slightly different delays. During the first years of the recession at the beginning of the 1990s, the employment situation of women deteriorated more slowly than that of men, but when the recession eased, employment improved more rapidly among men than among women. When the rise of the employment rate was halted in the early 2000s, the change was first evident among men (Figure 105). A corresponding trend can also be seen when looking at unemployment. At the beginning of the 1990s, unemployment among men when at its highest was four percentage points higher than among women. The situation changed rapidly as Finland recovered from the recession, and by the end of the 1990s women's unemployment rate was about one percentage point higher than that of men. In recent years, the unemployment rates of women and men have been nearly equal. In 2003, unemployment rate among women and men was 8.9 and 9.2 percent, respectively (Figure 106).

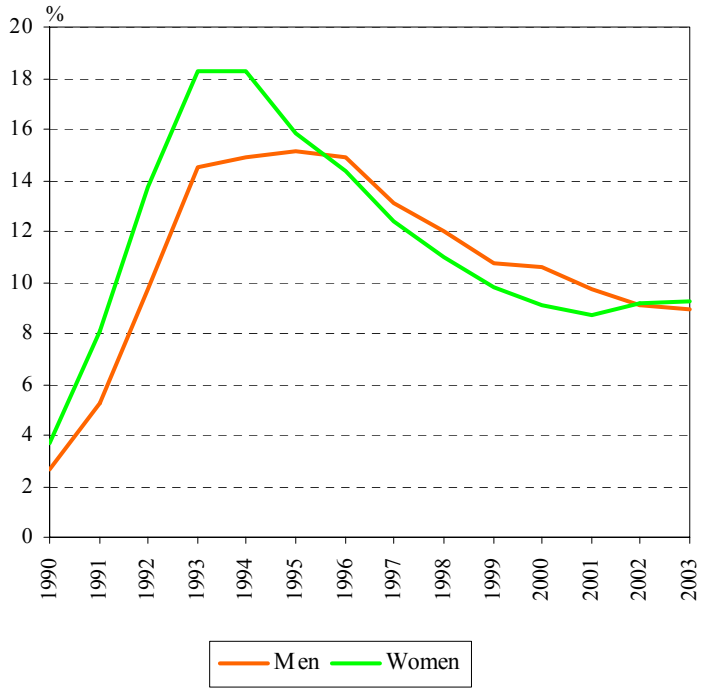
By international comparison, women's employment rate in Finland is high. The 60 percent goal for women's employment rate of the EU Lisbon Summit has clearly been exceeded, whereas men's employment rate falls even somewhat short of the 70 percent employment goal of the Lisbon Summit.

Figure 105. Employment rate by gender in 1990–2003, %



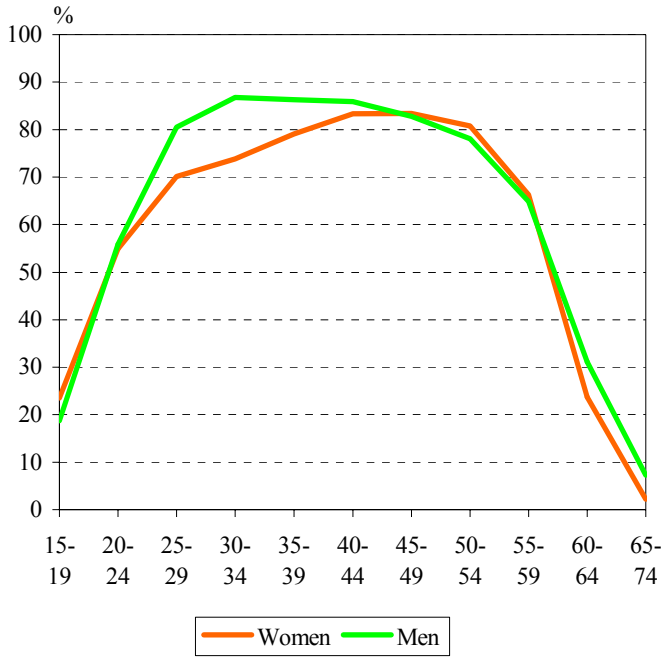
Employment rate: Employed persons as a proportion of population aged 15-64 yrs. Source: Statistics Finland, Labour Force Survey

Figure 106. Unemployment rate by gender 1990–2003, %



Source: Statistics Finland, Labour Force Survey

Figure 107. Age-group specific employment rate among women and men in 2003, %



Source: Statistics Finland, Labour Force Survey

Employment rates among women and men vary differently according to age. The employment rate is lower for women than men in age groups which have newborn children, while in these same age groups men's employment rate is at its highest. In older age groups, men's employment rate starts to fall gradually, while that of women continues to rise. Between 45 and 59 years of age, women's employment rate is slightly higher than that of men.

Although there are no marked differences in labour force participation rate between the genders, women and men do work in different industries and sectors within the labour market. Women are more often employed in the public sector and in caring professions, whereas men work more commonly in the private sector and in industrial jobs. In 2003, only 13 percent of the total employed labour force worked in professions with 40–60 percent of both women and men.

Table 22. Employed persons by industry in 2003

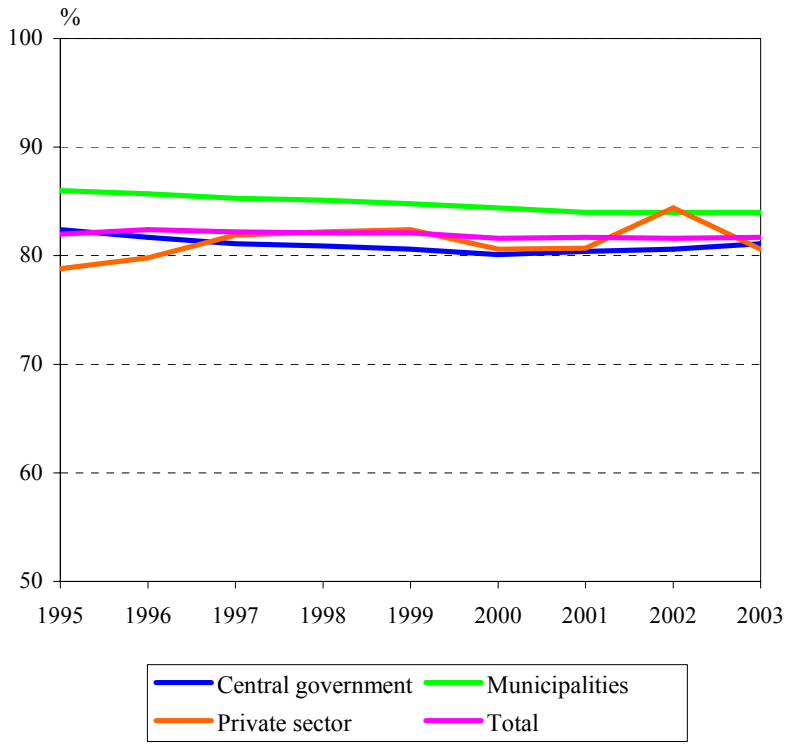
	Men	%	Women	%
Agriculture, game, forestry and fisheries	83,000	6.8	38,000	3.3
Industry	338,000	27.5	132,000	11.6
Construction	140,000	11.4	11,000	1.0
Trade, hospitality and catering	166,000	13.5	197,000	17.3
Transportation	128,000	10.4	45,000	4.0
Financing, insurance and business services	162,000	13.2	151,000	13.3
Public and other services	207,000	16.9	560,000	49.3
Unknown	5,000	0.4	4,000	0.4
Total	1,227,000	100.0	1,137,000	100.0

