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Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2011

Pensions, Health Care and Long-term Care

Finland

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
GVG

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1 Executive Summary

Pensions: There have been no remarkable changes in the system's characteristics during the reporting period. A minimum guaranteed pension above the level of the national pension was introduced in 2011. Working groups established in 2009 and 2010 around the issues of lengthening the working career and raising the effective retirement age gradually by at least three years by 2025 have given their reports. Further reforms based on these reports are under tripartite and government negotiations. In the earnings-related pension system, contributions were raised by 0.4 percentage points as agreed in employers' associations and trade unions agreement on 21 January 2009. This was the first raise in a series to come during the years 2011–2014, when the contributions will be raised annually by 0.4 percentage points. Long-term voluntary pension savings, established in 2010, have not gained popularity in the first year.

Health: Arrangements to make greater units for delivering primary health care and closely related social welfare services continued, but the reform process was not rapid. The shortage of physicians was evident in some regions. The access to primary care physicians was relatively good. The productivity of specialised health care as measured by treatment episodes increased during the 2000s. More patients are treated in open care nowadays, and fewer patients are treated in hospital beds. The number of patients waiting for a long period to access hospital care decreased by 58% between 2007–2009. The number of private providers of health care increased steadily during the 2000s. The biggest increase was in the number of units in the sector of private physicians' services. The number of workers in health care increased during the 2000s. The number of workers with a foreign background increased, but their number is small. A comprehensive Health Care Act was passed in Parliament in 2010, and the act took effect on 1 May 2011. The development of health in all age groups was positive during the 2000s. The difference in health between the lowest and highest income groups widened. The problems of the current multi-channel model to finance health care were discussed, and proposals to implement a one-channel financing system were made.

Long-term care: Municipalities signed more contracts with private companies to provide services in comprehensive sheltered housing. In 2008, private providers produced about half of the services in these units. The number of elderly people in home care increased, and their cognitive and functional abilities were poorer than at the beginning of the 2000s. Family members, even old ones, were the most important carers of the elderly, and they usually took care without any economic support. Service vouchers were quite commonly offered to the elderly in order to be able to choose providers of long-term care. A proposal for an Act on Long-term Care of the Elderly was released in March 2011. The act will give subjective rights to long-term services, but the rights are based on assessment of functional abilities. Three assessments about quality of long-term care of the elderly written by official authorities reported shortages in care. Proposals to develop the financing of long-term care were made. A common feature of the proposals was that a basic amount of services should be supplied by the public sector and financed by taxes, but citizens should have a possibility to buy extra services paid by private insurance.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

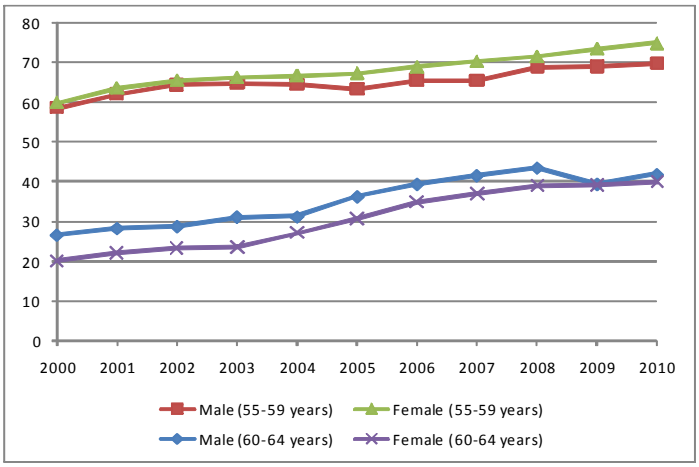
2.1 Overarching developments

According to the recent Economic Survey[1] Finland's strong public finances (4.2% in 2008) deteriorated sharply with the economic crisis, but the deficit in 2009 (-2.9%) and 2010 (-2.8%) did not exceed the 3% threshold specified in the Stability and Growth Pact, even though the deficit was estimated to slide to -4% of GDP in 2010[2]. Currently, public finances are set to improve in 2011 in the wake of economic recovery, tax hikes and the withdrawal of temporary stimulus measures.

The general government gross debt (EMU) to GDP ratio has risen from 34.1% at year-end 2008 up to 48.4% in 2010 and it is projected to rise every year during the budgetary planning period (2015), but should not exceed the 60% limit under the Stability and Growth Pact.

Early data from Statistics Finland indicate that annual GDP change in 2010 reached 3.1% and this year's projected growth rate is 3.6%. During 2010, the average number of people in employment continued to fall somewhat and the unemployment rate edged up to 8.4% (6.4% in 2008). The labour market situation is beginning to return to "normal". The projected unemployment rate for 2011 is 7.6%. It is projected that the employment rate (in the age group 15–64) will edge up to 69.1% (70.6% in 2008), continuing to rise from the level in 2010 (67.8%).

Figure 1: Employment rate of older workers (55-59 and 60-64-year-olds) by gender, in %.



Source: Statistics Finland, Labour Force Survey.

The process of demographic change is reducing the size of the working age population. Thus, there is a need for prolonging working careers. The employment rate of the elderly has

[1] See MINISTRY OF FINANCE (2011a), Economic Survey, Spring 2011. Economic Outlook and Fiscal Policy for 2011-2015, Ministry of Finance publications 15b/2011, 23.03.3011, Helsinki, retrieved 02 May 2011 from: http://www.vm.fi/vm/en/04_publications_and_documents/01_publications/02_economic_surveys/20110323Econom/TK_enkku_010411_NETTI.pdf.

[2] OSF, OFFICIAL STATISTICS OF FINLAND (2011), General Government Deficit and Debt [e-publication], Helsinki, retrieved on 03 May 2011 from: http://www.stat.fi/til/jali/2010/jali_2010_2011-03-31_tie_001_en.html.

increased in recent years. There are no significant gender differences in employment rates of older workers and the women's rate has even surpassed that of men (Figure 1). The employment rate of men (60-64 year-olds) fell, whereas the employment rate of women still managed to grow even during the crisis.

The financial position in the earnings-related pension schemes is fairly good, as the system is running on surpluses. However, the annual surplus in relation to GDP fell from 4% (2008) to about 3% in 2009 and it is projected to stay on that level due to population ageing and the growth of pension expenditure. In 2010, employment pension funds continued the strong growth that began in 2009. During the year, investments by earnings-related pension funds increased by EUR 13.9 billion, or some 11%. The market value of fund assets at year-end totalled EUR 138.8 billion, or 77% of GDP.[3]

The Ministry of Finance has estimated that over the 2015–2060 period, age-related public expenditure to GDP will rise by 4 percentage points. By 2060, most of the projected increase will come from rising costs of long-term care, but pension and health care expenditure will also rise appreciably. Age-related public expenditure will rise most sharply during the current decade, but in the 2030s it is anticipated that pension expenditure as a proportion of GDP will start falling (see also Elo Kalle et al. 2010). Health care and long-term care expenses will rise most sharply during the 2020s and 2030s, but it is anticipated that the latter in particular will continue to rise beyond that point.[4]

Because of the projected demographic trends and the associated increase in age-related expenditure, MoF has estimated that public finances are on an unsustainable path. According to the calculations, the sustainability gap in public finances is around 5% of GDP. However, according to the Research Institute of the Finnish Economy[5] the estimate of the sustainability gap is much smaller, 2.5% of GDP, for the period 2010–2060. The differing results show how the sustainability gap estimate is sensitive to the assumptions underlying the calculations and to the estimated structural balance of public finances at baseline.

The crisis had no significant effect on the long-term financing outlook and did not lead to a reorientation of pension policy. However, for management of the sustainability gap in public finances, as well as to ease ageing pressures for labour markets and sustainability of financing in the earnings-related pension scheme, the crisis has reinforced the main objectives of the previous 2005 pension reform and the need to lengthen the working career and to raise the effective retirement age.

The Finnish government has followed the political programme written in spring 2007, after the elections. The current political model is to motivate municipalities to merge and to form primary health care areas covering at least 20,000 inhabitants. A trial of a provincial model was started in Northeastern Finland a few years ago. The province covering 200,000 inhabitants and consisting of several municipalities provides financing and services of health care.

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3 MoF, Ministry of Finance (2011a), Economic Survey, Spring 2011. Economic Outlook and Fiscal Policy for 2011-2015, Ministry of Finance publications 15b/2011, 23 March 2011, Helsinki, retrieved 02 May 2011 from: http://www.vm.fi/vm/en/04_publications_and_documents/01_publications/02_economic_surveys/20110323Econom/TK_enkku_010411_NETTI.pdf.

4 Ibid.

5 ETLA, The Research Institute of the Finnish Economy (2011), Julkisen talouden rahoituksellinen kestävyys Suomessa (Financial Sustainability of the Public Sector in Finland), Discussion Papers 1237, 11 January 2011, Helsinki, retrieved on 03 May 2011 from: http://www.etla.fi/files/2587_no_1237.pdf.

The new Health Care Act, which combines services and functions of primary health care with those of specialised health care more closely than previously, was passed by the Parliament. The new law came into force on 1 May 2011. The financing of health care is not included in the paragraphs of this law. No changes in the financing model were made[6].

A proposal for an Act on Long-term Care of the Elderly was prepared in the Ministry of Social Affairs and Health. The proposal was made public in March 2011. The care needed by old persons and based on critical assessments will be ensured by this act. The proposal was sent to stakeholders, whose literary comments were requested by the end of May 2011. The proposal does not include changes in the financing model[7].

The above political decisions show that there is no reorientation in socio-political policies as such. However, the political goal to increase the possibilities of citizens to choose services, the poor financial situation of municipalities, the increase of need for services caused by the ageing of the population and shortage of primary care physicians in some areas of the country have led to an increase in the supply of private health care services. Although private health care services are partially reimbursed, they are more expensive to the users than public services. The statistics show an increase in differences between users of different health services by the level of income. The majority of users of private physicians belong to the highest income groups, employed people use occupational health care services, and the unemployed, persons belonging to the lowest income groups and inhabitants in rural areas form the major groups of the users of public services.

The multichannel financing model of the health care system was discussed in 2010. Several proposals for financing health care in the future were made. In November 2010, the experts in the National Institute for Health and Welfare made a proposal for the development of the financing of health care. Two possibilities to develop were proposed: 1. providing and financing health care through districts with at least 200,000 inhabitants (one-channel system); 2. developing the current multi-channel system by making several changes. In June 2010, the Finnish Innovation Fund gave its proposal about a one-channel financing system of health care and care of the elderly according to which the orders of services and the producers of services should be separated.

Proposals to finance long-term care of the elderly were made. The possibilities to include an additional way to pay one's long-term care by private insurance were a common theme in all proposals. The basic long-term care was proposed to be financed by taxes.

The Gallup polls and studies show that the majority of Finns support the Welfare State Model. The programmes of all political parties are based on this model, although there are some differences between the parties. A new parliament was elected in April 2011. The future government will have an important task in making decisions about the possible changes in the structure of health and long-term care and in their financing models.

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6 Terveydenhuoltolaki 30.12.2010/1326 (Health Care Act). Retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2010/20101326.

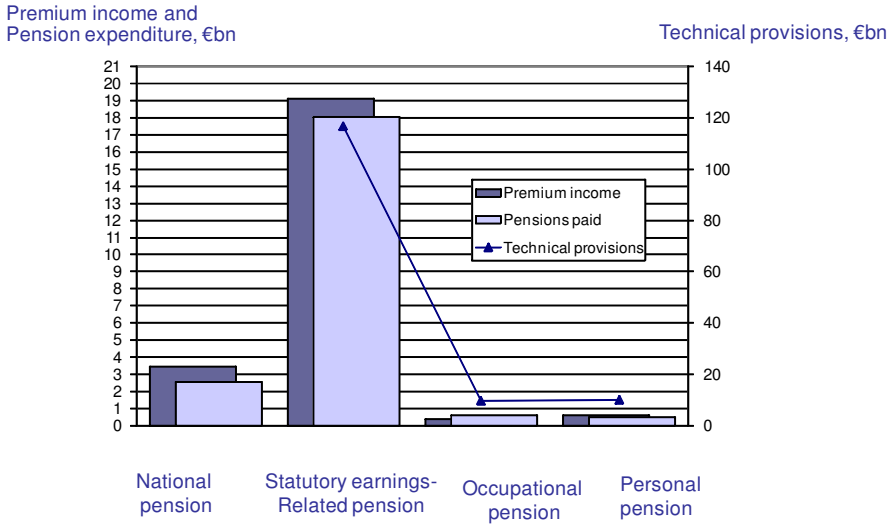
7 Luonnos laiksi iäkkään henkilön sosiaali- ja terveyspalvelujen saannin turvaamisesta. Proposal for Act on Long-term Care of the Elderly. STM 2011. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=2664824&name=DLFE-15130.pdf.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The Finnish pension system is made up of two statutory pension schemes. One is the national pension scheme based on residence that provides a guaranteed minimum pension. The other is the employment-based, earnings-related pension scheme. The statutory earnings-related pension scheme covers all wage and salary earners and self-employed persons. Voluntary pension schemes (the second and third pillars) play a minor role in Finland, due to absence of pension ceilings and the extensive coverage of the statutory first-pillar systems (Figure 2).

Figure 2: Pension insurance in Finland in 2009



Sources: Financial Supervisory Authority 2011; Finnish Centre for Pensions 2011; Kela 2011a,b

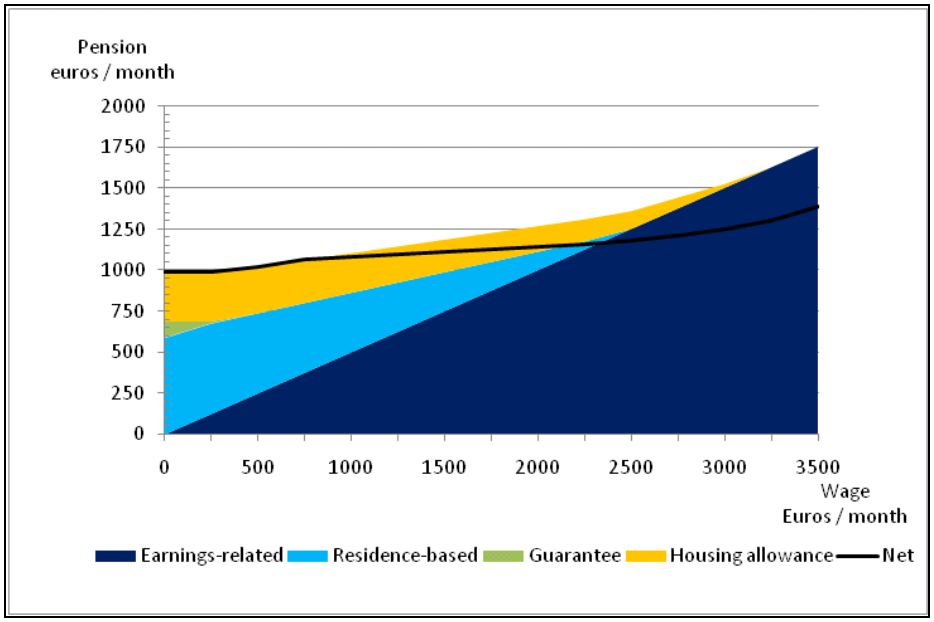
The statutory schemes are linked together, with the amount of the national pension benefit depending on the size of the earnings-related pension benefit (cf. Figure 3). Earnings-related pensions reduce the national pension by 50%. Pensioners who receive no earnings-related pension at all or whose earnings-related pension is less than EUR 1,212.21 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 2011, the full national pension is EUR 586.46 per month for single and EUR 520.19 for married persons at the age of 65. The age limit for early old-age pension is 62 years. However, the deduction 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 guarantee 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 101.28 per month. The minimum pension is EUR 687.74 per month regardless of the pensioner's family status. A total of around 120,000 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 being paid to a family.

Figure 3: Earnings-related pension, national pension, guaranteed pension and pensioners' housing allowance 2011



Source: Finnish Centre for Pensions 2011.

Since the beginning of 2010, the possibilities for disability pensioners to re-enter working life or to participate in work try-outs were improved. When the guaranteed pension took effect, the earnings limit was adjusted from the previous EUR 600 to EUR 687.74 per month. A person can earn up to the limit without this having a negative effect on the disability pension. A person drawing a full disability pension may still earn up to a maximum of 40% of the previous stabilised average earnings, and a person drawing a partial pension, 60%. If monthly earnings exceed EUR 687.74 or the above-mentioned limits, the pension can be suspended for a maximum of two years, without the fear of losing the approved disability pension if working proves to be impossible. The act (738/2009[8]) is temporary and in force from January 2010 to the end of 2013. The effects will be assessed then and on the basis of that evaluation decisions will be made whether the Act should be permanent.

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 insured 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.

[8] Laki työkyvyttömyyseläkkeellä olevien työhönpaluun edistämisestä. Retrieved from: http://www.edilex.fi/saadokset/smur/20090738.

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, was raised by one year to 58 from the beginning of 2011. 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 (discussed later on).

The pensioners' average pension in their own right (does not include survivors' and part-time pensions) was EUR 1,344 a month in 2009 (EUR 1,370 in 2010), about 46% of the average income (EUR 2,940[9]) in the said year. For men it was EUR 1,530 (2010: EUR 1,561) and for women EUR 1,196 (2010: EUR 1,217).

There are two types of indexation in the earnings-related pension scheme. The first (preretirement 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 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 provision 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).

Employers' and employees' organisations 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 a combination of a PAYG system and a prefunded system based on pension contributions from both employers and employees.

[9] Statistics Finland's Structure of Earnings statistics, retrieved from: http://www.stat.fi/til/pra/2009/pra_2009_2011-04-08_tie_001_en.html.

Approximately three quarters of the earnings-related pensions are financed through PAYG, with the prefunded scheme covering the rest. Despite being partially funded, Finland's earnings-related pension scheme is of the defined-benefit type.

The average earnings-related pension contribution rate (TyEL) for 2011 is 22.4% of wages, up 0.4 percentage points from 2010, as agreed in employers' associations and trade unions agreement on 21 January 2009. This was the first raise in a series agreed for the years 2011–2014, when the contributions will have been raised by a total of 1.6 percentage points. For persons aged under 53, the employee's pension contribution rate for 2011 is 4.7%, which is 0.2 percentage points higher than in 2010. For employees over 53, the 2011 contribution rate is 6%, i.e. 0.3 percentage points higher than in 2010. The average contribution rate for employers in 2011 will be 17.1%, up 0.2 percentage points from 2010.

The act (1183/2009[10]) 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, individuals have had 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.

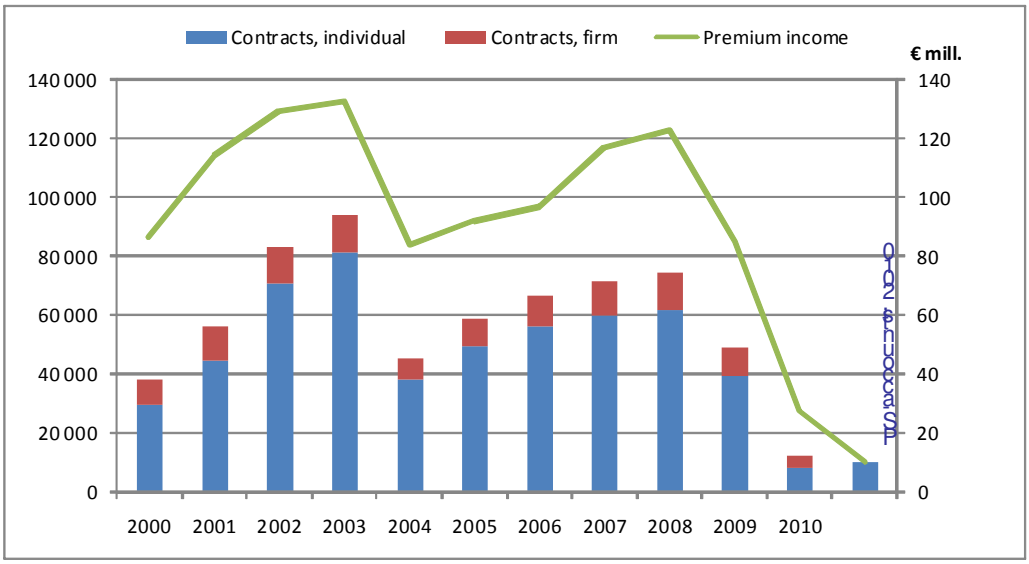
An important part of the reform was to extend the right of tax deduction to other than insurance savings, i.e. to also include long-term savings covered by the legislation. Premiums are tax-deductible up to the amount of EUR 5,000 per year; the flat tax rate for capital income, currently 28%, is applied (max. deduction is EUR 1,400). Individuals' savings will be allocated to personal accounts and only taxed when benefits are paid, according to the EET system[11]. In order to take advantage of the tax relief on premium payments, contributions will be locked in until the statutory retirement pension 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 for voluntary pension contributions. 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. 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, whereas the number of personal pension policies sold in 2009 was nearly 50,000, it was less than 22,000 in 2010. New PS agreements covered less than half (9,811) of this amount and long-term savings accounts amounted to EUR 9.9 million (BoF 2011) (see Figure 4). This is a lot less than expected from the reform.

[10] Laki sidotusta pitkäaikaissäästämisestä (PS-laki). retrieved from: http://www.edilex.fi/saadokset/smur/20091183.

[11] "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.

Figure 4: The number of (new) personal pensions and long-term savings (PS agreements) and premiums written, annual amounts in 2000-2010.



