Annual National Report 2010

Pensions, Health and Long-term Care

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Authors: Sirkka-Liisa Kivelä, Mika Vidlund

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Equal Opportunities

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1 Executive Summary

Pensions

There have been no remarkable changes in the system's characteristics since 2005. In the national pension scheme the employers' contribution has ceased since the beginning of 2010 and is financed solely by the state. A minimum guaranteed pension above the level of the national pension will be introduced in 2011. In the earnings-related pension system contributions will be raised annually by 0.4 percentage points during 2011–2014. Recent political debates concern lengthening the working career and postponing the retirement age. A target has been set of raising the effective retirement age gradually by at least three years by 2025. Working groups have been established to discuss this issue. A life expectancy coefficient determined for the first time in 2009 has become effective for those retiring from 2010 onwards, and this will adjust new pensions to higher life expectancy to strengthen the sustainability of the pension system. Citizens are also encouraged to prepare for retirement on their own initiative. The Act on long-term savings, which entered into force on 1 January 2010, introduces a new alternative to voluntary pension insurance.

Health

Municipalities have the responsibility to organise and provide public health and specialised hospital care to their residents. Employers have to provide preventive and first-aid services at work for their employees. The role of the private sector is mainly complementary. Development of primary health care is at the top of the programme list of the Government. Development of health services by implementing national programmes funded by the state and municipalities continued in 2009. An Act to combine primary health care and specialised hospital care into a comprehensive health care was prepared, and will be discussed in Parliament in spring 2010. It is intended to be implemented in 2011. An Act to give nurses with special training permission to subscribe certain medications was prepared, and the proposed Act will be discussed in Parliament in spring 2010. The Ministry of Employment and Economy initiated a strategic development project for the welfare sector in order to allow for the growing needs of services in the social welfare and health care sector.
The Association of Finnish Local and Regional Authorities drew up a concrete programme to save costs in municipal services during the financial and economic crisis. The crisis has not yet strongly impacted on the availability of health care services.

Long-term care

Municipalities are responsible for organising and providing long-term care to their residents. The opportunities for the aged to choose services were increased by expanding the service voucher programme. The Ministry of Social Affairs and Health prepared changes in the legislation which permit disabled persons in long-term care to select the municipality in which they reside. The Ministry of Education prepared an action programme on the well-being effects of art and culture. Development of long-term care by art and culture belongs to the objectives of the programme, which will be implemented in 2010–2014. Long-term care of the aged was strongly criticised in mass media, and specific legislation to ensure care of the aged was demanded by citizens and non-governmental organisations. The minister responsible for social and health care services promised in August 2009 that an Act of this kind will be drawn up in the near future.

Municipalities have tried to reduce the costs of long-term care in many ways: low prices were stressed in making contracts with private companies, numbers of incontinence nappies were decreased and even the quality of meals was decreased.

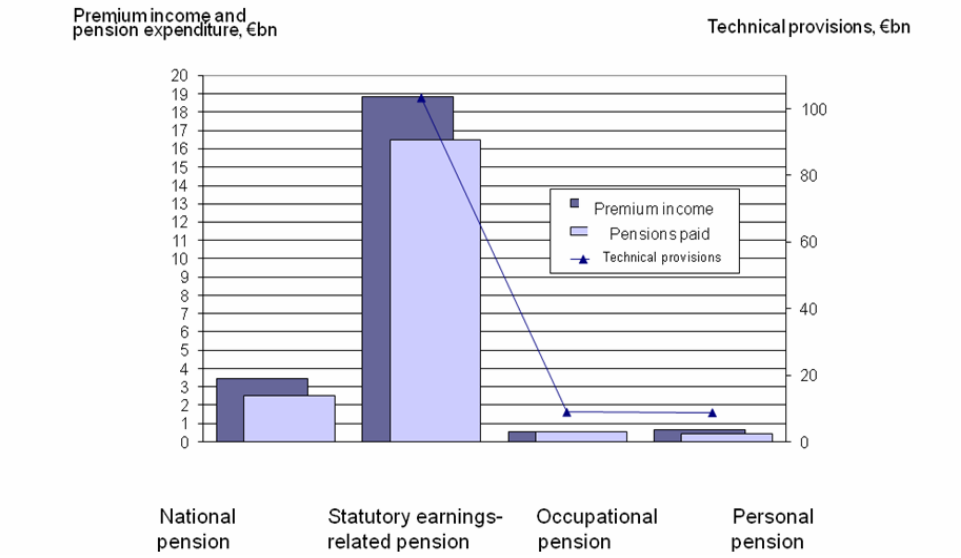
2 Current Status, Reforms as well as the Political and Scientific Discourse

2.1 Pensions

2.1.1 Overview of the system's characteristics

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 1).

Figure 1: Pension insurance in Finland in 2008.

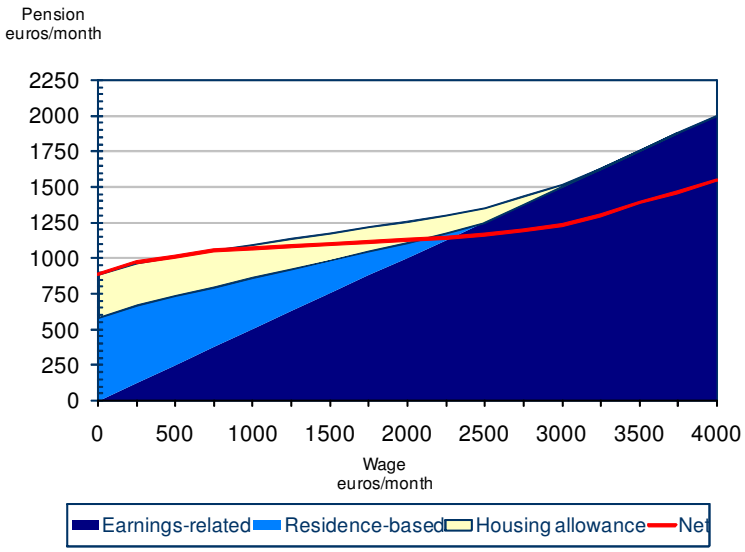


Source: Financial Supervisory Authority 2010; Finnish Centre for Pensions 2010; Kela 2010.

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 2). Earnings-related pensions reduce the national pension by 50%. Pensioners who receive no earnings-related pension at all or whose earnings-related pension is less than EUR 1207.38 per month (for single persons) are entitled to a national pension.

The total statutory pension expenditure in 2009 was slightly over 12% of the estimated GDP (10.8% in 2008), of which the employment-based, earnings-related pensions accounted for close to 90%, and the national pensions for the rest. In the future, the share of the national pensions in the total pension income will diminish (or remain constant, at most, depending on the level of increases made to the national pensions in addition to annual indexation), as the level and the coverage of earnings-related pensions will rise. The increase in pension expenditures in 2009 can be mainly explained by increased old-age pension expenditure and due to recession which shrank the GDP.

Figure 2: Earnings-related pension, national pension and pensioners' housing allowance 2010.



Source: Finnish Centre for Pensions, 2010.

In 2008, statutory earnings-related pensions were received by about 94% of all pension recipients, and national pensions by about 49%. About 7% of pensioners received a full national pension. Of those, 60% received disability pensions (mainly middle-aged men) and 40% old-age pension (mainly old-aged women).

The full national pension is granted on the basis of 40 years of residence in Finland. In 2010, the full national pension is EUR 584.13 per month for single and EUR 518.12 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.

As from 1 January 2010 national pensions are financed solely by state. Before that they were financed by contributions of employers and by the state. Employer contributions were lowered (0.8 percentage points) on 1 April 2009 and as a consequence abolished already then for a large number of employers.

The central government will compensate for the impact of lowering the labour costs by increasing income transfers made to social security funds. In connection with the abolition of the employers' national pension contribution, it was decided that replacement revenue would be found by raising energy taxation by around EUR 750 million in 2011. The aim is thus to implement balancing measures at a later date; at time when the recovery of economic conditions is expected to be on a stronger foundation.

National pensions are administered by the Social Insurance Institution supervised by 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 (19) and industry-wide pension funds (7). In addition farmers and seamen have their own funds. The Ministry of Social Affairs and Health is in charge of the general supervision of the private sector earnings-related schemes. Central and local government employees have their own earnings-related schemes. In principle, the pension benefits are similar for all sectors. While the administration of the earnings-related pension scheme is decentralised to several pension providers, some functions are handled centrally at the Finnish Centre for Pensions.

Employers' and employees' organisations have a strong position in 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 the 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. Approximately three quarters of the earnings-related pensions are financed through PAYG, with the pre-funded scheme covering the rest. The market value of the pension fund's assets was 73% of GDP in 2009. Despite being partially funded, Finland's earnings-related pension scheme is of the defined-benefit type. 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 4.0% (2008) to about 3.0% in 2009 (Ministry of Finance, 2010).

The 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 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.

Generous accrual rate for older workers (i.e. 4.5%) should work as a carrot encouraging continuing at work. However, also stick is used by using life-expectancy adjustment at retirement. When the old-age pension starts it is multiplied by the life expectancy coefficient which adjusts the earnings-related pensions automatically to changes in longevity. The coefficient will be determined for each cohort at the age of 62 years. It is the same for men and women. The coefficient was determined for the first time in 2009 for those born in 1947, when it was given the value 1. If life expectancy increases after this, the coefficient will decrease. Correspondingly, if life expectancy decreases, the coefficient will increase. The first cohort whose old-age pensions it affects are people born in 1948. The coefficient for the year 2010 is 0.99170.[1] The coefficient is also applied to disability pensions, and this will be discussed later on in chapter 2.1.2.

The underlying idea of the coefficient is to eliminate the extra burden for the pension system due to increased longevity. Together with the flexible retirement age, individuals have a possibility to choose whether they want to compensate the effect of the life expectancy adjustment and remain in the work force for a longer period of time, or retire with a lower pension. Broadly speaking, if life expectancy increases by four years, one must work two years more between 63 and 68 to compensate the impact of the life expectancy coefficient, i.e. to keep the replacement rate. In 2010 the life expectancy coefficient will reduce pensions on retirement by 0.8%, and this can be offset by working for one month longer, whereas people born in 1970 should work for 24 months longer (Elo & Hietaniemi 2009).

A part-time pension can be granted to an insured person aged 58–67 who has been permanently in active employment over the past few years. The working hours should be reduced so that the earnings from the part-time work amount to 35–70% of the earnings for the full-time work. The size of the part-time pension amounts to 50% of the difference between full-time and part-time earnings, but still up to a maximum of 75% of the old-age

[1] The calculations use lagged mortality data: for 2010, for example, the data are the average for 2004–08 compared to base year which is based on data for 2003–07.

pension accrued until the start of the part-time pension. In the national pension system a part-time pension does not exist.

The lower age limit for the part-time pension will be raised to 60 years from the current 58 years. At the same time 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. Persons who are older than this are still covered by the old rules

Unemployment pension may be awarded to a long term unemployed person born before 1950 both in national and in earnings-related pension schemes. The subsistence for the younger age groups of unemployed will be covered by unemployment benefits. The qualifying age for the unemployment pathway to retirement was increased from 59 to 60 years. This arrangement refers to the possibility to collect Unemployment Allowance for additional days. The changed rule applies to job seekers born in 1955 or thereafter.

