

Annual National Report 2012

Pensions, Health Care and Long-term Care

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1 Executive Summary

Pensions: There have been no remarkable changes in the system's characteristics during 2011-2012. The Act on Guaranteed Pensions took effect on 1 March 2011. The new government took office in 2011 and a government programme was published on 22 June 2011. Pension-related issues are discussed in the programme, but the main emphasis is on the lengthening of working careers and some of the "soft measures", following the results of the working group (Ahtela group) for improving wellbeing at work, are mentioned as a way to lengthen working careers. One of the reforms is a tightened requirement for eligibility to sickness allowance starting from June 2012. The social partners together with the government are still exploring further ways to rise the effective retirement age to the level of 62.4 years by 2025, to ensure a sufficient level of earnings-related pensions and the financial sustainability of the earnings-related pension scheme and to strengthen general public finances. The national indicator of effective retirement age has continued to rise up to 60.5 in 2011, though with much slower pace compared to change in previous years. The most heated topic under discussion is whether the minimum retirement age should be raised from the current level of 63 years. For example, the Social Democrats joined the government on condition that the minimum retirement age will not be raised during the present government term. Growth in private voluntary pension provision has diminished significantly. Long-term voluntary pension savings, established in 2010, have not gained popularity. A national action plan for promoting active ageing has been established for the year 2012 and is under the responsibility of the Finnish Institute of Occupational Health and the Ministry of Social Affairs and Health.

Health: The Parliament was elected in April 2011. The Programme of the Government includes the goal to diminish the number of municipalities and to organise high-quality, equal social welfare and health care services to all inhabitants by merging municipalities. The previous project to restructure local governments and services continued, leading to many types of service provision. A Comprehensive Health Care Act took effect on 1 May 2011. The changes caused by this act have not yet been assessed. The shortage of physicians was evident in some regions. The number of visits to health care centre physicians decreased during the 2000s, but the number of visits to other health care workers in health care centres increased. The costs of health care as assessed in big cities increased during the 2000s, but a small decrease in these costs was seen from 2009 to 2010.

Long-term care: A proposal for an Act on Long-term Care of the Aged was released in March 2011, and opinions of stakeholders were asked until the end of May 2011. The majority of stakeholders gave positive opinions. A working group in the Ministry of Social Welfare and Health is considering the proposals by stakeholders, and a new proposal will be made public in March 2012. According to the goal of the ministry, the act will take effect in 2013. The number of persons aged 75 years or over and their proportion of all inhabitants aged 75 years or over in long-term care institutions decreased during the 2000s, while the corresponding numbers and proportions in comprehensive sheltered housing, sheltered housing and home care increased. An assessment of the quality of long-term care in health centre hospitals revealed shortages in the basic education of workers and their number and in the quality of meals. Changes in the legislation of human rights of elderly clients of social welfare and elderly patients in health care services were proposed in order to specifically ensure the human rights of elderly clients and patients.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The deep recession in 2008 and 2009 and the stimulus measures implemented to alleviate it substantially weakened Finland's general government finances. In 2010, the general government deficit was 2.8% and debt 48.3% of GDP. General government debt was therefore 14½ percentage points higher than in 2008. The economic forecast published in December 2011 anticipates that the deficit in general government will fall to 1.4% of GDP in 2012. Finland's public debt-to-GDP ratio will increase, but will nonetheless remain below the 60% threshold of the Treaty (MOF 2012).

The latest figures from Statistics Finland show that unemployment in January 2012 stood at 7.8% (OSF 2012a)¹. Unemployment is anticipated to rise marginally in 2012, as labour demand slackens. However, the rise in unemployment will only be moderate and reach little over 8%, as businesses will use the number of hours worked as a primary means of adjusting labour input. Labour supply will also decline as the population is ageing (MOF 2012).

In the field of pensions, the crisis has not had a significant effect on the long-term financing outlook and has not led to a reorientation of pension policy. According to recent (2011) pension expenditure projections, the total statutory pension expenditure corresponded to 12.5% of GDP in 2010. At its highest, the share is projected to increase to 15.5% in the 2030s, after which it will decrease to an ample 14% as of the end of the 2040s (see Risku et al. 2011).

However, the economic crisis has reinforced the main objectives of the 2005 pension reform, i.e. the need to lengthen the working career and to raise the effective retirement age (discussed more thoroughly in the following chapters), in order to manage the sustainability gap in public finances, as well as to ease ageing pressures on labour markets and to ensure the sustainability of financing in the earnings-related pension scheme. Thus, the focus is rather on strengthening the current structure of the pension scheme than reorientation.

The current development in overall social protection, concerning especially for health care and long-term care, is to motivate municipalities to merge, in order to achieve economies of scale and increasing efficiency. Current municipalities are often small and municipal services are fragmented. Since 2005, the government's key strategy for municipal reform has been to create larger municipalities or enhanced cooperation among municipalities. The government has announced a "comprehensive nationwide reform to restructure municipalities and services, building on economically robust municipalities, enabling improvements in administrative structures, productivity and the effectiveness of municipalities" (Finnish Government 2011).

2.2 Pensions

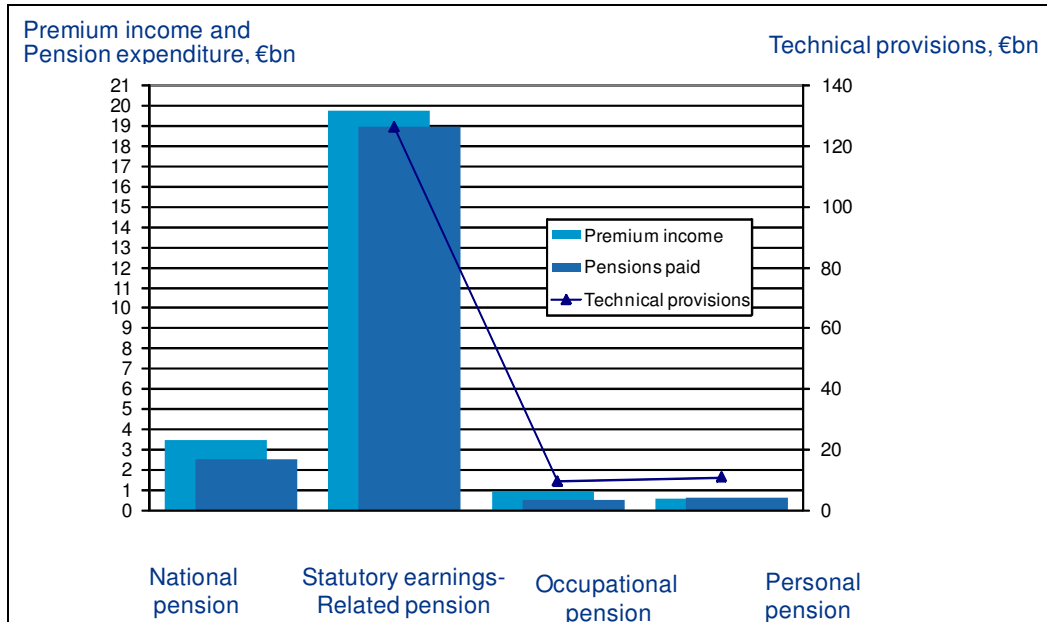
2.2.1 The system's characteristics and reforms

In Finland, the statutory (1st pillar) pension provision consists of defined-benefit (DB) earnings-related pension, which aims to maintain the attained income level to a reasonable degree, as well as residence-based national pension and guaranteed pension, which ensure minimum security. The Act on Guaranteed Pensions took effect on 1 March 2011. The statutory earnings-related pension scheme covers all wage and salary earners and self-employed persons. Due to

¹ http://www.stat.fi/til/tyti/2012/01/tyti_2012_01_2012-02-21_tie_001_en.html.

comprehensive coverage of the statutory schemes and the absence of a pension ceiling (neither in income nor in pension), the significance of supplementary pension, i.e. occupational pensions or individual pension insurance, is small. From the point of view of pension contribution, the total pension provision consists of 94% statutory pension provision and 6% supplementary pension provision (Figure 1).

Figure 1: Pension insurance in Finland in 2010



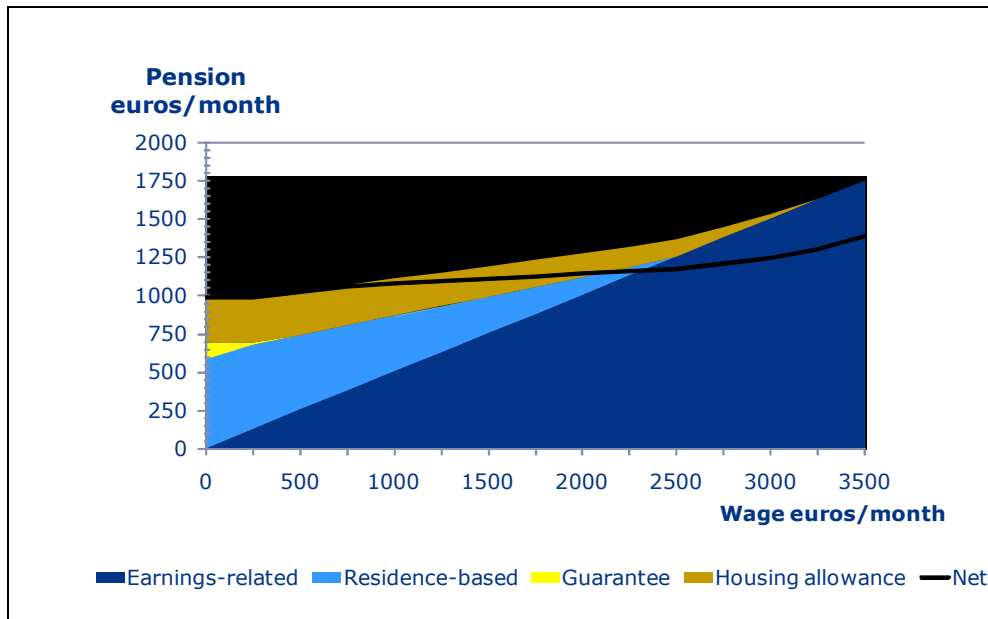
Sources: Financial Supervisory Authority; Finnish Centre for Pensions; Social Insurance Institution Kela

The statutory pension schemes are linked together, with the amount of the national pension benefit and guaranteed pension depending on the size of the earnings-related pension benefit (see Figure 2). Earnings-related pensions reduce the national pension by 50%. Pensioners who receive no earnings-related pension at all or whose earnings-related pension is less than EUR 1,257.96 per month (for single persons) are entitled to a national pension.

The full national pension is granted on the basis of 40 years of residence in Finland. In 2012, the full national pension is EUR 608.63 per month for single and EUR 539.85 for married persons from the age of 65. The full national pension is approximately 20% of the average wage. The minimum age for early retirement is 62 years. However, the deduction from old-age pension for early retirement is 0.4% for each month that the pension is taken before the age of 65, and the reduction is permanent.

The national pension is supplemented with a guaranteed pension as of March 2011. A single pensioner whose sole source of pension income is a full national pension would qualify for a guaranteed pension of EUR 105.10 per month. The minimum pension in total is EUR 713.73 per month (2012), regardless of the pensioner's family status. A total of around 116,000 pensioners will qualify for a guaranteed pension. This is a little less than 10% of all pensioners. The amount of the guaranteed pension is affected by any other pension income (from Finland or abroad). Other pension income is deducted fully from the full amount of the guaranteed pension. The guaranteed pension is not reduced by care allowance, earnings, capital income or assets. The guaranteed pension has some effect on the amount of housing allowance payable and the amount of income support paid to a family.

Figure 2: Earnings-related pension, national pension, guaranteed pension and pensioners' housing allowance 2012



Source: Finnish Centre for Pensions

The earnings-related retirement age is flexible (62–68) and pensions accrue from the age of 18 to 52 at the rate of 1.5% of wages per year, from 53 to 62 at 1.9% and from 63 to 68 at 4.5% a year. Study periods and periods of child care accrue 1.5% for the pension within certain limits. If the insuree takes the pension at the age of 62, it is permanently lower than the normal old-age pension. The pension is reduced by 0.6% for each month the pension is taken early before the age of 63.

The earnings-related benefit formula includes a life expectancy coefficient that reduces the pension in line with the increase in longevity. People need to work longer to compensate for the decreasing effect of the life expectancy coefficient on the pension.

The lower age limit for the part-time pension was increased from 58 to 60 as of the beginning of 2011. Furthermore, the pension accrual for the decrease in earnings will be removed, and during the period of drawing the part-time pension, new old-age pension rights will only accrue for the earnings from work. These changes will concern persons born in 1953 and later.

The minimum age of eligibility for the unemployment path to retirement (extended earnings-related unemployment security for elderly workers), by which the transition to retirement has quite commonly taken place in Finland, is 58. Unemployment allowance is then paid until the employee reaches the age of 60 years, after which an extended allowance (additional days) is payable. It is possible to transfer to the old-age pension from the unemployment path to retirement flexibly from the age of 62, without actuarial reduction. The abolition of this unemployment path has been discussed lately by labour market organisations as part of measures for increasing the effective retirement age.

The average pension in their own right (does not include survivors' and part-time pensions) was EUR 1,370 a month in 2010, about 45% of the average income (EUR 3,043²) in the said year. For men it was EUR 1,561 and for women EUR 1,217.

² Statistics Finland's Structure of Earnings statistics (2011), retrieved from: http://www.stat.fi/til/pra/2010/pra_2010_2011-11-11_tie_001_fi.html.

There are two types of indexation in the earnings-related pension scheme. The first (pre-retirement index) adjusts past earnings to the present level when calculating the pension at the time of retirement. This wage coefficient puts a weight of 80% on wages and 20% on prices. The other index (post-retirement index) aims to keep the purchasing power of earnings-related pensions ahead of inflation. This index has a weight of 80% on consumer prices and 20% on wages. The purchasing power of national pensions is retained by annual indexation based on the consumer price index.

Since 1 January 2010, national pensions (and guaranteed pensions) are financed solely by the state. National pensions are administered by the Social Insurance Institution supervised by the Parliament, subject to pay-as-you-go (PAYG) funding.

The implementation of statutory private-sector earnings-related pension provision has been decentralised to pension insurance companies (7), company pension funds (15) and industry-wide pension funds (7). The share of company pension funds is declining. In addition, farmers and seamen have their own funds. Central and local government employees have their own earnings-related schemes. In principle, the pension benefits are similar for all sectors. Since the beginning of 2011, the handling of pension provisions for employees who work for the state, a local government or the Evangelical-Lutheran Church of Finland has been centralised to Keva (former Local Government Pension Institution).

Employer and employee associations have a strong position in the administration of the pension schemes. The earnings-related pension scheme follows a so-called tripartite administrative model. The state, the employees and the employers as well as the entrepreneurs all influence the development of the legislation on the statutory earnings-related pensions. The final handling of changes to the earnings-related pension acts occurs in Parliament, which issues and changes the acts on earnings-related pensions.

The financing of earnings-related pensions is mixed, a combination of a PAYG system and a pre-funded system based on pension contributions from both employers and employees. Approximately four fifths of the earnings-related pensions are financed through PAYG, with the pre-funded scheme covering the rest. The market value of the pension funds' assets amounted to 77% of GDP in 2010 (and dropped down to 70% of GDP in 2011/Q3).

The average earnings-related pension contribution rate (TyEL) for 2012 is 22.8% of wages, up 0.4 percentage points from 2011, as already agreed on 21 January 2009 in an employer associations and trade unions agreement. The contribution level was then set for the years 2011–2014, when the contributions will have been raised by a total of 1.6 percentage points. In 2012, the employees' pension contribution under the age of 53 increased by 0.45 percentage points to 5.15%, and for those aged 53–67 by 0.5 percentage points to 6.5%. The average contribution rate for employers in 2012 is 17.3%, up 0.2 percentage points from 2011. A compensation of 0.2 percentage points was introduced by the government, which eases the income taxation from earnings to alleviate the increase in the earnings-related pension contributions of wage earners.

The act (1183/2009) on long-term savings, which entered into force on 1 January 2010, introduced a new alternative to voluntary pension insurance. With effect from 1 April 2010, individuals have the possibility to enter into a pension savings agreement (PS agreement) that enables them to save through shares, bonds, investment funds and accounts provided by banks and fund management companies, as well as other intermediaries. The government wants to increase savings for retirement but also increase competition, while at the same time reducing costs and boosting transparency in the market. The voluntary pension market in Finland has traditionally been insurance-oriented.

An important part of the reform was to extend the right of tax deduction to other than insurance savings, i.e. to also include long-term savings covered by the legislation. Premiums are tax-deductible up to the amount of EUR 5,000 per year; the tax rate for capital income, currently 30% or 32%, is applied depending on the amount of the taxable capital (max. deduction is EUR 1,600 in 2012). Individuals' savings will be allocated to personal accounts and only taxed when benefits are paid, according to the EET system³. In order to take advantage of the tax relief on premium payments, contributions will be locked in until the statutory retirement age (age of 63), and benefits paid over a period of 10 years, excluding existing pension insurance products. The former law stipulates 62 years as the earliest age at which savers can withdraw their benefits over a two-year period. Increasing the age when savers are eligible to cash in their benefits is part of the Finnish government's aim to raise the retirement age and increase the length of working life. The new law also makes it easy to move capital between different providers throughout the length of the savings period, without the loss of the tax benefits. However, providers will be allowed to charge a transfer fee. In the case of death, the capital will be automatically transferred to the beneficiaries of the estate.

Voluntary pension insurance has been growing all through the 2000s, but now this development has almost stagnated. The number of personal pension plans in 2009 was 770,000, compared to 320,000 in 2000, according to the Federation of Finnish Financial Services (2010). However, the number of new contracts in personal pension insurance has dropped dramatically. The number of contracts sold in 2011 was only 7,680 (including contracts made by firms and individuals), dropping down from 12,000 in 2010, and nearly 50,000 in 2009. PS-accounts have not been popular enough to fill this gap. In the first year (2010), less than 10,000 accounts of this type were opened, with an average monthly savings amount of EUR 120 (BoF 2011). In 2011, the total number of accounts rose only to 18,600 (BoF 2012). This is a lot less than expected from the reform. Expectations for future changes in tax rules and the uncertainty about what will happen to retirement age hinder the sale of these products.

2.2.2 Debates and political discourse

Debate on substantial changes to the earnings-related pension scheme to extend working lives and increase the retirement age has been on-going during the last three years. In 2009, the government and the social partners agreed that additional measures must be taken to raise the average effective retirement age by at least three years by 2025, compared to the situation in 2008 (59.4 years)⁴.

The social partners together with the government are exploring ways to raise the effective retirement age to ensure a sufficient level of earnings-related pensions and the financial sustainability of the earnings-related pension scheme. An additional major motivation to postpone retirement is to strengthen general public finances at a time when Europe is facing weak growth prospects and the Finnish population is ageing rapidly.

The Finnish government and social partners have expressed their concerns regarding declining replacement rates in the future. The increase in life expectancy has been more rapid than projected, which is resulting in a situation where pensions will be significantly lower than was projected in the drafting of the 2005 pension reform if working lives do not extend. The most

³ "EET" is an abbreviation for "Exempt-Exempt-Taxed". The first "exempt" refers to the tax deductibility of employer and employee contributions. The second "exempt" refers to the investment earnings being exempt from taxation. The "taxed" refers to the eventual taxation of retirement pensions and other benefits at the time they are paid to the employees and other plan beneficiaries.