Source: Federation of Finnish Financial Services; Bank of Finland

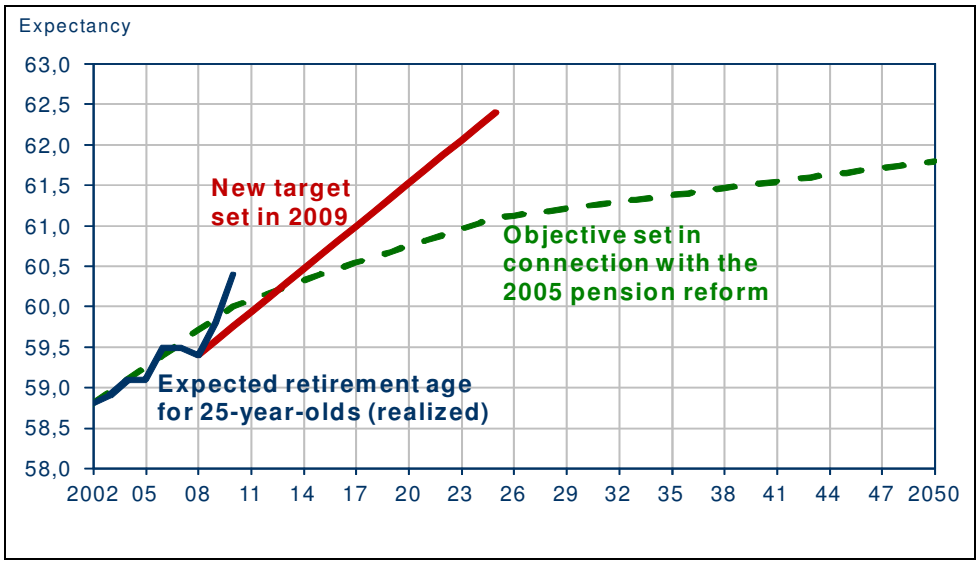
2.2.2 Debates and political discourse

Debate on substantial changes to the earnings-related pension scheme for extending working lives and increasing retirement age has been ongoing during the last couple of years. The social partners together with the government are exploring ways to raise the average retirement age to ensure a sufficient level of earnings-related pensions and the financial sustainability of the earnings-related pension scheme. The parties reached the consensus on 11 March 2009 of the main objective: to raise the effective retirement age by at least 3 years by 2025, compared to the situation in 2008[12]. The original plan, published by the government on 24 February 2009, to raise the minimum retirement age for earnings-related pension from 63 to 65 years has now turned into a much larger and more challenging objective where closer cooperation between different policy measures, i.e. in addition to a pension policy, are needed.

The reforms made so far (e.g. 2005 pension reform) are not sufficient to meet the above mentioned objective (see Figure 5), even though different forms of early retirement have largely been abolished. Unemployment pension was abolished in 2010. However, as was previously mentioned, prolonged unemployment benefit from the age of 58 until retirement exists. Employers have called for the abolition of the 'unemployment tunnel', whereas the trade unions want to keep the existing system.

[12] See PRIME MINISTER'S OFFICE (2009), Consensus to Settle Pensions Dispute, press release, Helsinki, 11 March 2009, retrieved on 03 May 2011 from http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2009/elake-110309/en.pdf.

Figure 5: Development of the expected effective retirement age



Source: Finnish Centre for Pension

Tripartite working groups were established in 2009 and 2010 to identify means to increase the effective retirement age. The findings of one of the two main working groups on improving wellbeing at work and reducing disability pensions was presented to the government in February 2010. The OECD stated the proposals were "very promising" but not sufficient.[13]

In March 2010, the government and labour market organisations appointed a working careers group and on 5 May 2010 expanded the preparatory work on the extension of working lives to be part of the larger sustainable economic growth and employment programme.[14]

The group submitted its report in February 2011. It addressed three specific objectives: securing an adequate level of earnings-related pension in a situation where the life expectancy coefficient is lowering future pensions to a much greater extent than previously anticipated; securing the financial sustainability of the earnings-related pension system; and affecting a sufficient increase in the average expected retirement age. The working group observed that all these three objectives could be promoted simultaneously through longer labour market careers. This can be achieved via economic growth or improved employment, changes in the workplace or through changes made to the pension system. Decisive details of the measures to reach the challenging target to postpone the effective retirement age by three years are still missing. These decisions and further changes to the pension scheme are expected in the context of the ongoing government programme negotiations (national elections were held in April).

[13] OECD, ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (2010), Increasing the Effective Retirement Age in Finland – Report by the OECD to the Prime Minister of Finland, Directorate of Employment, Labour and Social Affairs, Paris, retrieved on 05 May 2010 from: http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2010/oecd-elakearvio-08032010/fi.pdf.

[14] FINNISH GOVERNMENT (2010), Statement by the Government and Labour Market Organisations, Press release 169/2010, 05 May 2010, Helsinki, retrieved on 03 May 2011 from: http://www.valtioneuvosto.fi/ajankohtaista/tiedotteet/tiedote/fi.jsp?oid=294557.

2.2.3 Impact of EU social policies on the national level

The debate concerning the EU Green Paper on pensions has been moderate and not at all as visible as the discussions around the length of working careers. The Green Paper's holistic and integrated approach, whereby pensions are considered in a social context as well as a purely financial one, has been welcomed. However, one of the main reasons why the debate has been so moderate is because the main emphasis of the report is in the 2nd and 3rd pillar pension provisions and in Finland the pension is largely based on the 1st pillar.

The Open Method of Coordination (OMC) has not been a topic of discussions in the media in Finland. 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. This practice could benefit the Member States also in the future in their efforts to develop their pension systems.

Comparing the EU 2020 strategy, the recently published Finland's National Programme (MoF 2011b) and the previously mentioned objectives set in negotiations between the government and labour market organisations indicate that Finland is firmly engaged to the strategy and, in many respects, the national targets exceed those set at EU level. Reaching for higher employment rate 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. More detailed information will be obtained only after a common understanding of the concrete measures can be reached. The forthcoming government programme will also tell more about how the EU 2020 strategy will finally be translated into pension policy.

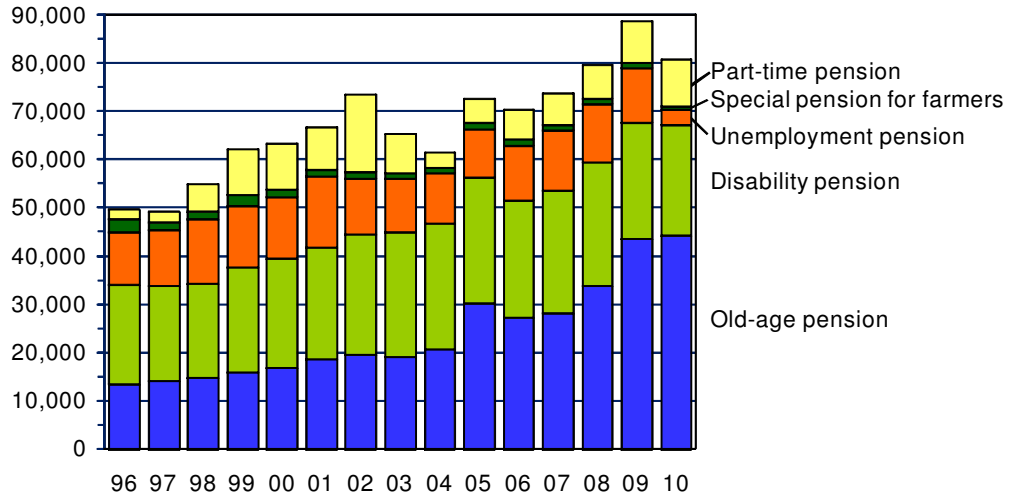
The objectives set in the Annual Growth Survey[15] in the field of pensions are reflected in the National Programme, except the development of complementary private savings, which has not been set as a strategic target in the previously mentioned manner (see 2.2.2) to enhance retirement incomes or sustainability of public finances.

2.2.4 Impact assessment

The employment rate of the elderly (55-64-year-olds) has been increasing in recent years and is currently with 56% above the EU average. Even though the economic crisis led to a decrease in the employment rate, it did not have serious effects on the employment rate of older workers. The employment rate for those aged 55-59 has risen from 60% to over 70% and for those aged 60-64 from 20% to over 40%. Some ten years ago the employment rate among the 60-64-year-olds fell considerably, when compared to the above-mentioned age group. This was largely due to early retirement, with main exit routes from the labour market either through the disability pension scheme or unemployment pensions. However, in 2010 nearly 2/3 of the new retirees retired directly on an old-age pension; whereas the equivalent ratio was 1/4 ten years ago (Figure 6).

[15] http://ec.europa.eu/europe2020/tools/monitoring/annual_growth_survey_2011/index_en.htm.

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 pension strand[16], the level of income for pensioners has remained stable at about 70% of the income of the entire population (median relative income of elderly people), women lacking somewhat behind the average. The aggregate replacement ratios have been stable as well, indicating 48% of income maintenance after retirement on average. Practically no gender gap exists in this indicator.

However, the gender gap is substantial in the case of at-risk-of-poverty rates. Elderly women face a clearly higher risk of poverty than men and this gap has increased during recent years. When poverty is defined on a relative basis, at-risk-of-poverty rates in Finland are higher than the EU average, whereas the severe-material-deprivation rate of older people in Finland is clearly below the EU average.

The higher poverty risk of women reflects to women's lower wage levels. In the length of working careers no large difference exists between women and men.[17] However, some women have never been in any gainful employment that would have accrued earnings-related pensions. Thus, the national pension accounts for a more significant part of overall pension provision for retired women than retired men. Nowadays, gender differences in employment rates of older workers do not exist and the women's rate is even higher than that of men. Still, 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 will promote equality between workers. In addition, since 2005, pension will accrue from unpaid periods under the same terms for both permanent employment and temporary employment, which was not the case before the reform. SPC

[16] Retrieved from: http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/omc_social_inclusion_and_social_protection/pension_strand.

[17] See e.g. VOGLER-LUDWIG KURT (2009), Monitoring the Duration of Active Working Life in the European Union – Final Report, Study for the European Commission Employment, Social Affairs and Equal Opportunities DG Unit D1 Contract VC/2008/0602, 19 August 2010, Munich, retrieved on 04 May 2011 from: http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=652&furtherNews=yes.

calculations on theoretical replacement rates[18] indicate that two children with three years of absence of work effects very little to the level of future pension. Longer absence creates bigger gaps to pension compared to working. How much depends on the wage level.

Unemployment breaks result in a loss of pension entitlements and lead to drops in replacement rates, showing bigger drops the longer the break. A young person would have an annual pension accrual of 75%, compared to that of work, if unemployed for a year. For young persons who become long-term unemployed the future pension level is more drastic, whereas for older persons, the pension level would be about 8% lower if the person would become unemployed at the age of 57 and would remain that way until the age of 63, compared to the pension a working person would get. The unemployment benefit may continue until 65 if the pension is not taken, but the pension accrual (1.5%) of the unemployment benefit earnings base stops at 63; otherwise it would be 4.5% after the age of 63.

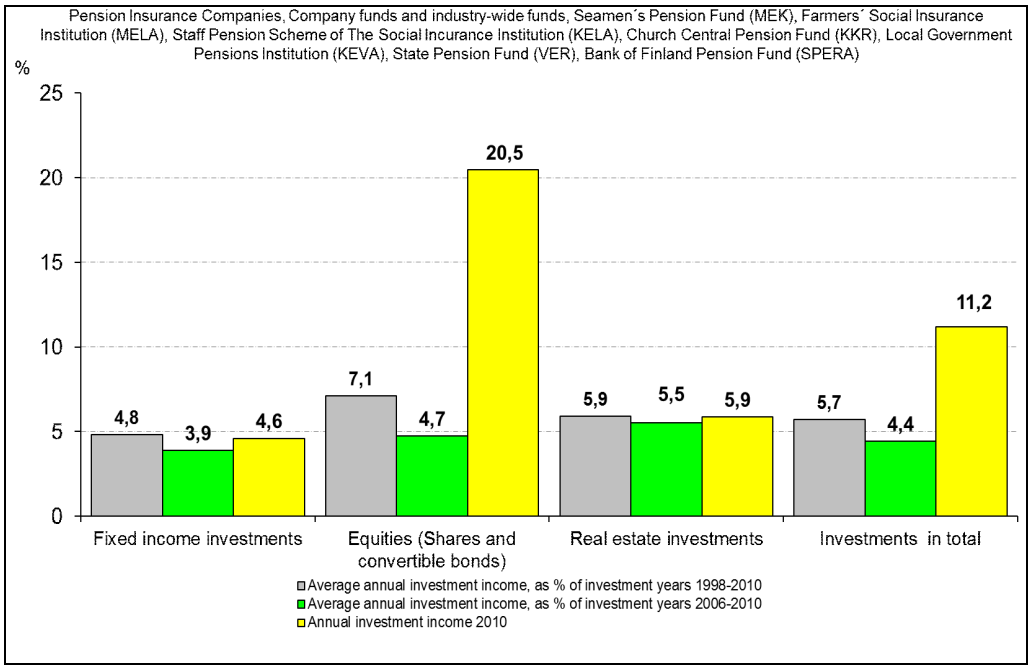
The private pensions play a minor role in Finland (see, e.g., Figure 2). Long-term savings (PS-accounts) established in 2010 have not gained popularity in the first year. The Ministry of Finance has proposed further changes in rules for supplementary private savings to enhance long-term sustainability and adequacy of public finances. In a report published by the ministry at the end of 2010, a new personal savings product would be offered for people aged 80 or over[19]. The right for this over-80's pension or a longevity pension, as the ministry calls it, would be on individuals after the payment of a lump-sum premium at the age of 60. According to a proposal, a supplementary annuity of EUR 800 a month would be secured after the payment of a lump-sum premium of between EUR 40,000-60,000. This longevity supplementary pension would come on top of the national pension and work-related pensions. According to the ministry's report, this additional pension would bring more resources to a time when a person's need, including for care and health services, is the greatest. The proposal has faced contradictory opinions with the main message that it is concentrated to the wealthiest senior citizens who would be able to avail themselves of this scheme.

For earnings-related pensions, the result of the crisis was a decrease in the capital investments of insurers. Total investments lost 16.4% of their value. However, an average return rate of about 15% in 2009 enabled funds to recover most of the losses and in 2010 funds returned an average 11.2% on investments, thus reaching the level of before the crisis (Figure 7).

[18] Retrieved from: http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp71_country_profiles_en.pdf; http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp71_annexes_en.pdf.

[19] See MÄKITALO RAILI, HAUTALA URPO, NARIKKA JOUKO, TUUKKANEN JORMA (2010), Hyvinvointia kestävästi, "Sustainable Welfare", Ministry of Finance, Helsinki, December 2010, retrieved on 03 May 2011 from: http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/08_muut_julkaisut/20110112Hyvinv/Hyvinvointia_kestaevaesti.pdf.

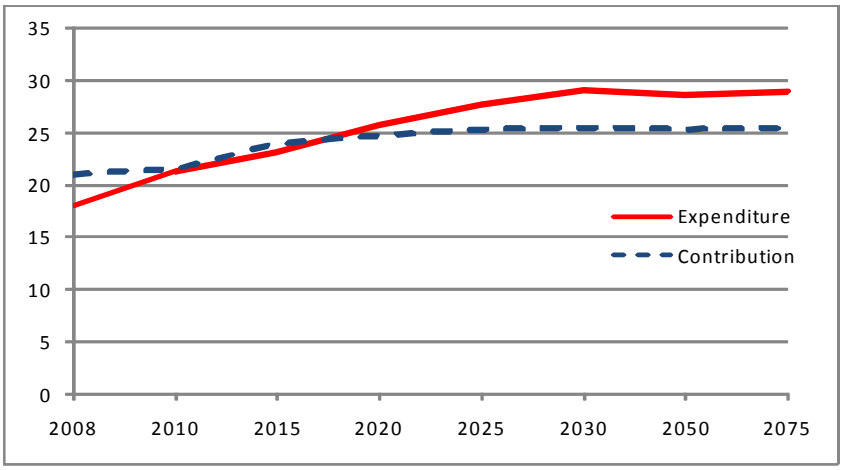
Figure 7: Nominal rate of return on investments for 2010 and on average for years 1998-2010 and 2006-2010.



Source: The Finnish Pension Alliance TELA

According to projections, the average (TyEL) contribution rate will rise from the current level of about 22% to approximately 25% in the long run. The increase in the TyEL contribution rate is a result of the increase in the pension expenditure. From the employers' side it has already been suggested that some sort of a ceiling for the rise of contributions should be adopted. So far, agreement exists for the years 2011–2014, during which the contribution level will be raised by 0.4 percentage points annually. At the moment the Finnish pension scheme is in a situation where private sector TyEL expenditures exceed the premium income (see Figure 8).

Figure 8: TyEL expenditure and contribution percentage in the years 2009–2075, in % of wages



Source: Uusitalo Hannu, 2011.

Pension funding alleviates the pressures to raise pension contributions with the ageing of the population and equalises the intergenerational income distribution. Investment returns play a key role in covering the difference between expenditure and contributions to avoid the risk of a sustainability gap.

The long-term pension contribution projections are based on to the real return assumption of 4%. In principle, if this level is not reached, the contributions must be raised or benefits need to be cut. 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).

The crisis did not have any immediate impact on pension levels. The possible impact is more indirect, based on the general development of the economy affecting, thus, the length of working careers. However, it seems that the labour market situation is beginning to return to "normal" (see 2.1) and, if the individual's unemployment period was short-term, it does not have a very big influence on the total pension.

2.2.5 Critical assessment of reforms, discussions and research carried out

Employment is a vital factor in view of the adequacy of pension provision. Since the beginning of the EU's open method of coordination process, Finland has continually reported that the risk of poverty for those relying solely on the national pension is a challenge, despite adjustments and increases of national pensions during the last years. However, the income of pensioners can be considered to be reasonable compared to the situation of some other population groups. The risk of poverty is greatest amongst ageing women in receipt of a national pension, whose working career has been short or there has not been any working career. This challenge linked to the income of pensioners with small pensions will partly be addressed by the reform regarding the guaranteed pension. Despite its importance, it remains to be seen what the real effect on the relative poverty rate will be. According to National Social Insurance Institution, about 120,000 are entitled to pension and 65% of those are women.

At the moment, a growing challenge is the population of young people, who after school do not take up studies and remain unemployed and will be unqualified for future jobs. These are decisive factors for future pension levels signalling the risk of being poor over an entire life cycle. If people cannot enter the labour market, they will never get any other pension than the basic minimum pension. When unemployment and income problems become a long-term issue, it is increasingly difficult to break the cycle of social exclusion, especially by means of pension policy.

The large number of people receiving disability pensions remains one of the main challenges for the sustainability of the Finnish pension system. Mental health problems are having a detrimental effect on the working capabilities of young Finns. According to a recent study, five young people retire every day due to mental health problems.[20] The study reveals that 2,612 people aged under 30 retired on a disability pension in 2009. Around 75% of them took retirement because of mental health problems. The Social Insurance Institution of Finland

[20] RAITASALO RAIMO, MAANIEMI KAARLO (2011), Nuorten mielenterveyden häiriöiden aiheuttamat sairauspoissaolot ja työkyvyttömyys vuosina 2004–2009 (Sickness Absences and Disability due to Young Persons' Mental Health Disturbances in 2004–2009), Net Working Papers Helsinki, retrieved on 05 May 2011 from: https://helda.helsinki.fi/bitstream/handle/10138/25936/Nettityopapereita23.pdf?sequence=4.

(Kela) compensated persons under the age of 30 for close to 860,000 sick days due to mental health problems in 2009, with an increase of about 37% compared to 2004. The biggest increase has been amongst young men from 16 to 19 years of age. A total of over 430,000 sick days were granted due to depression. Depression-related mental health problems have continued to rise for those under the age of 30, whereas for over 30-year-olds the trend is declining. The biggest increase since 2004 has been among young men and women between 25 to 29 years of age.

Over the past 15 years, a series of policy reforms have been introduced to reduce the widespread use of early exit pathways. A recent study which analysed the reforms established in unemployment pension, disability pension and part-time pension during 1997-2003 implies that these reforms have jointly raised the average age at which older workers leave employment by only 3.9 months. This increase is mainly due to a sharp drop in disability pension enrolment from age 58 upwards and to a lower incidence of unemployment at younger ages.[21]

The study did not cover the large 2005 pension reform and the other more recent reforms. The researcher's own estimate (HS 2010) is that, if these would be taken into account as well, the effect could be around 6 months and the rest of the total 9-10 months increase in effective retirement age during the years 1997-2009 would be explained by employment growth and economic development. Previously, according to Hakola and Määttänen[22], with an ex ante estimate, the 2005 reform as a whole will postpone labour market withdrawals by slightly more than half a year.

Current developments have been more encouraging though. However, considering these research results and the projections of expected effective retirement age (shown in Figure 5), it seems that the common goal of raising the effective retirement age by three years by 2025 is still far way. Substantial changes to the pension system can, thus, be expected for reaching the target. According to the OECD, in addition to improving working conditions, complementary structural reforms are needed. These would include abolishing the 'unemployment tunnel' and early retirement at the age of 62, as well as increasing the lower pension age to 65.[23]

The citizens' opinions about and confidence in the pension schemes are investigated from time to time by questionnaire surveys. The latest such survey was carried out at the end of 2010.[24] Compared with earlier surveys, the citizens' pessimism in retaining their own pension entitlements has increased. A markedly larger proportion (57%) of people believes that their pension benefits will be weakened compared with the previous survey of 2007 (45%). A narrow majority (53%) believe that there will be a reform in the next ten years that will reduce the pensions from the present level. In respect of financing sustainability, 50% think that there will be enough money to pay their pensions, although the pension benefits remain at the present level. According to the poll, the convenient retirement age would be 63, an increase of

[21] KYYRÄ TOMI (2010), Early Retirement Policy in the Presence of Competing Exit Pathways: Evidence from Policy Reforms in Finland, Government Institute for Economic Research Working Papers 17, October 2010, Helsinki, retrieved on 03 May 2011 from: http://www.vatt.fi/file/vatt_publication_pdf/wp17.pdf.

[22] HAKOLA TUULIA, MÄÄTTÄNEN NIKU (2007), Vuoden 2005 eläkeuudistuksen vaikutus eläkkeelle siirtymiseen ja eläkkeisiin "The Effects of the Pension Reform in 2005 on Transitions to Retirement and Pension Benefits", Report 2007:1, The Finnish Centre for Pensions, Helsinki.