Disability pensions in earnings-related pension schemes may be granted to insured persons who have reached the age of 18 but not yet 63. Depending on the reduction of their ability to work and on the earnings level, the disability pension is paid either as a full pension or as a partial pension. The partial disability pension is half of the insured's full disability pension. The disability pension consists of the pensions accrued during the work history and of the accrued pensions for the projected pensionable service, which is calculated from the year of the start of the disability to the age of 63. The requirement for the entitlement to a pension for the projected pensionable service is that the insured has earned at least a minimum amount during the 10 years preceding the start of the pension. The wage for the projected pensionable service is determined on the basis of the earnings of the five years preceding the year of the pension contingency, revalued in line with the wage coefficient.

Disability pensions in national pension schemes may be applied for persons aged 16–64. Partial pensions (partial disability and part-time pensions) are not paid from the national pension scheme.

Special assistance for immigrants may be awarded to claimants over the age of 65, and between ages 16 and 64 for those unable to work. Claimants must have lived in Finland for a consecutive period of at least five years after reaching the age of 16 and also before the assistance is to be paid. The amount of the assistance is reduced by the disposable income of the applicant and his/her spouse or cohabiting partner. This assistance will be replaced with the forthcoming guarantee pension (discussed later on).

The pensioners' average pension in their own right (does not include survivors' pensions) was EUR 1,263 a month in 2008 (EUR 1,344 in 2009), about 44% of the average income (EUR 2,876[2]) in the said year. For men EUR 1,437 (2009: EUR 1,530) and for women EUR 1,125 (2009: EUR 1,196).

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

The purchasing power of national pensions is retained by annual indexation based on the consumer price index. The national pension level remained unchanged in 2010. Under a

[2] Statistics Finland's Structure of Earnings statistics, retrieved from: http://www.stat.fi/til/pra/2008/pra_2008_2009-11-06_tie_001_en.html.

separate statute, the index was fixed at its 2009 level. Otherwise the rates of the national pension would have fallen 0.8% as a result of a declining price index. In addition to changes based on consumer price indexation there has been, from time to time (2001, 2005, 2006 and 2008 the latest), a so called "level increase" of the national pensions.

Statutory pensions are taxed as labour income (progressive tax rate) with special deductions (pension deduction) applying for smaller pensions. Those who get a national pension only are factually not taxed as a result of deductions.

2.1.2 Changes in the system's characteristics since 2009

As from the beginning of 2009, the taxation of pensioners has been changed. Before 2009, the incomes of pensioners were taxed more heavily than the salaries in certain income groups, owing to increased tax deductions with regard to earned income. Thanks to complicated changes the taxation is now about the same.

Statutory pension coverage was improved from the beginning of 2009, and grant holders have their own earnings-related pension insurance scheme. Previously grant holders were covered by basic provision, i.e. national pension. Now, artistic and scientific work financed through grants is put on a par with salaried work.

Employers' associations and trade unions made an agreement on 21 January 2009, commonly called the "social package". This package was part of the work under state committee (SATA) reforming the social protection (MSAH 2009a[3]). An important part of it dealt with unemployment benefits which were under preparation in a committee. But the pension policy played also a notable role and changes in part-time and disability pensions as well as changes of the financing systems were agreed in the package.

As mentioned above, the age limit for the part-time pension will increase from 58 to 60 as of 2011. Furthermore, there will no longer be any pension accrual for the decrease in income. The changes to the part-time pension concern persons born in 1953 and later.

Disability pensions paid under the statutory earnings-related pension insurance were increased at the start of the year through various measures, including an increase in the percentage by which pension entitlements accrue for projected service between the ages 50 and 63. The accrual rate for the whole period of projected pensionable service (from the year of onset of disability to the age of 63) will be 1.5%. If the disability started before 2010, the accrual rate is as before 1.5% from the year of onset of disability to the age of 50 and decreases to 1.3% after that.

The earnings on which the pension component for projected pensionable service is based were also improved. Especially persons who become incapable of work at a very young age will benefit from the change, whereby periods of study and periods of child home care allowance will be taken into account. The presumed earnings taken into account for these periods will be EUR 1,289.12 per month in 2010. This is double the amount of presumed earnings on the basis of which old-age pension accrues for such periods.

In addition the disability pension or the cash rehabilitation benefit are increased by a lump sum when the pension has continued for five full calendar years. The amount of the lump-sum increase depends on the pension recipient's age at the beginning of the year of the increase. The increase is 25% for those who are aged 24–31. The increase is reduced by 1 percentage point for each year from the age of 32. Persons who are aged over 55 at the beginning of the

[3] Agreement has been published in the SATA committee's pre-report (27 January 2009) presenting a proposal for the most important policy lines in the total reform of social protection (Annex 1 in the MSAH 2009a).

year of the increase do not receive a lump-sum increase. The lump-sum increase is also awarded to persons who already draw a pension. It was carried out for the first time at the beginning of 2010, at which time it concerned pensions which started before 2005.

The life expectancy coefficient applied to disability pensions was also changed. A new, commencing disability pension is multiplied by the life expectancy coefficient calculated for those who turn 62 years in the year of onset of disability. The coefficient applied is thus not the coefficient for the disabled person's own age group. However, only that part of the pension which has accrued up to the year of onset of disability is multiplied by the life expectancy coefficient. The pension component for projected pensionable service is not. This means that the younger a person who is actively participating in the labour market is when becoming disabled, the smaller is the effect of the life expectancy coefficient on the pension.

When the life expectancy coefficient is applied to the pension in this way, it means that the commencing disability pension itself will in the future be slightly lower than before, but the old-age pension will increase. The reason for this is that at the time of retirement age, the old-age pension will no longer be separately multiplied by the coefficient. Thus, the effect on the old-age pension of the life expectancy coefficient for a person who has taken a disability pension will be slighter than without the reform, because a more favourable life expectancy coefficient of an older cohort will be applied to this person.

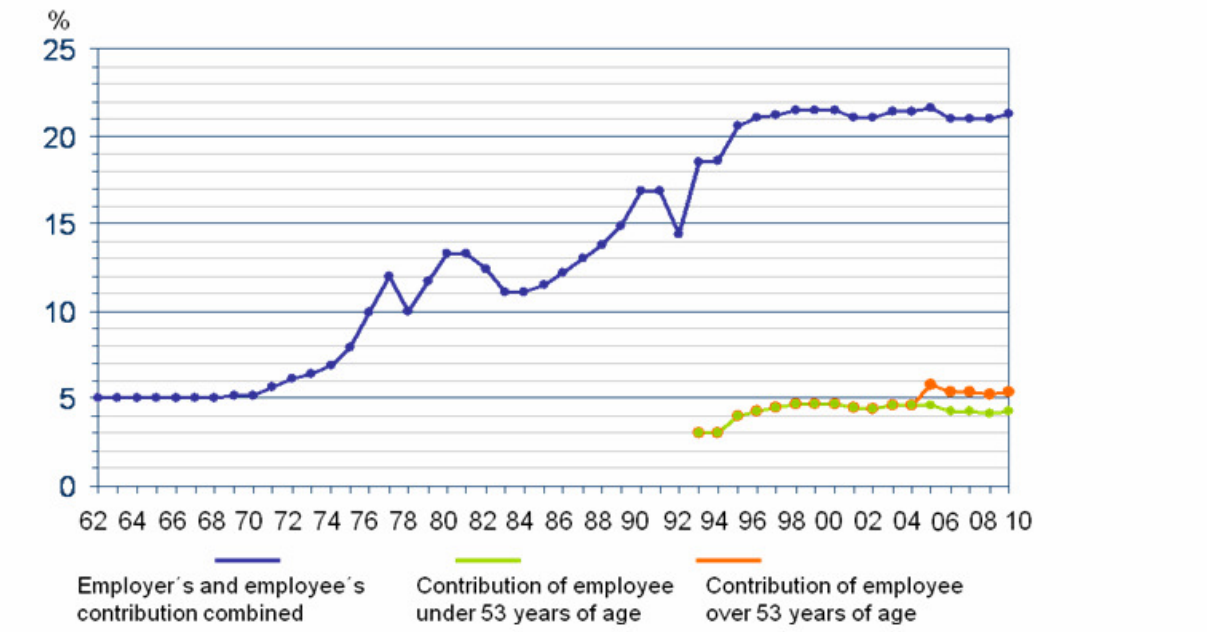
The different parts of the reform ("social package") will affect pension expenditure in different ways. As a whole, pension expenditure will increase slightly due to the combined effect of the changes. According to projections made by Finnish Centre for Pensions, changes in part-time pension will cut expenditure -0.17% by 2055 whereas changes concerning disability pension and adjustment in life-expectancy will increase expenditures by 0.87%. (Risku & Klaavo 2009a; 2009b)

Another reform concerning disability pensions is the possibility for disability pension recipients to re-enter working life or to participate in work try-outs. Possibilities to work were improved at the start of the year 2010 by raising the earnings limit up to EUR 600 per month on top of one's national pension or earnings-related pension 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 600 or the above-mentioned limits, the pension can be set aside for at most two years, without the fear of losing the approved disability pension if working proves to be impossible. The act (738/2009[4]) is temporary and in force from January 2010 to the end of 2013.

For pension financing, the above-mentioned "social package" included an agreement to increase contributions. The earnings-related pension (TyEL) contribution paid by employees and employers in the private sector will both be raised by 0.2 percentage points annually in the period 2011–2014, i.e. in total by 1.6 percentage points. Currently (2010), the average TyEL contribution is 21.6% of wages (21.3% in 2009) (Figure 3).

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

Figure 3: Average TEL/TyEL contribution in 1962–2010, % of wages.



Source: Finnish Centre for Pensions, 2010.

Proposals of the SATA Committee for reforming social protection will be implemented during the budget planning period.[5] Major social policy measures that have already been decided on include: a guaranteed pension which will increase the lowest pensions will be introduced on 1 March 2011[6]; and the minimum rehabilitation allowance and different daily allowances, child benefits, home care allowance and private care allowance for children, which have not been covered by index protection, will be linked as from 1 March 2011 to the national pension index reflecting the change in consumer prices.

The level of guaranteed pensions would stand at EUR 685 per month in current money, which is EUR 100 higher than the full national pension of today. The committee puts the idea as follows: "To guarantee a fair level of smallest pensions, a minimum pension will be adopted. It should secure better than the existing pension system the subsistence especially of those who have been disabled from their childhood. Its amount should be higher than the full national pension, and it would not otherwise change the general principles of the national pension scheme and the earnings-related pension system scheme." The reference to disabled pensioners is understandable by the fact that 60% of those who only get national pensions receive disability pensions, and the remainder old-age pensions.

The logic of the proposed minimum pension system becomes clear with the help of the following calculations. The costs of an increase of the smallest pensions by EUR 100 per month using the proposed minimum pension system amount to about EUR 110 million. It would increase the pensions of about 120,000 pensioners. If the same increase were realised by raising the national pension of about 675,000 pensioners, the cost would be about EUR

5 The Government set up a social protection (SATA) committee in 2007 to overhaul the social protection system. The aim is to create more incentives for people to work, to reduce poverty and to ensure an adequate level of social protection in all life situations. The Government has stipulated that the committee's proposals must be such that they do not pose a risk to the sustainability of the public finances in the long term. The committee completed its work at the beginning of December 2009 (MSAH 2009b).

6 The Government decided on the contents of the bill on 15 April 2010, and the President of the Republic presented the bill (HE 50/2010) to Parliament on 23 April.

810 million. Until now, the position of those pensioners with the smallest incomes has been improved by changing all national pensions by the same amount.