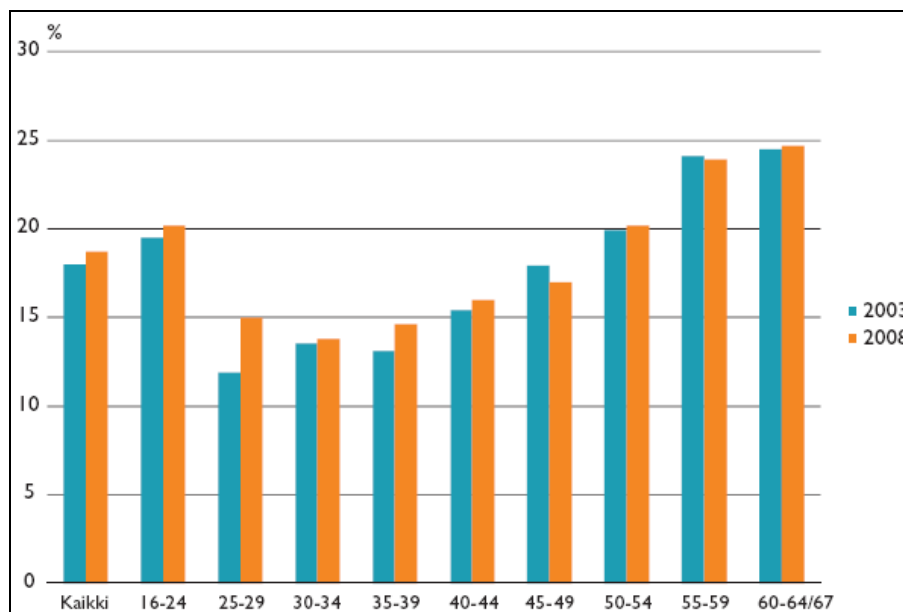
⁴ See PRIME MINISTER'S OFFICE (2009), Consensus to Settle Pensions Dispute, press release, Helsinki, 11 March 2009, retrieved on 12 February 2012 from <http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2009/elake-110309/en.pdf>.

heated topic under discussion is whether the minimum retirement age should be raised from the current level of 63. For example, the Social Democrats joined the government in 2011 on condition that the minimum retirement age will not be raised. Another big issue is the prolonged unemployment benefit for the aged. Employers have called for the abolition of the ‘unemployment tunnel’, whereas the trade unions want to keep the existing system.

The Confederation of Finnish Industries (EK) has voiced demands on joining together decisions on future pension contributions and the lower limit of retirement age. Labour unions are against this kind of coupling. However, according to Finland’s biggest newspaper Helsingin Sanomat (on 11 and 12 February 2012), recent comments made by the Central Organisation of Finnish Trade Unions (SAK) show signs of consensus and they are no longer as definitively opposed to a raising of the retirement age as they have been. However, according to SAK, this should be the last option if other measures are not effective enough. The Social Democrats still insist that the minimum retirement age will not be raised during the present government term. However, for the first time there are clear signs that some kind of solution to this heated topic might be reachable in the near future. A negotiation group (which consists of members from employer and employee organisations, the state and major pension insurance companies) is currently working on these issues and the Minister of Social Affairs and Health hopes to see the results by the end of February or early March.

One of the measures for prolonging working careers is the tightened requirement for eligibility to sickness allowance. Starting from June 2012, a medical statement is required by the occupational health service for an employee’s eligibility to sickness allowance after a sick leave of 90 days at the latest. The occupational health service should evaluate the employee's remaining work ability. This early intervention should prevent periods of prolonged disability more effectively. The share of long-lasting sickness allowance (over 60 working days) has in recent years increased, especially among the youngest age groups (see Figure 3). Musculoskeletal disorders (34%) and mental disorders (26%) were the main reasons for long-term sickness allowance granted in 2008. (Ministry of Social Affairs and Health 2011)

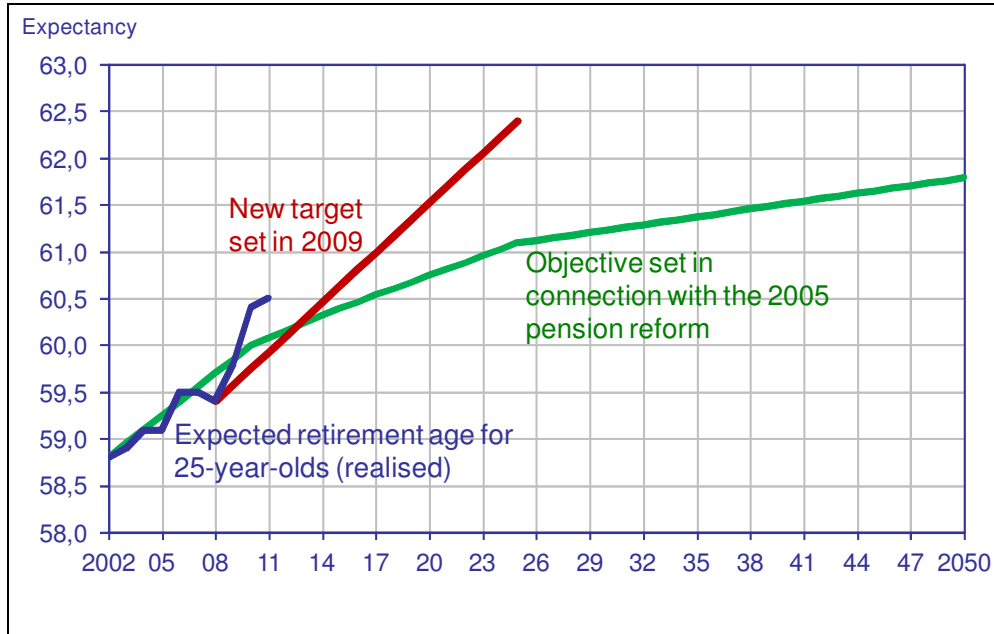
Figure 3: Share of sickness allowances paid for over 60 working days in relation to sickness allowances awarded in 2003 and 2008 by different age groups, in %



Source: Ministry of Social Affairs and Health 2011; Social Insurance Institution Kela

So far, the on-going abolishment of unemployment pension has resulted in a sharp rise in the effective retirement age. The national indicator of effective retirement age has risen from 58.8 years in 2000 to 60.5 years in 2011 (see Figure 4).

Figure 4: Development of the expected effective retirement age



Source: Finnish Centre for Pensions

The government programme states that an index-related working group will be established. This group will evaluate the possible need for changes in the indexation rules in the earnings-related pension scheme. The group's agenda will include the purchasing power of earnings-related pensions, the justice between generations, financial stability of the earnings-related pension scheme and reasonable pension contributions. Another requirement for the group is that the pensioners should be represented. This working group was, in fact, established by the Ministry of Social Affairs and Health on 22 December 2011 and the appointed chairman of the group is Jukka Rantala from the Finnish Centre for Pensions. The group's term of office ends at the end of 2012⁵. According to the assignment of the group, no high expectations for significant changes to the indexation rules exist.

2.2.3 Impact of EU social policies on the national level

The Open Method of Coordination (OMC) has not been a topic of discussions in the media in Finland. The most visible discussions in the field of pensions are the discussions around the length of working careers and the level of retirement age. However, the general perception of the OMC is positive. The OMC has been a useful framework in discussing common problems in pension policy and in learning from other Member States' experiences in the field.

Following the parliamentary elections in April 2011, the Finnish government updated its programme for the EU 2020 strategy⁶. The government's new full Europe 2020 programme will be submitted in April 2012. Comparing the one in hand with the new government programme and the objectives set in negotiations between the government and labour market

⁵ <http://www.stm.fi/vireilla/tyoryhmat/indeksityoryhma>.

⁶ Ministry of Finance (2011). Europe 2020 Strategy. Finland's National Programme Update, Autumn 2011, retrieved on 12 February 2012 from: http://www.vm.fi/vm/en/04_publications_and_documents/01_publications/02_economic_surveys/20111027Eu-rope/Europa_2020-2020_taitto_enkku.pdf.

organisations, with the focus on a multitude set of approaches to extend careers at the beginning, middle and end, indicates that Finland is firmly committed to the strategy. In addition, the national targets exceed in many respects those set at EU level. For example, the targets of raising the employment rate of 20–64 year-olds to 78%, raising the proportion of 30–34 year-olds with tertiary level education to 42% and keeping the proportion of early school leavers below 8% exceed the targets set in the EU: 75%, 40% and 10% respectively. The government is also aiming to reduce the number of people at risk of poverty and social exclusion by around 100,000, in order to fulfil the quantitative target of the Europe 2020 Strategy. Aiming for higher employment rates and reducing poverty by extending working careers is an important, albeit challenging, objective, which would help strengthen the financial base and long-term sustainability of the general government.

Even though high expectations for further measures exist in respect of the on-going tripartite negotiations, some measures for reaching the targets set for prolonging working careers and for EU 2020 are already being implemented, as presented below, and follow recommendations given by the Council to Finland on 12 July 2011⁷, and reflect objectives in the Annual Growth Survey⁸.

The government programme outlines the resources available for combating youth and long-term unemployment. The unemployment rate among young people aged 15 to 24 was 20.4% in January 2012, which was 1.3 percentage points higher than in January last year (OSF 2012a). According to Eurostat, the average rate for EU27 was 22.4% and 21.4% for EU-15. The implementation of the social guarantee for young people will begin in 2012, and it will come into force in full during 2013. The social guarantee will offer each young person under 25 and recently graduated people under 30 a job, on-the-job training, a study place or a period in a workshop or rehabilitation within three months of becoming unemployed. (Finnish Government 2011)

To reduce long-term unemployment, a fixed-term trial pilot programme, lasting until the end of this government's term, will be initiated in which, after 12 months' unemployment at the latest, the main responsibility for managing an individual's unemployment support will be transferred to the municipality or municipalities jointly. The employment opportunities of every unemployed person will be charted and progress actively monitored. In addition, the participation of the long-term unemployed in wage-subsidised work, training and other services will be increased. (MOF 2012)

Some measures are under preparation. For example, occupational health care and statutory health insurance will be developed on the basis of proposals made by the Ministry of Social Affairs and Health's working groups on occupational health care and wellbeing at work (Finnish Government 2011). According to the government's programme, the availability of high-quality occupational health care services must be ensured, whilst also refocusing occupational health care activities to better support the extension of working careers. The comprehensiveness, effectiveness and quality of occupational health care will be increased. The occupational health care of entrepreneurs, agricultural entrepreneurs and those in short-term employment must be further improved. Moreover, the opportunities of small-sized workplaces to acquire occupational health care services by forming joint acquisition must be improved. One of the reforms to stimulate prolonged working careers is the already mentioned tightened requirement for eligibility to sickness allowance only after a statement by occupational health care personnel.

⁷ http://ec.europa.eu/europe2020/tools/monitoring/recommendations_2011/index_en.htm.

⁸ http://ec.europa.eu/europe2020/reaching-the-goals/monitoring-progress/annual-growth-surveys/index_en.htm.

Tackling unemployment and disability (as early as possible) is important to secure future pension adequacy. When unemployment and disability become a long-term issue, it is increasingly difficult to break the cycle of social exclusion in particular, and only by means of pension policy. Earlier intervention is needed and, at the moment, the government together with social partners are promoting further measures for improvements in a person's working life and better transitions from school to work.

2.2.4 Impact assessment

Three different indicators are used for monitoring the postponement of retirement age. The main one is the above mentioned development of the expected effective retirement age (Figure 4). But also the duration of working life (see e.g. Vogler-Ludwig 2009) and employment rate of the elderly are used as indicators for monitoring the development. The employment rate of the elderly (aged 55 to 64) has risen by 15% since 2000, reaching 57% in 2010, which was well above the EU average. Even though the economic crisis led to a decrease in the overall (aged 15-64) employment rate, it did not have any serious effect on the employment rate of older workers. The employment rate has continued to rise even between the years 2010-2011.

Taking a closer look at the work activity in different age groups of seniors, we see that the employment rate starts falling considerably among the 60-64-year-olds. However, there is a clear rise in the employment rate for this group as well, from 23% in 2000 up to 42% in 2011. At the same time, the employment rate for those aged 55-59 has risen from 59% to over 72%. It is even higher than the employment rate for the age group 15-64 which was close to 69% (see Table 1).

Table 1: Employment rates of 15-64, 55-64, 55-59 and 60-64 year-olds, in %, in 2000-2011.

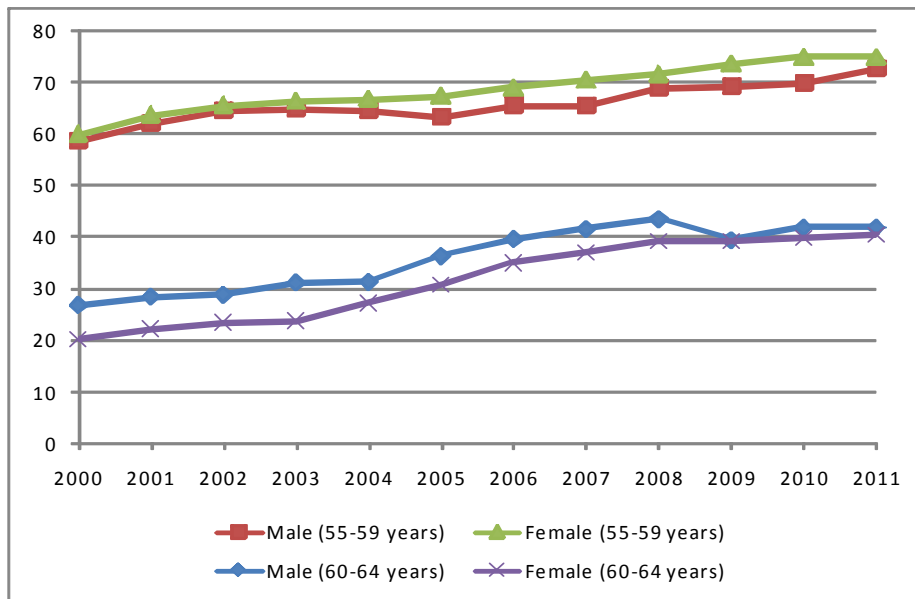
Age	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
55-59 years	58.5	62.4	65.2	65.7	65.3	65.4	67.3	67.9	70.3	71.4	72.5	72.7
60-64 years	22.8	25.2	26.5	27.4	30.2	33.5	37.2	39.1	41.2	39.3	40.8	41.8
55-64 years	41.6	45.7	47.8	49.6	50.9	52.7	54.5	55.0	56.5	55.5	56.2	57.0
15-64 years	66.9	67.7	67.7	67.3	67.2	68	68,9	69.9	70.6	68.3	67.8	68.6

Source: Statistics Finland, Labour Force Surveys

There are no significant gender differences in the employment rates of older workers, and the women's rate has even surpassed that of men (Figure 5). The employment rate of men (60-64 year-olds) fell, whereas the employment rate of women managed to grow, even during the crisis. This is explained by sectoral and occupational segregation on the labour market. The crisis first hit the export-oriented sectors, which are mostly male-dominated. The females dominate public social and health care sectors, where crises will usually show a delayed effect. According to the latest statistics, the number of employed persons in January 2012 was lower than the previous year, and the number of employees grew in the private sector but fell in the public sector (OSF2012a). However, even though the number of employees continues to decline, the likely changes in employment rates can be expected to be moderate in 2012 (see e.g. MOF 2011⁹).

⁹ Economic Bulletin 2/2011, retrieved from: http://www.vm.fi/vm/en/04_publications_and_documents/01_publications/02_economic_surveys/20111220Econom/sk_enku_joulukuu2011.pdf.

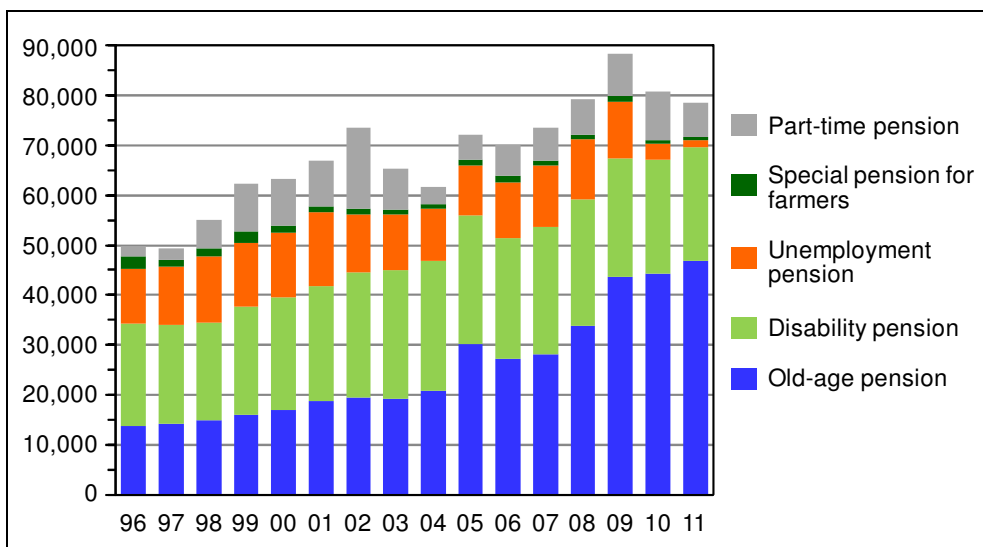
Figure 5: Employment rate of older workers (55-59 and 60-64-year-olds) by gender, in %



Source: Statistics Finland, Labour Force Surveys

According to the indicators regarding the duration of working life, the gap between men’s and women’s working careers is smallest among the EU-countries. Working life expectancy (for a 15-year-old) was 34 years - for men 34.3 years and for women 33.7 years - in 2011 (Finnish Centre for Pensions). For men it has risen by two and for women by three years during the 2000s. This trend is also visible when comparing the share of old-age pensioners among the new retirees. In the 1990s, main exit routes from the labour market were either through the disability pension scheme or unemployment pensions. However, in 2011, nearly 2/3 of the new retirees retired directly on an old-age pension; compared to 1/4 in 2000 (Figure 6).

Figure 6: Persons having retired on a statutory earnings-related pension in 1996–2010 by pension benefit



Source: Finnish Centre for Pensions

Referring to the Eurostat OMC indicators in the field of pensions¹⁰, the level of income for elderly people has remained stable during the 2000s at over 70% of the income of the entire population (aged 65+/aged 0-64), increasing up to 78% in 2010, although women lag behind the average. However, the level is around 10 percentage points lower than the EU average. The aggregate replacement ratios have been stable as well, indicating 50% of income maintenance after retirement on average. Practically, no gender gap exists in this indicator.

At-risk-of-poverty rate of people aged 65 is higher than the EU average (18.3% vs. 15.9%) and higher than for the population under the age of 65 (12.1%). Moreover, the gender gap is large in at-risk-of-poverty rates of those over 65, and especially for those aged 75+. Women's poverty rate exceeds men's by more than 10 percentage points and the gender poverty gap is clearly higher than the EU average.

The higher poverty risk of those aged 75 and over, whether compared to EU average or people aged under 65, is partly due to the gradual entry into force of the earnings-related pension scheme, low participation rate of older women in the labour market and relatively low national pension. The risk of poverty is greatest for older women in receipt of a national pension with short or no working careers. Women also dominate the oldest age cohort, as – on average – women live longer than men. Two thirds in this age group are women and one third men (OSF 2012b). Consequently, the period of retirement is longer for them and a major part of women live alone, thus facing a much higher risk of falling into poverty than older persons living as a couple.