[23] OECD, ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (2010), Increasing the Effective Retirement Age in Finland – Report by the OECD to the Prime Minister of Finland, Directorate of Employment, Labour and Social Affairs, Paris, retrieved on 05 May 2010 from: http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2010/oecd-elakearvio-08032010/fi.pdf.

[24] TELA, THE FINNISH PENSION ALLIANCE, TNS GALLUP (2010), Työeläkeasenteet 2010, Helsinki, retrieved on 05 May 2011 from: http://www.tela.fi/data/userpdf/Tyoelakeasenteet_2010.pdf.

1 year compared to the 2007 survey and 3 years more compared to results in 1998. This development shows evidence of the mental change and willingness to retire later.

2.3 Health Care

2.3.1 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.[25] Each municipality has the responsibility to organise adequate health services for their permanent residents. Municipalities have the right to levy taxes. They cover the costs of health 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 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.[26]

There also exists a third system for the provision of health services: occupational health care. Employers are obliged to provide preventive health 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.[27]

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 Finnish government working from spring 2007 to spring 2011 has stressed the development of primary health care and the possibilities of citizens to choose services.

Public primary and specialised health services could be delivered only by municipal organisations until 1993, when municipalities were given the freedom to buy services from

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[25] 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.

[26] 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.

[27] TYÖTERVEYSHUOLTOLAKI 21.12.2001/1383. Occupational Health Care Act. December 2001, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2001/20011383.

private providers.[28] Contracts between private companies and municipalities were uncommon until the beginning of the 2000s.

During the early 2000s, young physicians were interested in flexible contracts and working in the private sector and municipalities had problems to recruit primary care physicians, which led to an increasing amount of contracts between municipalities and private companies in medical services. Discussions about high expenditure in the public health sector and possibilities of municipalities to buy services from private companies led to several kinds of reforms in primary health care during the early 2000s. In some towns, internal purchaser-provider models were integrated into the management processes by separating the functions of purchasing and care delivery within the municipal administration. Primary health services and social services were integrated in some towns and municipalities. Some municipalities made contracts with private companies to deliver all primary care services or certain services, like emergency services.

Some tasks of physicians were given to nurses. This change, together with the shortage of physicians, led to a decrease in the number of visits to health centre physicians during the 2000s, while the number of visits to other workers in health centres increased.[29]

It seems that the shortage of physician is not as great any more as it was in the early 2000s. In October 2009, 26% of the population lived in regions, where all vacancies of primary care physicians were occupied. 7% of the population lived in regions, where over 20% of vacancies were unoccupied. The greatest shortage was in the north-eastern parts of the country.[30]

Long waiting times were a problem in primary health care during the early 2000s. These shortcomings led to legislation concerning access to health care in 2005, according to which health centres are required to ensure immediate contact with a nurse or a physician during working hours either by telephone or by a personal visit. In non-urgent cases, a visit to a health centre must be organised within three working days after the first contact of the patient.[31]

Statistics show that there are some problems to get contacts to health centres. In October 2009, over half of the population lived in primary health care regions where there existed occasional problems to get immediate telephone contacts to health centres. Assessments of need for care were usually made in due time (within 3 days) from 2005 onwards. In October 2009, every third inhabitant lived in regions, where visits to health centre physicians were provided within two weeks.[32]

A service voucher policy was introduced by the Parliament in 2004. At the beginning, it concerned mainly long-term services but the programme was extended in 2009 to include

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[28] LAKI KILPAILUNRAJOITUKSISTA 27.5.1992/480. Act on Competition Restrictions. May 1992, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1992/19920480.

[29] PERUSPALVELUJEN TILARAPORTTI 2010. Basic services in 2010. Ministry of Finance publications 12/2010. http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf.

[30] Ibid.

[31] LAKI KANSANTERVEYSLAIN MUUTTAMISESTA 17.9.2004/855, "Hoitotakuulaki". Access Legislation. September 2004, retrieved from: http://www.finlex.fi/fi/laki/alkup/2004/20040855.

[32] See PERUSPALVELUJEN TILARAPORTTI 2010. Basic services in 2010. Ministry of Finance publications 12/2010. http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf.

several kinds of social and health services.[33] Clients and patients select whether they use a voucher and which provider they use. Municipalities determine the economic value of the service vouchers they offer. In 2010, vouchers were mainly used to provide long-term services.[34]

In February 2007, the Parliament introduced an act, according to which primary health care services and closely related social welfare services must be delivered in health centre regions covering at least 20,000 inhabitants.[35] To achieve this minimum, municipalities with less than 20,000 residents must either merge with neighbouring municipalities or form collaborative areas which provide services. A transition period is allowed to municipalities until the beginning of 2013. In 2010, the number of municipalities was 342.[36] The picture of the expected development of the reform process by 2013 is still incomplete. According to the plans made by municipalities, the final number of municipal actors organising primary health care services and closely related social welfare services will be between 120 and 125 in 2013.[37]

In 2007, the government set three large policy programmes consisting of cooperation of several ministries for the period 2007–2011. A programme to promote health was one of the programmes.[38] In 2010, the assessment made by the National Audit Office about the achievements of this large programme showed that cooperation between the ministries had strengthened and the programme had raised important topics for general discussion.[39]

The "Effective Health Centre" project, launched by the Ministry of Social Affairs and Health in 2008, belongs to the national projects, the aims of which were to develop the quality of primary health care. The project continued in 2010 and several seminars and meetings of the actors from the state, municipalities, universities and other organisations were held.[40]

Previous studies showed that socio-economic and regional differences in health, morbidity, disability and mortality increased from the 1990s onwards. In 2008, the Ministry of Social

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[33] LAKI SOSIAALI- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. Service Voucher Legislation. July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569.

[34] KSITYINEN PALVELUTUOTANTO SOSIAALI- JA TERVEYDENHUOLLOSSA. Private Social Welfare and Health Services. Suomen Virallinen Tilasto, Sosiaaliturva. Helsinki: National Institute for Health and Welfare. www.thl.fi/yksityinenpalvelutuotanto.

[35] LAKI KUNTA- JA PALVELURAKENNEUUDISTUKSESTA 9.2.2007/169. Act about Restructuring Municipalities and Services. February 2007, retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2008/?_offset=2.

[36] KUNNAT. Municipalities. Suomen kuntaliitto 10.6.2010. Retrieved from: http://www.kuntaportaali.org/k_etusivu.asp?path=1.

[37] KOKKO S, HEINÄMÄKI L, TYNKKYNEN L-K, HAVERINEN R, KASKISAARI M, MUURI A, PEKURINEN M, TAMMELIN M. Kunta- ja palvelurakenneuudistuksen toteutuminen. Kuntakysely sosiaali- ja terveyspalvelujen järjestämisen ja tuottamisen ratkaisuista 2009–2013. Implementing the Finnish Act on Restructuring Local Government and Services. Survey of Municipal Solutions in Organising and Providing Social and Health Services in 2009–2013. National Institute for Health and Welfare. Raportti 36/2009. Retrieved from: http://www.thl.fi/thl-client/pdfs/eaf43d23-6dd0-4e42-b4f6-5b8243c3386e.

[38] TERVEYDEN EDISTÄMISEN POLITIIKKAOHJELMA. Policy Programme for Health Promotion. Ministry of Social Affairs and Health. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/terveyden_edistamisen_politiikkaohjelma.

[39] POLITIIKKAOHJELMAT OHJAUSKEINONA – Esimerkkinä Terveyden edistämisen ohjelma. Policy Programmes as Means for Guidance. Valtiotalouden tarkastusviraston tuloksellisuuskertomus 212/2010. Retrieved from: http://www.vtv.fi/files/2360/Netti_212_2010.pdf.

[40] TOIMIVA TERVEYSKESKUS-TOIMENPIDEOHJELMA. Effective Health Centres - Programme. Ministry of Social Affairs and Health. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/toimivaterveyskeskus.

Welfare and Health launched a project called "Health 2015 – Public Health Programme" in order to increase the amount of healthy years of life and to decrease the mentioned differences. This project continued in 2010.[41]

A large national project, launched by the Ministry of Social Affairs and Health in 2008, the "Kaste" Programme (the National Development Programme for Social Welfare and Health Care, 2008–2011) was continued in 2010. The funds of about EUR 25 million were provided for the development of projects within the programme in 2010.[42] Two assessments of the programme were published in 2010. They showed that the programme has strengthened the guidance of health care by information and increased discussions between municipal authorities and practical workers. Positive outcomes of the assessments resulted in the planning of a similar programme, which will be implemented from 2012 onwards.[43]

The "Masto" Programme was launched in 2007, with the aim to prevent a decline in working abilities caused by depressive disorders. The programme consisted of four parts: 1. promotion of mental health and wellbeing at work; 2. prevention of depressive disorders; 3. early diagnosis and treatment of depressive disorders; and 4. rehabilitation of persons recovering from depressive disorders and supporting these persons in returning to work.[44] Altogether, 20 projects were carried out during the programme (2007–2011). The development of treatment of depressive disorders in primary health care and occupational health care, further education of occupational health care personnel about mental health and treatment of psychiatric disorders, and the development of good practices to support recovering persons in returning to work are examples of projects. Sick leave and disability pensions caused by depressive disorders decreased during the period 2008–2010. At the end of 2010, a total of 38,200 persons received disability pensions due to depressive disorders, which represents 14% of all disability pensions.[45]

An act to give permission to nurses with special training to prescribe certain medications was passed in Parliament in 2010.[46] The training programmes for nurses were planned in order to launch them at the beginning of 2011, when the act took effect. It seems that the training will take time, and the trained nurses will be able to take up this task in 2012.

In specialised health care, central hospitals provide services to the residents of the municipalities which belong to the federation of the hospital district concerned. The coverage of hospital districts varies from 65,000 to 1.4 million inhabitants, and the amount of member

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41 TERVEYS 2015 –KANSANTERVEYSOHJELMA. Health 2015 – Public Health Programme. Ministry of Social Affairs and Health. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/terveys2015.

42 SOSIAALI- JA TERVEYDENHUOLLON KANSALLINEN KEHITTÄMISOHJELMA. KASTE-ohjelma 2008–2011. National Development Programme for Social Welfare and Health Care. Ministry of Social Affairs and Health. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/kaste.

43 VIRTANEN P. Kaste-ohjelman arviointi. Kehittämisprosessien tuomio vai tuki? Kaste syystapaaminen Helsinki 1.10.2009. Assesment of Kaste-Programme. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=319339&name=DLFE-10102.pdf.

44 MASTO-HANKE MASENNUSPERÄISEN TYÖKYVYTTÖMYYDEN VÄHENTÄMISEKSI. Project to Reduce Depression-Related Work Disability. Ministry of Social Affairs and Health. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/masto.

45 MINISTRY OF SOCIAL AFFAIRS AND HEALTH, Masto-hankkeen loppuraportti 15.2.2011. Assessment of Masto-Programme. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=2872962&name=DLFE-15344.pdf.

46 LAKI SAIRAANHOITAJIEN RAJATUSTA LÄÄKKEENMÄÄRÄMISOIKEUDESTA 2.12.2010/1088. Act on Prescriptions by Nurses. Retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2010/20100148.pdf.

municipalities varies from six to 58.[47] A complete set of specialist health services is provided in nearly all hospitals, although the trend is to centralise some expensive, highly specialised treatments to certain central university hospitals. Patients are referred to central hospitals by health centre physicians, private physicians or occupational health physicians.

According to legislation of the year 2005 concerning access to health care, the need for treatment of patients referred to central hospitals must be assessed within three weeks. In non-urgent cases, hospitals must provide treatment within six months of the assessment. Assessments of need for treatment were made commonly in due periods, and the number of patients waiting for treatments for a long period decreased by 58% from 2007 to 2009. Regional differences in waiting periods narrowed.[48]

The productivity of specialised health care measured by treatment episodes increased by 7% during the period from 2003 to 2007. The expenditures to hospitals increased by 13% during the same period. The increase in costs was greater than the increase in production.[49]

More patients in specialised health care are nowadays treated in open care, compared to previous years. The number of open care visits increased by 20% and the number of treatment days in hospitals increased by 17% during the period from 2000 to 2008.[50]

Regional differences in expenditures for health care and care of the elderly are quite great. Calculated per inhabitant, municipalities in the Kainuu region (North-eastern Finland) use the smallest amount for these services, and municipalities in the capital area, Western Coast and Northern Finland use the greatest amount.[51]

A Comprehensive Health Care Act was passed in Parliament in 2010, and the act took effect at the beginning of May 2011. 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 of the act is to reinforce the role of primary care. The key features of the act are 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; 4. to centralise the organisational responsibility of ambulance and emergency services; and 5. 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.[52]

The status of citizens is strengthened in the new Health Care Act. The citizens' possibilities to choose health care services are increased by enabling citizens to visit any health centre in their

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47 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.

48 PERUSPALVELUJEN TILARAPORTTI 2010. Basic services in 2010. Ministry of Finance publications 12/2010. http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf.

49 Ibid.

50 Ibid.

51 SUURIMMAT TERVEYSMENOT PÄÄKAUPUNKISEUDULLA, PIENIMMÄT KAINUUSSA. Expenditure on Health Services. National Institute for Health and Welfare, 2010. Retrieved from: http://www.thl.fi/fi_FI/web/fi/tiedote?id=22091.

52 TERVEYDENHUOLTOLAKI 30.12.2010/1326. Health Care Act. Retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2010/20101326.

hospital district. Patients, together with their physicians, have the right to choose any hospital in the tertiary care region (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.[53]

The municipalities belonging to a certain central hospital district have to prepare a plan for organising primary health care in the district. A unit of primary health care must be founded in every central hospital (hospital district), and units have to participate in preparing these plans. Cooperation between health care and social care and promotion of health and wellbeing of the population are stressed in the act.[54]

As mentioned, private companies provide primary care and specialised health services. In 2007, the number of private providers was 3,730, and the number of health care units owned by these providers was 6,800. The number of private providers increased by 1,500 from 1996 to 2007. Physiotherapy services were the most common services provided by private companies; the number of units was 1,700 in 2007. Private physicians comprised the second biggest group (1,560 units) and occupational health care the third one (700). The biggest increase in the number of units during the 2000s was in the sector of private physicians' services.[55]

The proportion of private provision in health care measured as the number of workers was 19.4% in 2007. In health care, 4.2% of personnel worked in private organisations owned by non-governmental organisations, and 15.3% worked in other private companies. The proportion of private provision measured by the number of workers increased by 3% during 2000–2007. The majority of personnel in private companies work in the southern part of the country. About half of the workers in the private sector work in medical services.[56]

2.3.2 Debates and political discourse

Ageing of the population, financial problems of municipalities and differences in user groups of health services are some of the causes for discussion about the future of the health care system consisting of three models to deliver services and of many channels to finance services. Two reports about the structure of the health care system and financing services with proposals to reform the system were published in 2010.

In June 2010, the Finnish Innovation Fund published a proposal for structuring and financing primary and specialised health care and care of the elderly (long-term care). The responsibility of citizens to promote their health is stressed in the proposal, and the proposed model gives everybody the freedom to choose health services. Orders of services are proposed to be separated from producers of services, and producers should have the freedom to compete with each others using predetermined (fixed) prices. Payments to producers are based on health risks and illnesses of customers and on the success of health promotion. Services are proposed to be financed through one national channel, which connects current

[53] Ibid.
[54] Ibid.
[55] YKSITYINEN PALVELUTUOTANTO SOSIAALI- JA TERVEYDENHUOLLOSSA. Private Social Welfare and Health Services. Suomen Virallinen Tilasto, Sosiaaliturva. Helsinki: National Institute for Health and Welfare. www.thl.fi/yksityinenpalvelutuotanto.
[56] Ibid.

state subsidies, municipal taxes, health insurance payments and payments of employers used nowadays in the financing of health services.[57]

In November 2010, the expert group of the National Institute of Health and Welfare published its report about advantages, disadvantages and developmental needs in the financing of social and health care via a multichannel model. Two kinds of proposals were considered: 1. a total reform of the financing system; and 2. reforms on the fringes of various financing channels of the current multichannel model. The need for a total reform was stressed. A total reform was proposed to be achieved by regional experimental development projects, during which reforms on the fringes should be made in order to minimise the disadvantages of the current model. The goal of the proposed reform is to pass the responsibility for provision and financing of all social welfare and health services onto regional organisations consisting of at least 200,000 inhabitants. The current public funds should be gathered within these regional organisations (12 to 15 in the country), which are responsible for providing and financing social welfare and health care services to inhabitants in the region. The current model to finance private health services and occupational health care are proposed to be withdrawn. Preventive services in occupational care are proposed to be increased in order to increase the length of working years. Citizens would have the possibility to select the producer of services, and the regional organisation would be responsible for expenditure on services. Producers consist of organisations in public sector, private companies and units of occupational health care. The freedom to choose would be carried out through service vouchers or contracts between a financier and a producer. The model would increase the equality of both citizens and producers of services. It would help the integration of private and occupational health services to the production of services. The reform would change the health care system towards the systems in other European countries.[58]

A proposal to establish social companies was made by a working in the Ministry of Employment and Economy, which considered possibilities to develop new models to produce social welfare and health services.[59]

The increase in differences in health and income of citizens and the future of social and health policy in a welfare state have been discussed quite widely. One example is a seminar organised the Social Insurance Institution of Finland at the end of 2009 and the report of the seminar published in 2010. Three international researchers were asked to give answers to specific questions about possibilities for future development in health care and their effects on welfare and equality of the population. Three possible ways to continue were discussed in the report.[60]

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[57] ARONKYTÖ T, HALLIPELTO A, KANGASHARJU A. Uusi terveydenhoidon rahoitus- ja ohjausjärjestelmä. A New System to Finance Health Care. Sitran selvityksiä 24. Sitra 2010. Retrieved from: http://www.sitra.fi/julkaisut/Selvityksiä-sarja/Selvityksiä%2024.pdf?download=Lataa+pdf.

[58] PEKURINEN M, ERHOLA M, HÄKKINEN U, JONSSON PM, KESKIMÄKI I, KOKKO S, KÄRKKÄINEN J, WIDSTRÖM E, VUORENKOSKI L. Sosiaali- ja terveydenhuollon monikanavaisen rahoituksen edut, haitat ja kehittämistarpeet. Multichannel System to Finance Health Care. THL 2010. Retrieved from: http://www.thl.fi/thl-client/pdfs/0fde485f-a347-40de-96b7-7e77656276bb.

[59] YHTEISKUNNALLISEN YRITYKSEN TOIMINTAMALLI TULEVAN HALLITUKSEN TYÖLISTALLE. Social Companies. National Institute for Health and Welfare, 2011. Retrieved from: http://www.thl.fi/fi_FI/web/fi/uutinen?id=24363.

[60] HIILAMO H, KANGAS O, MANDERBACKA K, MATTILA-WIRO P, NIEMELÄ M, VUORENKOSKI L. Hyvinvoinnin turvaamisen rajat. Näköaloja talouskriisiin ja hyvinvointivaltion kehitykseen Suomessa. Limits to Secure the Welfare State. Views towards the economic crisis and the development of the welfare state in Finland. Kela 2010, 48 p. Retrieved from: http://hdl.handle.net/10138/17612.

The first way to continue was called the model of withering public health care. It included the idea that no changes will be made in the current health care system and in its financing model. If no changes are made, economic problems in municipalities may cause problems to finance and provide public health services. Specialised health care may take a majority of economic municipal resources. The number of primary care services may decrease, and the quality of services may worsen. These may lead to an increase in the usage of private services by richer people. Employees continue to use occupational health services. Unemployed and poor people continue to use public primary health care. Health care workers may not be interested in working in withering primary health care, which further may decrease the quality of primary care services.[61]

A starting point for the second model is a possible change to two financing models of health care. When economic problems in municipalities lead to withering public health services, the existing system may be replaced by a two-way financing system: 1. private insurances and 2. taxes. Private health insurances may cover both open and hospital care and their costs depend on the coverage of insurance. Inhabitants whose economic resources are good may take insurance and use private health services covered by insurance. Unemployed and poor inhabitants would continue to use public services provided by municipalities and financed by taxes. Inequality between population groups may increase.[62]

The international experts stressed that the equality of the population in health care will be achieved by a total change in the model to finance health care. There is a possibility to provide an adequate amount of high-quality health services for all if the three-channel model is replaced by a one-channel model and if economic resources for health care to municipalities are given based on the health care needs of the population.[63]

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 services and the discrepancy between the welfare state model to provide services and the market model. The forum to minimise the number of poor people and to integrate poor and marginalised people into society was carried out by debates about different aspects of poverty and marginalisation in the media. The activities in the Year Against Poverty were coordinated by the National Institute of Health and Wellbeing.[64]

The National Programme 2010 includes only a few sentences about health policies. They cover the following aspects: an extensive service system safeguards free or reasonably priced services for all, public social welfare and health services are highly significant for low-income households, legislation on social welfare and health services is currently being reformed with the intention of safeguarding the effectiveness of the service system. A particular effort will

[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] EUROOPAN KÖYHYYDEN JA SOSIAALISEN SYRJÄYTYMISEN TORJUNNAN TEEMAVUOSI 2010. 2010: European Year for Combating Poverty and Social Exclusion. National Institute for Health and Welfare, 2010. Retrieved from: http://www.thl.fi/fi_FI/web/fi/uutinen?id=24363; Europe 2020 Strategy. Finland's National Programme 2010. Ministry of Finance publications 14c/2011. Retrieved from: http://ec.europa.eu/europe2020/pdf/nrp/nrp_finland_en.pdf.

be made to support low-income and needy citizens, and the narrowing of differences in health and wellbeing is a long-term endeavour.[65]

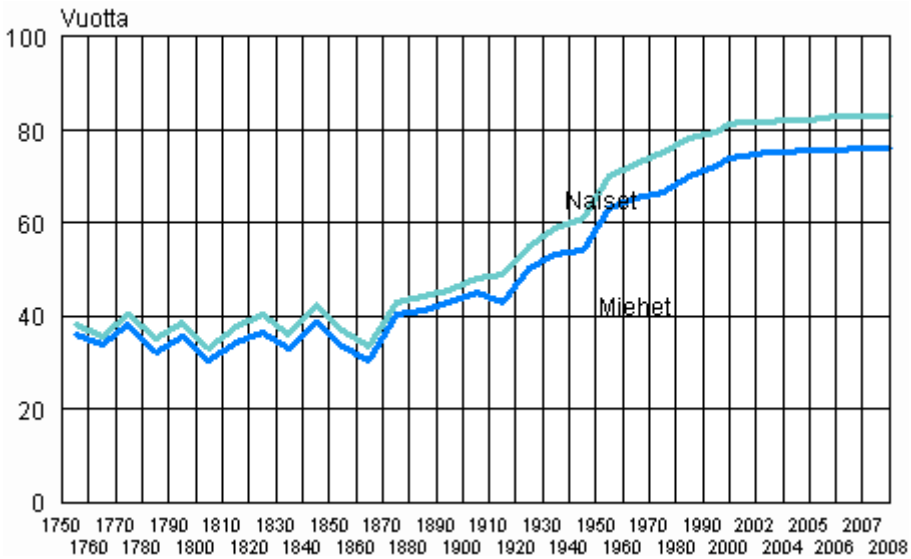
No official planning group for activities in 2012, the European Year of Active Ageing, is set. However, an unofficial group consisting of some active persons in the Ministry of Social Affairs and Health is working towards making preliminary plans.[66]

2.3.4 Impact assessment

The effects of health 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 exists 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.