Alongside pension reform, the unemployment security system has been reformed. 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, will rise by one year to 58 from the beginning of 2011. Unemployment allowance is then paid until the employee reaches the age of 60 years (currently 59), 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.

Citizens are also encouraged to prepare for retirement on their own initiative. The premium income from individual voluntary pension insurance under the third pillar has been increasing for several years.

The act (1183/2009[7]) on long-term savings, which entered into force on 1 January 2010, introduces a new alternative to voluntary pension insurance. With effect from 1 April, individuals have the possibility to enter into a pension savings agreement (PS agreement) that enables them to save through shares, bonds, investment funds and accounts provided by banks and fund management companies, as well as other intermediaries. The Government wants to increase savings for retirement but also to increase competition, while at the same time reducing costs and boosting transparency in the market. The voluntary pension market in Finland has until now been insurance-oriented.

This savings form will also include tax incentives. The former right of deduction for pension insurance premiums is now extended to cover also long-term savings, other than insurance savings, covered by the legislation. Premiums are tax-deductible up to the amount of EUR 5,000 per year. Individuals' savings will be allocated to personal accounts and only taxed when benefits are paid, according to the EET system[8]. 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.

2.1.3 Reforms under discussion

Finland's pension system has been reformed on several occasions since the early 1990s. The most recent comprehensive reform took effect at the beginning of 2005. The aim is to strengthen the sustainability of the pension system by adjusting pensions to changes in life

7 Laki sidotusta pitkäaikaissäästämisestä (PS-laki). Retrieved from: http://www.edilex.fi/saadokset/smur/20091183.

8 "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.

expectancy and encouraging older workers to stay longer in employment. The employment rate among older workers has been rising considerably, indicating that the pension reforms have served their purpose. The employment rate in the age group 55–64 has risen from 35.6% in 1997 to 56.5% in 2008 and is well above the EU average (Eurostat 2010).

However, the recession has exacerbated the challenges arising to public finances from population ageing. As a post-recession exit strategy and to reduce the impact of population ageing, the Government outlined its aim of extending working careers, e.g. by shortening study times and raising the retirement age, in a statement made on 24 February 2009. For pension policy the most visible means was the announcement to raise the minimum retirement age for earnings-related pension from 63 to 65 years. With this procedure the Government took the initiative into its own hands, departing from the normal practice of tripartite decision-making process usually adopted when developing collective framework agreements on pension and social policy, ensuring a broad consensus in advance.

This gave rise to heated discussions and, as a consequence, in March 2009 the Government gave up its intention to raise the retirement age, but two tripartite working groups were established. The Government and social partners agreed that the effective retirement age will be raised by at least three years by 2025. It is estimated that pension reforms already implemented will raise the effective retirement age by 1½ years by 2025, so the Government's goal by means of new measures is to postpone retirement by a further 1½ years on top of this by 2025. For the target of postponing retirement by three years to be fulfilled, it will not be sufficient solely to postpone retirement on the old-age pension. The risk of retiring on disability pension must also be reduced. At the end of 2009 7.6% of the population aged 16–64 was on disability pension.

The first of the working groups, led by Jukka Ahtela, director at the Confederation of Finnish Industries (EK), has outlined proposals to improve well-being at work and tackle high rates of youth unemployment and disability pensions through reforms in occupational health care and education. The other group, led by Jukka Rantala, director of the Finnish Centre for Pensions (ETK), focused on reforming the regulatory framework so that the average effective retirement age would gradually increase. In 2009, the average effective retirement age in Finland was 59.8 years (59.4 years in 2008).

The first group (the so-called Ahtela group) tasked with proposing overall improvements in working life reached an agreement and submitted its proposals to the Government in February 2010 (Working group on working life 2010). However, the other working group did not submit its proposals because trade unions and employer representatives failed to reach agreement on an increased retirement age, and the elimination of the so-called "unemployment tunnel", whereby older unemployed persons (58 years or older) have an extra-long period of income-related unemployment benefit. Employers have called for the abolition of the unemployment tunnel, whereas the trade union side wants to keep the existing system.

As a consequence, six tripartite Working Groups in different ministries have been created on the basis of Ahtela's group proposals. The working groups were set up after the agreement between social partners and the Government on 11 March 2010. Prolonging working careers is now part of a larger programme aiming to increase economic growth, employment, productivity and competitiveness. Social partners and Government have regular meetings once a month and results are expected already in mid-September.

One of the big issues dealt with is the relation between disability and work. About one third of all new approved disability pensions are due to problems in mental health. The Ministry of Social Affairs and Health (MSAH 2008b) has set up a project to reduce depression-related

work disability. The term of the project (MASTO) is from 1 November 2007 to 31 May 2011.[9] It covers the entire population of working age.

If the numbers of people starting on disability pensions because of depression could be halved, the overall average age of retirement would rise by about half a year. The corresponding period for people with muscular-skeletal disorders is smaller – a third of a year – because disability pensions in this area generally concern an older age group than that affected by depression.

Especially partial disability pensions are largely discussed as one means of ensuring employment for people with impaired working capacity. Though this means has been increasingly used in recent years, it is still not used much. By the end of 2008, only 9% of all work disability pensions under the earnings-related pension scheme were partial in nature. The proportion of depression-related partial disability pensions was even smaller, just under 6%. The SATA committee has proposed to include partial disability pensions in the national pension system. Up to now, partial disability pensions are included only in the earnings-related pension scheme.

2.1.4 Impact assessments, debates and critical assessments

The OECD, in addition to evaluations made in Finnish research institutes (the Labour Institute for Economic Research, PT; the Research Institute of the Finnish Economy, ETLA; and the Finnish Centre for Pensions, ETK), was asked to assess the proposals put forward by the Ahtela working group on quality issues of working life, to reform the country's old-age and disability pension schemes. The OECD stated the proposals are "very promising" but not sufficient to achieve the stated objectives, e.g. the target of reducing disability benefit inflow by half by improving wellness at work (and thus extending working life by one year). Measures presented were assessed as too "soft". In addition to improving working conditions complementary structural reforms would be needed. These would include abolishing early retirement at age 62 and increasing the lower pension age to 65 (OECD 2010).

In particular, the OECD report showed that employees currently have a strong incentive to stay in work until age 63; although after this point workers face a "high implicit tax on staying in the workforce longer". This occurs despite the increase in pension accrual from 1.9% of earnings for each contribution year between the ages of 53 and 62 to 4.5% from age 63, because the increase is "not high enough to compensate for the discounting of future benefits and an increasing death risk at higher ages". Raising the retirement age to 65 and abolishing early retirement at the same time "would increase pension wealth for both average and low earners until around age 66". Although it would decline steeply after this point, the OECD argued workers would face a strong incentive to stay in the market until the normal pension age (OECD 2010.).

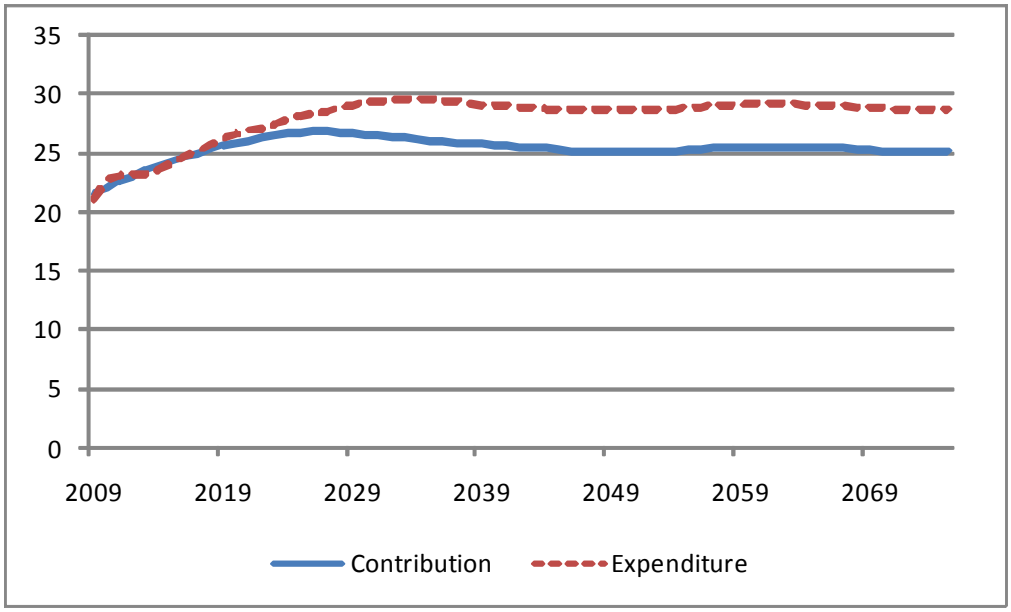
The OECD's assessment did not come as a surprise. The organisation has also previously given similar kind of recommendations. All of the above-mentioned research institutes share a view that it is difficult and even impossible to give an exact evaluation from the working group's proposals and the effectiveness of the measures in postponing retirement. Thus, further work and examination of details is needed to put the proposals into practice, and this is now in the hands of the above-mentioned working groups. The employees' side has underlined the measures to improve working life conditions in order to postpone the retirement age and sees the proposals as sufficient to reach the target, whereas, the employers' side shares more the view presented by the OECD.

[9] Project Masto - Frontpage- http://www.tartumasennukseen.fi/en.

Negotiations concerning for lengthening the working career and raising the effective retirement age are a key issue in preparation for the after-crisis era to ease ageing pressures for labour markets and sustainability of the pension system. At the moment the Finnish pension scheme is facing a situation where private sector TyEL expenditures exceed the premium income (see Figure 4). Investment returns are then in the key role of covering the difference. A percentage point in average investment returns has an effect of approximately two percentage points on the TyEL contribution, since the amount of pension funds is approximately double in relation to the wage sum. The aim is to increase the return on the investments of the entire pension system in the long term, thus reducing pressure to raise the earnings-related pension contributions in the future years. This is also one of the objectives of the legislative reform discussed later on in chapter 3.1.2.

As was already mentioned, the contribution level will be raised by 0.4 percentage points annually in the period 2011–2014. This will not be enough, and it is easy to foresee heated discussions of the ways to cover or to avoid the possibly needed extra contributions. According to projections the TyEL contribution rate will rise from the current level of about 22% to approximately 27% by 2025. Following this, the contribution level will decrease by two percentage points. 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.

Figure 4: TyEL expenditure and contribution percentage in the years 2009–2075, % of wages.



Source: Elo Kalle et al., 2009.

The challenges for the financial sustainability of the pension system are linked to population ageing. A considerable reform in view of sustainable financing is the life expectancy coefficient, which will adjust the starting pensions to developments in life expectancy. However, this has also raised a discussion concerning the adequacy of earnings-related pension provision. In their statement (Government Communications Unit 2010) the Finnish Government and representatives from labour market organisations have expressed their worries of declining replacement rates in the future. The increase in life expectancy has been more rapid than projected, which is resulting in a situation where pensions will be significantly lower than was projected in the drafting of the 2005 pension reform, if working lives do not extend. The following three objectives have now been taken into agenda in a

continuum of the work of the above mentioned working groups for prolonging working lives and raising retirement age:

- 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.

As was previously mentioned in the context of social package and the reform of disability pensions this problem of declining future pensions has already arisen for the insured who are not able to continue to work as long as they should to compensate the impact of the life-expectancy coefficient.