At-risk-of poverty rates drop significantly by using 50% of median income as a cut-off point. Even women aged 75+ settle down to EU average and men clearly below. This indicates that in Finland, a large share of the elderly have an income between 50 and 60% of the median income. Severe material deprivation among the aged is with 1.7% for the 65+ and 2.6% for 75+ groups clearly below the EU-average (6.4% and 6.5% respectively) and they are better off than younger age groups (3.1%). The rate shows that older people can afford necessities considered essential to live a decent life. Income distribution has stayed among the lowest in the EU.

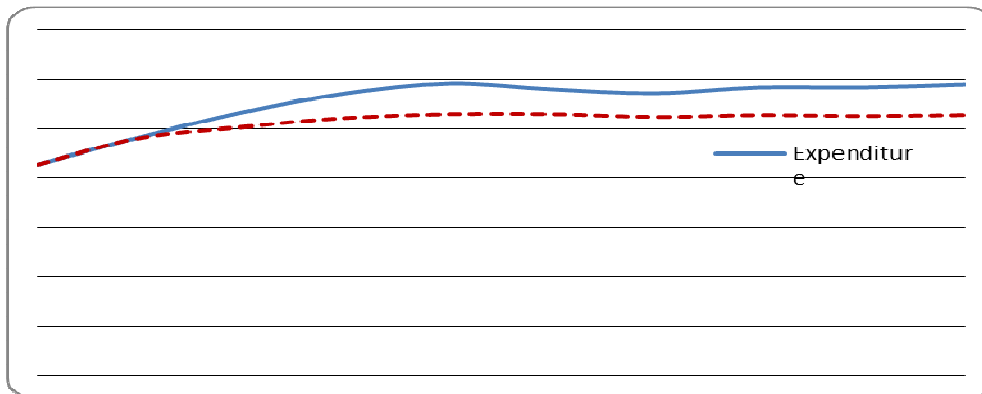
Women's wage-earning careers are interrupted more often than men's because of child care, for instance. But the provisions included in employees' pension legislation since 2005 concerning unpaid periods promote equality between workers. In addition, since 2005, pension accrues from unpaid periods under the same terms for both permanent employment and temporary employment, which was not the case before the reform. EU Social Protection Committee's (SPC) calculations on theoretical replacement rates (TRR) indicate that having two children with three years of absence of work for each child has very little effect on the level of future pension. The net TRR with a child care break is projected to be 61.3% in 2050 compared with 62% for a base case (with a 40-year career). The negative effect was much higher before the 2005 reform. Currently, pension accrues until the child reaches the age of three. Longer absence creates bigger gaps in pension compared to working. How much, depends on the wage level. The national pension partly compensates for a smaller earnings-related pension.

Pension accrues also from earnings-related unemployment benefits, but not from basic benefits. It is possible to receive a maximum of 500 days (23 months) of unemployment benefit at a time, with the exception of older unemployed. If unemployment begins after the age of 58, the benefit continues until retirement age. At the age of 62, it is possible to receive old-age pension without any actuarial reductions. Thus, a disincentive for work exists for older unemployed, as the status of unemployment has very little effect on the level of future pensions.

¹⁰ Retrieved from:
http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database.

Currently, the Finnish statutory pension scheme is in a situation where private sector (TyEL) expenditure approximately equals the premium income. In the future, however, the expenditure will exceed the contribution income (see Figure 7). According to the latest projections in 2011, the average (TyEL) contribution rate will rise from the 2010 (base year) level of about 22% to approximately 26% in the long run. The level of contribution is somewhat higher than in the previous 2009 projection, largely due to the impact of the crisis, diminishing expectations on future investment returns. Investment returns play a key role in covering the difference between expenditure and contributions to avoid the risk of a sustainability gap.

Figure 7: TyEL expenditure and contribution percentage from 2010–2080, in % of wages

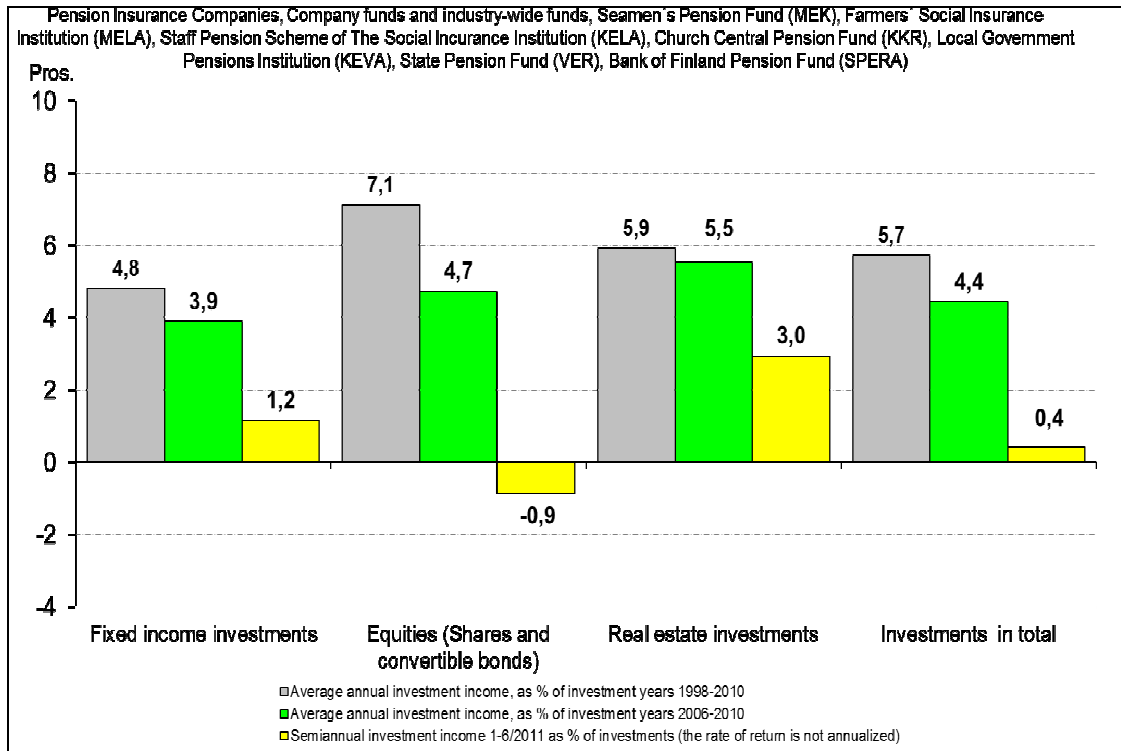


Source: Risku et al. 2011

The long-term pension contribution projections are based on to the real return assumption of 3.5%. In the previous (2009) report it was more optimistic: 4%. In principle, if this level is not reached, the contributions must be raised or benefits need to be cut.

Pension funding alleviates the pressures to raise pension contributions with the ageing of the population and equalises the intergenerational income distribution. The year 2011 was again a challenging year for investment performance and, as a result, an average (nominal) return rate of about 11% in 2010 turned into a return of 0.4% in the first half of 2011 (Figure 8). In 2010, the real return was 8%, in 1998-2010 the annual real return was 3.8%, and for the last five years it was 2.3% annually (Finnish Pension Alliance Tela). Basically, one extra percentage point in the long-term return is equal to about two percentage points in the TyEL contribution (since the amount of pension funds is approximately double in relation to the wage sum). Investment returns do not have any immediate impact on pension levels.

Figure 8: Nominal rate of return on investments for the first half of 2011 and on average for the years 1998-2010 and 2006-2010.



Source: The Finnish Pension Alliance TELA

2.2.5 Critical assessment of reforms, discussions and research carried out

The recently established guaranteed pension improves the economic welfare of low-income pensioners. However, if it is the only source of income, the amount is not sufficient to be above the level of poverty threshold measured in relative terms. According to Statistics Finland, 60% of median income per household consumption unit was EUR 1,228 per month in a one person household in 2010 (OSF 2012). But according to a recent study regarding the advent of the guaranteed pension, pensioners are able to meet computed reasonable minimum living costs out of their income. By comparison, the income of other types of household on basic benefits only covers about two thirds of reasonable minimum living costs (THL 2011). However, according to a survey by Statistics Finland (OSF 2011a), the number of pensioner households with difficulties in making ends meet increased and rose from 22.1% in 2009 to around 24.5% in 2010.

In general, work and work ability is vital for future pension adequacy. The 2005 pension reform has improved the incentives to stay longer at work, which increases the level of earnings-related pensions and has a favourable effect on adequacy of pension provision. The higher risk of poverty continues to be a challenge for those who for some reason are not able to accrue earnings-related pension, e.g. persons who become disabled for work at a young age as well as young persons who become long-term unemployed.

For future pension adequacy it makes a difference at which age a person becomes unemployed, for how long, and whether this person is entitled to earnings-related benefit that gives entitlement to pension rights or not. Young people in particular are facing increasing challenges in the transition from school to work. Many young people become unemployed and extended unemployment often leads to exclusion from work life. Uncertainty regarding employment also leads to mental and other health problems. A recent study (Blomgren et al. 2011) found that a significant part of those retiring on disability pension had a background of long-term

unemployment. Long-term unemployment was a common background, especially among disability retirees due to mental disorders. Mental disorders (33%) alongside musculoskeletal disorders (32%), was the biggest reason for disability retirement in 2010 (OSF 2011b). Especially depression-related mental health problems have continued to rise for those under the age of 30 (see e.g. Raitasalo & Maaniemi 2011). More generally, the inflow into disability benefit continues to be high and those retiring on earnings-related disability pension are still around 25,000 new retirees per year, with total recipients of over 200,000. People retire on a disability pension at the average age of 52 years (OSF 2011c).

Disability increases the risk of poverty. The poverty rate for pensioner households under the age of 55 is clearly the highest and the poverty rate has increased substantially during the 2000s (Table 2). The size of household makes no difference, according to the result shown below (see Rantala 2011). The number of low-income pensioners is still the highest among the aged over 74.

Table 2: The poverty risk for pensioner households according to age in 2000, 2005 and 2009

Age	At-risk-of-poverty rate (< 60% of median income)			Number of pensioners with low-income (< 60% of median income)		
	2000	2005	2009	2000	2005	2009
under 55	19.0	26.9	35.7	19,200	26,042	31,200
55-64	9.9	11.3	12.4	23,500	30,796	33,200
65-74	8.2	11.9	7.9	34,800	52,021	36,800
over 74	13.7	19.4	17.3	43,500	72,236	70,500

Source: Rantala 2011

Current developments since the 2005 pension reform have been encouraging. The expected effective retirement age has increased more than projected (see Figure 4) but the objective to postpone retirement set in 2009 tripartite negotiations will most likely not be reached without further reforms.

The focus in tripartite negotiations and in different working groups has been and continues to be on finding ways how to extend careers at the beginning, middle and end. The focus is on a multitude set of approaches instead of a single solution to rise the official retirement age, which on its own is most probably not a sufficient measure for safeguarding the future pension adequacy.

For future pension adequacy, one of the decisive elements is the effect of the life expectancy coefficient and people's reactions to flexible retirement. The question that arises is whether the life expectancy adjustment encourages long enough careers for decent living. It is still too early to answer this question, as the mechanism was only established in 2010. However, if people retire immediately when they reach the minimum retirement age, it is worth considering whether the level of minimum retirement age should be higher, in order to safeguard the adequacy of future pensions. The Council has taken a step further by recommending a link between statutory retirement age and life expectancy (Official Journal of the European Union 2011)¹¹.

The OECD (2012¹²) also recommends rising the minimum and maximum retirement age and tightening early retirement routes by abolishing the unemployment pipeline. In addition,

¹¹ http://ec.europa.eu/europe2020/tools/monitoring/recommendations_2011/index_en.htm.

¹² OECD, ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (2012) Economic Survey of Finland, retrieved on 12 February from: http://www.oecd.org/document/8/0,3746,en_2649_33733_49514888_1_1_1_1,00.html.

according to OECD, study periods should not be eligible for pension credit accumulation, and the effectiveness of the higher accrual rates for older workers should be scrutinised.

2.3 Health

2.3.1 Overview of the system's characteristics and reforms

The Finnish legislation gives the task to organise health care services to the municipalities. The public municipal system covers primary health care and specialised health care.¹³ Each municipality has the responsibility to organise adequate health care services for their permanent residents. Municipalities have the right to levy taxes. They cover the costs of health care services with municipal taxes, state subsidies and user fees.

Primary health care services may be organised by a single municipality or in cooperation with several municipalities. Specialised health care services are organised by 20 federations of municipalities, and the country is divided into 20 hospital districts for specialised health care. These districts are grouped into five tertiary care regions around the universities with medical schools. In these regions, central hospitals are called university central hospitals.

Health services are also provided by the private sector. Users of private health care pay the fees themselves, but they receive a partial reimbursement through the obligatory National Health Insurance System.¹⁴

There also exists a third system for the provision of health care services: occupational health care. Employers are obliged to provide preventive health care services (those necessary to address work-related risks) and first-aid services at work for their employees. Many big and medium-sized employers provide even basic outpatient treatment of common diseases for their employees. There are no patients' fees. Costs are covered by obligatory payments of employers and employees to the National Health Insurance Income Insurance Pool.¹⁵

At state level, the Ministry of Social Affairs and Health defines general health policy guidelines and directs the health care system. The health care system is decentralised, and national governance is weak. Every municipality or federation of municipalities determines the scope of health care services within the limits set by national legislation. The ministry directs the system by preparing legislation, setting broad national development goals and implementing national development programmes in cooperation with municipalities.

The election of the Parliament caused some changes in the political goals. Furthermore, the implementation of the Comprehensive Health Care Act in May 2011, gave new orientations and tasks to health care districts. Rules and regulations about the operation of health care and contents of services in the Primary Health Care Act and in the Act on Specialised Medical Care were brought together in the new act. The act does not include rules and regulations about financing services. The central aim is to reinforce the role of primary care. The key features of the act are

¹³ See KUNTALAKI 17.3.1995/365. Legislation about Municipalities and Tasks of Municipalities. March 1995, retrieved from: <http://www.finlex.fi/fi/laki/ajantasa/1995/19950365>; KANSANTERVEYSLAKI 28.1.1972/66. Primary Health Care Act. January 1972, retrieved from: <http://www.finlex.fi/fi/laki/ajantasa/1972/19720066>; ERIKOISSAIRAANHOITOLAKI 1.12.1989/1062. Act on Specialised Medical Care. December 1972, retrieved from: <http://www.finlex.fi/fi/laki/ajantasa/1989/19891062>.

¹⁴ TEPERI J, PORTER ME, VUORENKOSKI L, BARON JF. The Finnish Health Care System: A Value-based Perspective. Sitra reports 82, Sitra, Helsinki 2009, 115 p., retrieved from: <http://www.sitra.fi/julkaisut/raportti82.pdf?download=Lataa+pdf>.

¹⁵ TYÖTERVEYSHUOLTOLAKI 21.12.2001/1383. Occupational Health Care Act. December 2001, retrieved from: <http://www.finlex.fi/fi/laki/ajantasa/2001/20011383>.

1. to increase patient choice;
2. to lower barriers between primary and specialised health care and to improve cooperation; 3. to improve the mobility of patient records;
3. to centralise the organisational responsibility of ambulance and emergency services; and
4. to strengthen the role of tertiary care regions (central university hospital regions).

The act offers a possibility to provide both primary and specialised services by merging and forming health districts. The act does not replace any previous acts on health care (TERVEYDENHUOLTOLAKI 2010).

Furthermore, the status of citizens is strengthened in the Comprehensive Health Care Act. The citizens' possibilities to choose health care services are increased by enabling citizens to visit any health care centre in their hospital district. Patients, together with their physicians, have the right to choose any hospital in the central university hospital region to which the municipality of the residence of the patient belongs. The act includes rules in order to ensure an access to care and to increase the security of patients (TERVEYDENHUOLTOLAKI 2010).

According to the programme of the new government, the provision of public social and health care services by the public municipal system should be emphasised and the possibilities of municipalities to provide services will be further strengthened. Coordination of social welfare services and health services, promotion of wellbeing and health of citizens and appreciation of clients and patients belong to the main themes in the welfare policy. The problems caused by the multichannel financing model of health care will be diminished by increasing cooperation between municipal health care and health insurance system. An act on organising, financing, developing and controlling social and health care will be composed, and the reform of the Social Welfare Act will be continued. Tackling the problems noticed in applying the Act on Competition Restrictions in delivering services belongs to the goals of the government. (PÄÄMINISTERI JYRKI KATAISEN HALLITUKSEN OHJELMA 2011).

The implementation of the programme of the government means that municipalities must merge. Collaborative areas for providing social welfare and health care services are not recommended anymore. Thus, the plans in the programme can be seen as a second step compared to the act from 2007, which orders that primary health care services and closely related social welfare services must be delivered in health care centre regions covering at least 20,000 inhabitants and which allows a transition period for municipalities until the beginning of 2013. In the act from 2007, it is ordered that in order to achieve this minimum, municipalities with less than 20,000 residents must either merge with neighbouring municipalities or form collaborative areas which provide services (LAKI KUNTA- JA PALVELURAKENNEUUDISTUKSESTA 2007).

2.3.2 Overview of debates/political discourse

The discussion about the future of the health care system and financing health care continued in 2011. The Prime Minister's Office published a theoretical assessment of four previously published proposals to structure and finance social welfare and health care. Two of these were based on a model in which services were to be delivered and financed by one national organisation which could order services from several providers. Two of the assessed models were based on a regional model in which the region could both order and provide services. One of these latter models was based on large municipalities, which have the right to levy taxes. The models were assessed from a wide range of viewpoints, and their supposed positive and negative effects were commented upon (EHDOTUKSET SOSIAALI- JA TERVEYDENHUOLLON RAHOITUKSEN KEHITTÄMISEKSI 2011).

The Finnish Business and Policy Forum EVA participated in the discussions about possibilities to develop health care and to produce savings in health care costs. Altogether 19 proposals were made by this organisation. The most important proposals included the following ones:

1. Contractors and providers of health care services should be separated;
2. Primary health care and specialised medical care should not be tasks of separate organisations;
3. Management of health care should be developed;
4. Tasks of physicians and nurses should not be separated compulsorily;
5. Treatment mistakes/errors caused by the system should be decreased systematically;
6. Measures of effects of treatment and care should be applied to practice;
7. Financial resources for development programmes should be distributed in a new manner;
8. Employees should be encouraged to decrease leaves due to illness or disability;
9. Best practices should be implemented systematically;
10. Financial incentives should be implemented within primary health care;
11. Social welfare services should be connected to health care services;
12. Tasks to give medication and travel reimbursements should be given to organisations which order health care services.

It was estimated that about EUR 2.5–3.0 billion could be saved by implementing the proposed reforms (LEIKOLA MARKUS 2011).

The increase of differences in health and poverty and the increase in inequality between citizens have led to quite wide discussions by researchers and journalists.

Furthermore, the working group whose tasks were to make proposals to develop the rights of clients of social welfare and health care services published its report. The group assessed problems in the rights and equality of clients and found several problems, especially in the areas of psychiatric care, care of the disabled, elderly care and long-term care, where the rights and equality of clients seem restricted, despite the fact that the legislation does not specify restrictions. Several proposals about legislative changes were made in order to ensure the human rights of clients. In addition, proposals about changes in the administrative bodies and in the guidance of clients, as well as a proposal about a research project covering human rights and legislation were made (LAKI JA ASIAKKAAN OIKEUDET 2011).