Mortality among the total population has decreased during the previous 50–60 years. The decrease is evident also among those aged 65 years and over, and the average life expectancy has increased in both the total and the older population (Figure 9 and 10) [34]

Figure 9: Average length of life (vuotta=years) in Finnish women (naiset) and men (miehet) from 1750 to 2008.



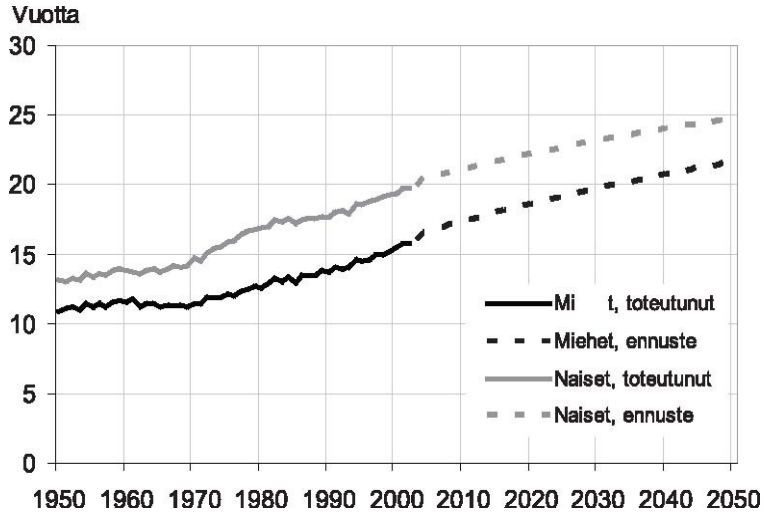
Source: Eläketurvan kehitysnäkymiä. Development Views of the Retirement Plan. Tilastokeskus 2010. Retrieved from: http://www.etk.fi/Binary.aspx?Section=45538&Item=59855

The development of health in the total Finnish population has been positive. The proportion of the adult population without chronic disease and of adults perceiving health to be good are higher in 2004 than in 1996. A similar trend has continued from 2004 onwards up to 2009 in the total population, and especially among those aged 55 to 65 years or 65 years or over. However, the inequality in health related to socio-economic status has increased during the period from 2004 to 2009. Health measured by the occurrence of chronic diseases or by self-perceived health has worsened among the population belonging to the lowest income levels

[65] EUROPE 2020 STRATEGY. Finland's National Programme 2010. Ministry of Finance publications 14c/2011. Retrieved from: http://ec.europa.eu/europe2020/pdf/nrp/nrp_finland_en.pdf.
[66] VOUTILAINEN PÄIVI 27.4.2011, an email report.

(Table 1 and 2). The difference in health between the population belonging to the lowest income levels and those belonging to the two highest levels of income has widened.[67]

Figure 10: Average length of life(vuotta=years) in Finnish women (naiset) and men (miehet) aged 65 years or over from 1950 to 2009, and projections to 2050



Source: Eläketurvan kehitysnäkymiä. Development Views of the Retirement Plan. Tilastokeskus 2010. Retrieved from: http://www.etk.fi/Binary.aspx?Section=45538&Item=59855

Table 1: Proportion of inhabitants (18 yrs.+) who suffer from a chronic disease, by level of income and year

Level of income	2004 %	2006 %	2009 %
Lowest 1	36.7	34.8	37.8
2	36.8	34.6	29.6
3	32.1	32.2	28.9
4	31.6	30.3	26.4
Highest 5	28.9	25.8	22.3
All	33.2	31.5	29.0

Source: Klavus, National Institute for Health and Welfare, 2010

[67] KLAVUS J. Suomalaisten terveys, terveyspalvelujen käyttö ja kokemukset palveluista. Health, Use of Health Services and Opinions about Services .In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Wellbeing in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 28–43. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

Table 2: Proportion (%) inhabitants (18 yrs.+) who perceive their health to be "good", by level of income and year

Level of income	2006 %	2009 %
Lowest 1	66.3	63.3
2	66.4	72.0
3	70.3	70.4
4	71.2	75.3
Highest 5	76.8	80.0
All	70.2	72.2

Source: Klavus, National Institute for Health and Welfare, 2010

The differences between socio-economic groups are evident also in the use of health care services in 2009. The majority of visitors to health centre physicians belong to the three lowest levels of income, while the visits to occupational health care and private physicians are the more frequent the higher the income level of the family (Table 3).[68]

Table 3: Proportion of inhabitants (18 yrs.+) visiting a physician in 2009, by level of income

Level of income	Health centre %	Occupational health care %	Private physician %
Lowest 1	46.5	9.8	18.1
2	43.5	18.4	19.9
3	35.8	28.2	25.7
4	36.3	29.2	23.4
Highest 5	30.1	30.4	29.0
Visits per inhabitant	1.0	1.7	0.5

Source: Klavus, National Institute for Health and Welfare, 2010

Finns are quite satisfied with the quality of public health services. In 2009, the quality was assessed as excellent by 12% of the population, and as good by 42%. Satisfaction with private health services was somewhat better: 24% of the population assessed private services as excellent, and 37% as good. The longitudinal data from 2004 to 2009 show that the inhabitants think that nowadays there is less need to develop health services than in 2004 (Table 4). Care of the elderly is the only exception. The access to primary care and specialised health services is nowadays better than at the beginning of the 2000s (Table 5). Occupational

[68] Ibid.

health care services are the only exception. The development process seems to have had a positive impact on the customer level.

Table 4: Proportion of inhabitants, who have given positive answers to certain questions about needs to develop health services, by year of interview

Development need	2004	2009
	%	%
Shorten access to physicians	82	69
Shorten access to treatments in hospitals	86	68
Develop primary health care services	78	68
Develop special health care services in hospitals	67	54
Develop care of the elderly	67	70

Source: Klavus, National Institute for Health and Welfare, 2010

Table 5: Proportion of inhabitants with excessive waiting period for a health service, by service and year of interview

Service	2004	2006	2009
	%	%	%
Health centre physician	55	46	44
Policlinic in hospital	32	34	23
Operation in hospital	32	34	27
Health centre dentist	17	24	20
Occupational health care physician	6	5	12
Private physician	5	4	6

Source: Klavus, National Institute for Health and Welfare, 2010

Although the amount of private social welfare and health care services has increased, the Finnish population gives support to the public care sector. According to an interview study, 60% of the population says that the public sector should produce all social and health care services. 30% thinks that the public sector should produce the majority of the services, but the amount of private services should be increased.[69]

Finns do not want to save expenditure on social welfare and health care services. Only 15% of inhabitants and 15% of policymakers consider that savings in the sector of social welfare and health care services should be the target of savings in municipalities. More savings should be targeted to the sectors of children's day care, schools and education, and income support[70]

The legislation ensures primary and specialised health services to every citizen. Each municipality has the responsibility to provide health services to persons residing in the region of the municipality. All citizens or citizen groups are covered by the health system. However, as mentioned above, the users of the three systems differ from each other.

The financial and economic crisis has had no strong negative effect on the access and the provision of health care services. Access to primary health care and to specialised health care improved in the period 2004–2009, and access to preventative services has been good, as described previously.[71]

The effectiveness of hospital treatment improved in the 2000s, but great regional differences are still evident. An example is the improvement of the treatment of heart attack patients.[72]

The health care system seems to be sustainable in terms of health care personnel. Physicians and nurses have not emigrated to foreign countries in greater amounts. However, the ageing of the population increases the demand for health services. The number of workers in health care per 1,000 inhabitants increased during the 2000s. In 2009, 61% of the personnel in health care worked in specialised health care, and 39% worked in primary care.[73] The number of workers in social and health care with a foreign background doubled from 2000 to 2007, but their number is still small (N=about 10,000 in 2008). Two thirds of these workers were citizens of Finland, and one third had foreign citizenship. The majority of workers with foreign citizenship worked as physicians, cleaners or helpers in kitchens. The number of Finnish physicians working abroad is very similar (N=880 in 2008) to the number of foreign physicians working in Finland (N=870 in 2008). The number of Finnish nurses working abroad (N=3,800 in 2008) is bigger than that of foreign nurses working in Finland (N=950 in 2008). The majority of workers with an education in social and health care work in Sweden.

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69 MUURI A, MANDERBACKA K. Hyvinvointivaltion kannatusperusta. Opinions about the Welfare State. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Wellbeing in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 96–111.Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

70 KANSALAISMIELIPIDE JA KUNNAT. ILMAPUNTARI 2010–2011. Opinions of Citizens about Municipalities. Kunnallisalan kehittämissäätiön Polemia-sarjan julkaisu nro 79 Retrieved from: http://www.kaks.fi/sites/default/files/Polemia_79_net_0.pdf.

71 PERUSPALVELUJEN TILARAPORTTI 2010. Basic services in 2010. Ministry of Finance publications 12/2010. http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf.

72 Ibid.

73 KUNTIEN TERVEYS- JA SOSIAALIPALVELUJEN HENKILÖSTÖ 2009. Personnel in Social Welfare and Health Services in 2009. National Institute for Health and Welfare. Tilastoraportti 28/2010. Retrieved from: http://www.stakes.fi/tilastot/tilastotiedotteet/2010/Tr28_10.pdf.

About half of the Finnish workers leaving the country move back to Finland within one year.[74]

2.3.5 Critical assessment of reforms, discussions and research carried out

The merging of municipalities in order to create bigger entities to organise primary care was 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 has not been easy to carry out. Not all municipalities have been eager to merge with each other or to form cooperative units. Political parties in the government have not been unanimous about the best structure of primary health care. In Northeastern Finland, a trial of a provincial model to organise primary health care services was implemented before the previous election in 2007. In this model, municipalities are independent and primary health care services are organised by their union called "the province". This trial has continued, and the Centre Party of Finland is the main supporter of this model to restructure primary health care. The National Coalition Party has supported mergers of municipalities with each other.

The New Comprehensive Health Care Act, which was passed in Parliament in 2010 and implemented in May 2011, opens the second phase in the structural development of the health care sector. The goals which are stressed in the act, namely to strengthen primary care, to develop cooperation between primary and specialised care and to develop cooperation between health and social welfare care, are important ones. Municipalities provide and finance both primary and specialised health care but their possibilities to control operations and expenditure on specialised health care, which is organised by federations of municipalities with their own administrations, are quite poor. Operations and effects of operations in specialised health care have not been analysed sufficiently to highlight inadequate operations. More studies about the effects of treatments and comparisons of operations, the difference in effects and costs between specialised health care districts were carried out during the 2000s. Their results can be used to show adequate and inadequate operations. The traditional opinion about a high status of specialised health care and a low status of primary care is common in the population and even in health care staff. Development of cooperation between primary and specialised care is not easy. Similarly, the traditional opinion about a high status of health care and a low status of social welfare care hinders cooperation between these two sectors. The new 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.

The advantages and disadvantages of the multichannel system to finance health services and the three ways to organise services were discussed in 2010, and proposals to restructure the system were made by researchers and other partners. The economic and financial crisis and ageing of the population decreased the sustainability of the current model. There is a need to restructure the financing model within the next few years in order to ensure access to services and equality of the population in receiving services.

Specialised and primary health care were originally implemented decades ago by acts which obliged municipalities to provide health services. At the beginning of the 2000s, services were

[74] SOSIAALI- JA TERVEYSPALVELUIDEN ULKOMAALAINEN HENKILÖSTÖ JA SUOMALAISET ULKOMAILLA. Foreign Workers in Social Welfare and Health Services. National Institute for Health and Welfare. Tilastoraportti 18/2010. Retrieved from: http://www.stakes.fi/tilastot/tilastotiedotteet/2010/Tr18_10.pdf.

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 change and restructuring of the system. Problems of employing physicians in some municipalities, the policy goal to increase possibilities to choose services, the increase in the number of private services, competition, the three systems to supply health services, several kinds of development programmes and the increase in differences in income levels within the population are probable backgrounds of the opinions of Finns about the ways to provide and finance health services. A great majority of Finns support public health services financed by taxes. The population seems to support the welfare state and the equality of citizens.[75] Their opinions do not strongly support the goal to increase competition in health care services. However, the proposals to restructure the system seem to combine the welfare state model with the market economy intelligently.

The increase in inequality of health between socio-economic groups is opposite to the goals of the government. The economic depression in the 1990s led to an increase in unemployment, and in spite of the rapid economic development during the early 2000s, long-term unemployment is common. Unemployment figures are high among all age groups, even in the young population. Problems in primary care were evident at the beginning of the 2000s. The government, however, put efforts into the maintenance of a high-quality special health care sector. The withering of public health care started in the 1990s and continued in the early 2000s. Operations to develop and save primary care services were started after the election in 2007, four years ago. The political support for primary care started in a later phase. The economic depression in the 1990s, the privatisation ideology amongst certain physicians at the beginning of the 2000s, problems in providing public primary care services and late support for primary care belong to the probable backgrounds of the increase in inequalities in health. Increasing the equality in health belongs to the most important goals in the health policy in the future. Many kinds of operations are needed to ensure health promotion, early detection of illnesses and good care of illnesses for the population belonging to the lowest socio-economic groups.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Somatic long-term care is separated from psychiatric long-term care and from care of the mentally disabled. The majority of persons receiving somatic long-term care services belong to an older (65yrs+) population. Thus, somatic long-term care and long-term care of the elderly are nearly synonyms. The following part of the report describes somatic long-term care, and the terms long-term care of the elderly and care of the elderly are used as synonyms for long-term care.

The main responsibility to provide long-term care of older persons lies within the social welfare service sector. A smaller proportion of long-term services are delivered as a part of primary health care. Municipalities are legally required to offer both social welfare and health care services for their residents. Social welfare and primary health care services may be delivered by separate organisations. The costs of long-term services are covered by municipal taxes, state subsidies and user fees.

[75] MUURI A, MANDERBACKA K. Hyvinvointivaltion kannatusperusta. Opinions about the Welfare State. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Wellbeing in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 96–111.Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

Long-term services include auxiliary home help, home help, home nursing, day centres, sheltered housing ("semi-open care"), comprehensive sheltered housing ("semi-open care"), group homes ("semi-open care"), nursing homes (institutional care), and long-term institutional care in health centre hospitals. Home care consists of a combination of auxiliary home help, home help and home nursing. Some municipalities have developed other forms of services, such as "hospital at home". Medical care in nursing homes is the responsibility of primary health care according to the Primary Health Care Act. The provision of medical care in sheltered housing, comprehensive sheltered housing and group homes is not determined by legislation.

Health centre hospitals and the majority of nursing homes are owned by municipalities. Sheltered housing and group homes were originally established in the 1980s by non-governmental, non-profit organisations, and municipalities purchased these services outside open competition. The foundation of private group homes and private comprehensive sheltered housing started in the 1990s, when municipalities were given the freedom to purchase services from private providers (1993). Open competition initiated by municipalities is common for providing sheltered housing, comprehensive sheltered housing, group home care, home help and auxiliary home help services for the elderly. Some companies deliver home nursing services in larger towns, but the provision of home nursing based on open competition is uncommon in rural areas. From the 1990s onwards, non-governmental organisations established companies to produce long-term services and to be able to take part in open competition.

With the developments that started in the 1990s, significant changes have taken place in the service structure delivery in long-term care of the elderly. A typical feature is a decline in the number of the elderly in long-term institutional care in hospitals and nursing homes and an increase in the number of the elderly living in different types of sheltered housing and group homes. This fact and the increase in purchasing "semi-open" services from the private sector are evident in the municipal expenditure on services for the elderly. The analysis of total expenditure on services for the elderly showed a gradual decrease in the proportion of expenditure accounted for long-term institutional care in hospitals and nursing homes since 1995. At the same time, expenditure on sheltered housing, comprehensive sheltered housing and group homes for the elderly nearly doubled. A particularly sharp rise is seen in expenditure on "semi-open" services purchased by municipalities from private service providers. The current publications show the development of expenditure until 2008. Expenditure on "semi-open" long-term care for the elderly purchased from the private sector increased in real terms each year since 1995, declined for the first time in 2006, and continued to fall in 2008, dropping by 1.4% on the previous year. These figures show that competition in providing long-term care has increased.[76]

The above changes were caused by the political goals. From the early 1990s onwards, the goal has been to reduce the proportion of the elderly living in long-term institutions (hospitals and nursing homes) and to increase the proportion living at home or in "semi-open" facilities. A change is evident. In 1995, 15.4% of the population aged 85 years or over lived in long-term institutions, while the corresponding proportion was 9.4% in 2007. During the same period, the proportion of the elderly living in sheltered housing and group homes increased, the

[76] TERVEYDENHUOLLON MENOT JA RAHOITUS V. 2008. Health Expenditure and Financing 2008. Suomen virallinen tilasto. Terveys 12/2010. Retrieved from: http://www.stakes.fi/tilastot/tilastotiedotteet/2010/Tr12_10.pdf.

proportion of the elderly receiving home help services decreased, and the proportion of the elderly in economically supported care by relatives increased.[77]

At the end of 2009, 42,802 elderly persons lived in nursing homes and comprehensive sheltered housing. Their mean age was 83 years. Females comprised 72.5% of these persons. At the end of 2008, about 8,800 persons aged 75 years or over were in long-term care in health centre hospitals. About 7,000 elderly persons lived in sheltered housing without 24-hour assistance.[78]

The number of the elderly in sheltered housing, comprehensive sheltered housing and group homes increased by about 20% during the period from 2003 to 2008. Private providers offered about half of these "semi-open" services in 2008. Companies owned by non-governmental organisations offered 65% of the "semi-open" services offered by all private providers.[79]

According to the political goal, 13–14% of persons aged 75 years or over should receive regular home care in 2012. The number of the elderly receiving home care increased steadily in the 2000s, especially among the population aged 85 years or over. However, the proportion of the elderly receiving home care decreased during the period from 2001 to 2008. In 2008, 11.2% of persons aged 75 years or over received home care. Current home care patients are more disabled than patients were at the beginning of the 2000s. A small increase happened in the amount of home care workers during the 2000s. However, monthly hours of home care per patient decreased. According to estimates, 6% of home care patients need long-term care in a "semi-open" facility.[80]

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.[81] In 2009, 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% in order to get home nursing or meals as auxiliary home help. Every third municipality which did not

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77 HEINOLA R, FINNE-SOVERI H, HEINOLA R, NORO A, KAUPPINEN S, KOSKINEN S, MARTELIN T, SAINIO P. Vanhusten kotiin annettavat palvelut ja omaishoidon palvelut. Home Care Services and Help from Family Members among the Elderly. In: Kauppinen S (ed.) Terveyden ja hyvinvoinnin laitoksen asiantuntijoiden arvioita peruspalvelujen tilasta. Peruspalveluiden tila-raportin tausta-aineisto. Assessments of Experts about Basic Services. National Institute for Health and Welfare, Raportti 9, Helsinki 2010, p. 34–43. Retrieved from: http://www.thl.fi/thl-client/pdfs/0f7be8e6-0385-46a0-902d-c2f3602193a0.

78 PALVELUASUMISEN JULKISEN RAHOITUKSEN LINJAUKSIA. Public Expenditure on Sheltered Housing. Ympäristöministeriön raportteja 1/2011. Retrieved from: http://www.ymparisto.fi/download.asp?contentid=124392&lan=fi.

79 YKSITYINEN PALVELUTUOTANTO SOSIAALI- JA TERVEYDENHUOLLOSSA. Private Social Welfare and Health Care Services. Suomen Virallinen Tilasto, Sosiaaliturva. Helsinki: National Institute for Health and Welfare. Retrieved from: www.thl.fi/yksityinenpalvelutuotanto.

80 PERUSPALVELUJEN TILARAPORTTI 2010. Basic Services in 2010. Ministry of Finance publications 12/2010. Retrieved from: http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf; SÄÄNNÖLLINEN KOTIHOITO. KOTIHOIDON LASKENTA 30.11.2009. Count of Regular Home-Care Clients, 30 November 2009. National Institute for Health and Welfare. Tilastoraportti 16/2010. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/toimivaterveyskeskus.