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. According to Finnish National Strategy Report (MSAH 2008a) a full national pension is less than half of the median income of 60 per cent. In practice, all recipients of the national pension are thus living below the relative poverty line unless they obtain income from other sources. The risk of poverty is greatest among ageing women in receipt of a national pension whose working career has been short or there has not been any working career (MSAH 2008a). In addition, risk of poverty for person living in single households is greater than for those living in households of several persons and the share of single households is higher among women (cf. e.g. Ahonen & Bach-Othman 2009). This challenge linked to the income of pensioners with small pensions will partly be addressed by reform regarding the guarantee pension. However, as the guarantee pension is EUR 100 higher than the full national pension of today it will not be sufficient means as such.

In addition to pension policy also other measures such as promoting health and functional capacity and making work more attractive are needed for supporting the future employment growth and economic wellbeing. Not forgetting the fact that the favourable economic development and good demand for labour are essential factors for increasing employment. Large scale working groups have now been established around all these issues and intensive discussions can be expected to continue as the groups are searching for common ground and finding ways to put the proposals into practice.

2.2 Health care

2.2.1 Health: system characteristics

The Finnish legislation gives the task of organising health care services to the municipalities. The public municipal system covers primary health care and specialised health care.[10] The number of municipalities is rather large (348 at the beginning of 2009), and the number of residents in a majority of municipalities is small (less than 10,000).[11] According to the legislation, each municipality has the responsibility to organise adequate health services for its permanent residents.[12]

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 by a federation of 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.[13]

In addition to the public health care system, health services are also provided by the private sector. The role of the private sector is most prominent in specialised outpatient care in towns. The private sector covers about a quarter of such visits. Most private sector physicians are public sector employees, and they work on a part-time basis in the private sector. Physicians` private practices located in shared facilities that are owned by private companies are the most common organisational model. During the 2000´s, some private health care companies have employed physicians directly. There exist about 40 private hospitals in the country. Two large companies own outpatient and inpatient facilities in many parts of the country. Users of private health care pay the fees themselves, but they receive a partial reimbursement through the obligatory National Health Insurance system.[14]

There exists also a third system for the provision of health services: occupational health care. The Occupational Health Care Act of 1979[15] obliges employers 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. Costs are covered by obligatory payments of employers and employees to the National Health Insurance Income Insurance pool.

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10 Kuntalaki 17.3.1995/365. March 1995, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1995/19950365 "Legislation about Municipalities and Tasks of Municipalities"; Kansanterveyslaki 28.1.1972/66. January 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1972/19720066 ,"Primary Health Care Act"; Erikoissairaanhoitolaki 1.12.1989/1062. December 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1989/19891062 ,"Act on Specialised Medical Care".

11 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/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

12 Kansanterveyslaki 28.1.1972/66. January 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1972/19720066. "Primary Health Care Act"; Erikoissairaanhoitolaki 1.12.1989/1062. December 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1989/19891062 ,"Act on Specialised Medical Care".

13 Ibid.

14 Teperi J, Porter ME, Vuorenkoski L, Baron JF. "The Finnish health care system: A value-based perspective." Sitra reports 82, Sitra, Helsinki 2009, 115 p., retrieved from: http://www.sitra.fi/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

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

Employers pay two thirds of the costs, and the remainder is paid by employees.[16] During the past years, a shift in the use of basic health care services took place. More employees use occupational health services when they need treatment of illness.[17]

At the 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 setting broad national development goals, preparing legislation and implementing national development programmes in cooperation with municipalities.

The Primary Health Care Act implemented in 1972 obliges every municipality to organise and deliver a large range of preventive and curative outpatient and inpatient primary care services to their residents. Legislation does not give detailed definitions about the scope of services, and municipalities have the right to decide the scope independently.[18] Health centre staff covers a wide range of professionals traditionally employed by municipalities. Physicians with a background of other specialisations than family medicine (general practice) belong to the staff only in big towns. In 1993, municipalities were given the freedom to buy services from private providers.[19] During the 2000s, some municipalities have made contracts with private companies to deliver all primary care services or certain services, like emergency services. Some municipalities, mainly towns, have integrated an internal purchaser-provider model into their management processes by separating the functions of purchasing and care delivery within the municipal administration. Young physicians are interested in private sector and flexible contracts, and some municipalities have had problems to recruit physicians. This is part of the background for the contracts between municipalities and private companies in medical services. In 2009, altogether 37 health clinics provided medical services for 400,000 inhabitants in different parts of the country based on contracts between municipalities and private companies. About 60% of working hours in emergency services in the whole country were done by these kinds of contracts in 2008.[20]

According to the Finnish primary health care model, residents in municipalities are users and payers of health services. They have to use the services organised and delivered by the municipality whose residents they are. In order to provide more choice to patients, a service voucher policy was introduced by Parliament in 2004. Municipalities were given the possibility of using service vouchers in the provision of home care services. At the beginning, the service voucher programme concerned mainly long-term services. Patients who received a voucher could make their own choice of the provider of health care services. The service voucher programme was extended in 2008 to include home nursing.[21] At the beginning of

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16 Työterveyshuoltolaki 21.12.2001/1383. December 2001, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2001/20011383, "Occupational Health Care Act".

17 Kimanen A, Manninen P, Kankaanpää E, Räsänen K, Husman P, Rautio M, Husman K. Sairaanhoito työterveyshuollossa: toimintalukujen ja kustannusten vertailua. Suom. lääk.lehti 63:21:1965-1970, 2008 "Treatment of diseases in occupational health care".

18 Kansanterveyslaki 28.1.1972/66. January 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1972/19720066, "Primary Health Care Act".

19 Laki kilpailunrajoituksista 27.5.1992/480. May 1992, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1992/19920480, "Act on competition restrictions".

20 Mikkola H. Toimiiko kilpailu lääkäripalveluissa? Kunnallisalan kehittämissäätiön Kunnat ja kilpailu -sarjan julkaisu nro 15, Helsinki 2009, 50 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=538&src=dr "Does competitition work in medical services?".

21 Laki sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569 ;"Service voucher legislation".

2007, a quarter of municipalities were organising certain social and health care services by offering service vouchers.[22]

Long waiting times have been an evident problem in health care during the 2000s. Those shortcomings led to legislation concerning access to health care in 2005 according to which health centres are required to guarantee 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 with the patient.[23]

The economic recession at the beginning of the 1990s in Finland impacted on the economic situation of municipalities. The economic growth was rapid in the late 1990s and in the early 2000s. However, the population has been ageing, and the need for services has increased. Some small municipalities have had problems to ensure primary health care services in the quantities needed by residents. In February 2007, the Parliament introduced a law according to which primary health care services must be delivered in health centres covering at least 20,000 inhabitants.[24] A transition period has been allowed to municipalities until 2012. The Government has been motivating municipalities to merge by means of extra state subsidies. Reforms of restructuring municipalities by merging or by attaching parts of municipalities to other municipalities have been put into practice quite widely. In addition, primary health care services have been restructured by cooperation between municipalities. The Ministry of Finance has been encouraging and supporting municipalities to a customer-oriented and effective provision of services by the "Best Service Practices for Municipalities" project from 2007 onwards. A new kind of partnership between the public, private and third sectors has been stressed.[25] In fact, the number of municipalities decreased from 453 in 2000 to 348 in 2009.[26]

Strengthening of primary health care has been stressed in the later half of the 2000s, and the Ministry of Social Affairs and Health has set specific targets to municipalities to improve public health during 2008–2011.

Several local and regional development programmes have been implemented in the field of primary health care with financial support from the Ministry of Social Affairs and Health, regional EU funds and municipalities, aiming to modify the structure of health services and to develop them.

One initiative to support municipalities in increasing the quality of primary health care is the large "Effective Health Centre" project launched by the Ministry of Social Affairs and Health in 2008. The programme covers a wide range of elements and addresses many problems in cooperation with actors from the state, municipalities, universities and other organisations.

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22 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/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

23 Laki kansanterveyslain muuttamisesta 17.9.2004/855. "Hoitotakuulaki", September 2004, retrieved from: http://www.finlex.fi/fi/laki/alkup/2004/20040855, "Access legislation".

24 Laki kunta- ja palvelurakenneuudistuksesta 9.2.2007/169 February 2007, retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2008/?_offset=2, "Act about restructuring municipalities and services".

25 Valtiovarainministeriö. Kohti tulevaisuuden palveluja. Kuntien parhaat palvelukäytännöt –hankkeen loppuraportti. Valtiovarainministeriön julkaisuja 21/2009. Helsinki 2009, 72 p, retrieved from: http://www.vm.fi/vm/fi/04_julkaisut_ja_asiakirjat/01_julkaisut/03_kunnat/20090422Kohtit/name.jsp "Towards future services - the final report of the best municipal service practices project".

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/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

The main goal is to improve access to primary care and to develop practices in health centres.[27]

Another large national project launched by the Ministry of Social Affairs and Health and partially funded by the Ministry is the "Kaste" programme (the National Development Programme for Social Welfare and Health Care). The Ministry will provide funds of about EUR 25 million annually in the period 2008–2011 for local development projects within the scope of this programme, and municipalities will partly cover the costs.[28]

Studies have shown that socio-economic and regional differences in health, morbidity, disability and mortality have increased from the 1990s onwards. In order to mitigate these differences and give better opportunities for unemployed and poor people to take care of their health, the Ministry has launched a project (2008–2011) tackling the issue.[29]

One example of the nationwide projects is the "Masto" project (2007–2011), the goal of which is to prevent decline in working abilities caused by depressive disorders. The project consists of development of prevention and development of treatment and rehabilitation of depressed persons in the working-age population.[30]

A policy programme to promote health is one of the three policy programmes of the current Government. Municipalities and many ministries participate in this programme, which has been implemented from 2007 onwards.[31]

In specialised health care, central hospitals give 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 number of member municipalities varies from six to 58.[32] 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 university central hospitals. Patients are referred to central hospitals by health centre physicians, private physicians or physicians providing occupational health services.

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27 Sosiaali- ja terveysministeriö. Toimiva terveyskeskus – toimenpideohjelma. February 2009, 14 p., retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/toimivaterveyskeskus, "Effective health centre".

28 Sosiaali- ja terveysministeriö. Sosiaali- ja terveydenhuollon kansallinen kehittämisohjelma. KASTE-ohjelma 2008 – 2011. January 2008, 62 p., retrieved from: http://www.stm.fi/julkaisut/julkaisuja-sarja/nayta/_julkaisu/1063225#fi.
"National development plan for social and health care. The KASTE programme 2008–2011"

29 Sosiaali- ja terveysministeriö. Kansallinen terveyserojen kaventamisen toimintaohjelma 2008 – 2011. Sosiaali- ja terveysministeriön julkaisuja 16, Helsinki 2008, 168 p., retrieved from: http://www.stm.fi/julkaisut/julkaisuja-sarja/nayta/_julkaisu/1063837#fi, "Action plan to narrow differences in health 2008-2011".

30 Sosiaali- ja terveysministeriö. Masennuksen ehkäisyyn ja masennuksesta aiheutuvan työkyvyttömyyden vähentämiseen tähtäävä hanke. Masto-hankkeen toimintaohjelma 2008-2011. Sosiaali- ja terveysministeriön selvityksiä 2008:41, September 2008, 69 p., retrieved from: http://www.stm.fi/julkaisut/selvityksia-sarja/nayta/_julkaisu/1374577#fi .
"Action plan to prevent depression and disability caused by depression 2008-2011"

31 Valtioneuvosto. Terveyden edistämisen politiikkaohjelma, December 2007, retrieved from: http://www.vn.fi/toiminta/politiikkaohjelmat/terveys/fi.jsp, "Policy programme to promote health".