Shortages of medical staff have been a common topic of discussions in newspapers during the past years. A similar trend continued in 2011. Young physicians have not been interested in working in primary care, and municipalities have had problems in recruiting physicians in the 2000s. This fact has led to several kinds of contracts between municipalities and private companies in order to deliver primary medical care services. In 2011, the discussions widened to the quality and costs of these contracts. The young age, insufficient skills and rapid change of physicians working in private companies were criticised. Some municipalities aimed to decrease the amount of physicians working through the contracts with private companies, while others aimed to continue the contracts. The Minister of Health and Social Services stated that privatisation of primary health care services would not continue as extensively in the future as in previous years (MEDIUUTISET 2011; 2011a).

The Finnish Federation for Social Welfare and Health carried out an opinion survey amongst Finns about access to social and health care services. The report was widely quoted in newspapers. Every second participant considered that the waiting lists within health care services, especially those of primary health care physicians, are too long. 15% reported that they had not received adequate medical help to tackle their health problems within the previous year. Problems with access to medical care services were most common among unemployed people (SILTANIEMI AKI et al. 2011).

In November 2011, the newspaper “*Iltasanomat*” (“Evening Post”) revealed the identity of a fraudulent physician, who had worked several years as a licensed physician (ILTASANOMAT 2011). The permission to work as a physician had been given by the National Supervisory Authority for Welfare and Health (Valvira), and the permission was based on a false certificate about studies in medicine in Russia. This raised a vivid discussion about the supervision and control of health care services, which showed that many citizens have lost their confidence in the National Supervisory Authority for Welfare and Health and other organisations responsible for supervision and control. The call for the director of the National Supervisory Authority for Welfare and Health to resign was made in the newspapers, but she did not leave the job. The Minister of Health and Social Services appointed a committee consisting of three experts to assess the overall operations within the National Supervisory Authority for Welfare and Health. The committee will give its report during the first half of 2012 (HELSINGIN SANOMAT 2011; 2011a; ILTALEHTI 2011).

2.3.3 Impact of EU social policies on the national level

The OMC in the field of health care has not been a topic of discussion in the media in Finland. The EU 2020 Strategy has mainly impacted on debates on competition in providing health care services and the discrepancy between the welfare state model and the market model in providing services.

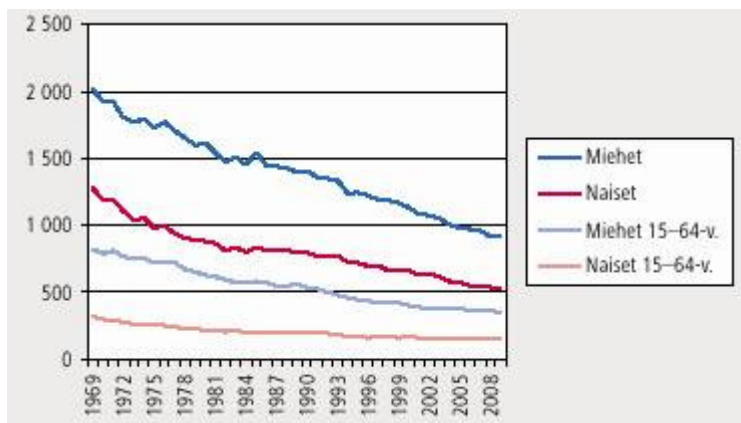
The National Programme, updated in autumn 2011, includes some sentences about health policies. For example, the government will reinforce the basic structures of the welfare state and ensure sufficient resources for public services and social security. Social welfare and health care services will be delivered as an integrated system, emphasising preventive measures and the position of the client. The primary emphasis in improving the population’s occupational and functional capacity as well as social security is on enhancing the quality, availability and effectiveness of services and on developing benefits, so as to ensure everyone’s livelihood. A supplementary appropriation of EUR 145 million will be allocated to developing social welfare and health care services. The government will prepare a wide-ranging action plan to reduce poverty, inequality and social exclusion. The government will launch a second National Development Programme for Social Welfare and Health Care (KASTE II), which will be directed towards the prevention of social exclusion, development of informal care support services, general development of services, reduction of long-term homelessness, and prevention of domestic violence. Good practices, which will be created in a range of development projects, will be implemented across the entire country. High-quality, needs-based care for the aged will be protected by an act on long-term care of the aged, which will come into force from the beginning of 2013. A housing policy action programme will be drawn up by the end of 2011 (EUROPE 2020 STRATEGY 2011).

2.3.4 Impact assessment

The effects of health care policy have been assessed by describing and analysing health habits, morbidity and mortality in the population by gender, age and socio-demographic and socio-economic factors. Many of these analyses have been performed for decades. Thus, there exist longitudinal data to show the development. In addition, several kinds of indicators to measure the impact of certain treatments have been developed and used in studies.

The age-adjusted mortality decreased in the 2000s (see Figure 9). Ischemic heart disease is still the most common cause of death, although the number of deaths from these diseases has decreased during the past 40 years, especially among middle-aged men. On the contrary, deaths from lung cancer and chronic obstructive pulmonary disease have increased. Alcohol-related deaths and suicides are common causes of death in the working-age population, although the number of suicides decreased in 2010. Among women, alcohol-related causes have become more common compared to previous decades. The number of accidental deaths has decreased during the past decades (PENTTILÄ IRMELI 2011).

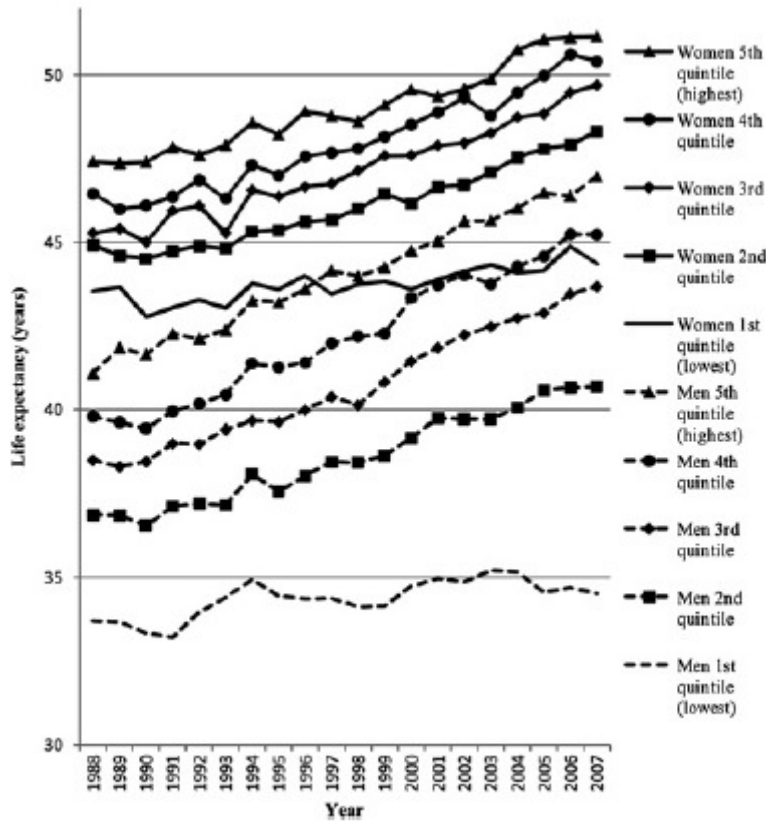
Figure 9: Age-adjusted mortality of men and women per 100,000 inhabitants in 1969 – 2009.



Dark blue: all men; dark red: all women; light blue: men 15-64 yrs.; light red: women 15-64 yrs.
Source: Penttilä, 2011

Differences in health between social groups have increased during the past 25 years. This development is evident in the life expectancy between population groups with different income levels. In 2007, the difference in life expectancy between the highest fifth and the lowest fifth was 12.5 years among men and 6.8 years among women. Life expectancy has not changed in the lowest fifth, while life expectancy has increased in all other income level groups (Figure 10) (TARKIAINEN LASSE et al. 2011).

Figure 10: Life expectancy of men and women aged 35 years by income quintile in 1988 – 2007.

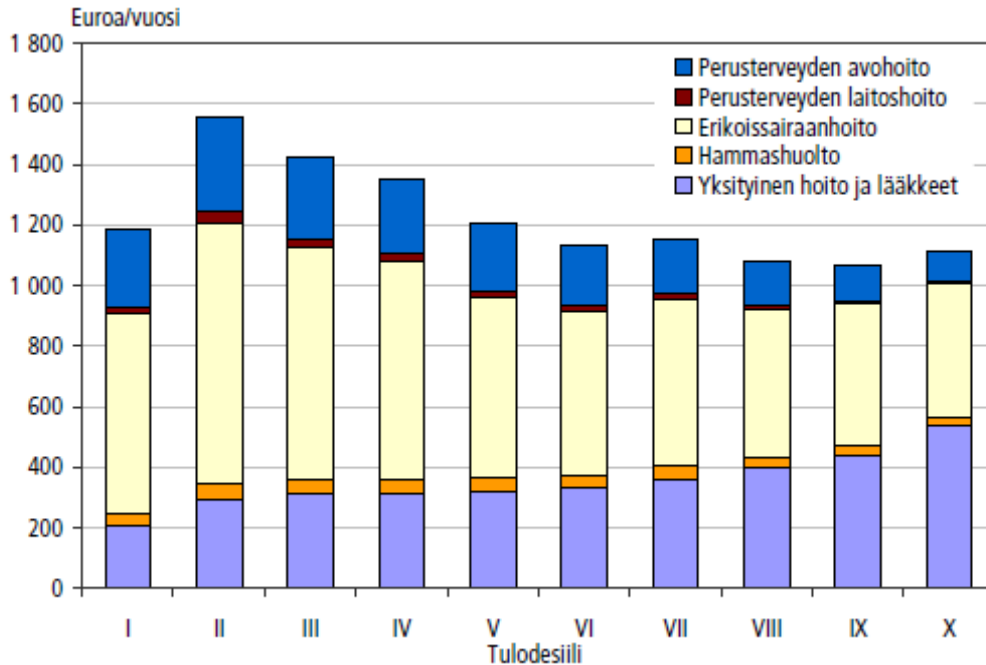


Source: Tarkiainen, Martikainen, Laaksonen, Valkonen, 2011.

The researchers in the National Institute for Health and Welfare published a report about trends in health inequalities in the period 2007–2010. They concluded that the worrying trend in social determinants of health may further intensify health inequalities. Poverty has increased and the level of basic social security has fallen far behind the general wage development. The harmful effects of tobacco and alcohol consumption significantly contribute to the causation of health inequalities. However, inequalities persist, despite efforts to reduce them. Some political decisions may have widened the health gap even further. Social policy over the past twenty years has contributed to a growing inequality, which is difficult to reduce with separate action plans (ROTKO TUULIA et al. 2011).

The results about the distribution of public welfare services in the population and about the effects of public services on diminishing economic differences in the population showed that public health care services and long-term care services diminished economic differences especially among those aged 65 years or over (Figure 11). Occupational health care services were not included in these analyses, which is a pitfall. The users of occupational health care services are employed working-age people, many of whom do not belong to the lowest income levels (VALTIONEUVOSTON KANSLIA 2011).

Figure 11: Distribution of costs of primary health care, specialised medical care, dental care and private services (costs of medicines included) in the population aged 0-64 years based on equivalent incomes, by income group. The mean subsidy to services expressed in Euros.



Dark blue: open care in primary health care; red-blue: hospital care in primary health care; yellow: specialised medical care; yellow-red: dental care; light blue: private health care and medications.

Horizontal line: decile of income

Source: Prime Minister's Office, 2011.

An opinion survey about social welfare and health care services and the equality in access to services was carried out amongst a sample of 3,600 Finns in early summer 2011. Over half of the respondents answered that citizens are not equal in receiving social welfare and health care services. Two out of three persons thought that the quality of services will weaken in the future. Based on these results, it was calculated that the salaries, pensions or other income of over 500,000 adults are not sufficient to cover health care costs. Every second participant considered that waiting lists of health care services, especially those of primary health care physicians, are too long. 15% reported that they had not received adequate help with their health problems during the previous year. Unemployed people form a group where suffering from diseases, limited economic resources and inequality in access to social welfare and health care services is common (SILTANIEMI AKI et al. 2011).

In February 2012, the National Institute of Health and Welfare published a report about the costs of health and long-term care services. In 2005–2009, the costs per inhabitant increased by 0.8% per year, and the needs of care increased by 1.65% per year. In 2010, the costs per inhabitant were 1.8% lower than in 2009, although the needs of care increased by 1.9%. In relation to the needs of care, municipalities used fewer economic resources for health and long-term care services in 2010 compared to the previous year. The increase in the needs in every year was caused by the ageing of the population. In 2010, the average costs of health and long-term care per inhabitant were EUR 2,001 (HUJANEN TIMO, HÄKKINEN UNTO, PELTOLA MIKKO, 2012).

The health care system seems to be sustainable in terms of health care personnel. Physicians and nurses are not emigrating to foreign countries in great numbers. However, the ageing of the population increases the demand for health services..

2.3.5 Critical assessment of reforms, discussions and research carried out and policy recommendations

Merging of municipalities or forming cooperative units between municipalities, in order to create bigger entities to organise primary care, belonged to the first phase in the structural changes of the health care sector. This phase has not progressed rapidly. The history of independence of municipalities is long in Finland, and many municipalities are small. Restructuring primary health care by mergers and cooperative units has not been an easy task to carry out. Not all municipalities have been eager to merge with each other or to form cooperative units.

The current government will decrease the number of municipalities. It is mentioned in the Programme of the Government that economically robust municipalities consist of customary commuter areas large enough to be able to provide basic public services with the exception of specialised medical care and demanding social welfare services. The implementation of the Programme of the Government means that municipalities must merge. Collaborative areas for providing social welfare and health care services are not recommended any more. Thus, the plans in the programme can be seen as a second step compared to the act from 2007, which orders that primary health care services and closely related social welfare services must be delivered in health care centre regions covering at least 20,000 inhabitants and which allows a transition period for municipalities until the beginning of 2013 (PÄÄMINISTERI JYRKI KATAISEN HALLITUKSEN OHJELMA 2011).

The implementation of the plan to decrease the number of municipalities started in late 2011 by informing municipalities and citizens about the plans. The renewal of the municipal system in this way is important for financing municipal services and for providing services with a good quality, but it is not easy to carry out these kinds of changes.

In North-eastern Finland, a trial of a provincial model to organise primary health care services was implemented in 2007. In this model, municipalities were independent, and primary health care services were organised by their union called “the province”. This trial continued until the end of 2011, when one municipality belonging to the union decided to leave the union because the costs of health care had increased and the quality of primary health care had decreased during the trial. This decision means that this model will not continue from 2012 onwards. This trial is an example about difficulties in cooperation between municipalities.

The New Comprehensive Health Care Act, which was implemented in May 2011, opened a new phase in the structural development of the health care sector. The goals, which are stressed in the Act, i.e. to strengthen primary care, to develop cooperation between primary and specialised care and to develop cooperation between health and social welfare care, are important. Municipalities organise, provide and finance both primary and specialised health care, but their possibilities to control operations and costs of health care are quite poor. The possibilities to control are especially poor in the case of specialised health care, which is organised by federations of municipalities with their own administrations. Operations and effects of operations in specialised care have not been analysed sufficiently to show inadequate operations. Only few comparisons of operations, effects and costs between specialised health care districts have been published during the 2000s. However, these kinds of studies are needed, as their results can be used in showing adequate and inadequate operations. The traditional opinions about a high status of specialised health care and a low status of primary care are common in the population and even in the health care staff. The development of cooperation between primary and specialised care is not easy. Similarly, the traditional opinions about a high status of health care and a low status of social welfare care hinder cooperation between these two sectors. The Comprehensive Health Care Act includes many

important regulations which are needed in the development of services, but an improvement of cooperation will need several programmes and several years. Thus far, no assessments exist about the implementation of this act.

The advantages and disadvantages of the multichannel system to finance health services and the three ways to organise services were already discussed in 2010, and proposals to restructure the system were made by researchers and other partners. The discussion continued in 2011, and the Prime Minister's Office has recently published a report. The economic and financial crisis and ageing of the population have decreased the sustainability of the current model. There is a need for restructuring the financing model within the next few years, in order to ensure access to services and equality of the population in accessing services. The participation of the Prime Minister's Office in the discussion is an indication that a restructuring of the system will come in the near future.

Specialised and primary health care were originally, i.e. decades ago, implemented by acts which obliged municipalities to organise health care services for a period of several years ahead. At the beginning of the 2000s, services were developed by adding paragraphs of specific tasks to the existing acts and by national development programmes, which led to a quite slow progress in the development of the system. There is need for real changes and restructuring of the system. Problems in employing physicians in some municipalities, policy goals to increase choice of services, an increase in the number of private services, increased competition, three systems within which to supply health care services, several kinds of trials and development programmes and an increase in differences in the health and income levels of the population have been widely discussed during the last few years. The Finnish public and all political parties are supporters of public health care services financed by taxes. They want to save the welfare state and the equality of citizens. These opinions do not strongly support the goal of increasing competition in health care services. Combining the welfare state model to the market economy intelligently is problematic.

The increase in inequality of health between socio-economic groups stands in contrast to the political goals. The economic depression in the 1990s led to a rise in unemployment, and in spite of the rapid economic development during the early 2000s, long-term unemployment is quite common. Unemployment figures are high among all age groups, even in the young population. Problems in primary care have been evident from the beginning of the 2000s. The governments, however, put their efforts into the maintenance of a high-quality special health care sector at the beginning of the 2000s. The withering of public health care started in the 1990s and continued during the 2000s. Operations to develop and save primary care services were started in 2007, and they have now been on-going for about 5 years. The political support for primary care was started in a late phase. The economic depression in the 1990s, the privatisation ideology among certain physicians at the beginning of the 2000s, problems to provide public primary care services and the late onset of concrete support to the withering primary care belong to the probable backgrounds of the increase in inequalities of health care. Several proposals to decrease inequality were made by researchers in 2011, and increasing equality in health care belongs to the most important goals in the health policy. Many kinds of operations are needed to ensure health promotion, early detection of illnesses and good treatment of illnesses in the population belonging to the lowest socio-economic groups.