Source: Statistics Finland, Labour Force Survey

7.3 Differences in pay between women and men

Differences in pay between women and men can be looked at from several angles. Earnings can measured in terms of total earnings, or as is more common, as average income earned for regular working time. In the comparison, hourly, monthly or annual earnings may be compared.[40] Differences in pay can further be compared in terms of absolute sums in euros, or more commonly in terms of relative differences in pay. In that case, the comparison is made by calculating women's earnings as a percentage of men's earnings.

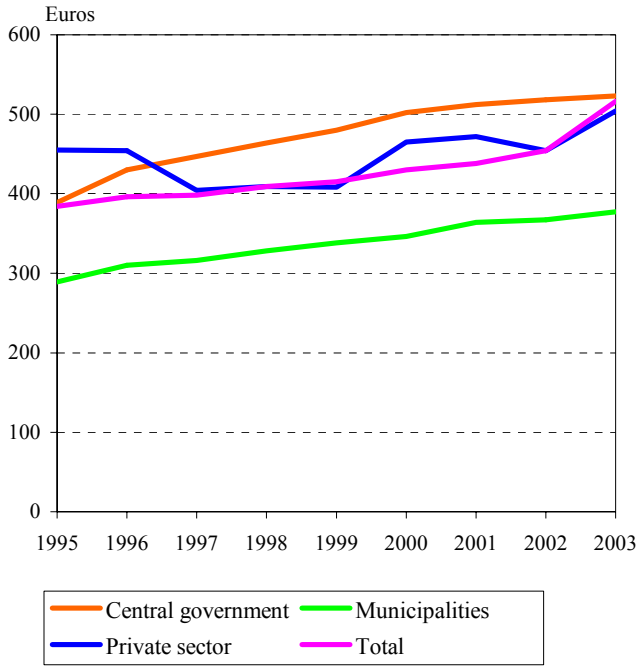
Figure 108. Wage earners' average earnings for regular working time by sector in 1995–2003. Women's earnings as a percentage of men's earnings



Source: Statistics Finland

The relative differences in pay calculated from average earnings for regular working time has long remained at about 80–82 percent. From the beginning of the 1990s, the relative wage gap has narrowed in the private sector, whereas it has widened in the public sector. Surveys where e.g. industry and profession have been taken into account have failed to account for about half of the difference in pay. The most important factor explaining differences in pay is industry and profession. Average earnings are lower in industries where women make up most of the labour force, even if the demands concerning educational level are similar. The group lagging the most behind their male colleagues are highly educated middle-aged women with demanding jobs; they earn on average 6–8 percent less than their male colleagues working for the same employer.

Figure 109. Differences in pay between women and men in euros in 1995–2003, at 2003 prices



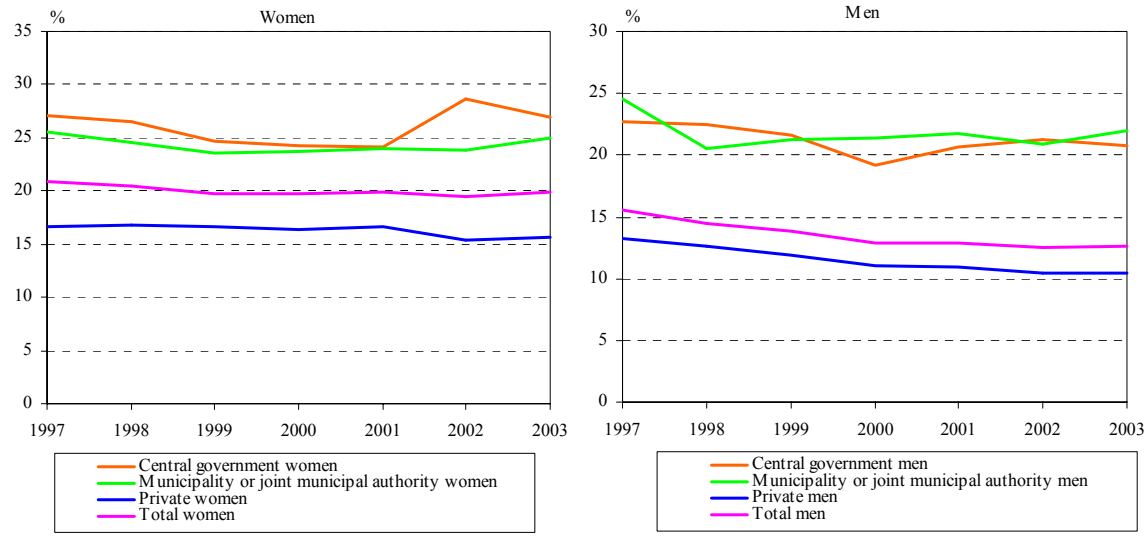
Sources: Statistics Finland, Wage earners' monthly earnings according to earnings level index and consumer price index.

According to a survey conducted by a rapporteur, the government needs to come up with a programme aimed at promoting pay equity jointly with labour market organisations. The reform of the Act on Equality between Women and Men that is currently being prepared is also aimed to have an impact on pay equity. One possible way of promoting equal pay is adoption of new wage systems with built-in incentives.

7.4 Fixed-term employment contracts

In 2003, 83.6 percent of all wage earners had a permanent employment contract, either for full or part-time. Permanent employment contracts were clearly more infrequent among women compared to men; 80 percent of female and 87 percent of male wage earners were permanently employed. Of those with a fixed-term employment contract 62 percent were women and 38 percent were men. Fixed-term employment contracts are more common in the public than in the private sector. Between 1997 and 2003, the proportion of fixed-term employment contracts fell somewhat among both women and men. The share of fixed employment contracts declined more rapidly among men compared to women, which means that the difference between men and women grew.