32 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/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

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.[33]

In the 2000s, there was a tendency to form internal markets in hospital districts for instance by separating laboratory services to form independent companies within districts. Cooperation of hospital districts with private hospitals by purchasing certain specified services is quite uncommon. Several other development programmes were implemented also in specialised health care during the 2000s.

A large project to improve the mobility of electronic patient records in the whole country and to improve cooperation between primary health care and specialised care was launched in the mid 2000's. An electronic system to prescribe medications was taken into use in the later phase of the 2000s.

2.2.2 Health reforms

The current Finnish Government has worked since the election in spring 2007. The political parties having members in the Government are the following: The Centre Party, the National Coalition Party, the Green League of Finland and the Swedish People´s Party. Its main goal has been to strengthen health care, especially primary health care.[34] In order to succeed in this, the Government has planned a structural change in the health care system, combining primary and specialised health care. Next to this, solutions include development by large national projects partially funded by the Ministry of Social Affairs and Health and other Ministries. Another important goal is to increase possibilities of citizens to choose services.

In order to implement the structural change mentioned above, from 2007 a working group elaborated proposals for a comprehensive Health Care Act, integrating the Primary Health Care Act and the Act on Specialised Medical Care. The proposal was released in June 2008, and the opinions of relevant stakeholders were asked in autumn 2008. The opinions were collected and discussed in the Ministry during 2009, and the proposed Act will be discussed in Parliament in spring 2010. The new Act is aimed to be implemented at the beginning of 2011. The central aim of the comprehensive Health Care Act is to reinforce the role of primary health care. The key features of the law are 1. to increase patient choice; 2. to lower barriers between primary and specialised health care and 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 (university central hospital regions). The law will offer a possibility to provide primary and specialised services by merging health districts.[35]

The citizens' possibilities for choosing health care services will be increased by the comprehensive Health Care Act, enabling citizens to visit any health centre in their hospital district. Patients have the right to choose together with their physicians any hospital in the

[33] Laki kansanterveyslain muuttamisesta 17.9.2004/855. "Hoitotakuulaki", September 2004, retrieved from: http://www.finlex.fi/fi/laki/alkup/2004/20040855 , "Access legislation".

[34] Hallitusohjelma. Pääministeri Matti Vanhasen II hallituksen ohjelma 19.4.2007, 77 p., retrieved from: http://www.valtioneuvosto.fi/hallitus/hallitusohjelma/en.jsp
"The Government Programme. Prime Minister Matti Vanhanen's second Cabinet".

[35] Sosiaali- ja terveysministeriö. Uusi terveydenhuoltolaki. Terveydenhuoltolakityöryhmän muistio. Sosiaali- ja terveysministeriön selvityksiä 2008:28, June 2008, 172 p., retrieved from: http://www.stm.fi/julkaisut/nayta/_julkaisu/1066999
"The new Health Care Act. Memorandum of the working group preparing the Health Care Act".

tertiary care region (university central hospital region) to which the municipality of the residence of the patient belongs.[36]

The idea about merged health districts in the proposal for the new Health Care Act includes also the idea of guaranteeing the quality of primary care services by integrating specialists who traditionally work in hospitals into primary health care.[37]

A new Act to further expand the service voucher programme was introduced in August 2009. New legislation allows municipalities to offer service vouchers to clients and patients for the use of several kinds of social and health care services. Municipalities select the social and health care services provided by service vouchers. Clients and patients select whether they use a service voucher, and also the service provider they use. There are some social and health care services which cannot be provided by service vouchers. Municipalities determine the financial values of the service vouchers which they offer.[38]

Medications used in outpatient care are partly reimbursed by the National Health Insurance scheme. Due to the rising reimbursement costs, Parliament has decided to further promote price competition by basing drug reimbursement on the price of the cheapest generic alternative from April 2009 onwards. The patient decides whether she/he buys the branded drug or its cheaper generic equivalent; however, the reimbursement will be on the level of the cheapest generic alternative.[39]

Public health nurses traditionally have a central and important role in preventive services in primary health care, but the role of nurses executing curative tasks is considered as "secondary" by some experts. There exist good experiences and results from "policlinics" for diabetic or hypertensive patients in primary health care, in which qualified nurses have the main responsibility. These experiences together with the problems to recruit physicians have led to the idea of giving permission to subscribe certain medications to nurses with special training. Such a suggestion was made by the Minister of Health and Social Services in 2008. In 2009, the Ministry of Social Affairs and Health prepared an Act to give this kind of permission to nurses with special training in pharmacology. The Act includes a possibility for municipalities to take a patient fee when the patient visits a nurse in a health centre. The fee may be taken even if a nurse does not subscribe a medication.[40] The proposed Act will be discussed in Parliament in spring 2010.

Studies showed that municipalities have reduced the amount of resources for preventive maternity, child health and school health services during the mid and late 2000´s. The Ministry of Social Affairs and Health prepared a decree to ensure these preventive services. The decree took effect in the mid of 2009.[41]

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36 Ibid.

37 Ibid.

38 Laki sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569 , "Service voucher legislation".

39 Laki sairausvakuutuslain muuttamisesta 5.12.2008/803. "Lääkkeiden viitehintalaki" December 2008, retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2008/?_offset=2 "Act about prices of medications".

40 Hallituksen esitys laiksi terveydenhuollon ammattihenkilöistä annetun lain muuttamisesta ja eräiksi siihen liittyviksi laeiksi StVM 2/2010 vp, January 2010, retrieved from: http://www.eduskunta.fi/faktatmp/utatmp/akxtmp/stvm_2_2010_p.shtml "The proposal of the Government for changes in the Act about workers in the health care sector".

41 Valtioneuvoston asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta 28.5.2009/380 http://www.finlex.fi/fi/laki/alkup/2009/20090380 "Decree on welfare clinic services, school and student health services, and preventive oral health services for children and youngsters".

In February 2009, the Ministry of Employment and Economy initiated a strategic development project for the social welfare and health care sectors. The aims of the project are: 1. to safeguard conditions for the supply of skilled labour in a situation in which service needs are growing at the same time as sector workers are retiring; 2. to improve conditions for entrepreneurship and start-up, growth and internationalisation of business activities and 3. to boost the productivity of the social welfare and health care sector. The project stresses wide cooperation between public and private sectors in order to allow for the growing needs of the services in the social welfare and health care sectors.[42]

The previously started nationwide programmes, the "Best Service Practices for Municipalities" project, the "Effective Health Centre" project, the "Kaste" programme and the "Masto" project continued in 2009.

Merging of municipalities and restructuring primary health care services by cooperation between municipalities also continued in 2009. A few municipalities outsourced the provision of sections of primary health care services to private companies in 2009. However, at least one municipality that had previously outsourced a health clinic made plans to provide these services by the "traditional" model. Thus, there existed changes in both directions in 2009.

2.2.3 Health debates and political discourses

The stakeholders gave their statements about the proposal for the new Health Care Act to the Ministry of Social Affairs and Health. Some critical statements were made that considered the new Act to be irrelevant. The new Act will not combine the previous Acts, and the existence of many Acts about organising and providing primary health care, specialised health care and psychiatric care was criticised in these statements. It was stressed that the new Health Care Act will not lead to a structural reorganisation of health services.

The problems to recruit family physicians were evident in many municipalities from the mid 2000s onwards. These problems were discussed in Parliament during many years. Many municipalities were obliged to "purchase" family physicians for emergency services or other services in health centres from private companies. Some municipalities made contracts with private companies to deliver all primary care services or certain services, like emergency services. The problems of getting services led to discussions in mass media over many years, and debates continued in 2009. Contracts with private companies were criticised, too.

Some private companies employed medical students or young physicians to work on the basis of short-term contracts in health centres. Citizens criticised private companies about the lack of continuity in medical treatment and about the young age and poor experience of the physicians. Salaries of these physicians were higher than those of more competent family physicians employed by municipalities, which further fuelled discussions in mass media. Many citizens seemed to believe that the system of delivering all primary health care services or a specific part of services by making contracts with private companies is more expensive to tax payers than the "traditional" system. In 2009, opinions of this kind were publicised in mass media.

Difficulties in visiting primary health care services due to the lack of physicians were reported in certain regions, mainly in the north-eastern part of the country. Long waiting times in

[42] Työ- ja elinkeinoministeriö. Hyvinvointialan työ- ja elinkeinopoliittiset kehittämistavoitteet. Hyvinvointihanke-HYVÄ, Helsinki, February 2009, retrieved from: http://www.tem.fi/?l=en&s=3124 "Ministry of Employment and Economy. Labour and industrial policy development in welfare management - the HYVÄ project".

emergency services were also reported. Restructuring of municipalities led to a centralisation of services, which was criticised in mass media.

The expenditures and health gains of municipally financed and those of privately provided primary care services were discussed not only in mass media, but also in the research reports of the Association of Finnish Local and Regional Authorities[43] and independent researchers.[44]

The proposed Act to give nurses permission to subscribe certain medications raised a lively discussion in mass media. The Finnish Medical Association and many physicians opposed the proposal. The possibilities to arrange adequate further training to nurses without extra costs to the municipalities and the state were also doubted. The main independent newspaper, Helsingin Sanomat, opposed patient fees for visits to nurses in its editorial at the beginning of 2010. The editor wrote that socio-economic differences in health have widened in Finland during the past decades, and therefore possibilities for poor citizens to get adequate treatment should be extended and not minimised by new patient fees.

Health centre physicians have and use public power in some cases. Referring a patient to a psychiatric hospital against her/his own will according to the Act about the treatment of psychiatric disorders is one example of these cases. There are other examples in the Act about the treatment of contagious diseases. The contracts of municipalities with private companies led to situations which contravened the legislation, because physicians working in primary care were not employed by the municipality. The Parliamentary Ombudsman sent a notice about this fact to the Ministry of Social Affairs and Health already in 2007, but the Ministry did not correct the situation. The Parliamentary Ombudsman sent a reminder notice to the Ministry in March, 2010, and demanded that the Ministry corrects the situation according to the Acts.[45] The Ministry promised to put things right.

The bankruptcy of one hospital was experienced by Finns in 2010. The special hospital for rheumatic diseases in Heinola, owned by a foundation, went bankrupt, which led to a heated discussion in mass media. In the 2000s, central hospitals started to treat rheumatic patients, and the Social Insurance Institution of Finland arranged competitive tenders and selected cheaper hospitals for the rehabilitation of rheumatic patients. This was the background to the bankruptcy. Patients, especially parents of rheumatic children, were afraid of a decrease in the quality of treatment. From 2010 onwards, the treatment of rheumatic diseases will be arranged in central hospitals and health centres. Some central hospitals have to employ more specialists in order to arrange the treatment.

2.2.4 Overview of published studies

Systematic monitoring and evaluation of the Finnish health care system are non-existent. The overview given here is based on selected reports published in 2009 or early 2010. A search for publications about health care, health care services, health services, and health care system was performed in Finnish and English databases. In addition, published studies were looked for on the web pages of relevant institutions.

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43 Mikkola H. Toimiiko kilpailu lääkäripalveluissa? Kunnallisalan kehittämissäätiön Kunnat ja kilpailu -sarjan julkaisu nro 15, Helsinki 2009, 50 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=538&src=dr
"Does competitition work in medical services?".