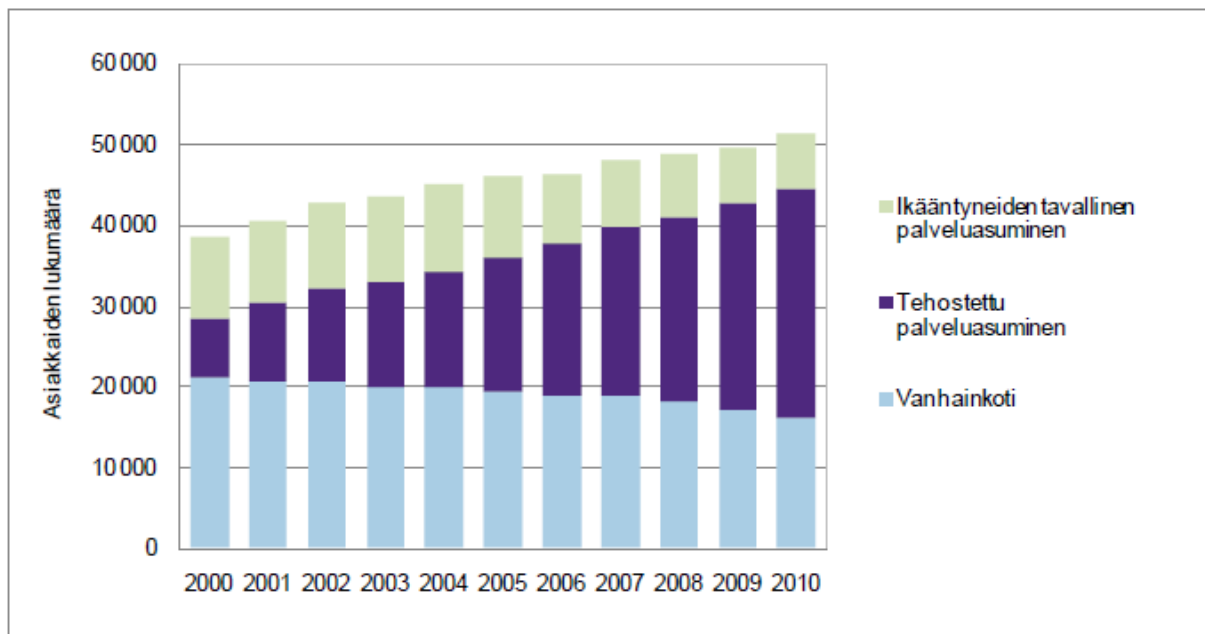
2.4 Long-term Care

2.4.1 Overview of the system's characteristics and reforms

The current parliament was elected in April 2011. The government was formed in June 2011 and consists of representatives of six parties. The Programme of the Government includes several aims regarding the development of long-term care and elderly care. Renewal of the client fee system in elderly care and strengthening the control of social welfare and health care services belong to these aims. Furthermore, an Act about Long-term Care of the Aged will be prepared. The preparation of this act; the promotion of wellbeing and health in the aged population; and development of home and family care of the elderly belong to the important aims regarding long-term care of the elderly. A large programme to develop housing for elderly people will be planned in cooperation with many ministries, municipalities, private sector and non-governmental organisations (PÄÄMINISTERI JYRKI KATAISEN HALLITUKSEN OHJELMA 2011).

The political goal in long-term care and elderly care is to reduce the number and the proportion of elderly people living in long-term institutions (hospitals and nursing homes) and to increase the number and the proportion of elderly people living at home or in “semi-open facilities”. This goal has been pursued since the beginning of the 1990s. The newest figures are from 2010. They show that the number of persons aged 75 years or older living in nursing homes has decreased from 2000 to 2010 (see Figure 12). The number of elderly people living in comprehensive sheltered housing has increased, and the number of elderly people living in usual sheltered housing has decreased (VÄYRYNEN RIIKKA & KURONEN RAIJA 2011).

Figure 12: Number of elderly (75 years or older) persons living in sheltered housing, comprehensive sheltered housing or nursing homes in 2000 – 2010.

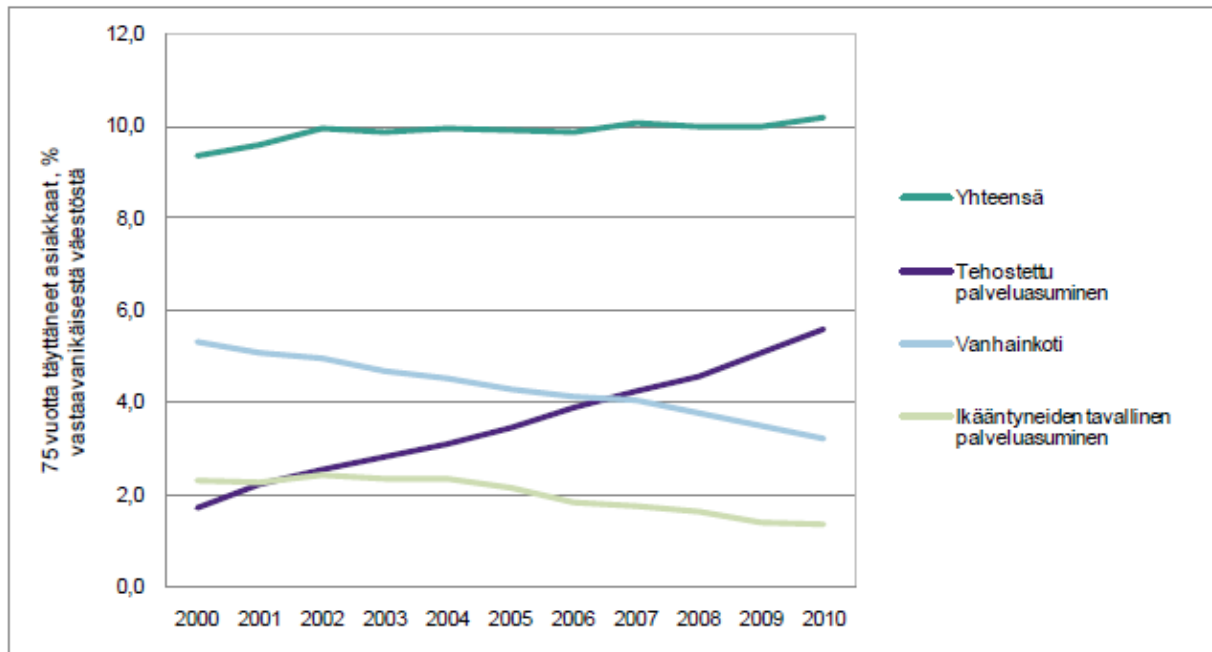


Green: sheltered housing; dark blue: comprehensive sheltered housing; light blue: nursing homes

Source: Väyrynen, Kuronen, 2011.

The proportion of persons aged 75 years or older living at home in 2010 was somewhat smaller than 90% (see Figure 13). About 5.7% lived in comprehensive sheltered housing, about 1.5% lived in usual sheltered housing, and about 3.5% lived in nursing homes (VÄYRYNEN RIIKKA, KURONEN RAIJA 2011).

Figure 13: Proportion of persons aged 75 years or older living in sheltered housing, comprehensive sheltered housing or nursing homes (calculated from the total population 75 years or over)



Light green: sheltered housing; dark blue: comprehensive sheltered housing; light blue: nursing homes; dark green: total

Source: Väyrynen, Kuronen, 2011.

The large national project called the “Kaste” Programme, launched and partially funded by the Ministry of Social Affairs and Health, was continued. It included three quite great subprojects to develop elderly care in three areas of the country. The number of activities arranged in the national action programme “Art and Culture for Wellbeing” (2010-2014) to develop long-term care by implementing art and culture activities was small (TAITEESTA JA KULTTUURISTA HYVINVOINTIA – EHDOTUS TOIMINTAOHJELMAKSI 2010).

The work on the reform of the social welfare legislation continued in the Ministry of Social Affairs and Health. It is assumed that the preparation of this large piece of legislation will last until 2013 or 2014 (LAKI SOSIAALIHUOLTOLAIN MUUTTAMISESTA 2010).

A proposal for an Act on Long-term Care of the Aged was released in March 2011, and the opinions of relevant stakeholders were asked until the end of May 2011. According to the proposed Act, elderly people will have subjective rights to receive long-term services, but the rights are based on assessments of physical, mental, cognitive and social functioning. Promotion of health, functional abilities and wellbeing of the elderly and delivering high-quality services belong to the goals emphasised in the act. Every elderly person in long-term care has the right to services of a municipal worker who coordinates her/his services. Workers in long-term elderly care are obliged to report malpractice or abuse of an elderly person and other serious problems in their workplace (LUONNOS LAIKSI IÄKKÄÄN HENKILÖN SOSIAALI- JA TERVEYSPALVELUJEN SAANNIN TURVAAMISESTA 2011).

The stakeholders considered that this act is important for providing an adequate amount of good quality long-term services. Many stakeholders emphasised that the minimum number of workers with different professional educational backgrounds in different long-term care services should be added to the act. Some stakeholders demanded that there should be rules and

regulations usable in preventing physical and chemical abuse and orders about sanctions for municipalities which do not follow the act.

In late autumn 2011, the Minister of Health and Social Services appointed a committee to prepare the proposed act by taking into account the opinions of the stakeholders. The deadline of the committee is the end of March 2012. The act will be presented in Parliament in 2012. It is supposed that the act will take effect in 2013.

Home care provided by family members is economically supported since the mid 2000s. Municipalities pay a small sum of money to those who care for a disabled person at home. The payments are based on the disability of the person and on the ability of the relative to work as a carer (LAKI OMAISHOIDON TUESTA 2005). However, due to the poor financial situation of many municipalities, the expansion of this kind of care has been slow, and some municipalities have decreased the financial support to carers during the past years. According to the political goal, 5–6% of inhabitants aged 75 years and over should receive economically supported home care in 2012. The statistics show that the number of elderly living at home with the assistance of this kind of support increased during the 2000s, but the political goal has not yet been achieved. At the end of 2009, 4.1% of inhabitants aged 75 years or over received economically supported home care (PERUSPALVELUJEN TILARAPORTTI 2010). The Programme of the Government, released in May 2011, includes the aim to further develop home care provided by family members. Any political action programme to implement activities towards achieving this aim has not yet been published.

In order to increase citizens' possibilities to choose services, an act about the use of service vouchers was introduced at the beginning of 2004, and the programme was expanded to nearly all social and health care services in 2009. Municipalities may offer a service voucher (financial support) to the person in need of care. The user may select a service provider from the list of providers with which the municipality holds a contract. The latest figures are from 2009, when a quarter of municipalities offered service vouchers to the elderly to receive cleaning services as auxiliary home help or to get helpers to relatives who are economically supported carers. About 20% of municipalities offered service vouchers to the elderly to get home help, and 10% to get home nursing or meals as auxiliary home help. Every third municipality which did not offer vouchers for these services aimed to include vouchers in their programmes in the future years (YKSITYINEN PALVELUTUOTANTO SOSIAALI- JA TERVEYDENHUOLLOSSA 2012).

Non-governmental, non-profit organisations and the parish welfare work belong to the supporters of many elderly persons. The non-governmental organisations cover their functions partly by funds from the Slot Machine Association (association which has the monopoly on gambling in Finland). Other forms of funding include legacies of Finns and funds from foundations. The functions of these organisations consist of the provision of information, social support, home visits and assistance in daily tasks, shopping and outdoor visits.

Municipalities are obliged to provide long-term care to their residents. The elderly in long-term care are cared for in the municipality whose residents they are, even if all their middle-aged or older children live in other regions of the country. An act which permits a disabled person in long-term care to select the municipality in which she/he resides and to move to a long-term care facility in another municipality, e.g. in the municipality where her/his child lives, was passed in Parliament in 2010. The act was implemented at the beginning of 2011. (KOTIKUNTA- JA SOSIAALIHUOLTOLAIN MUUTOKSET VUODEN 2011; LAKI KOTIKUNTALAIN MUUTTAMISESTA 2010; [LAKI SOSIAALIHUOLTOLAIN MUUTTAMISESTA 2010](#)). The effects of this change in the act have not been evaluated yet.

As mentioned before, family members are important helpers of the elderly. In order to promote caring by family members, a change in the Act on Contracts of Employment was passed in Parliament during 2010 - 2011. The act took effect in April 2011. Employers have to give unpaid leave to workers who care for their relatives (LAKI TYÖSOPIMUSLAIN MUUTTAMISESTA 2011). The effects of this change in the act have not been evaluated yet.

The austerity programmes have not led to changes in long-term care arrangements or in the financing model. Many municipalities have raised municipal taxes and borrowed more money in order to provide health and long-term care services. In many municipalities, services such as cleaning of homes of home service patients and the delivery of medications to home service patients are nowadays the tasks of private companies and patients have to pay the companies for these services directly.

2.4.2. Overview of debates/ political discourse

The National Supervisory Authority for Welfare and Health continued its assessment of the quality of elderly care (75 years and over). The assessment, which was published in 2011, was made in health centre hospitals by sending inquiries to 182 chief health centre physicians in winter 2010–2011. Altogether, 90% of physicians took part. The report described the quality of care in 536 health centre hospitals. The number of elderly patients in these hospitals was 11,958 and their proportion of all 16,009 patients was 75%. Every second elderly patient was in long-term care. Every third elderly patient could walk independently. Every third of these patients could not walk at all. Shortages were found in the basic education and number of personnel involved in their care. Shortages in meals and long periods between supper and breakfast were evident. Medications used by the elderly were not assessed regularly as proposed by the Ministry of Social Affairs and Health. The quality of medical records did not follow the proposals by the ministry (SOSIAALI- JA TERVEYSALAN LUPA- JA VALVONTAVIRASTO VALVIRA 2011).

The reports published in 2010 about the possibilities to finance long-term care in the future and the proposals about alternative models did not cause discussions about funding models in 2011.

The working group whose task was to make proposals to develop the rights of clients of social welfare services and patients of health services published its report in 2011. The group assessed problems in the rights and equality of clients and found several problems. There are no regulations or orders about the prevention of restrictions and the prevention of violations of human rights of elderly people in the Finnish legislation. However, several areas where the rights and equality of clients seem restricted were identified, despite the fact that the legislation does not specify restrictions. This shows that actions to prevent the violation of human rights of the elderly are needed, and there is a need to pass a new legislation about the human rights of clients of social welfare services and patients of health care services. Several proposals about changes in the legislation were made in this respect. In addition, proposals about changes in administrative bodies, in the guidance of clients and patients and a proposal about a research project covering human rights and legislation are made in the report (LAKI JA ASIAKKAAN OIKEUDET 2011).

Non-profit, non-governmental associations participated in discussions. One example is a book published by such an association about the experiences of elderly people and their families in respect of long-term care. The letters of citizens analysed in the book showed that the variation of the quality of long-term services is wide. There are excellent and good services, but many letters reported poor quality of food and hygiene, lack of appreciation of elderly clients and their relatives by workers, shortcomings in supervision, use of mechanical and chemical restraints and lack of social activities in long-term care. The authors made several proposals,

which included e.g. developing gerontological and geriatric education of workers, setting boundaries to competition, delivering care in small group homes and small comprehensive sheltered housing projects and better cooperation between professionals, elderly clients and their families (KIVELÄ SIRKKA-LIISA & VAAPIO SARI 2011).

The poor quality of care in long-term institutions was also discussed in newspapers. Ageing Finns do not like to be cared for in long-term institutions. Inquiries made among the population aged 55 years or over showed that a great majority (92%) of Finns want to live in their own home until death, and 73% were afraid of care in long-term institutions (KAARAKAINEN MINNA & HYTTINEN VIRVA 2011).

The malpractice in some private Swedish long-term units was described in Finnish newspapers, and these articles were followed by reports about the profits of private health care companies in Finland. The taxes paid by some private international health care companies were found to be extremely low in Finland (HELSINGIN SANOMAT 2011; KAUPPALEHTI 2011).

2.4.4 Impact of EU social policies on the national level

No public discussion about the OMC in the field of long-term care existed.

The National Programme 2011, update autumn 2011, included some considerations about long-term care policies. The most important of these was the aim to protect high-quality, needs-based elderly care by an Act on Long-term Care of the Aged, which will come into force from the beginning of 2013. A housing policy action programme will be drawn up by the end of 2011, and the development of elderly housing will be taken into account in this programme (EUROPE 2020 STRATEGY 2011).

The EU 2020 Strategy did not have an important role in long-term care reform debates. Debates were based on the results of Finnish studies, opinions of researchers, reports by authorities and complaints by citizens about poor quality of long-term care. Non-governmental, non-profit organisations of senior citizens and pensioners, older citizens and the families of older persons had an impact on debates.

Although the EU 2020 Strategy was not discussed vividly in newspapers and other media, EU strategies have had an effect on the national policy. Long-term services were opened to competition, and the freedom to choose services belongs to important policy goals.

According to the legislation, all groups of inhabitants are allowed to use services financed by public expenditures. Long-term care has no formal connection with poverty. Indicators such as low income levels, poorly equipped housing and being a tenant are related to admissions to comprehensive sheltered housing or long-term institutional care. Thus, there seems to be a connection between poverty and long-term institutional care in practice. However, even rich people are cared for in public long-term institutions and in public comprehensive sheltered housing.

2.4.5 Impact assessment

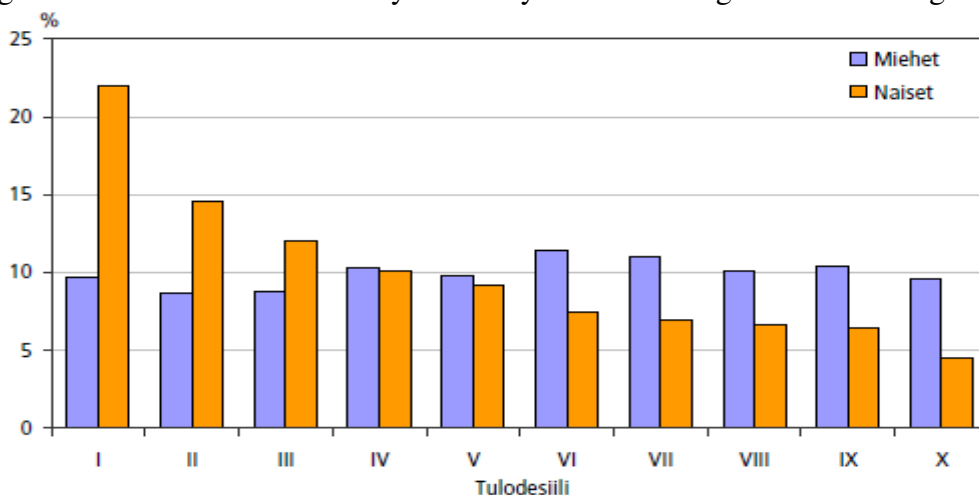
The quantity of long-term care is usually assessed by collecting national data about the number of elderly persons and that of workers in different types of long-term services. These kinds of data collections and studies have been performed for several years. Longitudinal descriptions showing the changes in these numbers together with the changes in the numbers of inhabitants aged 75 years or older are used to show developmental trends. These trends are reported by classifying long-term services into “institutional”, “semi-open” and “open” ones or by classifying them by the owner of the service (“municipality”; “private”, “non-profit organisation”).

The usual indicators of quality of long-term care consist of indicators describing the structure or process of care or opinions of the elderly, their family members or some other groups of inhabitants about the quality of long-term care. The effects of care on health, functional or cognitive abilities or well-being of the elderly have been assessed only in relatively few studies. Cost-benefit or cost-effectiveness analyses have been performed for only very few services.