81 LAKI SOSIAALI- JA TERVEYDENHUOLLON PALVELUSETELISTÄ SEKÄ SOSIAALI- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. Service Voucher Legislation. July 2009. Retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569.

offer vouchers for these services aimed to include vouchers in their programmes in the future years.[82]

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.[83] However, due to the poor economy of many municipalities, the expansion of this kind of caring 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 was not yet received. In 2008, 4.1% of inhabitants aged 75 years received economically supported home care.[84]

Family members are the most important persons helping the disabled elderly who need help in their daily functions (Figure 11). This assistance is usually given without receiving any economic support from the municipality. Children and grandchildren are the most important helpers to 48%, the wife or husband to 14% and municipal home care to 18% of the elderly needing help. In addition, neighbours, volunteers and deacons give daily help to many old persons. Family members are the most important helpers in preparing meals and cleaning the 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 needing assistance. Family members help 86% of the elderly with shopping or other activities outside the home.[85]

Even old persons help their old family members, relatives or friends who need assistance. 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 for economically supported home care with municipalities.[86]

Non-governmental, not-for-profit organisations belong to the supporters of many older persons. They 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

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[82] YKSITYINEN PALVELUTUOTANTO SOSIAALI- JA TERVEYDENHUOLLOSSA. Private Social Welfare and Health Care Services. Suomen Virallinen Tilasto, Sosiaaliturva. Helsinki: National Institute for Health and Welfare. Retrieved from: www.thl.fi/yksityinenpalvelutuotanto.

[83] LAKI OMAISHOIDON TUESTA 2.12.2005/937. Act on Care Support by Relatives. Retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2005/20050937.

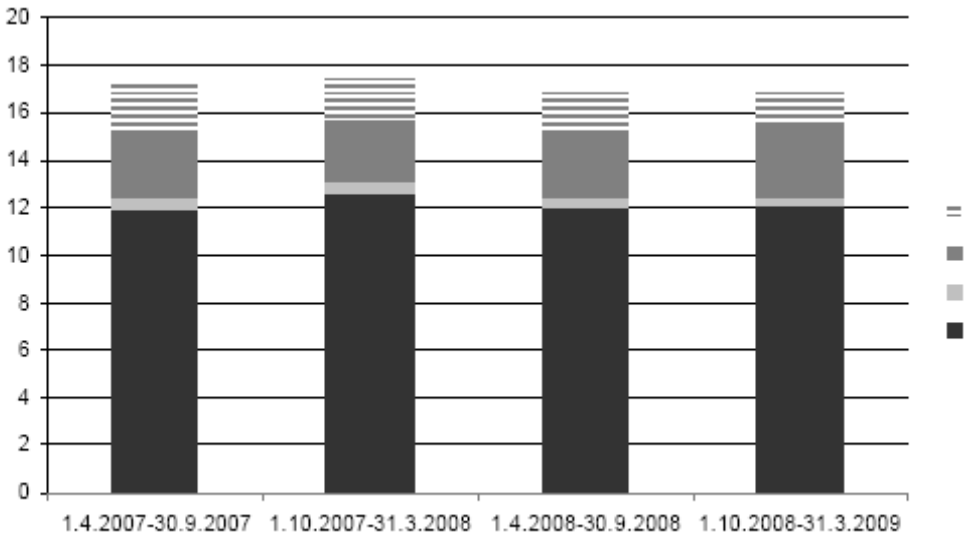
[84] PERUSPALVELUJEN TILARAPORTTI 2010. Basic Services in 2010. Ministry of Finance publications 12/2010. Retrieved from: http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf.

[85] VILKKO A, MUURI S, FINNE-SOVERI H. Läheisapu iäkkään ihmisen arjessa. Help by Family Members in the Older Population. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 60–77. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

[86] VILKKO A, MUURI S, FINNE-SOVERI H. Läheisapu iäkkään ihmisen arjessa. Help by Family Members in the Older Population. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 60–77. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

consist of provision of information, social support, home visits and assistance in daily tasks, shopping and outdoor visits.

Figure 11: Amount of care (hours per week) to home care patients by carer



Source: Heinola et al, 2010

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.[87]

The large national projects launched and partially funded by the Ministry of Social Affairs and Health (the "Effective Health Centre" project, the "Kaste" Programme and the "Masto" Project) focused mainly on children, youngsters and middle-aged inhabitants. A few proposals to develop long-term care for the elderly were accepted to be financed as a part of the "Kaste" Programme.

The implementation of the large five-year (2010–2014) action programme "Art and Culture for Well-being" was started in 2010. Development of long-term care by implementing art and

[87] KOTIKUNTA- JA SOSIAALIHUOLTOLAIN MUUTOKSET VUODEN 2011 alusta. Changes in Legislation about Municipality of Residence and Social Welfare. Kuntaliitto, 2010. Retrieved from: http://www.kunnat.net/fi/asiantuntijapalvelut/soster/hallinto-jarjestaminen-tuottaminen/jarjestamisvastuu/kotikuntalaki/Sivut/default.aspx; LAKI KOTIKUNTALAIN MUUTTAMISESTA 1377/2010. Act on Municipality of Residence. Retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2010/20100184.pdf ; LAKI SOSIAALIHUOLTOLAIN MUUTTAMISESTA 1378/2020. Change in Social Welfare Act. Retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2010/20100184.pdf.

culture activities was stressed in the programme plan. However, only a few art and culture programmes were implemented in long-term care in 2010.[88]

The working group in the Ministry of Social Affairs and Health, which was set up to prepare a reform of social welfare legislation, published its first proposals in May 2010. Social welfare legislation consists of the Social Welfare Act and a great number of acts which can be divided into acts about general principles and acts about special tasks. Long-term care in nursing homes, sheltered housing, comprehensive sheltered housing and group homes, home help and economical supported home care by relatives belong to social welfare services. Thus, long-term care was considered in the proposals of the working group.[89]

The first report of the working group included overall proposals of principles for reforming the social welfare legislation. The working group proposed that the legislation should be reformed in three phases complementing each other. The first phase should be drafting a new Social Welfare Act, the second phase revising the content of the special acts steering social welfare, and the third phase should be revising the regulations of interfaces in the social welfare legislation. In September 2009 (on 29 September 2009), the Finnish government, during the discussion in Parliament, promised that long-term services for the elderly will be ensured by a special act, and a proposal for the act will be ready in spring 2011. An act which ensures long-term services based on assessment of functional and cognitive abilities and needs of elderly persons was proposed by the working group.[90] The opinions of relevant stakeholders about the report of the working group were collected until autumn 2010. All non-governmental, non-profit organisations of pensioners and senior citizens supported the proposal for an act to ensure long-term care of the elderly.

A proposal for an Act on Long-term Care of the Elderly was released in March 2011, and the opinions of relevant stakeholders were asked for until the end of May 2011. According to the proposed act, the elderly will have subjective rights to receive long-term services, but the rights are based on assessment of physical, psychological, social and cognitive functioning of the elderly. Promotion of health, functional abilities and wellbeing of the elderly and delivering high-quality services belong to the goals highlighted in the act. Every elderly person in long-term care has the right to a municipal worker who coordinates her/his services. Workers in care of the elderly are obliged to report malpractice or abuse of the elderly and other serious problems in their workplace.[91]

As mentioned, family members are important helpers of the elderly. According to estimates, about 55,000 persons over 45 years of age are both taking care of their children and helping their old relative at least once a month. In order to promote caring by family members, a

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[88] TAITEESTA JA KULTTUURISTA HYVINVOINTIA – EHDOTUS TOIMINTAOHJELMAKSI 2010–2014. Art and Culture Activities in order to Promote Wellbeing. A Proposal for a Development Project. Opetusministeriön julkaisuja 2010:1, Helsinki 2010. Retrieved from: http://www.minedu.fi/export/sites/default/OPM/Julkaisut/2010/liitteet/OPM1.pdf?lang.

[89] SOSIAALIHUOLLON LAINSÄÄDÄNNÖN UUDISTAMINEN. Sosiaalihuollon lainsäädännön uudistamistyöryhmän väliraportti. Reform of Social Welfare Legislation Progress Report by the Working Group preparing a reform of social welfare legislation. Ministry of Social Affairs and Health 2010. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-11731.pdf.

[90] SOSIAALIHUOLLON LAINSÄÄDÄNNÖN UUDISTAMINEN. Sosiaalihuollon lainsäädännön uudistamistyöryhmän väliraportti. Reform of Social Welfare Legislation Progress Report by the Working Group preparing a reform of social welfare legislation. Ministry of Social Affairs and Health 2010. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-11731.pdf.

[91] LUONNOS LAIKSI IÄKKÄÄN HENKILÖN SOSIAALI- ja terveyspalvelujen saannin turvaamisesta. Proposal for Act on Care of the Elderly. STM 2011. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=2664824&name=DLFE-15130.pdf.

change in the Act on Contracts of Employment was passed in Parliament. The act took effect in April 2011. Employers have to give unpaid vacation to workers who care for their relatives.[92]

The economic and financial crisis did not lead to changes in long-term care arrangements or the financing model. The economic possibilities to provide long-term services were discussed, as described later.

2.4.2 Debates and political discourse

The complaints of the elderly and their families about the poor quality of long-term care continued in 2010. Now they were supported by three reports about the quality of long-term care of the elderly, written by authorities and published in 2010. The Parliamentary Ombudsman of Finland (emerita) published her report about long-term care of the elderly in comprehensive sheltered housing and long-term institutions. The report was based on enquiries to the Regional State Administrative Agencies.[93] The National Supervisory Authority for Welfare and Health published a report about the quality of care in comprehensive sheltered housing and nursing homes. This report was based on questionnaires sent to personnel in these facilities.[94] The National Audit Office of Finland published a report about the quantity and quality of home care of the elderly.[95]

The Parliamentary Ombudsman reported shortages in long-term care. She highlighted that periods between supper and breakfast were too long, showing a high risk of malnutrition in many sheltered housing and long-term care institutions. Education of workers about nutrition in old age was not adequate to assess the nutritional status of the elderly and to prepare and serve meals with adequate nutritional content. Incontinent elderly persons were not guided to toilets at intervals of some hours as recommended. Incontinence nappies were used in treating the incontinent elderly without trials to carry out more adequate and ethical treatments. Nappies were not changed at needed intervals, and the elderly had to use wet nappies. Even shortages in personal hygiene were noticed. In some units, the elderly who were unable to walk were not guided to toilets, and they had to urinate and defecate on the nappy put on the bed. Numbers of nurses and auxiliary nurses were not sufficiently great in some units. Shortages in possibilities to walk or to sit outdoors were noticed in many units.[96]

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[92] LAKI TYÖSOPIMUSLAIN MUUTTAMISESTA 197/2011. Change in Act on Contracts of Employment. Retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2011/20110197.pdf.

[93] EDUSKUNNAN OIKEUSASIAMIES. Parliamentary Ombudsman of Finland. Ympärivuorokautisessa hoidossa olevien vanhusten hoito ja sen valvonta. Care of the Elderly in Sheltered Housing with Workers during Days and Nights, and Supervision of Care. Eduskunnan oikeusasiamiehen päätös 18.2.2010, Dnro 213/2/09, 51 p Retrieved from: http://www.eduskunta.fi/triphome/bin/thw.cgi/trip/?${APPL}=ereoapaa&${BASE}=ereoapaa&${THWIDS}=0.30/1305110130_489127&${TRIPPIFE}=PDF.pdf.

[94] VALVIRA. SOSIAALI- JA TERVEYSALAN LUPA- JA VALVONTAVIRASTO. National Supervisory Authority for Welfare and Health. Vanhusten ympärivuorokautisten palvelujen valvonta. Supervision of Care in Sheltered Housing with Workers during Days and Nights. Valvira, raportti 22.6.2010;1882/05.01.05.07/2010, 9 p. Retrieved from: http://www.valvira.fi/files/Vanhusten_ymparivuorokautisten_palvelujen_valvonta.pdf.

[95] VALTIONTALOUDEN TARKASTUSVIRASTO. National Audit Office of Finland. Vanhuspalvelut. Säännöllinen kotihoito. Home Care of the Elderly. Valtiontalouden tarkastusviraston tuloksellisuuskertomukset 214/2010, Helsinki 2010, 124 p. Retrieved from: http://www.vtv.fi/files/2407/Vanhuspalvelut_netti.pdf.

[96] EDUSKUNNAN OIKEUSASIAMIES. Parliamentary Ombudsman of Finland. Ympärivuorokautisessa hoidossa olevien vanhusten hoito ja sen valvonta. Care of the Elderly in Sheltered Housing with Workers during Days and Nights, and Supervision of Care. Eduskunnan oikeusasiamiehen päätös 18 February 2010,

Mechanical and chemical restraints were used unnecessarily often. Use of psychiatric medications was common. Terminal care was not arranged in sheltered housing, and terminal-care patients were guided to hospitals. There were differences in the quality of nursing and medical care between these long-term units.[97]

The Parliamentary Ombudsman (emerita) put forward many proposals and gave tasks to Regional State Administrative Agencies. She proposed that these agencies should control nutrition, hygiene, possibilities to walk outdoors, overuse of psychiatric medications and overall medical care in long-term units. Restraints should be used only when there is a special need, and the use should be recorded carefully in nursing and medical records. She proposed that an act to strengthen the human rights and autonomy of the elderly in long-term care should be prepared and the control of long-term units should be developed.[98]

The National Supervisory Authority for Welfare and Health sent enquiries to 1,500 nursing homes and comprehensive sheltered housing. Answers were received from 1,237 units. Half of these units were owned by municipalities. Only 149 units met the quality criteria set in this investigation, at least on the lowest level. Only 7 units met these criteria very well.[99]

Shortages were found in the basic education and amount of personnel. 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. According to the proposal by the ministry, more than 90% of the elderly in long-term units should live alone in a dwelling consisting of a room, toilet and shower. Nearly half of the elderly in municipal units and every third in private units shared their dwellings with other persons.[100]

The National Supervisory Authority for Welfare and Health proposed that workers in long-term care should have at least basic education in social and health care and the number of workers should be great enough. Nutritional needs of the elderly should be met adequately. The Supervisory Authority aims to tighten control and supervision of the units in which the quality of care was very poor.[101]

In the assessment report about home care of the elderly, made by the National Audit Office of Finland, it was concluded that the equality of the elderly in receiving home care services was not fulfilled because every municipality makes its own decisions on the criteria to receive services, tasks included in home care and fees of care. Lengths of home visits were short, and only tasks supporting the elderly in basic care (hygiene, meals etc.) were performed during visits. Supporting and promoting functional and cognitive abilities, social participation and overall wellbeing of the elderly did not belong to tasks of home care workers.[102]

Dnro 213/2/09, 51 p Retrieved from: http://www.eduskunta.fi/triphome/bin/thw.cgi/trip/?${APPL}=ereoapaa&${BASE}=ereoapaa&${THWIDS}=0.30/1305110130_489127&${TRIPPIFE}=PDF.pdf.

97 Ibid.

98 Ibid.

99 VALVIRA. SOSIAALI- JA TERVEYSALAN LUPA- JA VALVONTAVIRASTO. National Supervisory Authority for Welfare and Health. Vanhusten ympärivuorokautisten palvelujen valvonta. Supervision of Care in Sheltered Housing with Workers during Days and Nights. Valvira, raportti 22.6.2010;1882/05.01.05.07/2010, 9 p. Retrieved from: http://www.valvira.fi/files/Vanhusten_ymparivuorokautisten_palvelujen_valvonta.pdf.

100 Ibid.

101 Ibid.

102 VALTIONTALOUDEN TARKASTUSVIRASTO. National Audit Office of Finland. Vanhuspalvelut. Säännöllinen kotihoito. Home Care of the Elderly. Valtiontalouden tarkastusviraston

Functional and cognitive abilities of the elderly in home care were poorer compared to those of home care patients in previous years. Many home care patients lived alone and many suffered from memory disturbances. In the 2000s, municipalities increased the number of workers in home care, but the amount is not great enough to provide the care needed by patients. The quantity of different types of services in the municipality affected the decisions on offered services. The National Audit Office highlighted that the lack of an official statement made by the Ministry of Social Affairs and Health about the extent of human and economic home care gives possibilities to provide low-quality care.[103]

At the beginning of 2011 (before the parliamentary election), the non-governmental organisations of pensioners asked the chairpersons of the political parties about their support to ensure long-term care of the elderly by an act which includes assessment-based subjective rights to services. The chairpersons of the National Coalition Party, the Finnish Social Democratic Party, the True Finns Party, the Left Alliance, the Greens of Finland and the Finnish Christian Democrats gave their support to this kind of act. The chairpersons of the Centre Party of Finland and the Swedish People's Party did not support the proposal to ensure long-term care of the elderly by a specific act.[104] Problems in care of the elderly and possible solutions of the problems were not common topics of discussions before the spring 2011 election. Internet enquiries made to the parliamentary candidates before the election showed that over half of the candidates supported an act to ensure long-term care of the elderly. The candidates in the National Coalition Party, the Centre Party of Finland and the Swedish People's Party gave the most negative answers: about two out of three candidates did not support the act. The proportions of supporters varied from 86 to 98% in other parties.[105]

In 2010, citizens and journalists continued the debate on poor access and poor quality of long-term care by reports in newspapers, radio and TV. Obligatory movements from comprehensive sheltered housing to cheaper sheltered housing or normal flats organised by municipalities, and lack of meals during many days when the municipality changed the private provider of meals to home care patients are examples of complaints written in newspapers.[106] Problems in outsourcing services belonged to other themes. Shortage of knowledge to tender services in municipalities was a topic of criticism.[107] Problems of small private companies to win tenders and an increase in the number of bigger international companies were discussed with a critical voice.[108] Decisions in municipalities to "pile" the elderly into big sheltered housing institutions in order to save costs of care belonged to other topics.[109]

The Ministry of Social Affairs and Health published a report about international models of funding of care and possible ways to finance long-term care services in the future. The proposals in the report were discussed in newspapers, but they did not raise any vivid discussion. Social insurance has been chosen to equal the risks in financing care in many countries, and the funds are collected by parafiscal charges. The application of such a model in Finland was discussed in the report. Funds may be allocated from social insurance to organising services via the present model according to the act on central government transfers

tuloksellisuuskertomukset 214/2010, Helsinki 2010, 124 p. Retrieved from: http://www.vtv.fi/files/2407/Vanhuspalvelut_netti.pdf.

[103] Ibid.
[104] ELÄKELÄINEN, February 2011.
[105] HELSINGIN SANOMAT, 22 March 2011.
[106] HELSINGIN SANOMAT 20 March 2010.
[107] HELSINGIN SANOMAT 25 February 2011.
[108] HELSINGIN SANOMAT 10 March 2011.
[109] HELSINGIN SANOMAT 25 April 2010.

to local government, which irons out regional inequalities, or via some other model that takes into account demands and circumstances. In a more advanced solution, resources may be allocated to the local service providers based on the inhabitants' care needs. This presupposes that a uniform assessment of needs of services is carried out throughout the country by an outside actor. Simultaneously, it may be determined in practice, which service needs people should be prepared to manage themselves.[110]

The Pellervo Economic Research Institute took part in the discussion about alternative models for long-term care funding by publishing a report focusing on voluntary private long-term care insurance. The importance of public provision of long-term care is stressed in the report. Complementing public provision with voluntary private insurance might improve welfare. Policies designed to stimulate private insurance demand will be of limited efficacy if long-term care insurance only replaces benefits that public programmes would otherwise provide. The availability of information and advice services to support decision-making are essential for the success of private insurance. The regional differences in public long-term care funding and provision should be diminished, since the expected utility of insurance should not be dependent on the place of residence.[111]

The Confederation of Finnish Industries (ETLA) took part in the debate about financing long-term care by publishing a report in autumn 2010. It proposed the development of a private insurance system for citizens to prepare for the costs of future long-term services. Services supplied by the public sector should be determined by an act, and citizens should have the possibility to buy extra services paid by private insurance. The purchase of private insurance should be compensated by tax reliefs.[112]

A working group in the Ministry of Environment investigated expenditure on comprehensive sheltered housing, sheltered housing and group homes and gave proposals for principles of public expenditure and cooperation between public and private sector. The working group proposed the development of strategic work in planning and organising several types of sheltered housing in municipalities. Public financing should be targeted to sheltered housing for those groups of inhabitants for whom low-price private sheltered housing are not available.[113]

Municipalities have the right to decide on client fees except for fees in long-term institutional care, which has led to differences in fees between municipalities and clients. Fees for services in comprehensive sheltered housing and group homes vary between municipalities. The working group in the Ministry of Social Affairs and Health, which was set up to make recommendations to the development of 24-hour long-term services and fees of these services, gave its report in autumn 2010. The group proposed a "one-level" model to provide 24-hour long-term services. Possibilities to live at home, in senior houses, societal group

[110] VOLK R, LAUKKANEN T. Hoivan rahoitus. Kansainvälisiä käytäntöjä ja kotimaisia vaihtoehtoja. Funding of Long-term Care. International Models and National Alternatives. STM:n selvityksiä 2010:22. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-12601.pdf.

[111] LEHTINEN M. Yksityinen varautuminen hoivamenoihin. Vaihtoehtoisia malleja oman hoivan rahoittamiseen. PTT raportteja 223/2010, 52 p. Alternative Models for Private Long-term Care Funding. PTT Reports 223. Retrieved from: http://www.ptt.fi/dokumentit/rap223_2809100853.pdf.

[112] LASSILA J, VALKAMA T. Vanhalle varaksi, turvaksi tutisevalle. Hyvinvointivaltiota etsimässä. Private incurance for Long-term Care. Elinkeinoelämän tutkimuslaitos ETLA 2010. 60 p. Retrieved from http://www.etla.fi/julkaisuhaku.php?type=details&id=1765.

[113] PALVELUASUMISEN JULKISEN RAHOITUKSEN LINJAUKSIA. Public Expenditure on Sheltered Housing. Ympäristöministeriön raportteja 1/2011. Retrieved from: http://www.ymparisto.fi/download.asp?contentid=124392&lan=fi.

houses or in small sheltered housing institutions were stressed. Fees for services should be similar in all municipalities.[114]

In 2010, the Ministry of Employment and Economy set up a working group for the development of social companies in the social and health care sector. The group gave its proposals in February 2011. They include the proposal to establish social companies within the basic social and health care sector.[115]

2.4.3 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 2010 does not include considerations about long-term care policies.[116] 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 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 have been opened to competition, and freedom to choose services has been stressed as an important policy goal.