44 Vohlonen I, Komulainen M, Vehviläinen A, Vienonen M. 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".

45 Oikeusasiamiehen päätös julkisen vallan käytöstä eoak 711/2009, Helsinki 2009, retrieved from: http://www.eduskunta.fi/eoaratkaisut/eoak+711/2009
"The decision of the Parliamentary Ombudsman about the use of public power".

Merging of municipalities and changes in delivering municipal services were the topics of many studies. In 2005, the Association of Local and Regional Authorities and the Foundation connected to the Association started a large research project for a wide assessment of competitive working culture in municipalities. The project consists of 32 studies reported before 2009, and two studies and the final report published in 2009. Three studies are in a reporting phase. The project has produced a lot of results. The opinions of citizens, administrators and politicians about competition in services, causes and current phase of competition in municipal services, working of competition and problems in changes from the traditional model to the competition model were assessed during this project.[46]

The final report of the above research project gives an overview of the results, and considers the movement from welfare state to competition state in Finland. Results obtained with questionnaires show that the opinions of Finns are in a phase of change. There exist both uncertainty about changes, and willingness to change. The opinions of politicians in municipalities seem to follow the traditional division into left- and right-wing parties. The left-wing parties stress the positive aspects of the welfare state. Population-based questionnaires give evidence that ageing citizens, those with lower education and lower income level, and those voting for the conservative party or the social-democratic party, think quite positively about competition in services.[47]

A few years ago, the city of Tampere implemented an internal purchaser/provider model for delivering social welfare and health care services. In addition, the reform consisted of the implementation of the mayor model and the client-centred process model. The assessment of the Tampere Model shows that it is considered particularly apt for operating environments that are complex and in need of continuous reforms. The model, however, opens up in so many directions that some actors perceive it as fragmentary, chaotic even, and the model gives rise to strong demands and creates room for diverse interests.[48]

A survey about competition in medical services made among chief physicians in central hospitals and health centres reveals that problems to employ physicians to health centres are the starting point of competition in medical services. There were only a few private companies in Finland, and the municipalities were obliged to make expensive contracts with private companies in order to provide medical services in health centres for their residents. Thus, the background for competition is not competition in its actual meaning in the market economy. A majority of chief physicians reported that there is a lack of knowledge about

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46 Mikkola H. Toimiiko kilpailu lääkäripalveluissa? Kunnallisalan kehittämissäätiön Kunnat ja kilpailu -sarjan julkaisu nro 15, Helsinki 2009, 50 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=538&src=dr
"Does competitition work in medical services?"; Martikainen T. Uudistaako kilpailuttaminen kuntia? Kunnat ja kilpailu -tutkimuskokonaisuuden loppuraportti. Kunnallisalan kehittämissäätiön Kunnat ja kilpailu-sarjan julkaisu nro 13, Helsinki 2009, 113 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=108&src=dr
"Does competition lead to new models in municipalities? The final report of the research project about competition and municipalities"; Fredriksson S, Hyvärinen O, Mattila M, Wass H. Kilpailuttaminen poliittisena päätöksenä. Kunnallisalan kehittämissäätiön Kunnat ja kilpailu-sarjan julkaisu nro 14, Helsinki 2009, 170 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=109&src=dr
"Competition as a political decision".

47 Martikainen T. Uudistaako kilpailuttaminen kuntia? Kunnat ja kilpailu -tutkimuskokonaisuuden loppuraportti. Kunnallisalan kehittämissäätiön Kunnat ja kilpailu-sarjan julkaisu nro 13, Helsinki 2009, 113 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=108&src=dr
"Does competition lead to new models in municipalities? The final report of the research project about competition and municipalities".

48 Stenvall J, Airaksinen J. Manse mallillaan – Tampereen mallin arviointi ja palveluinnovaatiot. City of Tampere and The Association of Finnish Local and Regional Authorities. Acta Publications No. 211/2009, Helsinki 2009, 136 p, retrieved from: http://hosted.kuntaliitto.fi/intra/julkaisut/pdf/p091116124624S.pdf
"Assessment of the Tampere Model and service innovations".

competition in municipalities, competition causes extra costs, and competition works poorly.[49]

The first study about the strengths and weaknesses of outsourced municipal ambulatory care compared to the "traditional" model was published at the beginning of 2010. The evaluation was based on a quasi-experimental design with before-and-after measurements in 2006 and 2008. Two outsourced health clinics were compared to two municipally run health clinics. The preliminary results show that the outsourced services in comparison to the municipally produced services did not lead to differences in either expenditures or health gains.[50]

The statistics of Kansaneläkelaitos (the Social Insurance Institution of Finland) show that nowadays private health care companies provide services for a third of employees, and the amounts paid to these companies equal one third of all costs of occupational health care. At the beginning of the 2000s the corresponding proportions were one fifth. Thus, the change to private system has taken place quite rapidly in the occupational health care sector.[51]

2.2.5 Critical assessment of reforms, discussions and studies

Great reforms of health care were performed in the 60s, 70s and early 80s. From the mid 80s onwards, health care services were developed mainly by national development programmes and by minor, special Acts having effects on one noticed problem. The Act about restructuring municipalities and services started a great reform, and the Comprehensive Health Care Act with the goal of combining primary care and specialised health care tries to expand the reform.

The Finnish legislation stresses the equality of citizens in visiting public preventive and curative health services. Until the beginning of the 90s, public services were organised and delivered by municipalities, but they were regulated by the State. The reform in the 90s decentralised the system by giving more independence to municipalities in organising and delivering services. The decentralised system together with the financial and economic crisis in the 90s led to differences in the quality and quantity of services between municipalities, and thus decreased the equality of citizens. One may suppose that the establishment of larger municipalities by merging municipalities leads to stronger units for organising and delivering services. However, the great extent of the country may cause problems. The equality of residents is not realised if health services are delivered mainly in the centres of large municipalities.

The financial and economic situation differs between municipalities, and there have been problems employing family physicians in some health centres. Thus there is a risk of great inequality between residents living in different municipalities. The Comprehensive Health Care Act may give possibilities to provide primary health care and specialised medical care services which are quite equal in all municipalities around the country. However, the existence of several separate Acts about health care services even after the implementation of

[49] Mikkola H. Toimiiko kilpailu lääkäripalveluissa? Kunnallisalan kehittämissäätiön Kunnat ja kilpailu -sarjan julkaisu nro 15, Helsinki 2009, 50 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=538&src=dr, "Does competitition work in medical services?".

[50] Vohlonen I, Komulainen M, Vehviläinen A, Vienonen M. 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".

[51] Kansaneläkelaitos – The Social Insurance Institution of Finland. Lääkärikeskuksista tullut suurin työterveyspalvelujen tuottaja. Kela, tilastokatsaus 2009, retrieved from: http://www.kela.fi/in/internet/suomi.nsf/NET/210901101350TL?OpenDocument "Private companies produce the majority of occupational health services".

the new Act may lead to problems. The change does not combine all Acts about organising and delivering health care services into one Act. It is not an actual structural reform.

The problems of municipalities in recruiting family physicians were evident in primary health care for many years, but previous governments supported the development of specialised health care. From this viewpoint, the main goal – the development of primary health care – of the Government is important.

All political parties stress the saving and existence of the welfare state. However, there are trends that do not support this idea. "Possibilities to choose" belongs to the main goals of the Government and the Ministry of Social Affairs and Health. Reforms in the health care sector are needed to achieve this goal. The Government tries to achieve the goal by increasing the possibilities of municipalities to offer service vouchers, which are practical means to give citizens more choice. However, service vouchers cannot be used if only public services are delivered by the municipality. There is a need for private producers with which municipalities may make contracts about the delivery of services. The goal to increase choice means that there must be several producers. Thus it is a way to increase private markets in the health sector. The welfare state and public services may be destroyed. Thus far, the development of the private sector has not been rapid, and international companies are not yet common service providers in primary or specialised health care.

The majority of citizens stress their support for the survival of health services on the welfare state model and the maintenance of equality of citizens. Fears about the division of citizens into rich and poor sections of the population are quite common. The fees for public services have increased. Private medical services and a majority of medications are only partly subsidised. There are poor citizens who have financial problems in visiting health services or buying medications.

The changes in the health care sector have interested many researchers in the years to 2010. The studies are mainly based on interviews. They cover many aspects of changes. The results currently available show mainly the opinions of citizens, politicians, administrators and health care personnel about merging of municipalities and about new systems to deliver services. To get critical answers about impacts of changes on health of the population and costs to the society will take a long period.

2.3 Long-term care

2.3.1 Long-term care: system characteristics

The main responsibility for organising and providing long-term care of older persons lies within the social welfare service sector. A smaller proportion of long-term services are delivered as 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, and this distinction has hindered cooperation between these two sectors. The costs of both social welfare and health care services are covered by municipal taxes, state subsidies and user fees.

Long-term services include auxiliary home help, home help, home nursing, day centres, sheltered housing, comprehensive sheltered housing, group homes, nursing homes, and long-term institutional care in health centre hospitals. Some municipalities have developed new forms of services, such as "hospital at home", in order to allow gravely and terminally ill people the opportunity to live at home. Home nursing, care in health centre hospitals and "hospitals at home" belong to the tasks of the health sector, while the rest of the services are

social welfare services. Medical care in nursing homes is the responsibility of primary health care according to the Primary Health Care Act. Sheltered housing, comprehensive sheltered housing and group homes have been developed after the implementation of this Act, and the provision of medical care in these services is not determined by legislation.

Nursing homes and health centre hospitals are owned by municipalities. Sheltered housing and group homes were established originally in the 1980s by non-governmental, non-profit organisations, and municipalities have purchased these services outside open competition. The foundation of private group homes and private sheltered housing started in the 1990s when municipalities were given the freedom to purchase services from private providers (1993). The number of private companies is quite high, and the majority are small ones: many companies own only one small group home. The recent development has led to a formation of medium-sized companies in this sector. Thus far, large international companies are not common as owners of long-term care facilities in Finland. Open competition initiated by municipalities is common for providing sheltered housing, comprehensive sheltered housing, group home care and home help and auxiliary home help services for the aged. Few companies deliver home nursing services in larger towns, but the provision of home nursing based on open competition is not common in rural areas. Due to the change in legislation, many non-governmental organisations have established companies to produce long-term services and to be able to take part in open competition.

Home care provided by wives, husbands, children or other relatives has been financially supported since the middle of the decade beginning 2000. Municipalities pay a small sum of money to those who take care of a disabled person at home. The payments are based on the disability of an aged person and on the ability of the relative to work as a carer.[52] However, due to the poor economy of many municipalities, the expansion of this kind of care has been slow, and many municipalities have even decreased the financial support to carers during the past years.

From the early 1990s onwards, the goal has been to reduce the proportion of the aged living in long-term institutions and to increase the amount of home help and home nursing. A change is evident. In 1995, altogether 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 aged living in group homes and sheltered housing has increased, the proportion of the aged receiving home help services has decreased, and the proportion of the aged in informal, financially supported care by relatives has increased.

Table 1: Proportion of persons aged 75 years or over by form of care.

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Regular home care 30.11.		12.1		11.4		11.5		11.3	11.2
Economically supported care by relatives	3.0	3.2	3.4	3.5	3.6	3.7	3.7	3.9	4.1
Sheltered housing, personnel working during daytime and nights, 31.12.	1.7	2.2	2.6	2.8	3.1	3.4	3.9	4.2	4.6
Long-term institutional care in nursing homes and long-term hospitals, 31.12.	8.4	8.0	7.8	7.3	7.1	6.8	6.5	6.3	5.9

Source: Heinola et al, 2010.