In 2011, the researchers in the National Institute of Health and Welfare published a report about the assessment of the quality of care, stress experienced by workers and costs of care and made comparisons between municipal and privately owned long-term care services and long-term services delivered by non-profit, non-governmental organisations. Care in sheltered housing, comprehensive sheltered housing, nursing homes and health centre hospitals were analysed. The functional and cognitive abilities of the elderly in nursing homes and health centre hospitals were poorer than those living in comprehensive sheltered housing or sheltered housing. Thus, they needed more help in daily activities and in total care. Effects of care were measured by the yearly changes in functional abilities of the elderly. These changes were similar in the elderly in comprehensive sheltered housing and in sheltered housing. Changes were not related to the owner of the facility when the baseline functional abilities of the elderly were standardised. Thus, the quality of care seemed to be similar in these facilities. The quality of care was not related to the number of workers per 10 elderly clients. Costs to municipalities were lower in municipal sheltered housing than in privately owned sheltered housing. This was caused by the smaller amount of workers per 10 elderly clients in municipally owned housing. Problems in management were most common in privately owned sheltered housing and in non-governmental nursing homes. Workers in municipal sheltered housing and non-governmental nursing homes were more stressed than workers in other facilities. The smaller amount of workers in municipal sheltered housing and the management problems in non-governmental nursing homes belonged to the explanations for this difference. Competition has not led to lower costs of care. Municipalities have problems to perform follow-up assessments about the quality of care in long-term services. In conclusion, these results showed differences between municipal long-term services compared to those delivered by private organisations or non-profit, non-governmental organisations, but no conclusion about the best quality could be drawn (SINERVO TIMO & TAIMIO HEIKKI 2011).

The results about the distribution of public welfare services in the population and about the effects of public services on diminishing economic differences in the population showed that long-term care services diminished economic differences among those aged 65 years or over (Figure 14) (VALTIONEUVOSTON KANSLIA 2011).

Figure 14: Distribution of subsidy to elderly care according to income and gender.



Transversal line: decile of income Blue: men; yellow: women (Source: The Prime Minister's Office, 2011)

2.4.6 Critical assessment of reforms, discussions and research carried out and policy recommendations

In spite of criticism about poor quality in long-term care, citizens have a relatively good access to long-term services. The political goal to decrease beds in long-term institutions and to increase the number of elderly people living at home, together with the increase in the number of elderly inhabitants, have led to an increase in the disability level of home care patients. They are more disabled than previously and many patients suffer from memory disturbances and live alone. Family members take a great responsibility of care of their elderly relatives. The sustainability of long-term care depends on the possibility of families to help their elderly members.

The variation in the quality of long-term care in institutions, comprehensive sheltered housing, sheltered housing and home care between municipalities and units is great. Poor quality has been detected in many units and municipalities. These findings were firstly made by researchers at the beginning of the 2000s. In 2010, the Parliamentary Ombudsman, the National Supervisory Authority for Welfare and Health and the National Audit Office of Finland all found evidence for poor quality. In 2011, the National Supervisory Authority for Welfare and Health showed many shortages in long-term care in health centre hospitals. There is a need to develop the quality of long-term care. The proposed act to ensure long-term elderly care may improve the quality. In addition, recommendations, training and further education of staff and development programmes are needed.

Family members, non-governmental organisations and parish welfare workers are important supporters of the elderly. Informal care given by family members should be developed and supported. The Programme of the Government includes this kind of a goal, but concrete plans to achieve the goal have not been made yet. The number of non-governmental organisations supporting the elderly is great, and many organisations are small. Cooperation between organisations has been emphasised for the past few years. This kind of cooperation and even mergers of small organisations are needed in order to increase the possibilities of non-governmental organisations to support the elderly. There are problems with the cooperation between workers in the social welfare and health care sectors, families of the elderly, volunteers working in non-governmental organisations and parish welfare workers. Many different kinds of programmes to develop cooperation are needed.

The number of elderly people who have the economic resources to buy private services which are not compensated by the society is small. The average pensions of elderly inhabitants in the future will be higher than those of people who are old today. This will make it possible to arrange economic compensation for only basic long-term services, and will make it possible for the elderly person to buy extra services from private markets with the assistance of pensions or private insurance. Finns are accustomed to greatly compensated services. A change in the attitude of the population is needed. There will be problems in changing the system to provide long-term services in a welfare state where the costs of services have almost totally been paid by taxes.

Increases in client fees caused by the financial and economic crisis, differences in fees between municipalities and open competition caused by EU regulations have led to opposite comments by many citizens. Increases in long-term service fees have mainly affected the economic situation of poor people. The number of poor people is quite high in the elderly population. The poor quality of long-term care has caused fears about ageing in the young-old population. There is a need to improve the quality of care, develop new models for long-term services, and increase equality of citizens in order to make the long-term system sustainable. Housing conditions of the ageing population should be improved, and many kinds of new housing

facilities are needed. The goal of the government to plan a large project to develop housing for the elderly is important, and its implementation will help elderly inhabitants to live at home. Non-governmental organisations of senior citizens and retired persons are active in their demands for changes in long-term care. Politicians must take into account their opinions.

The average health and functional abilities of the population aged 75 years or over have improved over the past 10 to 20 years. By age groups, the current relative increase in the number of population is the greatest among those aged 90 years or older. It is probable that the need for care will decrease in the future among the aged population, at least in the young-old and old population. The Comprehensive Health Care Act includes an order to arrange preventive and information services to the elderly. These services will help elderly people maintain their abilities if the services cover the total aged population. However, the ageing of the “baby-boom generation”, together with the supposed increase in the average life expectancy in both older women and men, will increase the need for long-term services in the future.

The development of long-term care needs well-trained workers. Young people are not very interested in elderly care. The basic training in geriatrics and gerontological nursing in medical schools and vocational education institutes is short. Training in geriatric psychiatry is nearly missing. Further education courses have been arranged for all worker groups. The need for further education is extensive, and this kind of training should be combined to practical development projects. Psychiatric medications are used more commonly in long-term care in Finland than in other Nordic countries, indicating a “care in bed” model in long-term institutions. Geriatric knowledge of physicians is needed in changing the model. The role of physicians in elderly care is important. However, there are problems in some municipalities with the employment of physicians, and many comprehensive sheltered housing, nursing homes and long-term hospitals rely on physicians visiting the institution once or twice a month or even less often. It is quite common that physicians do not visit comprehensive sheltered housing projects. The nursing personnel seem to be more interested in developing good, humane and ethical long-term care than physicians. However, one positive development is evident in the increase in the number of geriatricians. An adequate use of psychiatric and other medications in the elderly care has been a common topic in further education courses. Annual assessments of usage of medications are recommended to be carried out. It is presumed that these projects will increase the interest in the development of long-term care among Finnish physicians.

The sustainability of the system to finance long-term services by collecting taxes will depend on the economic situation of the country, number of unemployed citizens and solidarity between generations. The economic crisis in the 1990s in Finland has led to a problematic long-term unemployment. Some persons belonging to younger generations have made critical comments on the “richness” of older generations, but these comments are not common.

Proposals about financing long-term care in the future made in 2010 were not further discussed in 2011, which may be an indication of the unwillingness of the population to cover a greater proportion of costs of long-term care.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

The earnings-related pension scheme financially rewards long working careers with higher accrual. Financial incentives for continuing work after the age of 63, which is the qualifying age for the ordinary old age pension, is considerable: pension accrual (4.5% per year) more than doubles after this age. Another option is to transfer from full-time employment to part-

time employment, and take a part-time pension between the ages of 60 and 68. At the end of 2010, there were approximately 1,464,000 pension recipients. Of them, 28,800 received part-time pension (see also Figure 6) (OSF 2011b). It is also possible to retire on an old-age pension and continue working. It does not affect the pension in payment. Until the maximum age of 68, a new pension will accrue at a rate of 1.5% per year from earnings received while simultaneously drawing a pension.

The mandatory retirement age in Finland is 68, as stipulated by labour law. An employee's employment relationship is terminated without giving notice and without a notice period at the end of the calendar month during which the employee turns 68 years of age, unless the employer and the employee agree to continue the employment relationship.

In reality, it can be seen that Finland has a long tradition of active ageing strategies. For example, through different kinds of information programmes (e.g. National Programme on Ageing Workers, dating back to 1998) serious efforts have been made to increase senior workers' employment rates.

2.5.2 Participation in society

A pension accrues on the basis of all earnings between the ages of 18 and 68. Since 2005, pension also accrues from certain benefits received during which the person has no earned income. In addition, periods of study and childcare accrue earnings-related pension within certain limits. Volunteer work is not considered as contributory period. However, for those at work, job alternation leave compensation offers the possibility to do volunteer work during the period of 90-359 days, accruing pension as well.

Ensuring the ageing and aged population's possibilities to participate in society belongs to the political goals. The achievement of this goal is a task of all administrative fields and all ministries.

The activities of non-governmental, non-profit organisations consist of provision of information, counselling, social support, home visits and assistance in daily tasks, shopping and outdoor visits; counselling and social support are the main activities. The majority of members of these organisations are ageing or elderly persons themselves. Both recipients of counselling and support activities and givers of information and support belong to the group of members. Non-governmental, non-profit organisations offer good opportunities for ageing and elderly people to perform unpaid volunteer work. The organisations cover their activities partly by funds from the Slot Machine Association (association which has the monopoly on gambling in Finland). Other forms of funding include legacies of Finns and funds from foundations. The funds allow these organisations to employ working-age persons for administrative and other activities.

Parish welfare work traditionally offers opportunities for elderly people to participate in church activities and supports disabled elderly people's independent living at home. Workers of the Lutheran and Orthodox Church have been active in developing support services for elderly people, and many kinds of projects have been implemented.

Family members are important helpers of the elderly. In order to promote care by family members, a change in the Act on Contracts of Employment was passed in Parliament during 2010 - 2011. The act took effect in April 2011. Employers have to give unpaid leave to workers who care for their relatives (LAKI TYÖSOPIMUSLAIN MUUTTAMISESTA 2011). The effects of this change in the act have not been evaluated yet.

2.5.3 Healthy and autonomous living

Living at home either independently or with the help of home care services has been a priority goal in the elderly care during the previous 20 to 30 years. Home help services and home health care services have traditionally been separated from each other. Home help is the task of the social welfare sector, and home health care is the task of the health care sector. Developments in the 2000s have led to the disappearance of traditional home help services. They were replaced by auxiliary home services, e.g. meals-on-wheels. The cleaning of homes of disabled elderly persons was separated from the task of home help. Nursing and medical home health services are provided by health care centres. Elderly people in receipt of these kinds of services are more disabled today than those at the beginning of the 2000s. They need both home health care services and auxiliary home services, and both of these services are nowadays covered by the term home care services.

From the early 1990s onwards, the political goal has been to reduce the number and the proportion of the elderly living in long-term institutions (hospitals and nursing homes) and to increase the number and proportion living at home or in “semi-open” facilities. A change is evident, as described in the section concerning long-term care. Long-term institutions have been replaced by comprehensive sheltered housing in many municipalities. Both the number and the proportion of persons aged 75 years or over living in comprehensive sheltered housing or sheltered housing, and the number and the proportion of elderly people living at home have increased in the 2000s. To further support this goal, the Ministry of Social Affairs and Health has made proposals to develop home care in municipalities. As the elderly home care patients are nowadays more disabled and their number is greater than at the beginning of the 2000s, more home care workers are needed to care for them. Some municipalities have employed more workers to give home care, but this kind of a development has not happened in all municipalities. Shortages in the number of personnel and in the quality of home care are evident in many municipalities.

The majority of home care patients are physically disabled or suffer from memory disturbances. Many of these patients live alone. Home care workers do not have the time or possibilities to enable home care patients to participate in outings or to go outdoors. Being alone sat in front of the TV all day long describes the situation of many elderly home care patients. Family members, voluntary workers and parish welfare workers are needed to offer and arrange social activities and participation of these elderly persons. This problem is widely known, but only very few programmes have been implemented to increase the possibilities to participate among this group of elderly people.

Family members are the most important persons in supporting the elderly to participate in life outside the home and in helping disabled elderly people who need assistance with their daily lives. This support and assistance is usually given without the receipt of any economic support from the municipality. Children and grandchildren are the most important helpers to 48%, wife or husband to 14% and municipal home care to 18% of elderly people in need of help. In addition, neighbours, volunteers and deacons give daily support to many elderly people. Family members are the most important helpers in preparing meals and cleaning dwellings. Two thirds of the elderly receive help from their families in washing and bathing and taking care of their medications, and home care workers give help only to one third of the elderly in need of assistance. Family members help 86% of the elderly with the shopping or other activities outside the home (VILKKO ANNI et al. 2010).

Even other elderly persons support and assist their elderly family members, relatives or friends in participating in life outside the home and in managing daily activities. In an interview study, 12% of persons aged 80 years or over answered positively to the question of being a helper of

this kind. Half of these persons helped their relatives or friends, a third helped their wife or husband, and every tenth helped their children or grandchildren. Altogether 40% of these helpers gave assistance daily. Two thirds of helpers were females. Only 14% of these elderly helpers had made an official contract about economically supported home care with municipalities (VILKKO ANNI et al. 2010).

Promotion of health and prevention of diseases and disabilities of citizens belong to the tasks of primary health care. It has been emphasised for years that promotion of wellbeing and health of citizens is not merely a task of the social welfare and health care sectors, but that it must be taken into account in the activities of all administrative sectors and all ministries. Health promotion activities in health care centres have traditionally covered child and maternity health care and activities for schoolchildren. Preventive activities for the working-age population are mainly the tasks of occupational health care. Some health care centres introduced health promotion activities for the elderly back in the 1990s, but these activities are not common. The promotion of wellbeing and health of the elderly is now taken into account in the Comprehensive Health Care Act: the municipalities have to provide counselling services to elderly people. A similar order is in the proposal for the Act on Long-term Care of the Aged.

The Ministry of the Interior has coordinated a developmental programme to increase safety in the elderly population. Planning of the programme started in 2009, and the proposals were published in 2011. Many ministries and other partners participated in the programme. Ensuring the feeling of security, safe housing, prevention of accidents, safe moving and prevention of abuse and crimes are the issues which are emphasised in the report. Several proposals to ensure safety in these areas are made in the report. The proper programme to develop safety is aimed to be started in some pilot municipalities in the near future (SISÄASIAINMINISTERIÖ 2011).

In conclusion, active participation in life and promotion of wellbeing and functional abilities of the ageing and aged population is strongly emphasised in the policy papers and in the real actions of organisations working with elderly people. Many kinds of programmes have been implemented. However, these programmes do not sufficiently cover the mentally or physically disabled elderly who live alone and elderly people who live in remote areas.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions

- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R3, R4] BLOMGREN, Jenni, HYTTI, Helka, GOULD, Raija, Työkyvyttömyyseläkkeelle siirtyneiden työttömyys- ja sairaustausta eri eläkejärjestelmissä, KELA Online working papers 26, 2011, Helsinki, retrieved from:

<https://helda.helsinki.fi/bitstream/handle/10138/26640/Nettityopapereita26.pdf?sequence=2>

“Disability retirement - retirees’ unemployment and sickness background in different pension schemes”

This study uses register-based data for analysing paths to disability retirement and, especially the role of unemployment as a reason for retirement. The study focuses on those retired on disability pension in 2004 who were at least 25 years of age (N=24,404). The study found that a significant part of those retiring on disability pension had a background of long-term unemployment. Long-term unemployment was a common background, especially among disability retirees due mental disorders.

[R4] ILMAKUNNAS, Pekka, ILMAKUNNAS, Seija, Age segregation and hiring of

older employees: low mobility revisited, Laobur Institute for Economic Research, Discussion Papers 273, 2012, Helsinki, retrieved from:

<http://www.labour.fi/tutkimusjulkaisut/tyopaperit/sel273.pdf>

Age segregation in hirings and separations is analysed using linked employer-employee data from Finland in the period 1990-2004. This allows identification at the firm level of employees in different age groups that have been hired during the previous year, and employees who have exited the firms. Firm-level age segregation is analysed using segregation curves and Gini indices. The main result is that hirings of older employees have clearly been more segregated than exits or the stock of old employees, even though hirings have become slightly less segregated towards the end of the period in question. At the same time, age segregation in exits and stocks has increased and these trends are not sensitive to small unit bias in measurement. The paper also examines trends in hiring and exit rates using aggregate data. According to the results, the oldest age group is again underrepresented in hirings. There is a positive upward trend in their recruitment related to increasing cohort size, but it is much weaker than the trend in the relative share of older workers in employment. The exit rate of the older employees

indicates a cyclical variation, while the small number of hirings seems to be insensitive to changing labour demand. The paper presents a breakdown of employment change by age group and with that breakdown disentangles the role of hirings and exits from factors related to demographics and cohort effects. The latter factors include the effect of the large baby boom generation entering the age group of older employees with higher employment rates than earlier cohorts. Finally, regression analysis shows that larger firms are more likely to hire older employees, but their hiring rates are lower.

[R4] ILMAKUNNAS, Pekka, ILMAKUNNAS, Seija, Hiring older employees: Do incentives of early retirement channels matter?, Labour Institute for Economic Research, Discussion Papers 268, 2011, Helsinki, retrieved from:

<http://www.labour.fi/tutkimusjulkaisut/tyopaperit/sel268.pdf>

The paper examines the impact of Finnish reforms in the 1990s that restricted the use of particular early retirement channels, unemployment pension and individual early retirement, and simultaneously changed the rules of firm-size related experience rating in disability pensions. Emphasis is on how the reforms affected the incentives of the firms to hire older employees. A simple model illustrates how a forward-looking attitude of firms affects the value of a new hire. Simulations with the model illustrate that although the reform in the unemployment pension, in principle, affected particular age groups, 53-54 year olds in the case of unemployment pension and 55-57 year olds in the case of individual early retirement, the impact on hiring may have been felt also in other, younger age groups. On the other hand, the effects of both reforms are likely to have varied by firm size. In a differences-in-differences-in-differences analysis with firm-level data, the paper shows that the impact of the reforms has been to increase the probability of hiring, especially in the age group 51-52 and especially in the largest firms.

[R3] JAUHAINEN, Signe, RANTALA, Juha, Ikääntyvien työttömyys ja työttömyysputki, Finnish Centre for Pensions Reports 3, 2011, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/raportit/ikaantyvien_tyottomuus_ja_tyottomuusputki_katsaus_viimeaikaiseen_kehitykseen_7.pdf

“Unemployment of the elderly and unemployment pipeline”

This study presents a broad picture of the unemployment situation of the elderly and describes the labour market flows with a register-based data set from 1995 to 2009. The focus is on the raising of the eligibility age for the extended unemployment benefit. In addition, the data enable a study of the recent economic downturn in 2009. Simulations are calculated in order to locate further information on the effects of economic fluctuations and changes in the eligibility age. The results of this study show that the use of the unemployment route has decreased during the period under observation. In the future, an increase in the eligibility age might not have significant employment effects, since the age threshold is already quite high.

[R4] KUUVA, Niina, Takaisin työhön vai työkyvyttömyyseläkkeelle?, Finnish Centre for Pensions Working Papers 5, 2011, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/keskustelualoitteet/takaisin_tyohon_vai_tyokyvyttomyyselakkeelle_tyokykyya_palauttavat_prosessit_7.pdf

“Back to work or back to disability pension?”

This study, by describing the routes through which an individual suffering from problems in working ability travels in the social subsystems, analyses the processes leading to the person either applying for a disability pension or returning to work. The study reviews the way the processes progress from the point of view of the various subsystems: social insurance, workplace, health care, rehabilitation and employment and economic administration. Attention is paid to the different actors, the roles of the actors, measures taken and inter-system cooperation. The study indicates, that the Social Insurance Institution of Finland does not receive sickness absence data at an early enough stage. As a result, the uncovering of problems in an individual's working ability and the commencement of rehabilitation may be delayed. From the point of view of continuing at work, delays may occur not only between but also within these various subsystems. The individual may have active customer processes in various systems, and several actors are attached to the processes within one and the same system. Due to the delays, the individual may end up applying for a disability pension when his working ability could be restored with proper treatment, rehabilitation or a reorganisation of work.