Figure 110. Fixed-term employment contracts in different sectors according to gender in 1997–2003, %

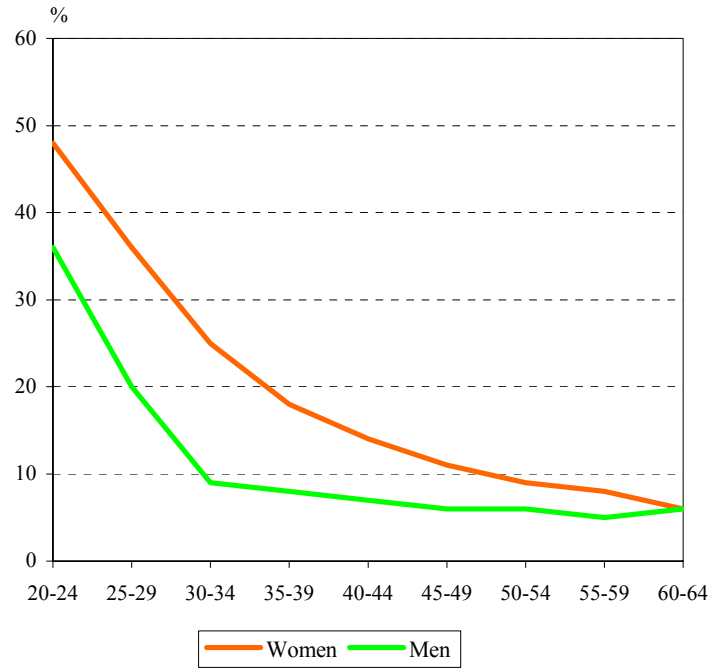


Source: Statistics Finland, Labour Force Survey

In addition to women and the public sector, fixed-term employment contracts are problematic for young people in particular. In 2003, half of those with fixed-term employment were under 30 years of age. The concentration of fixed-term employment contracts on the young makes it harder to start a family due to lack of economic security. The greatest gender differences are seen among young adults (25–34 yrs).

The Ministry of Finance has issued instructions concerning fixed-term employment contracts within the central government to ministries, government offices and departments. The grounds of fixed-term employment contracts are looked at, and action is taken to diminish the use of fixed-term employment contracts and to apply them only in well-motivated cases. The number of fixed-term employment contracts is monitored. The Commission for Local Authority Employers has also issued instructions to cut down the number of fixed-term employment contracts.

Figure 111. Proportion of fixed-term employment contracts according to age in 2003, %
Total for all sectors



Source: Statistics Finland, Labour Force Survey

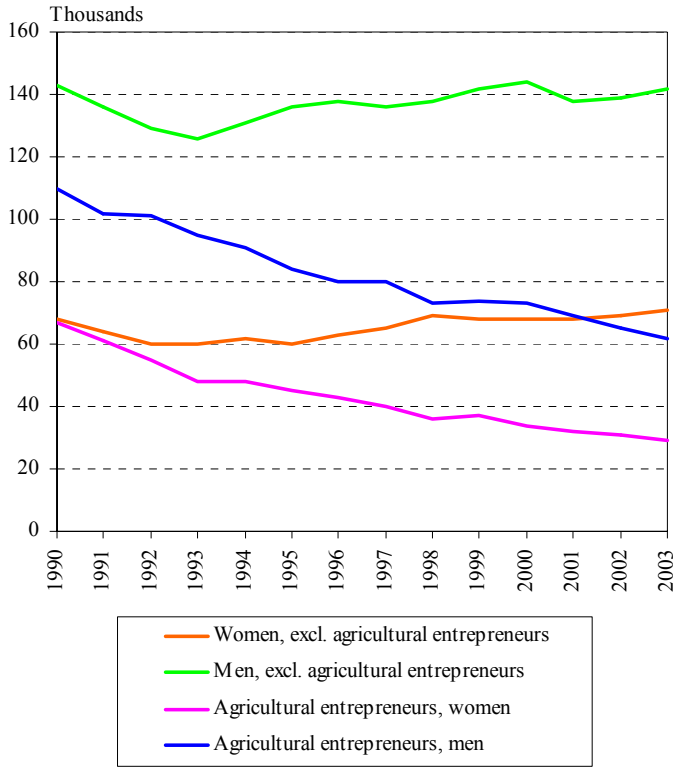
7.5 Women entrepreneurs

Women have long made up about one third of entrepreneurs and members of entrepreneur families. The number of women working as agricultural entrepreneurs declined steadily between 1990 and 2004, while the number of other women entrepreneurs has been rising slowly since the beginning of the mid-1990s.

Women have traditionally worked as entrepreneurs particularly in the service sector. Women's entrepreneurship has increased e.g. in the home service and care sector. The problems of women entrepreneurs are partially different from those faced by men; women's possibilities to work as entrepreneurs are particularly limited due to problems related to reconciliation of work and family life.

Entrepreneurship is less common in Finland than in many other EU member states, but women entrepreneurship is most common in Finland among the EU-15 states. Strengthening women entrepreneurship is part of the government's entrepreneurship policy programme. A statistical method suitable for monitoring the prevalence of women entrepreneurship is being developed during the current government period.

Figure 112. Entrepreneurs and members of entrepreneur families according to gender in 1990-2003