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 describing low income level, poorly equipped housing and being a tenant are related to admissions to long-term institutional care.[117] 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.

2.4.4 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 in several previous years. Longitudinal descriptions showing the changes in these numbers, together with the changes in the numbers of inhabitants aged 75 years or over, are used to show developmental trends. These trends are reported on by classifying long-term services into “institutional”, “semi-open” and “open” ones or by classifying them by the owner of the service (“municipality”; “private”).

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

[114] HOITOA JA HUOLENPITOA YMPÄRI VUOROKAUDEN – IKÄHOIVA-TYÖRYHMÄN MUISTIO. Care and Attention on a 24-hour Basis. Ministry of Social Affairs and Healthn selvityksiä 2010:28. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=2872962&name=DLFE-14929.pdf.

[115] YHTEISKUNNALLISEN YRITYKSEN TOIMINTAMALLIN KEHITTÄMISTÄ JATKETTAVA. Social Companies. Työ- ja elinkeinoministeriö 18.2.2011. Retrieved from: http://www.tem.fi/index.phtml?89508_m=102118&89508_o=10&s=2468.

[116] EUROPE 2020 STRATEGY. Finland’s National Programme 2010. Ministry of Finance publications 14c/2011. Retrieved from: http://ec.europa.eu/europe2020/pdf/nrp/nrp_finland_en.pdf.

[117] MUURI A, MANDERBACKA K. Hyvinvointivaltion kannatusperusta. Opinions about the Welfare State. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 96–111. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

cognitive abilities or wellbeing of the elderly have been assessed only in relatively few studies. Cost-benefit or cost-effectiveness analyses have been performed for extremely few services.

Losing confidence in long-term care seems to be evident, according to interview studies published in 2010. In 2009, about 40% of the elderly stated that they do not believe that they will receive public home care services if they are in need of these services.[118] The figure was bigger than in an interview study in 2006.

The citizens are aware of the need to develop long-term services. This is shown not only by letters to the editors in newspapers but also by interview studies. In such a study published in 2010, nearly 90% of the population stated that there is a need to increase the amount of tax revenues to care for the elderly. In addition, many citizens want to increase tax revenues to home care (64%). Except for child protection (72%), other sectors of social welfare care received less support.[119]

According to an interview study, care of the elderly was the least desired target of possible savings in the budgets of municipalities. Only 7% of citizens wanted to save municipal costs of care of the elderly, while 19% showed willingness to save costs of day care of children and 28% those of basic schools. The opinions of local councillors were quite similar to those of other inhabitants.[120]

The number of the elderly in a long-term unit, the number of persons living in one room and the number of workers per 100 elderly persons in a unit are common indicators of structure. Workers are usually classified according to their education in describing quality of care.

The length of hours between supper and breakfast, and use of nappies, mechanical restraints and psychotropic drugs are examples of indicators used to describe the process. In addition, workers have been asked to assess their work and work load with the help of structured questionnaires. Opinions of users of care and outsiders have been asked with several kinds of questions.

Changes in abilities to walk and manage activities of daily living, abilities to perform tasks requiring memory or other cognitive abilities, self-perceived health, quality of life, loneliness and life satisfaction are examples of indicators used in assessing the effects of services on users of services. The National Institute of Health has developed measures and scales to assess abilities of the elderly living in long-term care units in order to make comparisons between care units and to follow-up changes. The scales consist of several types of measures described above. These measures have been implemented in quite a lot of service units since the beginning of the 2000s. The effects of services on family members have been assessed in some studies by asking about their wellbeing and quality of life.

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[118] VILKKO A, FINNE-SOVERI H, HEINOLA R. Ikäihmisten palvelutarpeet ja saatu apu. Need of Services among the Elderly and Eources of Help. In: VAARAMA M, MOISIO P, y S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 44–59. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

[119] MUURI A, MANDERBACKA K. Hyvinvointivaltion kannatusperusta. Opinions about the Welfare State. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 96–111. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d.

[120] KANSALAISMIELIPIDE JA KUNNAT. ILMAPUNTARI 2010–2011. Opinions of Citizens about Municipalities. Kunnallisalan kehittämissäätiön Polemia-sarjan julkaisu nro 79 Retrieved from: http://www.kaks.fi/sites/default/files/Polemia_79_net_0.pdf.

No structural changes in financing long-term care or covering costs of care were made in 2010.

Recommendations have not been effective in ensuring the quality of long-term care and the equality of long-term care patients. The proposal for an act to ensure access to care and quality of long-term care of the elderly published in 2011 is an important initiative. Subjective, assessment-based rights are valuable, although specific requirements for care cannot be defined in an act. There is a need to prepare a decree and recommendations in which many specific requirements are defined. The recommendations by the working group of the ministry about the development of 24-hour-care are a step towards improving the quality of long-term care.

Medical care in health centre hospitals and nursing homes is a responsibility of primary health care according to the Primary Health Care Act. The provision of medical care in sheltered housing, comprehensive sheltered housing and group homes is not determined by legislation. Medical care in these units is delivered either by health centre physicians or the private physician of every elderly person. In many towns and great municipalities, medical care of the elderly in long-term care belongs to a certain physician or a group of physicians. Many of these physicians are geriatricians or family physicians with further education in geriatrics. The shortage of health centre physicians in eastern and northern parts – and even in other parts – of the country has caused problems in delivering medical care in long-term care. The small amount of geriatricians and family physicians with further education in geriatrics is a great problem. Many physicians working in private companies which have made contracts with municipalities are young ones with insufficient education in geriatrics, which is a problem. Geriatrics has been a medical speciality in Finland since the end of the 1980s. The number of geriatricians is 203 (195 aged under 65 years) in 2010. There are professors in geriatrics in every medical school, but the volume of teaching in geriatrics is small in the medical curricula. The lack of a medical speciality in geriatric psychiatry is a problem. There exists shortage in diagnosing and treating affective disorders in the elderly.

Family members are the most important persons who help the elderly living at home. The change in legislation, which gives employees the possibility of unpaid vacancy in order to care for their elderly relatives is a step towards helping family members.

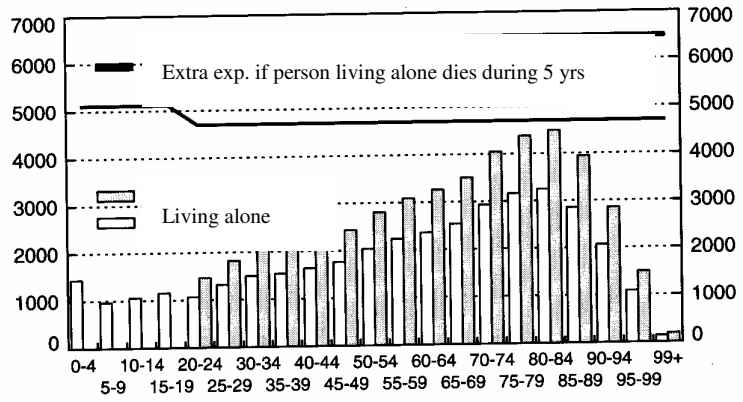
Some national estimates with regard to the future demand of long-term care expenditures, facilities, staff and services have been made. Future policy development is mainly based on longitudinal figures about changes in health, functional abilities and mortality of the elderly population and future projections of these figures. Figures about changes in the use of services and expenditures in long-term services, and opinions of citizens about provision and financing of long-term care are also used in the national policy development.

The Confederation of Finnish Industries (ETLA) made an estimate about expenditure on health and long-term care in the future. It was based on current expenditure and estimates of the number of inhabitants and their care needs in the future. The average public costs of health care are the highest in the age group 80–84 years (Figure 12). Living alone increases costs by about 40%. Calculations made according to life expectancy show that the highest expenses are among those who will die within the next 5 years. The average public costs of long-term care are higher the older the age group (Figure 13). Living alone increases the costs by 15%,

and the highest expenses are among the elderly living alone who will die within the next 5 years.[121]

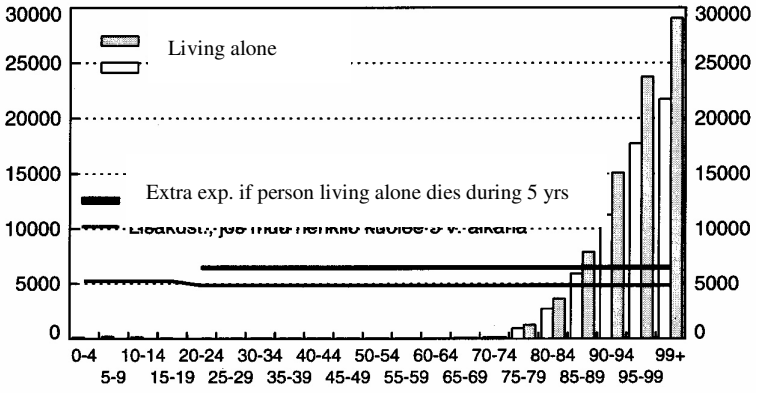
Projections for the future were modelled in the ETLA report by calculating an index of manpower need and combining it with a standardised proportion of GNP. The index describes health and long-term services in relation to GNP. The modelled projections show that the greatest increase in expenditure on care is in the expenditure on long-term services in relation to GNP (Figure 14).[122]

Figure 12: Expenditure on health care per inhabitant by age group (in 2006 value).



Source: ETLA

Figure 13: Expenditure on long-term care per inhabitant by age group (in 2006 value).

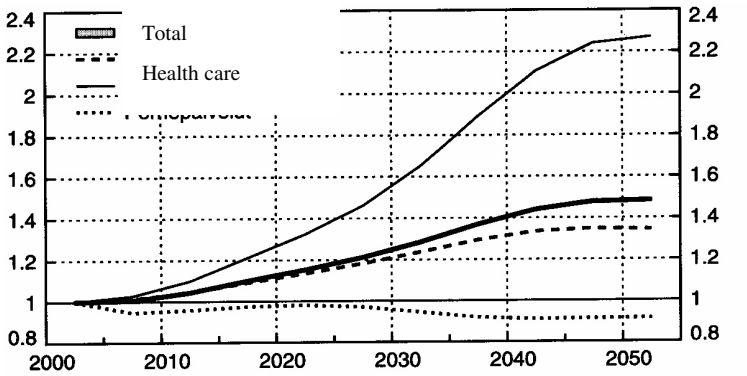


Source: ETLA

[121] LASSILA J, VALKAMA T. Vanhalle varaksi, turvaksi tutisevalle. Hyvinvointivaltiota etsimässä. Private incurance for Long-term Care. Elinkeinoelämän tutkimuslaitos ETLA 2010. 60 p. Retrieved from http://www.etla.fi/julkaisuhaku.php?type=details&id=1765.

[122] Ibid.

Figure 14: Expenditure on health care, long-term care and family care in relation to GNP by year.



Source: ETLA

2.4.5 Critical assessment of reforms, discussions and research carried out

In spite of complaints by citizens and criticism of authorities in respect of poor quality of 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 living at home and the growing number of old citizens 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 are living alone. It seems that home care does not meet even the basic needs of many patients. Savings in municipalities are made due to the unwillingness to organise the necessary comprehensive sheltered housing and due to the willingness to move the elderly living in comprehensive sheltered housing into ordinary flats. Family members take a great responsibility in the care of their elderly relatives. The political aim to lengthen working careers and to raise the retirement age, combined with these processes in long-term care, weakens the sustainability of long-term care.

On average, the quality of long-term care in institutions, comprehensive sheltered housing, group homes and home care is not good, but the variation between municipalities and units is great. The quality of long-term care should be developed. The proposed act to ensure long-term care of the elderly may improve the quality. In addition, recommendations, education and further education of staff and development programmes are needed. The proposal about developing a two-level 24-hour care of the elderly, made by the working group of the ministry, is an important supplement to the proposed act.

Today, the number of elderly people who have economic resources to buy private services which are not compensated by the society is small in Finland. The average pensions of the future elderly citizens will be higher than those of people who are old today. This provides the opportunity to arrange economic compensation to only basic long-term services and 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 opinions of inhabitants is needed. There will be problems to change the system to provide long-term services in a welfare state where nearly all the costs of services are paid by taxes.

The increase 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 economy 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 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. Non-governmental organisations of senior citizens and retired persons have activated and are demanding changes in long-term care. Their opinions will increase the possibilities to develop long-term care.

The average health and functional abilities of the population aged 75 years or over have improved during the previous 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 over. It is probable that the need for care will decrease in future among the elderly population, at least in the young old and old population. However, the ageing of the "baby-boom generation", together with the supposed increase in the average life expectancy in both women and men will increase the need for long-term services in future.

The development of long-term care needs well trained workers. Young people are not very interested in caring for the elderly. The basic education of geriatrics and gerontological nursing in medical schools and vocational education institutes is short. Education 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 education should be combined with 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 to change the model. The role of physicians in the care of the elderly is important. However, the nursing personnel seem to be more interested in developing good-quality, humane and ethical long-term care than physicians. An adequate use of psychiatric and other medications in the care of the elderly has been a common topic in further education courses. Assessments of usages of medications are recommended to be carried out every year. It is supposed that these projects will increase the interest in 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 harmony between generations. The economic crisis in the 1990s in Finland has led to a problematic long-term unemployment. Some persons belonging to young generations have made critical comments on "richness" of older generations, but these comments are not common. Proposals about financing long-term care in the future made in 2010 should be discussed further, and changes should be made within the next few years.

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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] von BONSDORFF, Monika E., VANHALA, Sinikka, SEITSAMO, Jorma, JANHONEN, Minna, HUSMAN, Päivi, Henkilöstön eläkeaikeet ja yrityksen menestyminen vuosina 1997 ja 2007 – tutkimus metalliteollisuudessa ja vähittäiskaupan alalla, Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 5, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64741

"Retirement Intentions and Company Performance in 1997 and 2007 – a Study among Metal Industry and Retail Trade Employees"

This study explores work ability, well-being and retirement intentions of ageing metal industry and retail trade employees, as well as the relationship between retirement intentions and company performance. The study is based on metal industry and retail trade employees in 1997 (company-level n=235, employee-level n=2,599), and in 2007 (company level n=129, employee-level n=1,281). This study focuses on respondents aged 45 and over.

Employees had experienced retirement intentions frequently. Employee work ability, organisational commitment and emotional exhaustion were related to retirement intentions. Retirement-related downsizing measures had occurred only seldom in the metal industry and retail trade companies. A low rate of retirement-related downsizing measures, bigger size of companies and fewer retirement intentions among the employees were related to better company performance in the metal industry in 2007. A higher rate of retirement-related downsizing measures and bigger company size were related to better company performance in the retail trade both in 1997 and 2007.

[R3, R4] GOULD, Raija, LAMPI, Jukka, NYMAN, Heidi, Työhönpaluu kuntoutustuen jälkeen, Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 3, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65238

"Return to Work after the End of Cash Rehabilitation Benefit"

Nearly half of all new disability pensions within the earnings-related pension scheme start as temporary cash rehabilitation benefits. This report includes three separate investigations which examine the use of the cash rehabilitation benefit and the return to work after the benefit has ended. The data consist of statistical information as well as two register-based data sets – the first one includes those who started receiving the cash rehabilitation benefit in 2005, and the second includes those for whom the benefit terminated in 2007. The results show that only a small number of those awarded a temporary cash rehabilitation benefit return to work. Job security during the benefit period was strongly associated with later work resumption. Beneficiaries who had a valid employment contract throughout the benefit period were more than twice as likely to return to work after the benefit as those without such contracts.

[R2, R4] GOULD, Raija, KALIVA, Kasimir, Työkyvyttömyyseläke ja ansiotyö, Eläketurvakeskuksen raportteja (Finnish Centre for Pensions Reports) 5, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64803

"Disability Pension and Gainful Employment"

This study examines gainful employment and the willingness to work among those receiving a disability pension. The study is based on a questionnaire sent in 2008 to persons receiving a disability pension under the earnings-related pension scheme, as well as register data of the Finnish Centre for Pensions (n = 2,315). Of those receiving a full pension, 5% were gainfully, while 21% were willing to work. The majority worked or wanted to work occasionally and only for a few hours a week. Of those receiving a partial pension, 68% were employed and 7% were willing to work. The employment was usually regular but part-time. A total of 19,000 disability pension recipients under the age of 63 engaged in gainful employment to some extent, while more than 33,000 persons were willing to work. Employment and the willingness to work were related to, among other things, working as a specialist, finding one's work ability to be moderate and being, on average, of a younger age. Of all disability pension recipients, 18% assessed that the earnings limits for the pension reduced employment.

[R2] HYYTINEN, Ari, MÄÄTTÄNEN, Niku, LASSILA, Jukka, VALKONEN, Tarmo, Eläkevaroilla vauhtia Suomen talouskasvuun? The Research Institute of the Finnish Economy (ETLA) Keskusteluaiheita (Discussion Papers) 1224, 2010, Helsinki, retrieved from:

http://www.etla.fi/files/2528_Dp1224.pdf

"Should Pension Funds Be Used to Boost Economic Growth in Finland?"

A debate has arisen on whether the pension funds should take a more active role in promoting employment, growth and domestic ownership of companies. This paper analyses the justifications presented for and against overweighting domestic investments in the portfolios of the pension institutions. E.g., is it possible to invest the funds in a way that generates a higher wage bill and more contribution revenue? Furthermore, have the pension funds incentives to promote such investments? Another important issue is whether there exist serious shortages in the domestic financial markets and whether the pension funds are the proper actors to fix these problems. A further raised issue is the role of the pension funds in the domestic infrastructure markets.

The overall conclusion is that excess weight in domestic companies is well justified only in cases in which the international investors misprice the companies, or for some other reasons

keep the conditions of financing the companies unreasonably stringent. In these cases, there is no conflict between promoting domestic investments and optimal combination of risk and yield. Disturbing the vital role of the financial markets in eliminating unviable projects would, however, weaken growth and employment.

[R2] JOHANSON, Jan-Erik, LASSILA, Jukka, NIEMELÄ, Heikki (eds.), Eläkevalta Suomessa, The Research Institute of the Finnish Economy (ETLA) B 250, 2011, Helsinki, retrieved from:

http://www.etla.fi/files/2637_elakevalta_suomessa.pdf

"Power over Pensions in Finland"

This publication consists of several articles focusing on pension governance in Finland. It discusses the pros and cons of the current decision-making, how it has developed over time and who has the power over pensions. Each article is complemented and further discussed by a commentator's (opponent's) view.

[R2] JOHANSON, Jan-Erik, SORSA, Ville-Pekka, Pension Governance in Finland. A Case Study on Public and Private Logics of Governance in Pension Provision, Finnish Centre for Pensions Reports 2, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64755

One of the key trends in European pension reforms has been the introduction of private elements to first-pillar public pension schemes. However, the administrative logics of these public private partnerships (PPPs) have not yet been studied systematically. This study develops a theoretical framework for studying the governance institutions of PPP-type organisation fields in the context of pension provision, and applies this framework to a case study on the Finnish TyEL scheme. The Finnish case illustrates a mature field, combining different modes of governance and revealing tensions that can be managed if not necessarily solved in PPP-type pension provision.

[R3, R4] JÄRNEFELT, Noora, Education and Longer Working Lives. A Longitudinal Study on Education Differences in the Late Exit from Working Life of Older Employees in Finland, Finnish Centre for Pensions Studies 1, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64788

This study analyses and elaborates on education-related differences in the likelihood of Finnish employees aged 50-64 to remain in employment up until old-age retirement. The study is based on a body of Finnish longitudinal register data, the sample of 66,000 subjects. The information on employment or exit from working life of the subjects was recorded every year during the period 1997-2000. The data also included information on the life courses of the subjects between the years 1970 and 1996. Moreover, indicators on the labour market context of the subjects were recorded. The associations between education, the adult life course, the labour market context, and the final exit from working life were studied by means of logistic regression analysis. In addition, education-related differences in the relative risk of various early exit routes were examined using complementary log-log models. The results show that the higher the level of education, the higher the probability of late exit from working life.

[R3] KANNISTO, Jari, HILTUNEN, Maija, Eläkkeellesiirtymisikä Suomen työeläkejärjestelmässä, Eläketurvakeskuksen tilastoraportteja (Finnish Centre for Pensions Statistical Reports) 5, 2010, & 2, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64749

http://www.etk.fi/Binary.aspx?Section=42845&Item=65248

"Effective Retirement Age in the Finnish Earnings-related Pension Scheme"

One of the main objectives set in connection with the 2005 pension reform was to postpone retirement by 2–3 years. The achievement of this long-term objective is monitored through the expected effective retirement age (expectancy) for 25-year-olds. In contrast to the average and the median age, the expectancy is not affected by the age structure of the population. Thus, it can be used to monitor the change over time in the effective retirement age. The expected effective retirement age is calculated for all those who have retired on an earnings-related pension.

In 2009, the expected effective retirement age was 59.8 years. This was an increase of 0.4 years from the previous year. It has now risen by approximately one year from the level prior to the pension reform, in other words nearly according to advance estimates.

In 2010, the expected effective retirement age was 60.4 years. It marked the first time the figure exceeded the 60-year limit. This was an increase of 0.6 years from the previous year. The expectancy has now risen by approximately 1.5 years from the level prior to the pension reform, in other words, even faster than predicted.

[R5] KARISALMI, Seppo, TUOMINEN, Eila, Palkkatyöstä eläkkeelle siirtyvien eläketaso yksityisaloilla, Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 1, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65159

"Level of Pension for Retiring Wage Earners in the Private Sector"

The objective of the study was to procure information on the level of the expected earnings-related pension for various groups of wage earners. The aim was to investigate what impact various factors have on the earnings-related pension. Furthermore, it was investigated how the life expectancy coefficient affects the amount of the expected pension. Research data consisted of the 45–64-year-old wage earners in the 2008 Finnish Quality of Work Life survey (n=799). As regards the group under study, the life expectancy coefficient will begin to reduce the earnings-related pension the most for those who were under the age of 55 at the time of the study. The gender difference between the average earnings-related pensions will remain at the current level. The main reason for this is that gender differences in wages have remained intact. Based on regression analysis, the amount of earnings-related pension can be explained mainly by other factors than gender: earnings, the level of education, the discontinuity of the career and the intended retirement age.