[R5] KAUTTO, Mikko (eds.), *Eläkkeet ja eläkkeensaajien toimeentulo 2000–2010*, Finnish Centre for Pensions Reports 4, 2011, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/raportit/elakkeet_ja_elakkeen_sajien_toimeentulo_2000_2010_7.pdf

“Pensions and pensioners’ income in 2000-2010.”

The report gives basic information on the pension recipients and the pension system, and a description of the changes that have taken place in pension policy during the review period. The actual review, based on data from the statistical registers of the Finnish Centre for Pensions and the Social Insurance Institution of Finland, evaluates the level and development of pensions. The perspective is also extended to pensioner households’ other income and received and paid income transfers. In addition, an assessment of pensioners’ ability to make ends meet based on the pensioners' own experiences is included. According to report, the level of income for pensioner households has remained stable during the 2000s at over 80% of the average income of the entire population. Also the income distribution is more equal in comparison to total population, even though the inequality has risen. Risk of poverty among the pensioners has increased faster during the 2000s than for the total population. The risk of poverty is significantly high for pensioner households under the age of 55. Also, people living alone and those aged 75 and over face a relatively high poverty risk.

[R1] LASSILA, Jukka, VALKONEN, Tarmo, ALHO, Juha, *Fiscal Sustainability and Policy Rules Under Changing Demographic Forecasts*, ETLA – The Research Institute of the Finnish Economy, Discussion Papers no. 1265, Helsinki, retrieved from:
http://www.etla.fi/files/2774_no_1265.pdf

All practical evaluations of fiscal sustainability that include the effects of population ageing must utilise demographic forecasts. It is well known that such forecasts are uncertain, and that has been taken into account in some studies by using stochastic population projections jointly with economic models. This approach is developed further by introducing regular demographic forecast revisions that are embedded in stochastic population projections. This allows to separate systematically, in each demographic outcome and under different policy rules, the expected and the actualised effects of population ageing on public finances. The paper shows

that the likelihood of sustainability risks is significant, and that it would be wise to consider policies that reduce the likelihood of getting highly indebted. Furthermore, although demographic forecasts are uncertain, they seem to contain enough information to be useful in forward-looking policy rules.

[R1] NURMINEN, Markku, Working-life Expectancy in Finland: Development in 2000–2009 and Forecast for 2010–2015. A Multistate Life Table Approach, Finnish Centre for Pensions Working Papers 6, 2011, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/keskustelualoitteet/working_life_expectancy_in_finland_development_in_2000_2009_and_forecast_for_2010_2015_a_multistate_life_table_approach_7.pdf

Working-life expectancy is the estimated future time that a person will spend in employment.

This paper is concerned with its estimation jointly with the time spent in the opposite state of unemployment, and their sum, the expected duration of active working life, that is, the length of a person's working career. The multistate life table approach first estimates year- and age-dependent probabilities of being in the working-life states by stochastic regression modelling. Updated estimates of probabilities, and subsequently of expectancies, are given for the data of Finnish men and women aged 15–64 years in the period 2000–2009. Further, model-based extrapolations are calculated for the years 2010–2015.

According to results, a general development of longer working careers is evident. During the past decade, the future employment time increased in all age groups and for both genders. For a 15-year-old male in 2009, the fitted estimate of the length of working career is 34.2 years, while for females, it tails at 33.8 years. During the ten-year period 2000–2009, there was an increase of 10 percentage points or more in the expectancies of future working life spent in the employed state for females, starting from age 40 and for males from age 50. The respective predicted working-career lengths for 2015 are longer: 36.0 years for males and 35.5 years for females. The female expectancy for ages 40 years and above is forecast to overtake the respective male figure by year 2010 and to continue to do so up to 2015.

[R1] RISKU, Ismo, ELO, Kalle, KLAAVO, Tapio, LAHTI, Sergei, SIHVONEN, Hannu and VAITTINEN, Risto, Lakisääteiset eläkkeet – pitkän aikavälin laskelmat 2011, Finnish Centre for Pensions Reports 4, 2011, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/raportit/lakisaaateiset_elakkeet_pitkan_aikavalin_laskelmat_2011_7.pdf

“Statutory pensions – long term projections 2011”

The report presents projections of the development of statutory pension expenditure and the average benefit level, as well as of the financing of private-sector earnings-related pensions from 2011 to 2080. The earnings-related pension expenditure for the whole economy was 25.6% of the wage sum in 2010. The cost ratio will continue to grow until 2030, when it will be 34%, after which it will decrease to approximately 31% of the wage sum. Total statutory pension expenditure corresponded to 12.5% of GDP in 2010. At its highest, the share is projected to increase to 15.5% in the 2030s, after which it will decrease to an ample 14% by the end of the 2040s. Over the projection period, the purchasing power of the average pension will more than double. However, relative to the average wage, the pension level will begin to

decrease at the end of the 2010s, mostly due to the life expectancy coefficient. The contribution under the Employees Pensions Act (TyEL contribution) will rise from the current level of 21% to approximately 26% by the 2030s and will stay at that level.

[R3, R4, H3] SINOKKI, Marjo, Social factors at work and the health of employees, Kela Studies in social security and health 115, 2011, Helsinki, retrieved from:

<https://helda.helsinki.fi/bitstream/handle/10138/25995/Tutkimuksia115.pdf?sequence=2>

Depression, anxiety, alcohol use disorders, and sleeping difficulties are common problems among the working population. These disorders and symptoms also incur a remarkable expense to society. The association between social support and team climate at work and various outcomes were studied in a sample of working population (n = 3,347–3,430) derived from the Health 2000 Study of the National Institute for Health and Welfare. Social support at work was measured using the Job Content Questionnaire (JCQ), and support in private life with the Social Support Questionnaire. Team climate was measured using a self assessment scale, which is included in the Healthy Organisation Questionnaire. The diagnoses of common mental disorders were based on the Composite International Diagnostic Interview. The prescriptions of antidepressants and hypnotics and sedatives were extracted from the prescription register of the Social Insurance Institution of Finland, and the disability pensions were extracted from the official records of the Finnish Centre of Pensions and the Social Insurance Institution. There was no difference between gender and the perceived team climate. Instead, women perceived more social support, both at work and in private life. Low social support, both at work and in private life, was associated with depressive and anxiety disorders and many sleep-related problems. Poor team climate was associated with both depressive and anxiety disorders. Low social support from supervisors and from co-workers was associated with subsequent antidepressant use. Poor team climate also predicted antidepressant use during the follow-up. Low social support from the supervisor seemed to increase the risk for disability pension.

[H] Health

[H2] HANKONEN Nelli. Psychosocial Processes of Health Behaviour Change in a Lifestyle Intervention. National Institute for Health and Welfare (THL), Research 51/2011, Helsinki 2011. Retrieved from:

<https://helda.helsinki.fi/bitstream/handle/10138/24850/psychoso.pdf?sequence=3>

The aims were to describe whether changes in psychological determinants during a 3-month intervention predict changes in exercise and diet behaviours over three months and 12 months and whether these results depend on social factors.

Finnish men and women (N = 385) aged 50–65 years who were at an increased risk of type-2 diabetes were recruited from health care centres to participate in a programme aimed to improve participants' lifestyle and decrease their overweight.

Increases in self-efficacy and planning were associated with three-month increases in exercise. One- and three-year waist circumference reductions were predicted by the initial three-month increase in self-efficacy. Psychosocial determinants predicted behaviour in all socio-economic groups. The agency predicted a 12-month waist circumference reduction among women. The only predictor of three-year waist circumference reduction was an increase in health-related self-efficacy during the intervention.

[H1] HEINÄMÄKI Liisa. Yhteistoiminta-alueiden sosiaali- ja terveystalvet 2010. Järjestämisen, tuottamisen ja hallinnon kysymyksiä uusissa palvelurakenteissa. National Institute for Health and Welfare (THL), Report 41/2011, Tampere, 2011, 100 pp. Retrieved from:

<http://www.thl.fi/thl-client/pdfs/882a70d8-8e25-4e4f-b1e3-0e700d774530>

“Social welfare and health care services in municipal partnership areas in 2010. Questions concerning provision, production and administration in a setting of new service structures”

A total of 66 partnership areas will be created in Finland as a result of the project to restructure local government and services (PARAS). In 2010, 48 of these areas (involving 172 municipalities) were operating and comprised a total population of 1,635,079 inhabitants. The partnership areas are a new organisational element, enabling municipalities to transfer the responsibility for providing social welfare and health care services to the partnership area. In 2010–2011, the National Institute for Health and Welfare implemented a cross-sectional study on the service structures of partnership areas in 2010. The study covers 47 of the partnership areas that were in operation in 2010. The areas comprise 170 municipalities with a population of 1.6 million. The municipalities in partnership areas formed on the joint municipal authority model are slightly smaller and more even in size than in those formed on the central municipality model. There are differences in municipal decision-making and in municipal decision-makers’ relationship with partnership, depending on the administrative format of the partnership area.

The organisational model is traditional in 16 of the partnership areas. Seven areas apply a life-cycle model, while 24 areas apply a mixed model for service organisation. The social welfare and health care services consisted of health care services in one partnership area; eleven partnership areas had a combination of social welfare and health care services in at least one sector; in the majority of areas social welfare and health care services existed as parallel but separate services.

[H3] HEISKANEN Jarmo, KÄRKKÄINEN Olli-Pekka, HAKONEN Harto, LINDHOLM Harri, EKLUND Jyrki, TAMMELIN Tuija, HAVAS Eino (2011). Suomalaisen työikäisen kestävyyskunto. Nykyhetken tilanne ja ennusteita. LIKES Research Reports on Sport and Health, Publications 247, 88 pp. Retrieved from:

http://www.likes.fi/pages/UserFiles/uutiset_ty%C3%B6ik%C3%A4iset.pdf

“Cardiorespiratory fitness of Finnish working-age population. Current situation and prognoses”

This study describes the cardiorespiratory fitness status of the Finnish working-age population, and predicts the development of the fitness status 10, 20, and 25 years ahead from a health perspective.

12,618 working Finns, aged 25 to 64 years, participated in the measurements. The participants were divided according to their cardiorespiratory fitness into seven fitness categories.

Assuming that the decrease of the cardiorespiratory fitness is 1% annually, the proportion of women aged 50 to 64 years who have poor fitness from a health perspective, will not grow substantially during the next 25 years. The proportion of unfit men in this age group will double. The proportion of younger than 40 year-old men in poor cardiorespiratory fitness is larger than expected, when the results are compared with the values from 20 years ago. The results are alarming, especially in young working-age men.

[H2,H4] Hyvinvointipalveluista saatavan hyödyn määrä ja kohde. Valtioneuvoston kanslian raporttisarja 10/2011. Reports of the Prime Minister's Office 10/2011. Helsinki 2011, 45 pp. Retrieved from:

<http://www.vnk.fi/julkaisukansio/2011/r10-hyvinvointipalveluista/PDF/fi.pdf>

„Benefits of public welfare services”

The results about the distribution of public welfare services in the population and about the effects of public services on diminishing economic differences in the population showed that public health care services and long-term care services diminished economic differences, especially among those aged 65 years or over. Occupational health care services were not included in these analyses, which is a pitfall. The users of occupational health care services are occupied working-age people, many of whom do not belong to the lowest income levels.

[H1, H2] JYRKKÄ Johanna. Drug use and polypharmacy in elderly persons. Publications of the University of Eastern Finland. Dissertations in Health Sciences 47. University of Eastern Finland, Kuopio 2011, 276 pp. Retrieved from:

http://epublications.uef.fi/pub/urn_isbn_978-952-61-0385-3/urn_isbn_978-952-61-0385-3.pdf

The overall aim was to evaluate the changes that have occurred in drug use and polypharmacy over time and with ageing since the late 1990s in Finnish elderly persons. Cardiovascular drugs were the most commonly used drugs. Over time and with ageing, the use of antithrombotic agents, vitamins and mineral supplements became more prevalent. From 1998 to 2004, the total mean number of drugs in use was seven. Changes were observed in the composition of medication, as the mean of regularly taken drugs, vitamins and mineral supplements increased, while the mean of as-needed taken drugs decreased. Those in institutional care used about three drugs more than those living at home. Excessive polypharmacy (EPP, 10+ drugs) was found in every fourth and polypharmacy (PP, 6–9 drugs) in every third elderly person. Over time, no remarkable changes occurred in the distribution of polypharmacy status, but with ageing the proportion of those with excessive polypharmacy increased.

[H5] KUUSIO Hannamaria, KOIVUSALO Meri, ELOVAINIO Marko, HEPONIEMI Tarja, AALTO Anna-Mari, KESKIMÄKI Ilmo (2011). Changing context and priorities in recruitment and employment: Finland balances inflows and outflows of health professionals. Chapter 6, pages 163–180. In: Matthias Wismar, Claudia B. Maier, Irene A. Glinos, Gilles Dussault, Josep Figueras (editors). Health Professional Mobility and Health Systems. Evidence from 17 European countries. World Health Organization 2011, UK, 632 pp, retrieved from:

http://www.euro.who.int/_data/assets/pdf_file/0017/152324/e95812.pdf

This report has assessed the cross-border mobility patterns of medical doctors, nurses and dentists in Finland. Foreign medical doctors and dentists represent important shares of the newly licensed medical workforce and signal a degree of dependence on foreign inflows. The free movement of labour allowed between Finland and the EU-10 countries in May 2006 facilitated especially the movement of health professionals from Estonia to Finland. At the same time, the Government Migration Policy Programme was adopted to promote labour migration to Finland in order to alleviate workforce shortages.

The Finnish health sector suffers from important workforce shortages and it is estimated that the need for more qualified health professionals will grow. Primary health care has lost much of its attractiveness as a career option for Finnish health professionals. All medical faculties have

increased the number of student posts since 1999 but still there is a chronic lack of candidates seeking general practitioner posts.

The international migration of health professionals has been a growing feature in Finland since the early 2000s. However, little information is available on their integration into the health care system, workplaces or the reasons behind their high non-employment rates.

[H2] MATTILA Yrjö. Suuria käännekohtia vai tasaista kehitystä? Tutkimus Suomen terveydenhuollon suuntaviivoista. The Social Insurance Institution of Finland, Studies in social security and health 116, 2011, 369 pp. Retrieved from:
<http://hdl.handle.net/10138/26343>

“Major turning points or measured progress? A study of development trends in Finnish health care “

The study investigates lines of development in Finnish health care from the 19th century to the present day, against the theoretical background of institutionalism, path dependency and functionalism. Its main focus is on institutions and their impact on health care provision. The interplay between the private and public delivery of health services is problematic and remains unsolved. The course of health care has been influenced by financial considerations, politics and institutions. Alternative models of provision have received scant attention. The strong emphasis on municipal autonomy in the provision of health services has resulted in a decentralised and fragmented system. Because of the priority given to decision making at the local level, centralised oversight and guidance are difficult to achieve.

[H1] MIKKOLA Teija. Suurten kaupunkien terveydenhuollon kustannukset vuonna 2010. Association of Finnish Local and Regional Authorities, Helsinki, 2011, 90 pp. Retrieved from:
http://shop.kunnat.net/product_details.php?p=2578

“Costs of health care in the biggest towns in 2010”

The aim was to describe the costs of health care in the biggest towns in 2010. The costs of home care of the elderly and those of 24-hour sheltered housing (which belong to social welfare services) were added to the costs of health care services. The study belongs to yearly follow-ups about the costs of health care in big towns.

Costs corrected by the age structure in 2010 were EUR 2,156 per inhabitant in Helsinki, EUR 2,153 in Oulu, EUR 2,151 in Tampere, and EUR 1,879 in Lahti. These figures show some differences between towns. Costs of health care corrected by the age structure were somewhat smaller in 2010 than in 2009; the costs decreased by 0.6%. The costs in Helsinki have been the highest ones in every follow-up year, but differences between Helsinki and other big towns decreased in 2010.

[H1] MIKKOLA Teija. Keskisuurten kuntien sosiaali- ja terveystoimen kustannukset vuonna 2010. Association of Finnish Local and Regional Authorities, Helsinki, 2011, 122 pp. Retrieved from:

http://shop.kunnat.net/product_details.php?p=2579

“Costs of social welfare and health care services in municipalities with quite large population figures in 2010”

The aim was to describe the costs of social welfare and health care services in eleven municipalities with a quite large population figures in 2010. The study belongs to yearly follow-ups about the costs of social welfare and health care services in the municipalities.

Day care of children and preschool of children (17.3%) and somatic specialised health care (15.4%) were the sectors which took the biggest amount of total costs. The costs in 2010 were higher than in 2009; the increase of the costs per inhabitant was 1.2%. When the age structure of municipalities was controlled, the costs per inhabitant varied between these municipalities. The highest total costs of social welfare and health care services per inhabitant were EUR 3,576 (Kirkkonummi), and the lowest ones were EUR 2,979 (Mustijoki). The results support the conclusion that the age structure of the municipality is not the only factor affecting the costs. Other factors consist of need of services, amount of produced services and costs per one produced service. The costs of salaries of workers have an effect on the costs per one produced service.

[H2] MÄKINIEMI Esa. Uusintamurtumien ehkäisy kaatumisen aiheuttaman yläraajamurtuman kokeneilla yli 50-vuotiailla henkilöillä. *Annales Universitatis Turkuensis C 315. Scripta Lingua Fennica Edita. Academic dissertation. Turku 2011, 138 pp. Retrieved from:*

<http://urn.fi/URN:ISBN%20978-951-29-4699-0>

„Prevention of new fractures among persons aged over 50 years suffering from an upper-limb fracture”

The aim was to describe the effects of a strengthened fracture prevention programme on the lifestyle, fracture risk factors, falls, falling injuries and quality of life of persons aged 50 years or over with upper limb fracture. 219 persons (50 years+) with upper-limb fracture due to a fall, who lived at home, were randomised into an intervention group (n=105) and a control group (n=114). The intervention included the development of an individual treatment and rehabilitation plan, and the invitation to join a training programme on fracture prevention. The control group was referred to a nurse counsellor. The prevention and follow-up lasted 14 months.

The daily intake of calcium increased significantly in the intervention group, but no change happened in the control group. As regards the other factors examined, no significant changes could be observed between the groups.

[H3] OKSANEN Tuula, VAHTERA Jussi, WESTERLUND Hugo, PENTTI Jaana, SJÖSTEN Noora, VIRTANEN Marianna, KAWACHI Ichiro, KIVIMÄKI Mika (2011). Is Retirement Beneficial for Mental Health?: Antidepressant Use Before and After Retirement. *Epidemiology* 2011;22:553–559, retrieved from:

http://journals.lww.com/epidem/Abstract/2011/07000/Is_Retirement_Beneficial_for_Mental_Health__20.aspx

This study examines longitudinally the changes in antidepressant medication use across the 9 years spanning the transition to retirement.

Participants were Finnish public-sector employees: 7,138 retired at statutory retirement age, 1,238 retired early due to mental health issues, and 2,643 retired due to physical health issues. Information on purchase of antidepressant medication 4 years before and 4 years after retirement year was based on national pharmacy records in 1994–2005.