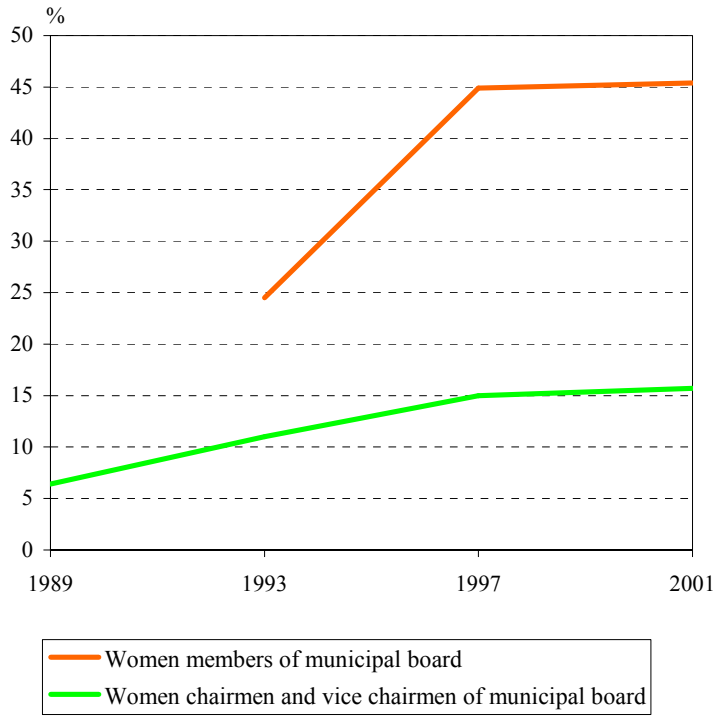
Source: Statistics Finland

7.6 Women's share in political and economic decision-making

Women and municipal decision-making

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

Figure 113. Proportion of women among municipal board members and chairmen, %



Source: Association of Finnish Local and Regional Authorities

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

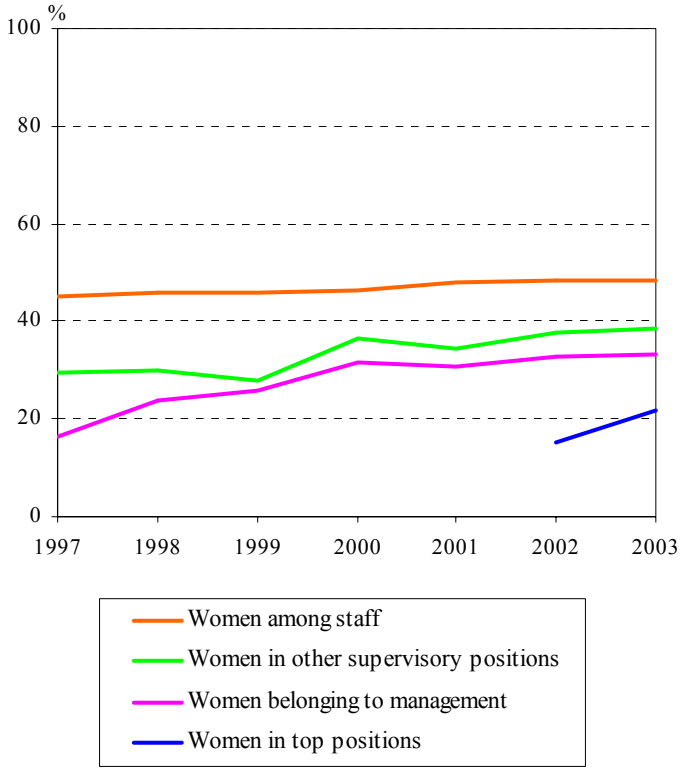
The share of women among elected members of municipal councils also showed a slight but steady growth in the 1990s. When looking at individual municipalities, the share of women varies between five and sixty percent, and in different regions it varies between 27 and 42 percent. In 2001, 23 percent of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

Women in top positions in central government administration

The gender distribution in the topmost central government administration has been followed since 2002, and that in upper and mid-level administration since 1997. The proportion of women among the highest positions, which depending on the time of study comprises nearly 200 persons, has risen considerably within a year. The share of women has also increased in upper and mid-level central government administration, but it is still nowhere near the proportion of women among central government employees. It is

estimated that by 2011, only 20 percent of the current directors are still at work; this may make it easier to increase the proportion of women in top positions.

Figure 114. Proportion of women among central government administration directors and staff in 1997–2003, %



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

Source: Naisjohtajat – uralla eteenpäin (Women directors – career advancement). Work group memos 5/2004. Ministry of Finance.

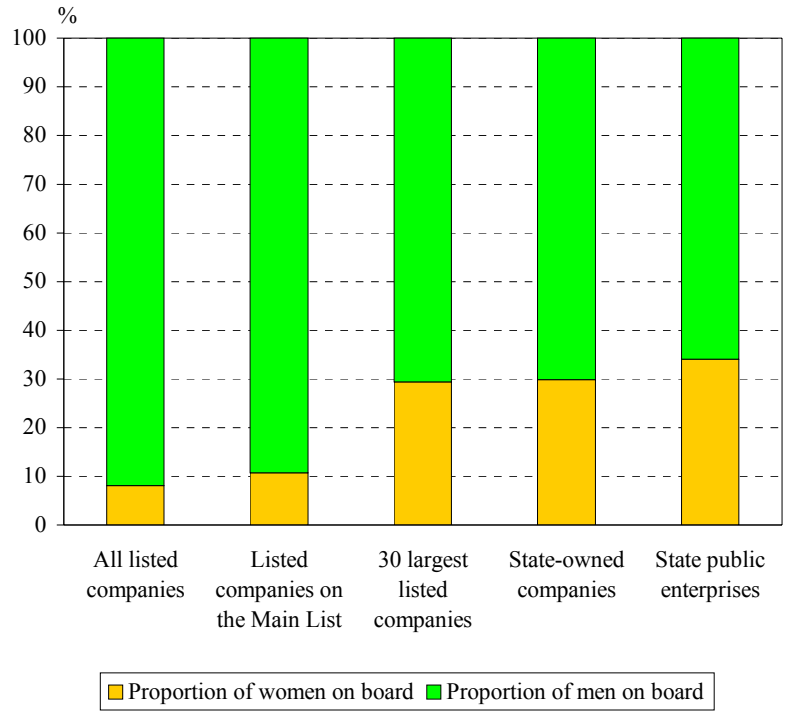
In March 2004, a Ministry of Finance working group completed its memorandum on the placement of women in top positions in central government administration. Using recommendations and examples, the Ministry informs the administration of actions aimed at increasing the number of women applicants to open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

Women and economic decision-making

Looking at gender distribution on corporate boards is one way of assessing the distribution of economic decision-making. The proportion of women as board members is

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

Figure 115. Gender distribution on the boards of state public enterprises, state-owned companies and listed companies, %



Situation in July 2004

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

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

The government is making an effort to increase the proportion of women on the boards of companies where the state holds shares. The aim is that in spring 2005, men and women each make up at least 40 percent of members of the board of public enterprises and state-owned companies; in companies where the state is a minority shareholder, the goal is to get as close to 40 percent as possible.