[52] Laki omaishoidon tuesta 2.12.2005/937>> retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2005/20050937 ,"Act on Supporting Care by Relatives".

In order to increase citizens´ freedom to choose services, an Act about the use of service vouchers was introduced at the beginning of 2004. Municipalities may offer a service voucher (financial support) to the person in need of long-term care. The user may select a service provider from the list of providers with which the municipality holds a contract. However, not all municipalities organise services offering service vouchers.[53] Auxiliary home help, home help, comprehensive sheltered housing and care in group homes are the most common services for which service vouchers are offered.[54] In 2008, the service voucher programme was expanded to include home nursing.

Non-governmental, not-for-profit organisations are among the supporters of many older persons. They cover their functions partly by funds from the Slot Machine Association (an association which has the monopoly on gambling in Finland). Other forms of funding include legacies of Finns and funds from foundations. The functions of these organisations consist mainly in the provision of information, social support, home visits, help in daily tasks, shopping and outdoor visits.

In the 2000s, the difference in the quantity and quality of long-term care between municipalities increased, which impacted negatively on the equality of old, disabled people.[55]

The poor quality of long-term care, especially care in health centre hospitals, has been the topic of criticism during many years in the 2000s. In 2006, the Minister for Health and Social Services appointed an administrator to make proposals for the development of care of the aged and of gerontological and geriatric education of workers in health care and social welfare care. The administrator proposed that long-term care of the aged should be assured by legislation and by appointing an officially authorised agent to detect problems in the overall situation and the well-being of the aged and to cooperate with politicians to minimise these problems.[56]

In 2008, the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities gave recommendations about the quality of care of the aged to municipalities. They include proposals concerning the quantity and quality of services, and the numbers and professional background of personnel. Proposals for development of management and care environments are given in this booklet. Municipalities may decide about the scope and quality of services, and the municipalities are not obliged to follow these guidelines.[57]

2.3.2 Long-term care: reforms

Developing long-term care of the aged is not one of the goals ranking high on the Government's agenda. In this sector, the policy goals of the Ministry of Social Affairs and

53 Laki sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569, "Service voucher legislation".

54 Hyvärinen O, Lith P. Kilpailuttamisen laajuus ja taustatekijät Suomen kunnissa. Kunnallisalan kehittämissäätiö, Kunnat ja kilpailu-sarja Nro 10, Helsinki 2008, 167 p., retrieved from: www.polemiikki.fi/files/1197-KunnatJaKilp_10_web.pdf "Quantity and background factors of competition in Finnish municipalities".

55 Kivelä S-L. Geriatrisen hoidon ja vanhustyön kehittäminen. Sosiaali- ja terveysministeriö, Report 30, Helsinki 2006, 123 p., retrieved from: http://www.stm.fi/julkaisut/selvityksia-sarja/nayta/_julkaisu/1063055 "Development of geriatric care and care of the aged".

56 Ibid.

57 Sosiaali- ja terveysministeriö, Kuntaliitto. Ikäihmisten palvelujen laatusuositus. January 2008, 55 p., retrieved from: http://www.stm.fi/julkaisut/nayta/_julkaisu/1063089, "National framework for high-quality services for older people".

Health include the goals of increasing access to home-based care, decreasing the proportion of the aged in long-term institutional care in health centre hospitals, developing new models to take care of the aged, and expanding informal care by relatives.[58]

The Ministry of Social Affairs and Health prepared an Act for expanding the service voucher programme to nearly all social and health care services in 2009, as described in the section "Health: reforms".[59] This Act was implemented in 2009.

Municipalities are obliged to provide long-term care to their residents. Disabled aged persons needing long-term care are cared in the municipality whose residents they are even if all their middle-aged or older children live in other regions of the country. This problem was a matter of complaints by citizens for many years. Now, the Ministry of Social Affairs and Health prepared changes in the legislation which permit a disabled person in long-term care to select the municipality in which she/he resides and move to long-term care e.g. to the municipality where her/his child lives.[60] The changes in the legislation are discussed in the Parliament in spring 2010, and they will be implemented in 2011.

Non-governmental organisations and associations for the welfare of the aged and a mass of citizens demanded in 2009 that long-term care of the aged should be assured by legislation as proposed by the administrator in 2006. In addition, the appointment of an officially authorised agent was demanded. The Minister for Health and Social Services promised in August 2009 that an Act to assure long-term care will be drawn up. The planning phase of the Act started in 2009, but the Act will not be discussed and implemented before the next elections of Parliament.

The large national projects launched and partially funded by the Ministry of Social Affairs and Health (the "Effective Health Centre" project[61], the "Kaste" programme[62] and the "Masto" project[63]) focused on children, youngsters and middle-aged inhabitants. A few proposals to develop long-term care of the aged were accepted to be financed as a part of the "Kaste" programme.

In February 2009, the Ministry of Employment and Economy initiated a strategic development project for the welfare sector. This project described in the section "Health: reforms" covers also long-term care.

The Ministry of Education prepared an action programme on the well-being effects of art and culture. The programme is being implemented from 2010 onwards, and will last until the end of 2014. The programme consists of three parts, one of which is art and culture as a part of

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58 Ibid.

59 Laki sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta 24.7.2009/569. July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569 , "Service voucher legislation".

60 Sosiaali- ja terveysministeriö. Kotikuntalain 3 §:n 2 kohdan muuttaminen sekä siihen liittyvän sosiaali- ja terveydenhuollon lainsäädännön muuttaminen. March 2010, retrieved from: http://www.stm.fi/vireilla/lainsaadantohankkeet/sosiaali_ja_terveydenhuolto/kotikuntalaki "Proposal for changes in the Act about residents of municipalities".

61 Sosiaali- ja terveysministeriö. Toimiva terveyskeskus – toimenpideohjelma. February 2009, 14 p., retrieved from: http://www.stm.fi/vireilla/kehittamisohjelmat_ja_hankkeet/toimivaterveyskeskus, "Effective health centre".

62 Sosiaali- ja terveysministeriö. Sosiaali- ja terveydenhuollon kansallinen kehittämisohjelma. KASTE-ohjelma 2008 – 2011. January 2008, 62 p., retrieved from: http://www.stm.fi/julkaisut/julkaisuja-sarja/nayta/_julkaisu/1063225#fi, "National development plan for social and health care. The KASTE programme 2008–2011".

63 Sosiaali- ja terveysministeriö. Masennuksen ehkäisyyn ja masennuksesta aiheutuvan työkyvyttömyyden vähentämiseen tähtäävä hanke. Masto-hankkeen toimintaohjelma 2008-2011. Sosiaali- ja terveysministeriön selvityksiä 2008:41, September 2008, 69 p., retrieved from: http://www.stm.fi.

social welfare and health care services. Development of long-term care is part of the objectives of the programme. The care of the aged is developed by increasing cultural activities in sheltered houses and long-term institutions. The large programme is implemented in cooperation with municipalities and several ministries.[64]

2.3.3 Long-term care: debates and political discourses

The poor quality of long-term care of the aged has been a popular topic of discussions about social and health care in mass media since the late 1990s. Governments have stressed the development of specialised medical care and primary health care and long-term care has not been among their priorities. These are the evident reasons for remarkably lively discussions about many kinds of problems in long-term care in mass media. In 2009 and at the beginning of 2010, old persons and their relatives told about their problems in newspapers, and journalists produced several articles and radio and TV programmes about problems in long-term care. Poor knowledge of physicians and other health care personnel in geriatrics and gerontology and small numbers of nursing personnel and physicians in long-term institutions were criticised. Examples of group homes delivering high-quality care were also shown. Several citizens sent complaints about poor care to official control organisations.[65] Better education of social welfare and health care personnel in geriatrics and gerontology was demanded. The poor quality of care in long-term institutions was discussed also in Parliament.

The common use of psychotropics as chemical restraints in long-term care was widely discussed in mass media. Researchers and relatives of the aged wrote examples of the negative consequences of the concomitant use of several psychotropics and examples of the positive consequences of the withdrawal of psychotropics on the cognitive and physical functioning of the aged.[66] Several TV programmes were shown.

The inequality of the aged in long-term care was also a topic of discussions in mass media. Many group homes and comprehensive sheltered houses provide long-term care with a good quality, but services with a low quality are common, too.[67]

Municipalities stressed low price in arranging competitive tenders for long-term care. Competitive tenders were arranged regularly with intervals of three to four years. Some municipalities changed the private company with which they had made a contract because they found a cheaper company in a new round of bids. Thus competition led to involuntary removals of the aged. Merging of municipalities was another reason for involuntary removals of the aged from long-term care in 2009.[68] There were cases where politicians decided that the disabled aged must move from the long-term institution where they had lived for years to the cheapest long-term institution in the region of the new municipality. In some municipalities, the aged, their relatives and even the private companies whose bids were unsuccessful collected lists of names of the residents, and insisted that politicians must change such

64 Taiteesta ja kulttuurista hyvinvointia –ehdotus toimintaohjelmaksi 2010–2014. Opetusministeriön julkaisuja 2010:1, Helsinki 2010, retrieved from: http://www.minedu.fi/OPM/Julkaisut/2010/Taiteesta_ja_kulttuurista_hyvinvointia.html?lang=fi
"Art and culture for well-being – a proposal for an action programme 2010–2014. Publications of the Ministry of Education, Finland 2010:1".

65 Turun Sanomat, 4.3.2010, "The Turku Newspaper".

66 Ibid.

67 Ibid.

68 Helsingin Sanomat, 7.10.2009, "The Helsinki Newspaper".

decisions. Citizens won in some municipalities, and the politicians changed their previous decisions.[69]

There were even decisions to force aged persons to move from their individual rooms in a group home to a bigger long-term institution to share rooms with another old, disabled person. These decisions were also strongly resisted by the aged and their children.[70]

Reports about the reduction of meals of the aged in long-term care, e.g. taking midday coffee off the menu in order to minimise the costs, were reported in mass media. Problems to deliver meals to home care patients were described.[71]

According to reports in newspapers, politicians were not unanimous in all municipalities in making the above decisions. The reports gave evidence to suppose that there were opponents of these kinds of decisions in all political parties.[72]

An interesting discussion was triggered by a book written by a previous (emerita) professor in social politics, published in early 2009. In this book, she carefully and critically presents the changes in social welfare and long-term care services in Great Britain and in Sweden from the 1980s onwards, and gives proposals to retain the equality of these services in Finland without dividing services and citizens into two classes ("services for poor people" and "services for rich people").[73] The changes in other European countries and the proposals by Koskiaho to save the social welfare and long-term services on the basis of the welfare state were discussed in several TV and radio programmes. She wrote about the possible problems, if the Finnish municipalities buy social welfare and long-term services from big international companies, whose aims are to collect economic profits to their owners. A part of the taxes paid by Finnish citizens will then move to foreign owners of services, who may invest the economic profits to other international companies and not to the development of social welfare and long-term services in Finland. Koskiaho proposed that social companies would be one way to avoid this problem.[74]

The public discussion about long-term care and care of the aged showed a wide variety of opinions. In February 2010, the chief director of the Association of Finnish Local and Regional Authorities proposed that ageing and aged citizens should write and sign their wills about treatments in cases of grave, acute illnesses and allow possibilities for non-active treatments.[75] Citizens and non-governmental organisations of the aged interpreted his words to mean that treatments and care of the aged are too expensive to municipalities, and Finns should decide to die younger. The proposal was strongly opposed in many newspapers.[76]