One year before retirement, the use of antidepressants was 4% among those who would retire at statutory age, 61% among those who would retire due to mental health issues, and 14% among those who would retire due to physical health issues. Retirement-related changes in antidepressant use depended on the reason for retirement. Among old-age retirees, antidepressant medication use decreased during the transition period. Among those whose main reason for disability pension was mental health issues or physical health issues, there was an increasing trend in antidepressant use prior to retirement and, for mental health retirements, a decrease after retirement.

[H3] PERÄLÄ Marja-Leena, SALONEN Anne, HALME Nina, NYKÄNEN Sirpa (2011). Miten lasten ja perheiden palvelut vastaavat tarpeita? Vanhempien näkökulma. National Institute for Health and Welfare (THL), Report 36/2011, Helsinki, 95 pp. Retrieved on [26.10.2011]:

<http://www.thl.fi/thl-client/pdfs/27f8cfeb-8fa8-402a-b3a0-e26dd8a7ba6d>.

"How do services for families and children meet the needs? Parents' opinions."

The study collected information on services for families and children in terms of need for services, access to support and help, service use, quality and service integration, and parents' involvement, partnership and involvement in decision making. The services were examined in five environments: paediatric health care clinics, day care, pre-school education, basic education and school health care. The parents had a positive view of their own health and that of their child, and of their own ability to cope with parenting, although one fifth of parents had some chronic disease or disability. 14% of children had some learning or development issue, more than one fourth had some illness, disability or developmental delay, while nearly one fifth had been bullied in the past six months. Parents were concerned with their children's physical health, psychosocial development and health, social relationships and emotional life. More than half were concerned for their own ability to cope. Other common worries included a lack of quality time with the child, couple relationship problems, and financial difficulties or unemployment. Mothers were more worried than fathers.

The majority felt that they had good access to receiving help with their worries. There were problems concerning access to psychosocial pupil welfare services, social welfare services, and psychiatric services for children. Access to services was best in private services, dental care, specialised health care with the exception of psychiatric care and health care centre services. Parents expressed the highest degree of satisfaction with the services in open preschool education and physical exercise that they used the most.

[H2] SALONOJA Maritta. Kaatumisten vaaraa lisäävät lääkkeet; Porissa toteutettu iäkkäiden monitekijäinen kaatumisten ehkäisy. *Annales Universitatis Turkuensis C 319. Scripta Lingua Fennica* Edita. Academic dissertation. Turku 2011, 152 pp. Retrieved from:

<http://urn.fi/URN:ISBN:978-951-29-4755-3>

"Fall-risk-increasing drugs; a multifactorial fall prevention among the aged in Pori"

591 community-dwelling older people participated in this randomised, controlled multifactorial fall prevention. The prevention lasted 12 months, and the follow-up lasted 2 years. The use of psychotropics, and the effect of withdrawal of psychotropics on the incidence of falls were analysed. Every fourth person used psychotropic drugs regularly. One-time counselling regarding these drugs with written instructions followed by a lecture about drugs and falls

decreased the regular use of psychotropics by a fifth and that of benzodiazepines or related drugs by over a third. The assessment of the risk factors of falls and planning measures to prevent falls and fractures among fallen patients treated in the health care centre or in special hospital care were scarce. The multifactorial prevention was successful to decrease the incidence of falls in depressive or multiple fallers but not in the total sample. The controls who continued to use psychotropics were more prone to falling and requiring medical treatment in the year after the intervention compared to the persons in the intervention group who withdrew these drugs.

[H3] SILTANIEMI AKI, HAKKARAINEN TYTYNE, LONDEN PIA, LUHTANEN MARJUKKA, PERÄLAHTI ANNE, SÄRKELÄ RIITTA (2011). Kansalaisbarometri 2011. Hyvinvointi, palvelut ja osallisuus kansalaismielipiteissä. Sosiaali- ja terveysturvaliitto, Finnish Federation for Social Welfare and Health, Helsinki 250 pp. ISBN 978-951-747-207-4, ISSN 1798-0755.

“Wellbeing, services and participation as assessed by citizens.”

An opinion survey about social welfare and health care services and the equality in access to services was carried out amongst a sample of 3,600 Finns in early summer 2011. Over a half of the respondents answered that citizens are not equal in receiving social welfare and health care services. Two out of three persons thought that the quality of services will weaken in the future. Based on these results it was calculated that the salaries, pensions or other income of over 500,000 adults are not sufficient in order to pay health care costs. Every second participant considered that waiting lists of health care services, especially those of primary health care physicians, are too long. 15% reported that they had not received adequate help with their health problems during the previous year. Unemployed people form a group where suffering from diseases, limited economic resources and inequality in access to social welfare and health care services is common.

[H3] TARKIAINEN Lasse, MARTIKAINEN Pekka, LAAKSONEN Mikko, VALKONEN Tapani. Trends in life expectancy by income from 1988 to 2007: decomposition by age and cause of death. *J Epidemiol Community Health*, Mar 4 [Epub ahead of print]. Retrieved on[27.10.2011]:

<http://jech.bmj.com/content/early/2011/03/04/jech.2010.123182.full.pdf>

This study assessed the change in life expectancy by income over 20 years in the Finnish general population. Life expectancy among 35-year-olds by household income quintiles was studied. Change in life expectancy from 1988-92 to 2003-7 was broken down by age and cause of death. The dataset contained 754,087 deaths by oversample of 80% of all deaths during the period.

The gap in life expectancy between the highest and the lowest income quintiles widened during the study period by 5.1 years among men and 2.9 years among women, and in 2007 it stood at 12.5 years and 6.8 years, respectively. Stagnation in the lowest income group was the main reason for the increased disparity for both sexes. Increasing mortality attributable to alcohol-related diseases and increasing or stagnating mortality for many cancers, and a slower decline in mortality due to ischaemic heart disease among men in the lowest income quintile, were the most significant factors increasing the gap.

[H] THL, THE NATIONAL INSTITUTE FOR HEALTH AND WELFARE (2011), Perusturvan riittävyys arviointiraportti, Avauksia 4, 2011, Helsinki, retrieved from: <http://www.thl.fi/thl-client/pdfs/d4f9b358-3440-4894-9004-0cdf6a21efe>

“An Overall Evaluation on the Sufficiency of Basic Benefits”

In December 2010, a legislative amendment entered into force pursuant to which an overall evaluation on the sufficiency of basic benefits shall be conducted every four years. The National Institute for Health and Welfare convened a working group with experts representing research institutions in the sector, the Social Insurance Institution (KELA), Statistics Finland and the University of Turku.

The working group based its evaluation on Section 19 of the Constitution of Finland, which lists the life situations where the public authorities must safeguard basic subsistence. Students and persons on a home care allowance were included in the evaluation. For households on basic benefits, the evaluation took into account social assistance and KELA benefits with a substantial impact on household income. Basic benefits trends were examined for the period 1990 to 2011, as this was the first report evaluating the sufficiency of basic benefits. Sufficiency of income in households on basic benefits, and trends therein, were evaluated using sample calculations for four different model families.

[H2] VAKKURI Johanna. Pilkahduksia Pilkkeestä. – Tutkimus ikääntyvien päihteidenkäyttäjien päivätoimintaryhmistä. Helsinki Deaconess Institute, Report 1/2011, Helsinki, 2011, 76 pp. Retrieved from:

http://www.hdl.fi/images/stories/liitteet/pilkahduksia_pilkkeesta.pdf

„Glimpses from the problem drinking prevention programme. A study about group support to aged problem-drinkers”

This study about the effects of group support to aged problem-drinkers in day care centres showed positive results. Discussion and activities in groups gave possibilities to structure days in a new way. Feelings of loneliness decreased. Many participants changed their drinking habits, and the use of alcohol decreased. Cooperation between home care personnel and non-governmental organisations in order to identify the elderly with alcohol problems in home care and to guide and to encourage them to participate in support groups were stressed in the conclusions of the report.

[L] Long-term Care

[L] JÄRNSTRÖM Sanna. “En tiedä, mitä ne ajattelee mun kohtalokseni” Etnografinen tutkimus asiakkuudesta ja asiakaslähtöisyydestä geriatrisessa sairaalassa. Tampere: University of Tampere, Social and cultural sciences unit, Dissertation 2011. Retrieved from: <http://acta.uta.fi/pdf/978-951-44-8508-4.pdf>

“I don’t know, what they are thinking for my destiny”. An ethnographical research about client hood and client orientation in a geriatric hospital“

This study concerns client hood and client orientation in a geriatric hospital. The material consists of theme interviews of 45 elderly people and their client reports, five multi-professional group interviews of employees and 32 observations of operational practices in a geriatric hospital in Southern Finland and its five wards.

The elderly people consider the following things as important in being cared for in a ward: implementation of their follow-up care, recovery, health, support of relatives, home, domestic

help, matters of faith, humour. The elderly were variably satisfied with personnel, getting out, getting everything ready, visits of hospital chaplain and rehabilitation they received. They felt discontent with personnel urgency and malice, the slowness of help, lack of resources, lack of activity and stimulus, lack of getting outdoors and diapers.

Client hood and customer orientation for elderly people in geriatric wards are challenged by efficiency thinking of the service system, inflexibility of the system and personnel orientation. Self-determination, participation and equal interaction do not materialise. The elderly felt that they received insufficient information, and many persons did not know about their follow-up care plans, their medicines or illnesses.

[L] SOSIAALI- JA TERVEYSALAN LUPA- JA VALVONTAVIRASTO VALVIRA (2011). National Supervisory Authority for Welfare and Health. Vanhusten hoidon laatu terveystieteiden tutkimuskeskuksella. Vuoden 2010 kyselyn tulokset. Valvira, selvityksiä 1:2011, Helsinki, 27pp. Retrieved from:

http://www.valvira.fi/files/Selvityksia_1_2011.pdf.

“Quality of elderly care in health centre hospitals.”

The National Supervisory Authority for Welfare and Health assessed the quality of care of elderly patients (75 years and over) in health centre hospitals by sending enquiries to 182 chief health centre physicians in winter 2010–2011. Altogether, 90% of physicians took part. The report described the quality of care in 536 health centre hospitals. The number of elderly patients in these hospitals was 11,958, and their proportion of all 16,009 patients in health centre hospitals was 75%. Every second elderly patient was in long-term care. Every third elderly patient could walk independently. Every third of these patients could not walk at all.

Shortages were found in the basic education and number of personnel involved in their care. Shortages in meals and long periods between supper and breakfast were evident. Medications used by the elderly were not assessed regularly as proposed by the Ministry of Social Affairs and Health. The quality of medical records did not follow the proposals by the ministry.

4 List of Important Institutions

Eläketurvakeskus (ETK) – Finnish Centre for Pensions

Address: Kirjurinkatu 3 (Itä-Pasila), Helsinki

Webpage: <http://www.etk.fi/>

A central body of the Finnish statutory earnings-related pension scheme and an expert in pension provision. Its objective is to efficiently arrange fair pension provision for employees and self-employed persons.

ETK monitors the achievement of the objectives of the pension scheme from the viewpoint of both social and financial sustainability. The aim is also to produce data to serve the development of the pension scheme. One crucial objective is, for instance, to monitor the effects of the 2005 pension reform. Research is done taking into account both scientific viewpoints and practical needs.

Elinkeinoelämän tutkimuslaitos (ETLA) – The Research Institute of Finnish Economy

Address: Lönnrotinkatu 4B, Helsinki

Webpage: <http://www.etla.fi/>

ETLA, the Research Institute of the Finnish Economy, is the leading private economic research organisation in Finland. It carries out research on economics, business and social policy as well as making economic forecasts. ETLA's activities facilitate financial and economic policy decision-making in the organisations sponsoring the Institute, Finnish companies and the entire economy.

Elinkeinoelämän valtuuskunta (EVA) – Finnish Business and Policy Forum

Address: Yrjönkatu 13A, Helsinki

Webpage: <http://www.eva.fi/>

EVA is a policy and pro-market think tank financed by the Finnish business community. EVA is a discussion forum and networking arena for decision makers both in business and society. EVA publishes reports, organises debates and publishes policy proposals. EVA works in close cooperation with the Research Institute of the Finnish Economy ETLA.

Kalevi Sorsa -Säätiö – The Kalevi Sorsa Foundation

Address: Saariniemenkatu 6, Helsinki

Webpage: <http://www.sorsafoundation.fi/>

The Kalevi Sorsa Foundation is an independent and open social democratic think tank. The Foundation's aim is to encourage public debate that promotes equality and democracy as well as to produce its own research and publications.

Kansaneläkelaitos – The Social Insurance Institution of Finland

Address: PO Box 450, 00101 Helsinki, Finland

Phone: +358 20 634 11

Webpage: <http://www.kela.fi/in/internet/english.nsf>

Institution providing social security benefits for all residents in Finland. The Research Department undertakes research and development projects focusing on the social security and health provision of the Finnish population and on the benefit schemes, client services and other operations of the Institution.

Kuntaliitto – The Association of Finnish Local and Regional Authorities

Address: Toinen linja 14, 00530 Helsinki, Finland

Phone: +358 9 7711

Webpage: http://www.kunnat.net/k_kuntaliitto_etusivu.asp?path=1;184

Kuntaliitto is the national association of municipalities in Finland. It collects data about services in municipalities, gives advice to municipal directors, arranges further education and negotiates with the state about cooperation.

Lääkealan turvallisuus- ja kehittämiskeskus Fimea – Finnish Medicines Agency

Address: P.O.Box 55, FI-00301 Helsinki, Finland

Phone: +358 9 473 341

Webpage: <http://www.fimea.fi/>

Fimea regularly controls medical products, medical devices and blood products. It gives permissions to carry out research into medications.

Palkansaajien tutkimuslaitos – Labour Institute for Economic Research

Address: Pitkäsillanranta 3 A 6. krs 00530 Helsinki

Webpage: <http://www.labour.fi/>

The Labour Institute for Economic Research is an independent and non-profit research organisation founded in 1971. The Institute carries out economic research, monitors economic development and publishes macroeconomic forecasts. The aim is to contribute to the economic debate and to provide information for economic policy decision-making in Finland. The main emphasis is on empirical research based on theoretical approaches. The main fields of research are labour market issues (labour supply and demand, labour mobility, wage formation and wage differentials, unemployment and efficiency of the labour market), public economics (welfare, inequality and economic exclusion, effects of taxation and public spending on the household sector, evaluation of public institutions and organisation of market structure in the production of public services) and macroeconomic issues and economic policy business cycles, monetary and fiscal policies, monetary integration, macroeconomics of employment and unemployment).

Sosiaali- ja terveysministeriö – The Ministry of Social Affairs and Health

Address: PO Box 33, FI-00023 Government, Finland

Phone: +358 9 160 01

Webpage: <http://www.stm.fi/en/frontpage>

The ministry is responsible for promotion of welfare and health, social welfare and health care services, social insurance, private insurance, occupational safety and health and gender equality.

Sosiaali- ja terveysturvan keskusliitto (STKL) – Finnish Federation for Social Welfare and Health

Address: Kotkankatu 9, Helsinki

Webpage: <http://www.stkl.fi/>

The federation's goals are to improve basic security, reduce disadvantages, strengthen social responsibility and increase people's scope for influence and participation. The Federation is an expert association which collaborates, lobbies and offers services like training and an information service. The Federation keeps under review developments in Finnish society and the effects of social changes from the angle of the social policy of the citizens' everyday life.

Suomen itsenäisyyden juhluvuoden rahasto SITRA – The Finnish Innovation Fund

Address: P.O.Box 160, FI-00181 Helsinki, Finland
Phone: +358 9 618 991
Webpage: <http://www.sitra.fi/en/>

SITRA is an independent public fund, which, under the supervision of the Finnish parliament, promotes the welfare of the Finnish society. “Think-tank” working and development projects belong to its main working manners.

Tekes – The National Technology Agency of Finland

Address: P.O.Box 69, FIN-00101 Helsinki, Finland
Phone: +358 1060 55000
Webpage: <http://www.tekes.fi/en/community/Home/351/Home/473>

Tekes is an organisation which funds development projects and supports companies. It gives funds mainly to private companies in order to develop technology.

Terveyden- ja hyvinvoinnin laitos – The National Institute for Health and Welfare

Address: P.O. Box 30, FI-00271 Helsinki, Finland
Phone: +358 20 610 6000
Webpage: http://www.thl.fi/en_US/web/en

The National Institute for Health and Welfare is a research and development institute under the Ministry of Social Affairs and Health. It was formed at the beginning of 2009 by combining the National Public Health Institute and Stakes.

Tilastokeskus – Statistics Finland

Address: FI-00022 Statistics Finland
Phone: +358 9 17341
Webpage: http://www.stat.fi/index_en.html

Statistics Finland collects and publishes statistical information on the Finnish society. The information covers many socio-economic sectors.

Työeläkevakuuttajat TELA – The Finnish Pension Alliance

Address: Lastenkodinkuja 1, Helsinki
Webpage: <http://www.tela.fi/>

TELA is a private association, not a government or public function. It represents its members (employee pension institutions) in order to protect, develop and strengthen the knowledge of statutory earnings-related pension schemes in the society. It lobbies for employee pension institutions and delivers information on pensions and pension policy.

Työ- ja elinkeinoministeriö (TEM) – The Ministry of Employment and the Economy

Address: Aleksanterinkatu 4, FI-00170 Helsinki, Finland
P.O. Box 32, FI-00023 GOVERNMENT, Finland
Webpage: <http://www.tem.fi>

TEM is responsible for labour policy strategy and implementation, improving the viability of working life and its quality, and promoting employment. The ministry’s tasks also include the planning and implementation of the Public Employment Service. The ministry is responsible for harmonising EU employment policy with national employment policy, EU professional life and labour law issues, the European Job Mobility Portal (EURES) job matching scheme, and matters to do with the International Labour Organisation (ILO) in Finland.

Valvira - The National Supervisory Authority for Welfare and Health

Address: Lintulahdenkuja 4, 00530 Helsinki

Webpage: <http://www.valvira.fi>

The National Supervisory Authority for Welfare and Health is responsible for supervision of social welfare and health care services and permissions of health care staff to work as professionals.

Valtioneuvoston kanslia – The Prime Minister’s Office

Address: Snellmaninkatu 1A, 00101 Helsinki

Webpage: <http://www.vnk.fi>

The Prime Minister's Office is responsible for the planning of social policy legislation that does not fall within the competence of any other ministry. Another duty of the Prime Minister's Office is to assist the prime minister and the government in their work and provide services to the public and public authorities. The Prime Minister's Office also carries out administrative duties related to a number of projects involving both permanent and ad hoc bodies.

Valtion taloudellinen tutkimuskeskus – Government Institute for Economic Research

Address: Arkadiankatu 7, 00101 Helsinki

Webpage: <http://www.vatt.fi/en/>

The Government Institute for Economic Research (VATT) is an independent applied economics research institute that operates under the authority of the Ministry of Finance in Helsinki. VATT produces research data in support of economic policy decisions and discussion of alternative courses of action.

Valtiovarainministeriö (VM) – Ministry of Finance

Address: Snellmaninkatu 1 A, Helsinki

Webpage: http://www.vm.fi/vm/fi/01_etusivu/

The ministry prepares economic and fiscal policy, drafts the annual budget and offers experience in tax policy matters. It is responsible for drafting policy on the financial markets and state employer and human resources policy, and for the overall development of public administration. Moreover, the ministry is in charge of the legislative and financial requirements of local government functions. It also participates in the work of the European Union and many international organisations.

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- (1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
- (2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
- (3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
- (4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
- (5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
- (6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:

<http://ec.europa.eu/social/main.jsp?catId=327&langId=en>