7.7 Violence against women and prostitution

Violence

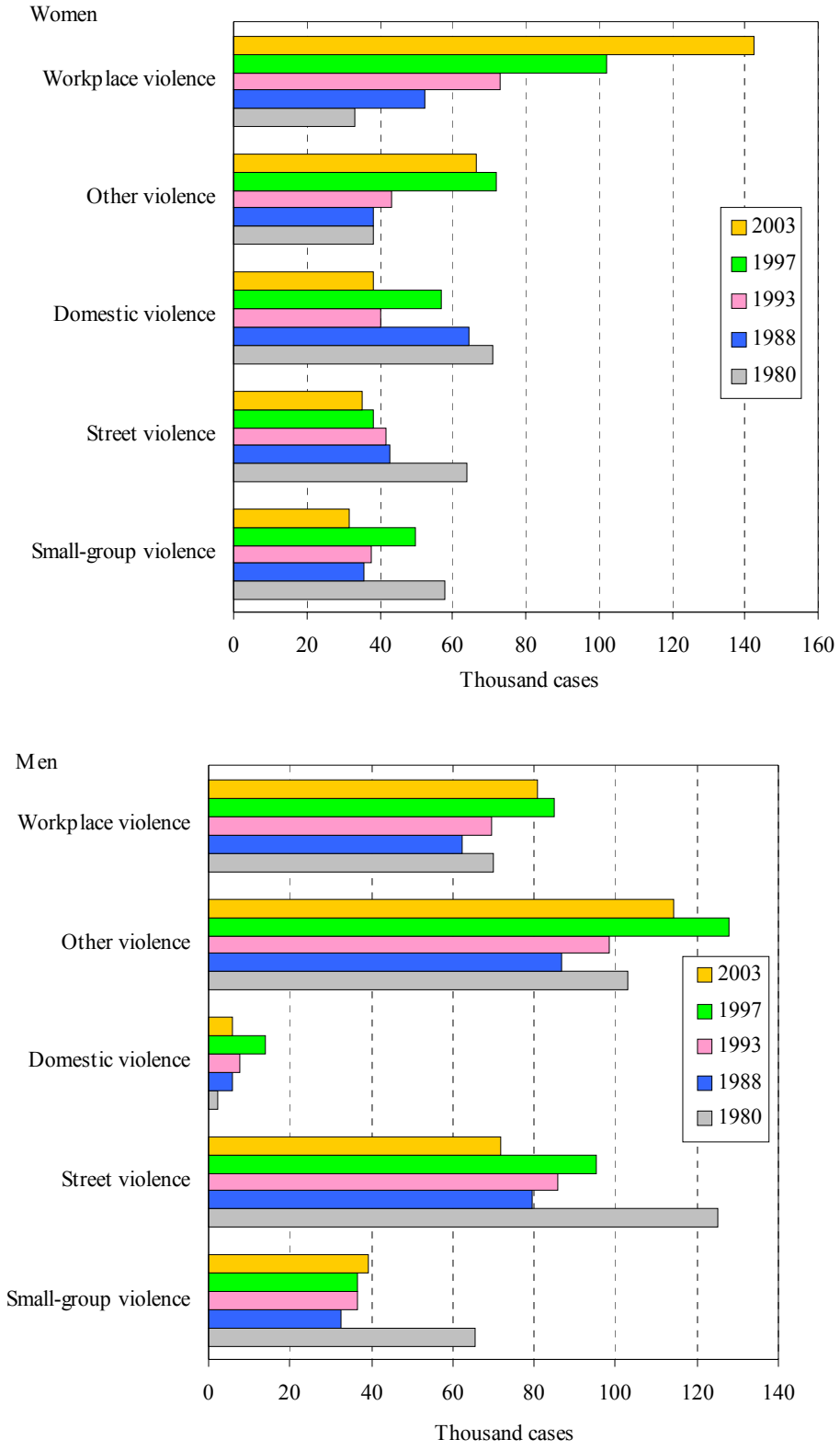
Being the victim of violence has been studied by various methods and in different settings, yielding varying results. [41] So-called general victim studies have been conducted in Finland since 1980. In general victim studies, threatening and violent situations are divided into five different categories. Domestic violence is defined as violence between family members. Small-group violence refers to violence between persons who are otherwise known to each other. Workplace violence occurs at work, while in street violence the perpetrator is unknown and the act takes place outside. Other occasional violence mainly comprises violence indoors, such as restaurants or amusement facilities committed by a previously unknown person.

Based on this study, street violence against men has decreased during the twenty years that the series of general victim studies covers, while other violence against men has primarily increased. At the same time, workplace violence against women has increased considerably, particularly between 1997 and 2003. The increase in workplace violence during that period was almost exclusively seen in the health care sector. Workplace violence against women surpassed that against men in the early 1990s, after which the gap has widened rapidly. The variation seen in the prevalence of some types of violence may be at least partly caused by random variation (e.g. other violence experienced by men).

A significant proportion of more serious violence is accumulated on socially excluded persons, who are often both perpetrators and victims of violence. There is a clear tendency for young men to fall victim to violence more often than other men, while a more even distribution is seen among women.[42]

Of all types of violence against women, domestic and violence in intimate relationships has attracted the most attention in gender equality policy so far. According to the results of the general victim study presented above, domestic violence against women seems to be on the decline. However, the results of the study concerning the prevalence of domestic violence against women should be viewed with caution. Different studies present a very different picture of the prevalence of domestic violence. This may be due to relatively minor differences in data gathering or in the way violence is defined. According to a female victim survey from 1997 entitled Usko, toivo, hakkaus (Faith, hope, battering, Heiskanen & Piispa 1998) that was more sensitive towards violence in intimate relationships, domestic violence is considerably more common than according to the general victim study. Among all forms of violence, domestic violence has in particular been seen as a gender equality problem, because it is related to the power relationships between the genders. Children are very often affected by violence in intimate relationships as well.

Figure 116. Being a victim of violent situations in 1980–2003
15–74 yrs, during the previous year



Source: Heiskanen Markku, Sirén Reino, Aromaa Kauko (2004). Suomalaisten turvallisuus 2003 (Safety among Finns 2003). The National Research Institute of Legal Policy research communications 58.

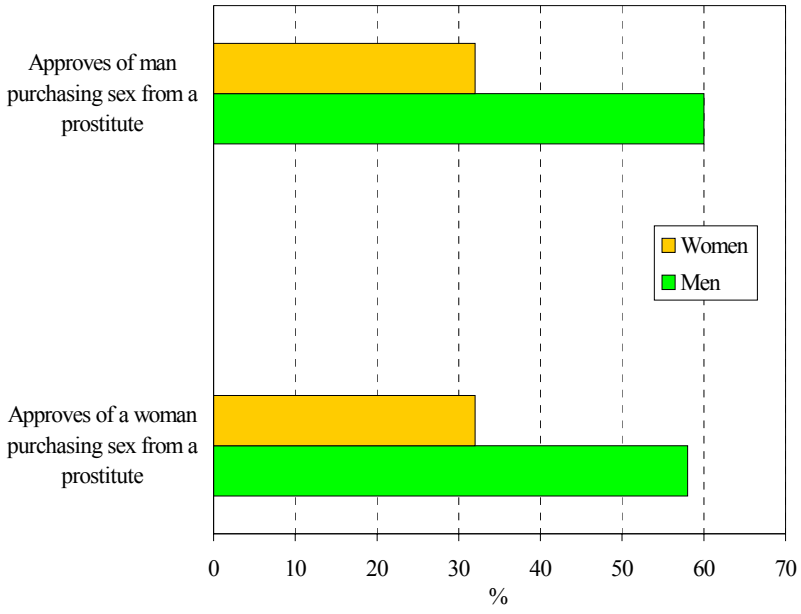
A national action programme has been drawn up for 2004–2007 at the Ministry of Social Affairs and Health aimed at preventing violence in close relationships. The action programme focuses on violence against women, violence in intimate relationships as well as violence in families and close relationships. Violence against women is also one of the themes of the national programme aimed at reducing violence. Anti-violence work in municipalities as well as coordination of work aimed at combating violence is made more effective. In addition, legislation related to violence will be reformed.