[R3] KARISALMI, Seppo, TUOMINEN, Eila, TAKALA, Mervi, KALIVA, Kasimir, Joustava vanhuuseläkeikä ja eläkesuunnitelmien toteutuminen, Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 4, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65240

"Flexible Retirement Age and Realisation of Retirement Plans"

The aim of the study is to examine the factors that impact older employees in their plans to continue to work or to retire, and to find out to what extent retirement plans are actually realised. The basis of the study is the model presented by Beehr (1986) on the retirement process. The target group of the study is private-sector wage-earners born between 1942 and 1945. The survey data from 2003 has been supplemented by register data on pension contingencies from the time of the survey until the end of 2009. The data is analysed using a logistic regression model.

The retirement intentions fairly successfully predict the actual retirement of those who intended to retire at the age of 63 at the earliest. The retirement intentions were realised the most poorly amongst those who had planned to retire early. Often, they retired at the age of 63 or later. To summarise with reference to Beehr, divergent factors are emphasised at different stages of the retirement process.

[R1] LASSILA, Jukka, VALKONEN, Tarmo, Julkisen talouden rahoituksellinen kestävyys Suomessa, The Research Institute of the Finnish Economy (ETLA) Discussion Papers 1237, 2011, Helsinki, retrieved from:

http://www.etla.fi/files/2587_no_1237.pdf

"Financial Sustainability of the Public Sector in Finland"

This study analyses the financial sustainability of the Finnish public sector. Current tax rates are unlikely to yield sufficient tax revenue for financing public expenditure under an ageing population. The estimate of the sustainability gap is 2.5% of GDP, for the period 2010–2060. The estimate is based on the 2009 population projection by Statistics Finland, where life expectancies are higher and net migration substantially larger than in earlier projections. Health and long-term care costs are modelled to be partly dependent on the proximity to death, and thus grow slowly compared to the growth in the number of old people. The higher initial public debt increases the vulnerability of the public finances to economic and demographic risks.

[R2] MAUNU, Tallamaria, TENHUNEN, Sanna, Eläkesäästäminen psykologisen taloustieteen näkökulmasta. Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 8, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64868

"Pension Saving from the Perspective of Behavioural Economics"

This review examines perspectives of behavioural economics on issues pertaining to financial preparation and the sufficiency of pension savings. According to previous research, preparing for retirement is at too low a level for many. In behavioural economics literature, the low rate of pension saving has been explained by, for example, the difference between short and long-term discounting, appearing for instance as a lack of self-control. Another explanatory factor to the low rate of pension saving is information and how it is processed. Consumers have been noted as having problems understanding economic concepts. Behavioural economics has also highlighted situations in which consumers deviate from rational behaviour when making

investment decisions. Behavioural economics literature seeks to clarify how the low rate of saving can be countered.

[R5] RIIHELÄ, Marja, VAITTINEN, Risto, VANNE, Reijo, Changing Patterns of Intergenerational Resource Allocation in Finland, Finnish Centre for Pensions, Reports 1, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65130

National Transfer Accounts (NTA) is a methodology used to measure intergenerational resource flows. This study, using the NTA methodology, evaluates of the implications of changing life-cycle patterns of earnings and consumption that have taken place in Finland from 1990 to 2006. Differences in consumption and production by age cause a life-cycle deficit (LCD). The changing age patterns of production and consumption in Finland have been manifested in a growth of the life-cycle deficit aggregated over the ages. On average, in the 1980s, the aggregate LDC was only a few percentage points relative to wages. After 1990, the deficit has increased considerably and amounted to approximately 17% of the wage sum in 2006. Approximately 40% of the growth can be attributed to changes in the population structure. The remainder is explained by shifts in age-specific consumption and wages. Without changes in consumption profiles by age, the LCD would have been 13 percentage points lower. The changing profiles of wages by age alone would have reduced the deficit roughly by 4%. A lengthening of working careers would have almost eliminated the burden of ageing at the given consumption structure. However, growth in private consumption relative to wages has increased the life-cycle deficit.

[R5] PALOMÄKI, Liisa-Maria, TUOMINEN, Eila, Työuran pituus ja siihen vaikuttavat tekijät 45–64-vuotiaassa palkansaajaväestössä, Eläketurvakeskuksen keskustelualoitteita (Finnish Centre for Pensions Discussion Papers) 9, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64937

"The Length of Working Careers and Factors Affecting It among Employees Aged 45 to 64"

The length of a working career is measured by three different indicators: the working time from the age of 23 to the end of 2007, i.e. pensionable working time; the relative duration of the realised working time during the period in question; and the total length of the working career based on the intended retirement age of respondents. Finally, the paper examines how different individual and work-related factors affect the density and total length of the working career. As research method logistic regression analysis is used. The data is from the Finnish Quality of Work Life Survey 2008 by Statistics Finland. Information on the length of working careers is attached to data from the employment register and the earnings register (n = 1,973).

The realised length of working careers among employees aged 45 to 64 was on average 26.7 years by the end of 2007, and the relative duration 87.6% of the maximum time. The total length of the working career was 35.6 years on average, provided that retirement intentions are realised. From the explanatory variables, individual factors affect the total length of working careers in such a way that women, those in the age bracket of 45–49 and widows have shorter working careers than men, those aged 50 to 54 and those living in relationships. Perceived level of health affects in a way, that those reporting their health as moderate or frail have shorter working careers than those perceiving their health as good. Of work-related

factors, the status of employee and working under temporary and part-time employment contracts tend to shorten careers. The length of working careers in the private sector remains shorter than in the public sector. When examining the line of business, working careers in industry are longer than in most other fields.

[R1–R5] PRIME MINISTER'S OFFICE, Työurat pidemmiksi – työeläkejärjestelmän kehittämisvaihtoehtojen tarkastelua. Työurien pidentämistä selvittävän työryhmän raportti, Valtioneuvoston kanslian julkaisusarja (Prime Minister's Office Publication Series) 4, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42777&Item=65189

"Longer Working Lives – Reviewing Development Possibilities for Earnings-related Pension Scheme. Report by the Working Careers Group"

This is the main report of the tripartite working careers group considering means by which the effective retirement age might be raised by at least three years by 2025. The purpose of the working careers group was to outline new minimum objectives and map out different possibilities to develop the earnings-related pension scheme without taking any position on any single alternative. The report contains several adjustments and options for development of the earnings-related pension scheme, enabling the guidelines for the forthcoming earnings-related pension reform. In addition to the main report more detailed background reports are published by the Finnish Centre or Pensions (see Uusitalo).

[R5] SALONEN, Janne, TAKALA, Mervi, Working Career and Income of Part-time Pensioners in Finland, Finnish Centre for Pensions Working Papers 2, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65163

This paper primarily examines part-time pension recipients who retired between the years 2005–2009. The report is based on register data, through which all earnings that accrue statutory pension are comprehensively taken into account. In the review it was discovered that persons retiring on a part-time pension have a clearly better income level than their peers. The pension level also increased over the years 2005–2009. Persons retiring on a part-time pension between 2005–2009 had careers of equal length or longer than their peers. The career length and higher income explain the increase in pension level. The income of persons transferring from full-time work to part-time pension does not decrease significantly, as salary from part-time work together with the part-time pension cover approximately 90% of the income received from full-time work.

[R5] SUONIEMI, Ilpo, RANTALA, Juha, Income Mobility, Persistent Inequality and Age, Recent Experiences from Finland, Finnish Centre for Pensions Working Papers 6, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64794

In this study, register-based income panel data with detailed information on the composition of income over a ten year time period (1995–2004) is used to examine Finnish income mobility. The study uses measures of income mobility which are based on the degree of income reduction over time (Shorrocks 1978). There is significant income mobility in the

Finnish income distribution, and mobility is decreasing with age, showing a further drop near retirement age. There is a decrease in income mobility if the late 1990s are compared with early 2000s. The drop in mobility is largest among the youngest age groups and the probability of staying in the lowest income decile has also increased. Permanent income inequality has increased in five-year cumulated incomes. The results suggest that distribution of lifetime income has widened. Decompositions of cumulated incomes by income components reveal that the increase in annual values of income inequality has been transformed almost one-to-one into an increase in permanent inequality.

[R5] SUONIEMI, Ilpo, RANTALA, Juha, Työstä eläkkeelle – tulokehitys ja korvaussuhteet, (Finnish Centre for Pensions Reports 3; Labour Institute for Economic Research Reports 18, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64774

"From Employment to Retirement – Development of Earnings and Replacement Ratios"

The study examined the changes in the level and composition of a person's income during the process of retirement. Special attention was paid to the pension's replacement ratio, i.e. to the ratio between the pension and the regular income prior to retirement. In addition to the replacement ratio, the change in gross income as a result of retirement was also analysed. According to the results, the median of the replacement ratio of retired employees was approximately 60%. Only on rare occasions was the replacement ratio below 50%. The study utilises a unique panel data comprising 500,000 people from Statistics Finland's population database in 1995–2004. The actual analysis was conducted on persons who retired from work between 1999 and 2003.

[R2] TENHUNEN, Sanna, VAITTINEN, Risto, Eläkejärjestelmän automaattiset vakautusmekanismit – teoriaa ja kokemuksia jarruista ja elinaikakertoimista, Eläketurvakeskuksen raportteja (Finnish Centre for Pensions Reports) 7, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64934

"Automatic Balancing Mechanisms of Pension Systems – Theory and Experiences of Brakes and Life-expectancy Coefficients"

This report investigates the automatic mechanisms that strengthen the financial stability of pension systems. The report analyses the different features of the automatic mechanisms and compares them to single reforms. Various practices have been implemented in different countries, through which the sustainability of pension system funding reacts to changes in the old-age dependency ratio. Different types of automatic balancing mechanisms are presented in the report, and their functionality is evaluated based on relevant literature. The report also discusses the interaction of cyclical fluctuations and automatic balancing mechanisms, the stabilising of the gross national product share of pension expenditure and the development of the replacement rate, as well as the allocation of various balancing systems on different generations.

[R3, R4] TUOMINEN, Eila, TAKALA, Mervi, FORMA, Pauli (eds.), Työolot ja työssä jatkaminen, Eläketurvakeskuksen tutkimuksia (Finnish Centre for Pensions Studies) 2, 2010, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=64853

"Study on Working Conditions and Continuing at Work"

The study consists of three articles. In the first article on the long-term trends of the working conditions in the municipal, government and private sectors in 1984–2008, sector-specific new information on working conditions and their changes is presented. The article on how to cope and carry on at work for as long as possible analyses workplace-specific issues that affect continued working and the support to carry on working. Support for continuing at work remains rare according to wage earners aged 45–64. In the article on wage-earners' retirement intentions in the 2000s, it has been established that the retirement intentions of 45–64-year-old wage earners were postponed due to a significant decrease of early retirement plans. The average intended retirement age increased by nearly one year between 2003 and 2008. The survey data consisted of the data of the Finnish Quality of Work Life Surveys from 1984 to 2008 by Statistics Finland.

[R1–R5] UUSITALO, Hannu (ed.), Työurat pidemmäksi – selvityksiä työuraryhmälle, Eläketurvakeskuksen selvityksiä (Finnish Centre for Pensions) 1, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65222

"Longer Working Lives - Clarifications for the Working Careers Group"

This report contains the background material (memorandums, projections, etc.) that was created for the use of the tripartite working group looking into working lives considering means by which the effective retirement age might be raised by at least three years by 2025.

[R1–R5] UUSITALO, Hannu (ed.), Työeläkejärjestelmän uudistamisen tavoitteiden mittaaminen –taustaselvitys työuraryhmälle, Eläketurvakeskuksen selvityksiä (Finnish Centre for Pensions) 2, 2011, Helsinki, retrieved from:

http://www.etk.fi/Binary.aspx?Section=42845&Item=65184

"Measurement of the Objectives of the Reform of the Earnings-related Pension Scheme – Background Report for the Tripartite Working Careers Group"

This report contains the background material (memorandums, projections, etc.) for options of measurements for the following three objectives that were set by the government and labour market organisations as part of the growth and employment programme for the reform of the earnings-related pension scheme:

- A sufficient level needs to be secured for earnings-related pension benefits in circumstances where life-expectancy coefficients lower future pensions considerably more than previously projected.
- Sustainability of earnings-related pension scheme financing needs to be secured by safeguarding the development of pension insurance contributions in a way which does not weaken the conditions for employment and economic growth.
- The average retirement age needs to be raised sufficiently, so that the above two objectives can be met.

[H] Health

[H2] GRÖNLUND Rainer. Pitkään kotona – kuntoutuksen avullako? Tutkimus ryhmämuotoisesta vanhuskuntoutuksesta. Sosiaali- ja terveysturvan tutkimuksia 111:2010. 218 p. Retrieved from: https://helda.helsinki.fi/handle/10138/17480

"Living at Home Longer – with Rehabilitation? Gerontological Group Rehabilitation Work Study"

The aim was to understand the group rehabilitation process of elderly people by using a qualitative ethnography method. Workers, clients and representatives of municipal social services were interviewed. The rehabilitation programmes' group and team meetings in a rehabilitation centre were videotaped. Data was collected in 2003. The multidisciplinary teams succeeded well in geriatric assessment and in achieving goals. In group-oriented rehabilitation, it was difficult to apply client-oriented methods for every individual and to use gerontological pedagogic methods. The group phenomena were difficult to apply in a heterogenic group with many different demands, possibilities and limitations. The participants appreciated the rehabilitation and their own success in managing the demanding participation. They made friends and experienced a lot together and supported one another. They received help for their problems and they learnt their lessons. They expected more group meetings to be arranged in their home municipality.

[H2] KALLIO Johanna. Hyvinvointipalvelujärjestelmän muutos ja suomalaisten mielipiteet 1996–2006. Sosiaali- ja terveysturvan tutkimuksia 108:2010. 225 p.

Retrieved from: http://hdl.handle.net/10138/15810

"Change of Welfare Services and the Evolution of Public Opinion in Finland 1996–2006"

The aim was to describe public attitudes towards local welfare services. The main questions were: 1) What was the state of public opinion about welfare services between 1996 and 2006 in Finland?; and 2) Were changes in the welfare state and welfare services followed by a change in the public opinion? The focus was on the citizens' attitudes towards the division in welfare services between public and private sector provision. Data were derived from multiple surveys collected in Finland during 1996–2006. Results indicated that citizens' support for the welfare state and public welfare services in Finland is strong. Results supported the hypothesis that the institutional, political and social context of one's home municipality is linked to one's attitudes towards welfare services. The main factor differentiating citizens' opinions was, at the macro level, the political balance of power, and, at the individual level, the respondents' party political preferences.

[H3] KLAVUS Jan. Suomalaisten terveys, terveyspalvelujen käyttö ja kokemukset palveluista.. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 28–43.

Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Health, Use of Health Services and Opinions about Services"

Health, use of health services and opinions on health services in 2004, 2006 and 2009 were described by using the materials of the interviews in the "Welfare in Finland" studies in these three years.

The development of health in the total Finnish population has been positive. The proportion of the adult population having no chronic disease and that of adults perceiving health to be good were higher in 2004 than in 1996. A similar trend continued from 2004 onwards up to 2009 in the total population and especially among those aged 55 to 65 years or 65 years or over. However, the inequality in health related to socio-economic status increased during the period from 2004 to 2009. Health measured by the occurrence of chronic diseases or by self-perceived health worsened among the population belonging to the lowest income levels. The difference in health between the population belonging to the lowest income levels and those belonging to the two highest levels of income widened.

The differences between socio-economic groups were evident also in the use of health care services in 2009. The majority of visitors to health centre physicians belonged to the three lowest levels of income, while the visits to occupational health care and private physicians were the more frequent the higher the income level of the family.

[H2] KOMULAINEN Mikko. Ulkoistaminen kunnissa: Oikeudellinen tutkimus ulkoistamisen ilmenemismuodoista ja vaikutuksista sekä ulkoistamisen rajoituksista ja sille asetettavista vaatimuksista yhtenä kunnallisten palvelujen tuottamismuotona. Acta Publications No.222. The Association of Finnish Local and Regional Authorities. Helsinki. 623 p.

Retrieved from: http://acta.uta.fi/pdf/978-951-44-8254-0.pdf

"Outsourcing in Finnish Municipalities. A Juridical Study on the Different Forms and Impacts of Outsourcing, and the Restrictions and Demands Placed on Outsourcing as one Form of Local Government Service Provision"

Since the beginning of the 2000s, municipalities have increasingly outsourced their services, which has emphasised the change in their role from service producers to that of service providers. The aim of this study was to analyse how regulations direct and constrain outsourcing; which requirements must be imposed upon it; what is meant by outsourcing; what effects it has and which problems are associated with its various manifestations. Outsourcing was divided into: total outsourcing, outsourcing of subareas and partial outsourcing.

Municipalities have been confronted with new legal issues because the various forms of outsourcing fall within many different legal areas. Applying different aspects of law is problematic from the perspective of legal administration. The role of elected representatives has changed, especially in municipalities which have adopted the purchaser-provider model.

The municipality cannot outsource functions that do not fall within its competence. In all action models and outsourcing stages attention should be paid not only to the requirements set by regulations but also to democratic considerations. Optimal preconditions for municipal autonomy must be ensured. It should be legally possible for municipalities to take a function back in-house after a certain period of time.

A problem emerging in the production of municipal services is the change in the supervision and monitoring function by elected representatives and office-holders, which fits poorly with traditional municipal administration.

From the perspective of residents, the private organ to which the functions have been delegated may not in all ways follow the same regulations or obligations as personnel under an official obligation by virtue of their employment.

The extent and content of the concept 'performance of functions' included in Section 2(3) of the Finnish Local Government Act is assessed from the perspective of outsourcing. This provision also entails the concept 'obligation to provide' which in certain aspects is legally problematic. The study will also examine statutory tasks whose outsourcing is restricted or which may not be delegated beyond the municipality or official organisation. In the various stages of outsourcing a balance must be found regarding which matters should be resolved on the basis of purely legal considerations and at which stages political directions should be taken into account.

[H2] KUIVALAINEN Susan, NIEMELÄ Mikko. From Universalism to Selectivism: the Ideational Turn of the Anti-poverty Policies in Finland. Journal of European Social Policy, July 2010; vol. 20, 3: pp. 263-276. Retrieved from: http://esp.sagepub.com/content/20/3/263.full.pdf+html

In the universalistic Nordic welfare states, targeted anti-poverty policies have not been considered as specific aims of social policy. The situation has, however, altered in Finland and there is now a new element in Finnish social policy that can be called 'anti-poverty policy'. This article explores when, how and why the policy paradigm relating to poverty changed in Finland. It includes an empirical analysis of the documents produced by key actors. Analyses show that the basic idea behind the policy prescriptions for alleviating poverty in Finland has changed from the idea of universalism to the idea of selectivism. The results emphasise that the Church, non-governmental organisations, the European Union's Lisbon Agenda as well as active opposition politics had an important agenda-setting role behind the ideational turn from universalism to the idea of selectivism.

[H2] Kunnallistalouden ja –hallinnon neuvottelukunta. Peruspalvelujen tila -raportti 2010. Ministry of Finance publications 12/2010, Helsinki 2010, 176 p. Retrieved from: http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20100317Perusp/Peruspalvelujen_tila-raportti_2010.pdf

"Synthesis Report on Basic Public Services 2010"

Opinions of Finns (N=1,009) and local councillors (N=895) about municipal administration targets of possible savings in municipalities were asked at the end of 2010, and the results were reported by the Advisory Committee on Local Government Finances and Administration. Care of the elderly was the most unpopular and least desired target of possible savings. Only 7% of Finns wanted to save expenses in the care of the elderly. 15% considered that expenses in health care might be the target of savings, 19% showed willingness to save expenses in the day care of children, and 28% thought that savings might be targeted at schools. Income support was considered to be a more appropriate target of savings: 42% put it on the list of possible saving. The opinions of local councillors about the targets of possible savings were similar to those of other inhabitants. Only 3% wanted to save expenses in the care of the elderly, while 36% showed willingness to save the expenses of income support.

[H2] MOISIO Pasi. Sosiaali- ja terveysalojen rakenne ja kehitys. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 20–27.

"Structure and Future Development of Social and Health Expenditures"

The total amount of public expenditure was EUR 91 billion in 2008. Its proportion of the GNP was 50%. Public health care accounted for 9% and public social care accounted for 6% of public expenditure, and 4% and 3% of GNP correspondingly.

According to the long-term projections made by the Ministry of Health and Social Welfare, the proportion of expenditure to public health care will increase from the current 4% to 5% by 2050. The proportion of expenditure to public social care is expected to increase from the current 3% to 4% by 2050, and the increase is mainly caused by the increase in expenditure for long-term care.

Public expenditure for social welfare and health consists of social expenditure and expenditure for social and health care services. The increase in life expectancy of the population affects the public expenditure for social welfare and health by increasing the expenditure for insurance (80% of the increase in expenditure by 2050) and the expenditure for social and health care services (20% of the increase by 2050). Thus, health and functional and cognitive abilities of the future elderly generations has an impact on expenditure on social and health care services. If all "additional" years received with the increasing life expectancy were healthy, and the need for services moved to later years of life in the future, the proportion of expenditure on social welfare and health of GNP would not increase.

[H2] MUURI Anu, MANDERBACKA Kristiina. Hyvinvointivaltion kannatusperusta. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 96–111. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Opinions about the Welfare State"

Opinions about the welfare state were described using the material of the longitudinal "Welfare in Finland" study in 2009. The results show that the Finnish population gives support to the public care sector. About 60% of respondents say that the public sector should provide all social and health care services. 30% think that the public sector should provide the majority of services, and the amount of private services should be increased.