Prostitution

There are no statistics available on prostitution clients, only individual studies. Recurrent information can be obtained from the Gender Barometer measuring people's attitudes; in 2004, questions were asked for the first time concerning attitudes towards purchase of sex. Because prostitution supply in Finland is primarily of foreign origin, Finns' attitudes towards selling sex do not have a major impact on supply; in this situation, attitudes towards purchase of sex have a key role in reducing prostitution.

The majority of men approve of purchasing of sex, whereas the majority of women do not. The results of the barometer do not indicate the existence of a so-called double standard, meaning that what is allowed for one gender is not allowed for the other. Because the clients of prostitution are primarily men, the results also indicate that in order to reduce prostitution, it is particularly important to influence attitudes among men. During the government period, a national action programme on human trafficking will be drawn up, and legislation concerning prostitution will be reformed.

Figure 117. Approval of sex purchasing according to gender in 2004



Source: Ministry of Social affairs and Health, Gender Barometer 2004

7.8 Assessment of gender equality policy from a male perspective

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

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

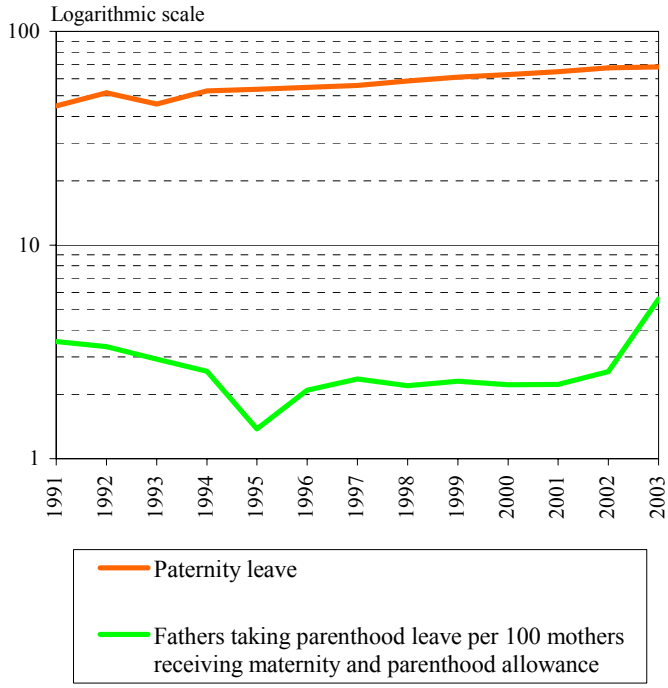
Fathers' use of family leave

The use of paternity leave has increased steadily since the early 1990s. In 1991, 45 percent of fathers took paternity leave; in 2003, the figure was up in 68 percent. The average duration of paternity leave has grown somewhat at the same time. The maximum duration of paternity leave is three weeks.

The use of parenthood leave is considerably less prevalent among fathers compared to paternity leave. The use of parenthood leave by fathers declined throughout the 1990s. Legislation on family leaves was changed as of the beginning of 2003 so that if the father uses the last two weeks of parenthood leave, he gets an extra two weeks of paternity leave (so-called bonus weeks). After the reform entered into force, the number of fathers taking parenthood leave more than doubled within a year, but the average duration of parenthood leave taken by fathers was shortened at the same time. When looking at the fathers who took so-called traditional parenthood leave, the changes between 2002 and 2003 are significantly smaller. After the reform, the number of days used entered into statistics as parenthood leave used by fathers increased by about a quarter.

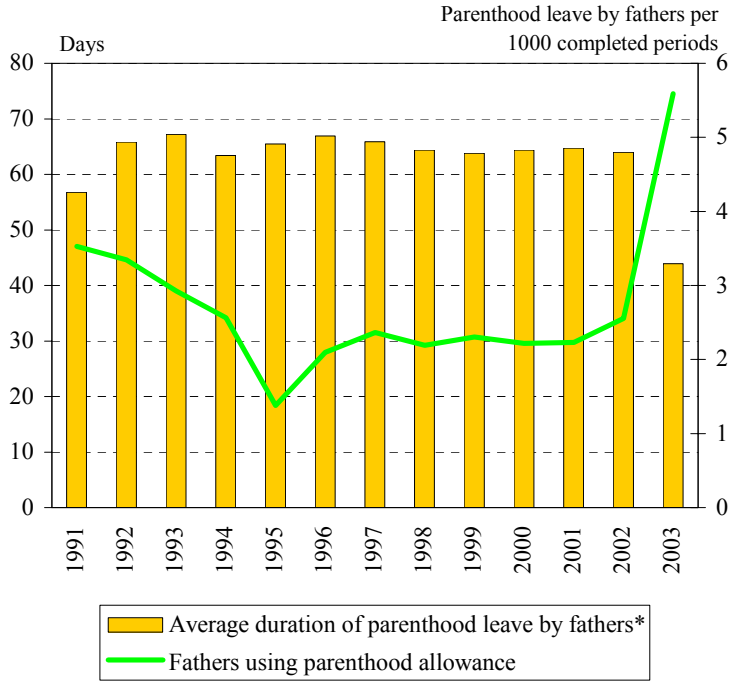
Statistics from the first quarter of 2004 indicate that the number of fathers taking the so-called bonus weeks has increased clearly compared to the previous year, and that the uptake of parenthood allowance by fathers is growing. Only a small percentage of fathers are using their right to bonus weeks so far. However, it is too early to assess the final effects of the law reform. The government is launching a survey on the development of family leave legislation and encourages fathers to take more parenthood leave than previously.

Figure 118. Use of paternity leave and parenthood leave by fathers per one hundred completed periods in 1991–2003, %



Source: Social Insurance Institution of Finland

Figure 119. Use of parenthood leave per one hundred completed periods in 1991–2003

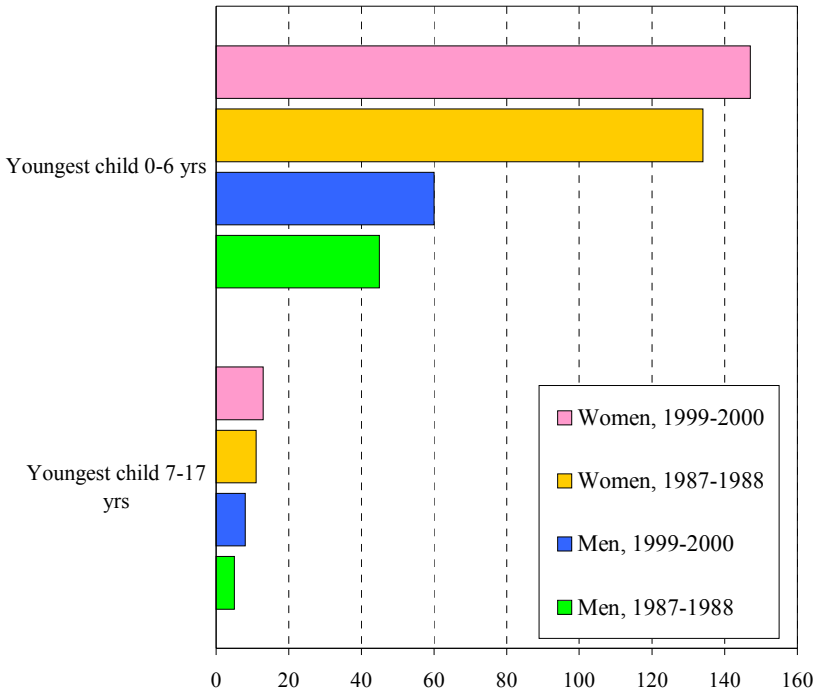


Source: Social Insurance Institution of Finland [43]

Participation in household work by men

Equal division of household chores between the genders strengthens the position of men in families and improves women's equal opportunities to participate in working life. The time used by fathers to care for children increased in the 1990s; however, women still bear the main responsibility for caring for young children in particular (Figure 120).

Figure 120. Average time per day used on child care according to gender and the age of the youngest child in 1987–1988 and 1999–2000
Two-parent families with children



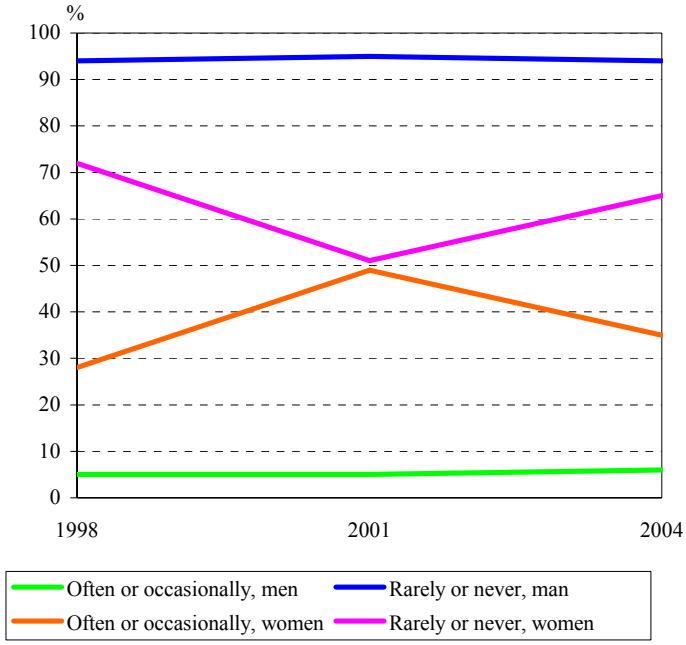
Source: Statistics Finland. Niemi & Pääkkönen 2001

Housework as a whole is also unevenly divided between men and women, particularly so in families with children under school age. In such families, women used twice as much time on household chores than men (1999–2000). The time devoted by men to household work did however increase significantly from the late 1980s to the turn of the millennium. In families with children under school age, the time used by men on household chores increased by over a fifth, while the time devoted to household work by women remained nearly unchanged during the same period.

Uneven division of housework is also reflected in the experiences on division of housework of parents in families with children. According to the gender barometer, only a small minority of fathers feel that they bear too much responsibility for housework, whereas nearly one mother in five often felt this to be the case. Half of all mothers in families with children felt that their responsibility for housework was at least occasionally too big. The division of housework may also reflect gender differences as

to what is considered important: single women also use more time on housework than do single men.

Figure 121. Experiences of excessive responsibility for housework among parents with children



Source: Ministry of Social Affairs and Health, Gender Barometer 2004

7.9 Mainstreaming of gender equality in central government administration

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

Since 2002, methods to assess gender impacts have been developed at the Ministry of Social Affairs and Health as a pilot project. Gender impact is one of the impact assessment points included in the new instructions on how to draw up government proposals. The Ministry of Social Affairs and Health has drawn up a guide on the assessment of gender impacts.

The government is promoting mainstreaming e.g. by providing training on assessment of gender impacts to officials taking part in legislation drafting and by creating a model for mainstreaming of budgets. In addition, training in mainstreaming and assessment of gender impacts is arranged for other officials working in central government administration. Ministries promote mainstreaming within their own administrative sectors. Projects and data provision promoting gender equality are included in result contracts. The organisation of gender equality matters is embedded in the operation and result contracts of departments working under different ministries as well as in other steering in each administrative sector.