[H1] SAARNI Samuli. Vaikuttavuuden huomiointi terveydenhuollon päätöksenteossa. National Institute for Health and Welfare (THL), Research 40. 190 pages. Helsinki 2010. Retrieved from: http://www.thl.fi/thl-client/pdfs/015a5de8-8d7f-4a78-a5c5-64f7e40e1b5b

"Effectiveness in Health Care Decision-making. An Ethical Analysis"

According to the study, the most common ethically problematic decisions facing Finnish physicians concern situations where limiting medical care is problematic: either the doctor feels the patients are treated too much, or too little. Over-treatment is most often explained by pressure from patients or relatives, whereas under-treatment is explained by inadequate resources. The results suggest there is a problem in the current way of deciding how clinical health care is decided upon: the views of the physicians, patients and those responsible for funding do not match. Effectiveness in information could be used for correcting both under- and over-treatment: on the one hand for explicit health care rationing, on the other for guaranteeing adequate treatment.

[H3] VAARAMA Marja, SILJANDER Eero, LUOMA Minna-Liisa, MERILÄINEN Satu. Suomalaisten kokema elämänlaatu nuoruudesta vanhuuteen. In: Vaarama M, Moisio S, Karvonen S (eds). Suomalaisten hyvinvointi. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p.126–149. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Quality of Life in Finns from Young Age to Old Age"

80% of Finns aged 18 to 69 years, 73% of those aged 70–79 years and 57% of those aged 80 years or over assessed their quality of life to be very good or good on average. Women assessed their quality of life to be somewhat poorer than men with the exception of indicators of social quality. Abilities to work and psychological factors were strongly related to quality of life in all age groups. Satisfaction with health and help received from family members, relatives and friends were related to good quality of life in older age groups.

[H4] VOHLONEN Ilkka, KOMULAINEN Mikko, VEHVILÄINEN Arto, VIENONEN Mikko. Ulkoistetun avosairaanhoidon toimivuus ja tulokset Kouvolassa. Suomen lääkärilehti 2010;65(9):817–827. Retrieved from: http://www.fimnet.fi/cgi-cug/brs/artikkeli.cgi?docn=000033622

"Evaluation of Outsourced Municipal Ambulatory Care"

As a solution to the shortage in supply of medical professionals prepared to work in municipal health centres, municipalities have outsourced the provision of medical services to private providers. In South-Eastern Finland, in the municipality of Kouvola, the outsourcing of ambulatory medical services started in 2007.

The evaluation was based on a quasi-experimental design with before-after measurements in 2006 and 2008 and comparisons of two outsourced health clinics with two municipally run health clinics. The evaluation criteria were based on a Balanced Score Card (BSC) frame of reference including the four main perspectives. The customer and health gain perspective was measured by Potential Years of Life Lost (PYLL). These data were based on the mortality register. The process and treatment perspective was measured by the coverage and repeated use of ambulatory medical services, treatment behaviour of physicians, waiting and recovery times related to secondary care, and the patient flows between primary and secondary care. These data were based on repeated population and patient surveys. The personnel perspective was measured by job satisfaction and the determinants thereof. The data were based on personnel surveys. The economic perspective was measured by two different methods. The use and expenditures of secondary care were measured on the basis of the DRG classified hospital discharge register of inpatients. The use and expenditures of ambulatory care were measured on the basis of the pDRG classified register of outpatients.

The evaluation demonstrated that in Kouvola, at least during the two-year follow-up period, the outsourced services in comparison to the municipally produced services did not lead to differences in either expenditures or health gains.

[L] Long-term care

[L] EINIÖ Elina K. Determinants of Institutional Care at Older Ages in Finland. Finnish Yearbook of Population Research XLV 2010 Supplement. University of Helsinki, Faculty of Social Sciences, Department of Sociology, Doctoral Dissertation 2010. 95 p. Retrieved from: http://hdl.handle.net/10138/23376

Population-based register data on Finnish older adults aged 65 and over (n=280,722) were used to analyse individual-level determinants of admission to long-term institutional care from January 1998 to September 2003. The main focus was on how chronic medical conditions, household income and other socio-economic factors, living with a spouse, and the death of a spouse were associated with admissions.

The results indicated that dementia, Parkinson's disease, stroke, depressive symptoms, other mental-health problems, hip fracture, and diabetes were strongly associated with an increased risk of admission when socio-demographic confounders and co-morbid conditions were controlled for. Older men and women in the lowest household income quintile group were more likely to be admitted to institutional care than those in the highest group, when age, first language, area characteristics, living arrangements and other socio-economic and chronic medical conditions were accounted for. Poorly equipped housing and being a tenant were associated with an increased risk of admission, and the possession of a car and living in a detached house were associated with a decreased risk. The lower risk of admission among those living with a spouse was mediated through favourable socio-economic, housing and medical conditions. The death of a spouse increased the risk of admission, the excess risk being highest during the first month following the death and decreasing over time in both genders. In conclusion, the need for long-term institutional care depends not only on the ageing of the population but also on the prevalence and severity of chronic medical conditions associated with admission, and on older people's income, housing conditions and spousal care.

[L] HEINOLA Reija, FINNE-SOVERI Harriet et al. Vanhusten kotiin annettavat palvelut ja omaishoidon palvelut. In: Kauppinen S (ed.) Terveyden ja hyvinvoinnin laitoksen asiantuntijoiden arvioita peruspalvelujen tilasta. Peruspalveluiden tila-raportin tausta-aineisto. Assessments of Experts of Basic Services. National Institute for Health and Welfare, Raportti 9, Helsinki 2010, p. 34–43. Retrieved from: http://www.thl.fi/thl-client/pdfs/0f7be8e6-0385-46a0-902d-c2f3602193a0

"Home Care Services and Help from Family Members among the Elderly"

According to the studies performed in the National Institute of Health and Welfare, family members are the most important helpers of the elderly living at home.

[L] LAITALAINEN Elina, HELAKORPI Satu, UUTELA Antti. Eläkeikäisen väestön terveyskäyttäytyminen ja terveys keväällä 2009 ja niiden muutokset 1993–2009. Terveyden- ja hyvinvoinnin laitos. Raportti 30/2010. Retrieved from: http://www.thl.fi/thl-client/pdfs/12023db0-7521-4e22-a80c-cb1dbb27b55a

"Health Behaviour and Health among the Finnish Elderly, Spring 2009, with Trends 1993–2009"

The National Institute of Health and Welfare has carried out surveys about the health behaviour, health, functional abilities, use of home care services and feelings of security among the Finnish population aged 65 to 85 years biennially since 1985. Stratified random samples drawn from the Population Register have been used to select the respondents. The results of the survey made in spring 2009 were published in 2010, and comparisons with the results of previous surveys during the period 1985–2007 were made.

The longitudinal comparisons showed that food habits of older Finns have markedly improved during the period from 1985 to 2009. Use of butter has decreased and skimmed milk is chosen more and more often as the preferred type of milk. Use of vegetables and fruits and berries has increased. Smoking among older men has decreased since the mid 1980s, and among women it has remained at a low level. The use of alcohol has increased particularly among men and women aged between 65 and 74, and abstinence has decreased over the long-term. Being physically active frequently at least four times a week has become more uncommon.

Functional abilities and abilities to cope with daily activities have improved during the research period. Feelings of security have decreased between 2003 and 2009. The factors causing insecurity in 2009 were scarcity dependent on other's help and a weakening of memory.

[L] MUURI Anu. Väestön mielipiteet sosiaalipalveluista.. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 78–95. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Opinions about Social Services"

Opinions about social services and changes in opinions were described using the materials of the "Welfare in Finland" study collected in 2004, 2006 and 2009. The population seems to trust in social services, although somewhat more criticism is stated in 2009 compared to earlier years. Trust in receiving home help when one is in need of this service has declined during the years from 2004 to 2009.

[L] MÄKINEN Tomi. Trends and Explanations for Socioeconomic Differences in Physical Activity. National Institute for Health and Welfare (THL), Research 41, 138 pages. Helsinki, Finland 2010. Retrieved from:
https://helda.helsinki.fi/bitstream/handle/10138/20337/trendsan.pdf?sequence=2

This study examines a) how socio-economic differences in leisure-time and commuting physical activity have changed in Finland from 1978 to 2002 and b) the contribution of childhood socio-economic position, adolescence sports and exercise, adulthood socio-economic position, working conditions and other adulthood health behaviours to socio-economic differences in leisure-time physical activity.

This study utilised three population-based datasets collected by the National Institute for Health and Welfare. Survey information was collected by self-administered questionnaires, interviews at home, and measurements made at the study site.

Those with low income were physically inactive during leisure time and while commuting from 1978 to 2002. Manual worker women, however, were more physically active commuters compared to their counterparts. Parental socio-economic position contributed directly to

adulthood educational differences in leisure-time physical inactivity but also indirectly through adulthood socio-economic position (occupation, household income) and other unhealthy behaviours (mainly smoking). Among those with low education, participation in competitive sports in youth and, among those with high education, exercise in late adolescence contributed to leisure-time physical activity in adulthood. Long exposure to physically strenuous working conditions in men and current job strain in women contributed to occupational class differences in leisure-time physical activity.

Socio-economic differences in physical activity have remained similar for twenty years in Finland. Educational career seems to have a strong contribution to physical activity. To adopt a lifelong physically active life-style, one should participate in a range of different sports and exercise in adolescence and in youth, have a low exposure to physically and mentally strenuous working conditions in later life and have other healthy behaviours in later life.

[L] SINERVO Timo, NORO Anja, TYNKKYNEN Liina-Kaisa, SULANDER Juhani, TAIMIO Heikki, FINNE-SOVERI Harriet, LILJA Reija, SYRJÄ Vesa. Yksityinen vai kunnallinen palveluasuminen? Kustannukset, asiakasrakenne, hoidon laatu ja henkilöstön hyvinvointi.. National Institute for Health and Welfare, Raportti 34/2010, Helsinki 2010, 91 p.

Retrieved from:
http://www.thl.fi/thl-client/pdfs/3b5d56f5-e461-414e-bc4d-f70be2952269

"Sheltered Housing – Private or Municipal? Costs, Clientele Structure, Quality of Care, and Well-being of the Personnel"

Earlier studies on the effects of the use of private services and competitive bidding have provided rather conflicting results.

Research data were collected from 134 enhanced sheltered housing units for elderly residents. Of the total, 53 sheltered accommodation units belonged to municipalities, 29 to commercial enterprises and 52 to non-profit private organisations. In addition, 45 units located in nursing homes were included in the project.

Sheltered housing units belonging to municipalities, commercial enterprises and non-profit organisations differed in their client structure and costs. The units belonging to enterprises and non-profit organisations were mainly dementia units, whereas the residents of municipal units were very diverse. Residents of municipal units were clients needing assistance in their daily activities, and they included clinically demanding clients and clients exhibiting a variety of dementia symptoms. Clients in municipal units required slightly less care, though the units had clearly lower staffing levels. The units belonging to non-profit organisations had decidedly the most clients requiring plenty of assistance. Non-profit units had the highest staffing levels and operating costs and municipal units had the lowest costs. Taking client care needs into consideration, the units belonging to enterprises were slightly more expensive than the units belonging to non-profit organisations and the municipal units were the least expensive.

The results for the quality of care differed depending on the quality factor measured. More residents of municipal sheltered housing used more than nine medicines, while in private units fewer clients used so many medicines. Non-profit organisation clients used more sedatives and hypnotics than clients in other facilities. In the municipal sheltered units, again, the clients had better access to mobility aids. Untreated pain and depressed mood were more commonly found in municipal units.

In the sheltered housing belonging to non-profit organisations, factors related to staff well-being came out the best. Management, work satisfaction and control over work (autonomy and the use of skills) were at a high level in municipal sheltered housing, though stress among the staff was high. There was little stress in sheltered housing belonging to enterprises, but management, employee autonomy and satisfaction were at a lower level.

The results indicate that there are differences between the private and the public provision of services, but no clear order of superiority can be established.

[L] Suomen lähi- ja perushoitajaliitto SuPer ry. (The Finnish Union of Practical Nurses) Usein joutuu miettimään, mikä on heitteillejättöä, mikä ei. Selvitys laitospaikkojen vähentämisen vaikutuksista kotihoitoon. Suomen lähi- ja perushoitajaliitto SuPer ry., Helsinki 2010, 28 p. Retrieved from:

http://www.superliitto.fi/datafiles/userfiles/File/ajankohtaiset/SuPer_Selvitys_kotihoito_2010_verkkoon.pdf

"The Effects of the Decrease in Beds in Long-term Institutional Care on Home Care Services"

The Finnish Union of Practical Nurses sent a questionnaire to the members of the union (N=4,500) who worked in home care. The aim was to assess the effects of the decrease in the amount of beds in long-term hospitals on home care. The results showed that home care patients are nowadays physically and cognitively more disabled compared to patients about 3 years earlier. Many home care patients live alone, are unable to walk outside home or have memory disturbances. According to home care workers the number of patients who want to leave their homes and to move to sheltered housing is not very small. Visiting times of workers are short, and the workers manage to do only basic tasks (washing, bathing, warming of food, asking about well-being and symptoms and delivery of medicines). 15% of the respondents felt that working in home care is physically too heavy. About half of the respondents stated that their workload is nowadays heavier compared to the workload about 3 years earlier.

[L] SYRJÄ Vesa. Vanhusten asumispalveluiden kilpailuttamiskokemukset.. National Institute for Health and Welfare, Raportti 35/2010, Helsinki 2010, 102 p. Retrieved from: http://www.thl.fi/thl-client/pdfs/85fa11a2-b520-4918-b579-f20e12fd815f

"Competitive Tendering Experiences in Sheltered Housing for Older People"

Competitive tendering is a recent phenomenon in social and health services. Services were provided by municipalities, and services purchased from outside of the municipal organisation were acquired directly through negotiations during the previous years. Long-term care, especially sheltered housing, is nowadays commonly organised by competitions. Four major cities (Helsinki, Espoo, Vantaa and Tampere) were selected for the study about the competitive tendering processes for sheltered housing for older people and about the results and impacts of competitions. The period covered the years from 2006 to 2008. Semi-structured thematic interviews of purchasing officials in the municipalities and private service providers and tender documents were used in collecting data.

Competition existed among suppliers because supply exceeded demand in these big towns. The terms of quasi-markets were only partially realised. Competitive tendering in its current

form increases the service price because suppliers try to eliminate the financial risk included in a framework agreement.

The tightening of quality criteria and the increasing need for services caused by the ageing population contribute to the higher price level. Absolute quality criteria used in competitive tendering and agreements that are defined more tightly are used to guarantee a certain minimum quality standard for clients.

Quality criteria are focused on the structural and processing factors of services. There are few quality criteria in use that relate to the outcome and effectiveness of care-giving activities. Competitive tendering in its current form does not increase client options because vacant sheltered housing places are filled from a waiting list for care, and the standardisation of services makes the provision of services more unbalanced.

[L] Säännöllinen kotihoito. Kotihoidon laskenta 30.11.2009. National Institute for Health and Welfare. Tilastoraportti 16/2010. Retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/toimivaterveyskeskus

"Count of Regular Home-Care Clients, 30.11.2009"

Data for 2009 show that the percentage of older people regularly receiving home-care services stayed at about the same level as the year before. At the end of November 2009, 11.4% of the population aged 75 and over were receiving home-care services on a regular basis. The proportion varied between different regions, between 9% and 15.3%. The aim of 13–14% set in the quality recommendations for services for the elderly was exceeded in many municipalities: 131 municipalities exceeded 13%, while 107 municipalities had figures of over 14%.

People in need of continuous 24-hour care accounted for 6% of all regular home-care clients. The proportion varied between different regions between 3.3 and 22.2%. Just under a quarter (22.5%) of clients receiving home-care services had more than 60 visits a month. There are considerable differences between regions in the number of visits. There was a great deal of variation in the number of visits even to the most elderly clients.

More than half (55.3%) of clients entered regular home care directly from home. Just over a quarter (27.2%) of the clients came from a hospital or health centre. In most cases, the reason for admission was physical (26.9%) or neglect of personal care (25.9%).

It was estimated by the staff that a great majority (85.2%) of clients had received the treatment best suited to their needs, i.e. home care. It was further determined that 2,943 clients (4.5%) could manage at home by themselves, without regular home-care services.

[L] VAAPIO Sari, SALMINEN Marika, HINTSALA Malla, VAHLBERG Tero, KIVELÄ Sirkka-Liisa. Iäkkäiden arvostus ja vanhusten hoito ikääntyvien arvioimana. Yleislääkäri 2010;6:24–9. (. J Gen Pract) Retrieved from: http://www.coronaria.fi/vaihe3/yle/kl/YL1006.pdf

"Are the Elderly Appreciated? Opinions of Elderly Finns"

Finns aged 65 to 70 years were asked their opinion by telephone calls about the overall appreciation of the elderly in Finland and the quantity and quality of care of the elderly. About half of the respondents thought that the elderly are not appreciated in Finland. Nearly half thought that the appreciation is nowadays poorer than in previous years. According to

every fifth respondent, the quality of care of the elderly is good, but every third respondent thought that the quality is rather or very poor. Every third respondent was concerned about the quality of care in the future, and presumed a change to poorer and poorer care.

[L] VAARAMA Maria, SILJANDER Eero, LUOMA Minna-Liisa, MERILÄINEN Satu. 80 vuotta täyttäneiden koettu elämänlaatu.. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 150–167. Retrieved from: http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Quality of Life among the Population Aged 80 Years or Over"

Quality of life, functional abilities and housing of the population aged 80 years or over were described by using the data from a longitudinal "Welfare in Finland" study.

There is evidence that a positive development in functional abilities of the elderly occurred in the 2000s. The comparisons between the year 2004 and the year 2009 show that the functional abilities of the population aged 80 to 84 years were better in 2009. Some positive changes were evident also amongst those aged 85 years or over.

The development in housing facilities of the elderly – as measured by the equipments in the homes – has been positive. In 2009, about every tenth person aged 80 years or over had inadequate washing facilities at home, and less than every tenth had inadequate cooking facilities. In 2009, about every tenth elderly person reported to have barriers at home which cause problems in moving indoors. The corresponding proportion was nearly 30% in 2004. Although the dwellings are nowadays better than previously, every tenth old person lives in a dwelling with poor facilities.

[L] VILKKO Anni, FINNE-SOVERI Harriet, HEINOLA Reija. Ikäihmisten palvelutarpeet ja saatu apu. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 44–59. Retrieved from:
http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Need of Services Among the Elderly and Sources of Help"

Service needs and sources of help among the population aged 80 years or over in 2009 were described based on the interviews made in the "Welfare in Finland" study. The results showed that many elderly home care patients live alone at home, and they have very few social contacts. Feelings of loneliness are common. Distrust in home care services is quite common. Family members are the most important persons who give advice to the elderly.

[L] VILKKO Anni, MUURI Anu, FINNE-SOVERI Harriet. Läheisapu iäkkään ihmisen arjessa. In: Vaarama M, Moisio P, Karvonen S (eds). Suomalaisten hyvinvointi 2010. Well-being in the Finnish Population in 2010. National Institute for Health and Welfare, Helsinki 2010, p. 60–77. Retrieved from:
http://www.thl.fi/thl-client/pdfs/8cec7cec-5cf3-4209-ba7a-0334ecdb6e1d

"Help by Family Members in the Older Population"

Help provided by family members was described in a population aged 80 years over using the data of the "Welfare in Finland" study from the year 2009.

The political aim to decrease the proportion of elderly in long-term institutional care and to increase the proportion of elderly living at home has increased the amount of elderly with memory disturbances or strong physical disabilities who live at home. Although the municipalities have increased the amount of personnel working in home care, there are unmet needs. Family members are the most important persons who help the elderly living at home. Many young, middle-aged and elderly persons help their old family members daily. Middle-aged persons working outside home and helping their old family members daily and old couples in which a wife or a husband helps her/his demented or disabled spouse belong to risk groups of burn-out, depression and sick leave. The poor quality of home care is a risk factor for the aim to lengthen working careers and for the aim to increase the amount of old persons living at home.

[L] ZECHNER Minna. Informaali hoiva sosiaalipoliittisessa kontekstissa. University of Tampere, Department of Social Research, Doctoral Dissertation 2010. 115 p. Retrieved from: http://acta.uta.fi/pdf/978-951-44-8190-1.pdf

"Informal Care in the Context of Social Policy"

This study analyses informal care of older people defined as help given to one another by adults who are close. The data consists of interviews with people in need of care and of those giving care. The topics of the interviews consisted of practices and stages of care, and about interviewees' attempts to seek benefits and services and their experiences as users of them. Turning points and stages of care, negotiating processes concerning care and transnational care were the issues which were analysed.

Very personal and often very intimate needs of a person are fulfilled in the care process. Many elderly persons receive care from people who are close and from services. In care services, trust is placed twofold. It is important to be able to trust the organisation which hopefully offers services as the laws dictate, and it is necessary to trust the professionals who do the practical work. Informal care is based on common history, closeness of the relationship, duty or money.

The actions of professionals are regulated by the laws, rules and instructions. These different actors need a joint understanding about the need for care of and how and by whom it will be answered. Changing needs for care or changes in the life situations of carers or of those in need of care create a new process of verifying the need.

The social policy context of informal care expands when the carer and the person in need of care reside in different countries. In transnational care the connections with different social policy systems may become manifold. A great part of social policy systems are national, and they do not recognise or offer support to transnational caring activities.

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: Pitkänsillanranta 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 juhlavuoden 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
Mail: 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.

Työterveyslaitos – The Finnish Institute of Occupational Health

Address: Topeliuksenkatu 41 a A, 00250 Helsinki, Finland
Phone: +358 30 4741
Webpage: http://www.ttl.fi/internet/english

The institute is a research and specialist organisation in the sector of occupational health and safety. The tasks cover scientific researches and developmental projects.

Työeläkevakuuttajat TELA – The Finnish Pension Alliance

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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.

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.

Valtioneuvoston kanslia – The Prime Minister's Office

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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.

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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