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Notes

1 Factors affecting social expenditure and its financing have been extensively looked at in reports of the SOMERA committee.
2 In its report on Finland, OECD has used the same assumption of productivity growth. The approach is naturally simplified; for example, changes in productivity growth and employment rate are assumed to be independent of each other.
3 E.g. employment pension contributions could in principle be levied exclusively from the wages of the insured. If gross wages were to be increased by the same amount, labour costs, pension contributions and net wages would remain unchanged, even though the contribution shares of employers and the insured would change. In practice, the matter would not be quite so simple, e.g. due to the special features related to financing of employment pensions.
4 In Estonia, Latvia and Lithuania, for example, the GDP share of social spending was about 16-17% in 2000. Nordic Social-Statistical Committee (2003).
5 For a more detailed account, see Koskela, Pirttilä and Uusitalo (2004), which is a recent Finnish review of research on the link between employment and taxation, and Nickell (2004).
6 See e.g. Pyyhtiä (2002) and Koskela and Uusitalo (2003)
[7] Arjona, Ladaique and Pearson (2001)
8 The reform might however have an impact on income distribution within families, because the recipient of child allowance and the person using the tax credit are not necessarily one and the same. The implementation of the tax credit might also cause administrative problems in situations where the family structure changes in the course of the year. There are experiences of practical problems related to such tax deductions e.g. in Australia.
9 Body mass index 25 or more
10 Alcohol disease as primary disease
[11]Uninterruptedly long-term unemployed, repeatedly unemployed, unemployed after participating in measures and repeated participation in measures
[12] The scales of different factors are not commensurable. Formula for calculating the index: those who have not completed basic education = total number of target population / number of persons of working age * 20; children placed in care outside the home = total number of target population / number of persons aged 0-14 yrs / 5; Single homeless = total number of target population / total population; long-term unemployment rate = %; self-experienced poor health – proportion of persons reporting this / 2; proportion of those receiving long-term social assistance = proportion of target population / 10; Poverty risk = proportion of persons in target population / 2; Substance-related deaths = total number of target population / total number of population *10; Persons suspected for drug crimes = total number of target population / total number of population.
[13] Theoretical distribution of medicine expenses between prescription drugs and hospital drugs on the basis of wholesale selling is 80-20 percent. This result is arrived at if the discounts given to hospitals for their drug purchases are not taken into account. Accurate figures are not available. It is generally assumed that hospitals get on average a 15 percent discount.
[14] Mortality amenable to health care refers to deaths due to causes of death that are assessed as being receptive to health care measures. This mortality figure is regarded as reflecting the impact of the operation of the health care system better than normal mortality figures.
[15] The better queuing situation of coronary bypass and balloon angioplasty compared to other operations may be explained by the rapid decline in morbidity. The growing prevalence of a healthy lifestyle has decreased coronary morbidity. See also chapter 2.
[16] In the prediction, the exit from health care professions makes up a total of 73 percent of the need for new labour in the basic career alternative. This means that change in the number of labour accounts for a total of 27 percent of the need of new staff.
[17] Part of subsidies given to other domains is directed to health care as well.
[18] The figures under different headings are not necessarily addable, because data have been gathered from several statistical sources.

[19] The sales of prescription drugs in outpatient care at taxable retail prices in 2002 totalled € 1,478 million, and those of self-medication drugs € 260 million, i.e. € 1,738 million in all. Of this sum, € 859 million was refunded by health insurance during 2002 (if extra refunds paid in 2003 for purchases made in 2002 are taken into account, the amount came to € 865 million).
[20] In 1998-2003, income taxation was eased e.g. by reductions in health insurance contributions by the insured. The general health insurance contribution levied from the insured was lowered in 1998. The increased health insurance payment levied from pension income was gradually abolished in 1998–2003.
[21] Just like under the present health insurance system, the income subject to municipal taxation would be the basis used for calculating the new health insurance payment.
[22] Pension recipients' housing allowance, child home care allowance, disability allowance, general family pensions and ex-servicemen's benefits are entirely financed by the central government, while 29 percent of pension-tested national pensions is financed by the central government.
[23] Assessment of pressure to increase pension contributions is naturally just one way of looking at the sustainability of pension system financing. For an account of issues related to indicators describing the size of different pension funds in the Finnish employment pension system, which is a defined benefit plan, and partly a defined contribution plan, see Risku (2001).
[24] Index adjustments of national pension and labour market support are made on the basis of price changes during the previous year. In the figure, the real change has been calculated on the basis of price change during the year in question. In times of lowering or rising inflation, this may result in changes in the real value of benefits, even if price changes are taken fully into account.
[25] Child allowances were cut in July 1995. Because the cut was made in mid-year, its impact is not seen fully on annual level until 1996.
[26] Many municipalities also pay municipal supplements.
[27] The fact that earned income deduction in municipal taxation has only been limited to wage or entrepreneurial income from 1997 has tightened the taxation of other taxable income transfers than pensions. Pension income was not eligible for earned income deduction prior to this reform either.
[28] This compensation percentage is applied for income below € 2,084.40 per month. The percentage used for income exceeding this limit is 20.
[29] The earnings-related amount of unemployment allowance is 45 percent of the difference between daily salary and the basic amount. However, if monthly salary exceeds € 2,084,40 (in 2004, income limit = 90 times the amount of basic daily allowance), the earnings-related amount for the sum exceeding the limit is only 20 percent.
[30] Gender differences in the link between mortality and income level are an issue in themselves.
[31] Minimum sickness allowance is paid to people with no income or low income, or those lacking work qualifications after 55 days of uninterrupted disability or immediately after user deductibility period, if it is apparent that duration of disability will exceed 300 weekdays. During the first 55 days of disability, sickness allowance is defined based on earned income. The allowance is lower than minimum if the person in question has a small income. Allowance below minimum is also paid to students, whose allowance is equal in size to student allowance. Persons with no income get no allowance at all during the first 55 days.
[32] Despite efforts to improve comparability between income statistics from different countries, there may still be problems of comparability in the data.
[33] Defining it more closely, disposable income proportioned to household's size, i.e. disposable income per consumption unit.
[34] Persons who have worked full- or part time for at least six months are as a rule defined as wage earners.
[35] The result changes, if changes in earnings level are not taken into account, but the calculation is done using the same nominal wage level based on 1996 and 2004 grounds. In that case, the threshold level of those receiving a higher than average allowance has risen somewhat. Cf. Figure 3.23 in the publication Talouden rakenteet 2003. Government Institute of Economic Research.
[36] Households are classified according to the main activity of the member with the highest income. In the case of the unemployed, extra income may be related to short temporary jobs, and those of wage earners to e.g. overtime or change of jobs. The income traps of the unemployed are partly caused by the adjustment of unemployment security (income testing) in connection with part-time work. This may be regarded as a special case among income traps. It is something of a borderline case between unemployment and income trap.
[37] Total fertility rate refers to actuarial number of children born per woman.
[38] Age-group specific fertility rates show the number of live-born children in each age group per 1,000 women in that age group.

[39] Family policy support is a somewhat more extensive concept than expenditure on the main social spending category of Families and Children; it also includes general housing allowance paid to families with children as well as the support coming from the tax deductibility of child maintenance payments. The child increments of unemployment allowance are also left outside the scope of both concepts.
[40] The earnings of persons paid by the hour are often compared on a monthly level using actuarial monthly working time.
[41] For more detail, see Aromaa & Heiskanen 2000.
[42] For more detail, see Heiskanen, Sirén, Aromaa (2004).
[43] In order to obtain comparable data, the average duration of parenthood leave by fathers in 2003 has been calculated as follows: ((users of bonus leave * average length of bonus leave) + (all recipients of parenthood allowance * average length of parenthood leave)) / fathers receiving parenthood allowance in all.

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