In spring 2009, the Parliamentary Ombudsman asked the official organisations in provincial governments responsible for controlling social welfare and health care services to prepare summaries of complaints about the round-the-clock long-term care of the aged, which were made to these official control organisations. In February 2010, the Parliamentary Ombudsman gave her report and proposals based on these summaries. The report showed that mechanical and chemical restraints are used quite commonly, numbers of nurses and auxiliary nurses are not sufficiently great in some group homes, comprehensive sheltered houses and long-term

69 Helsingin Sanomat, 25.4.2010, "The Helsinki Newspaper".
70 Helsingin Sanomat, 25.3.2010 and 29.03.2010, "The Helsinki Newspaper".
71 Helsingin Sanomat, 7.10.2009, "The Helsinki Newspaper".
72 Helsingin Sanomat, 18.4.2010, "The Helsinki Newspaper".
73 Koskiaho B. Hyvinvointipalvelujen tavaratalossa. Osuuskunta Vastapaino, Tampere 2008, 272 p. "A welfare service market".
74 Ibid.
75 Helsingin Sanomat, 26.2.2010, "The Helsinki Newspaper".
76 Helsingin Sanomat, 27.2.2010, "The Helsinki Newspaper" and Iltalehti, 27.2.2010, "The Evening Newspaper".

hospitals, and there is need for more control inspections. The Parliamentary Ombudsman proposed that the human rights of the aged who need long-term services should be secured by a specific Act.[77]

The attractiveness of long-term care is quite low among social welfare and health care professionals. Some municipalities had problems to recruit physicians and nursing staff for long-term care. The possibility to "import" foreign workers to long-term care was discussed in mass media. The opinions of politicians about the need for professionals with a foreign background to work in long-term care vary from negative to positive. The number of workers with a foreign background is quite small.

2.3.4 Overview of published studies

Studies about long-term care were found by performing a systematic search in Finnish and English databases and on the web pages of relevant institutions. The number of studies published in 2009 was not big. Their topics covered some important, actual trends and problems, as the provision of long-term services for the aged, cooperation between social welfare and health care sectors and non-governmental organisations, and the quality of long-term services.

A study performed in Eastern Finland showed that many municipalities have integrated social welfare and health care services for the aged. Several methods of integration were found, e.g. home care units, boards responsible for home care or combined health and social welfare departments. The overall quality rated by family members was found to be better in unintegrated home care than in integrated home care, but no similar trend was found in the ratings of clients and employees.[78] Another study performed among home care clients and their professional carers showed problems in communication and collaboration between clients and professionals. The care provided by professionals sometimes conflicted with clients' expectations and did not always support clients' resources[79] Spousal care was proven to be important. It helps home care clients to manage tasks of everyday life.[80] In addition, volunteers are meaningful resources in long-term institutions. They create social arenas, give stimuli in daily life and bring security.[81]

The quality of long-term institutional care from the viewpoint of the use of mechanical and chemical restraints has been the interest of at least three research teams. The use of physical

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77 Ympärivuorokautisessa hoidossa olevien vanhusten perus- ja ihmisoikeuksien turvaaminen. Eduskunnan oikeusasiamiehen raportti ja ehdotus lääninhallitusten esityksistä 213/2009, 51 p, retrieved from: http://www.eduskunta.fi/eoaratkaisut/eoae+213/2009. "Protection of civil and human rights of the aged in round-the-clock long-term care. Parliamentary Ombudsman's report and proposal for the county performances".

78 Tepponen M. Kotihoidon integrointi ja laatu. Kuopio University Publications E 171, Kuopio 2009, 224 p, retrieved from: http://www.uku.fi/vaitokset/2009/index_tekija.shtml, "Integration and quality of home care"

79 Eloranta S. "Supporting older people's independent living at home through social and health care collaboration." Annales Universitatis Turkuensis D 869, Turku 2009, 88 p, retrieved from: https://oa.doria.fi/handle/10024/47133.

80 Mikkola T. Sinusta kiinni: Tutkimus puolisohoivan arjen toimijuuksista. University of Helsinki, 2009, 216 p, retrieved from: http://urn.fi/URN:ISBN:978-952-493-067-3
"Depending on you – a study of spousal care, everyday life and agency".

81 Hartikainen A. Vapaaehtoiset vuodeosastolla: Etnografinen tutkimus vanhusten ja vapaaehtoisten kohtaamisesta. University of Helsinki, 2009, 154 p, retrieved from: http://urn.fi/URN:ISBN:978-951-806-133-8, "Volunteers at the inpatient ward – an ethnographic study on the encounters of older people and volunteers".

restraints was found to be quite common.[82] Comparisons between Finland, Switzerland, Hong Kong, Canada and the U.S. showed that the use of antipsychotics was most common in Finnish nursing homes and the use of physical restraints was also quite common in Finland. In all these countries there were great differences between nursing homes in the use of restraints, which indicates wide differences in the quality of long-term care.[83] One report from a Finnish long-term health centre hospital showed that the concomitant use of many psychotropics was very common. The criteria for use and the negative consequences of use on the cognitive and physical functioning of the aged gave evidence to determine the use as elder abuse.[84] These studies showed that there are problems in long-term institutional care.

During the past years, the use of psychotropics has decreased in many group homes and comprehensive sheltered houses, and a study about the good results of withdrawal of psychotropics among the aged living at home was published.[85]

2.3.5 Critical assessment of reforms, discussions and studies

The Ministry has tried to guarantee the quality and quantity of long-term care for the aged by giving recommendations to the municipalities. Municipalities decide the amount and quality of long-term care, and they need not follow these recommendations. The decentralised information guidance system together with ageism has led to differences in long-term care between municipalities and even between long-term institutions in a certain municipality. There are no concrete plans for any great reform, although problems in long-term care have been evident from the late 1990s onwards and citizens and non-governmental organisations have demanded a reform by new legislation, which would guarantee equal and high-quality long-term care for the aged. The Minister of Health and Social Services promised that the services for the aged will be guaranteed by an Act, but the next elections of the Parliament in 2011 may hinder this reform.

Parliament, i.e. the state, passes Acts about social welfare and health care. The municipalities organise and deliver services. The subsidies of the state to the municipalities do not cover only social welfare and health care services. They also cover other kinds of tasks of municipalities, e.g. day care of children and schools. There are no specific subsidies for the social welfare and health care sector. The use of subsidies of the state is decided by the politicians in the municipalities. If the politicians in a certain municipality do not want to organise and deliver long-term services with a good quality, the state subsidies calculated on the basis of the amount of aged residents in this municipality and originally aimed to the care of the aged may be used to other tasks of the municipality. The lack of specific state subsidies for long-term care increases potential for differences in services between municipalities.

The Ministry of Social Affairs and Health has not previously launched any large national programme to develop long-term care of the aged. The development is based on small

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82 Saarnio R. Fyysisten rajoitteiden käyttö vanhusten laitoshoidossa. Acta Universitatis Ouluensis D 1024, Oulu 2009, 122 p, retrieved from: http://herkules.oulu.fi/isbn9789514292088/
"The use of physical restraints in institutional elderly care".

83 Feng Z et al. "Use of physical restraints and antipsychotic medications in nursing homes: a cross-national study." Int J Geriatr Psychiatry 2009; 24(10):1110–8, retrieved from: http://www3.interscience.wiley.com/journal/122253757/abstract.

84 Nurminen J et al. "The use of chemical restraints for older long-term hospital patients: a case report from Finland." Journal of Elder Abuse & Neglect 2009;21:89–104, retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/19347712.

85 Salonoja M et al. One-time counselling decreases the use of benzodiazepines and related drugs among community-dwelling older persons. Age and Ageing Advance Access published online on January 20, 2010, retrieved from: http://ageing.oxfordjournals.org/cgi/content/full/afp255v1?view=long&pmid=20089547.

programmes, many of which are launched by non-governmental organisations and partly funded by the Slot Machine Association. Now an action programme to develop long-term care by integrating art and culture to care is being implemented from 2010 onwards. The programme may give possibilities for changes in the conservative culture of care.

The political strategies of the State and municipalities stress that the proportion of the aged in long-term institutions should be decreased, and the proportion of the aged population living at home should be increased. Development of home care services, many kinds of group homes and sheltered houses and new forms of care of the aged is stressed, too. Thus far, there do not exist concrete plans to develop these services. Neither are there concrete plans to develop ordinary housing of the aged.

Training of physicians, nurses, physiotherapists and other social welfare and health care personnel does not consist of training about care of the aged to the extent needed in practical work. Poor knowledge of the personnel in geriatrics and gerontology hinders the development of long-term care.

The discussions in mass media show that the majority of citizens want municipalities to provide equal and high-quality long-term services with reasonable fees to the aged. The citizens demand equality of the aged, but the Government and the municipalities are not eager to respond.

There are some active research teams, and the number of studies about long-term care is bigger than in previous years, showing a growing interest of researchers in long-term care of the aged. The scope of the studies covers many current and important topics of long-term care. The results show that there exist problems in long-term care, and the quality of care varies between long-term institutions.

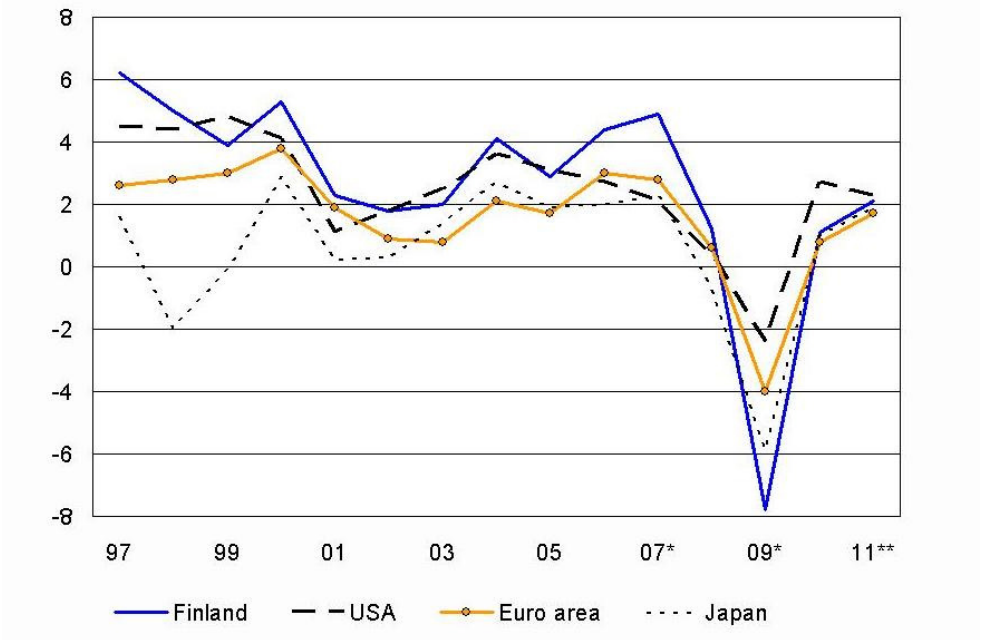
3 Impact of the Financial and Economic Crisis on Social Protection

3.1 Pensions

3.1.1 Cyclical outlook[86]

The year 2009 was exceptionally bad in the Finnish economy. According to preliminary figures from Statistics Finland, GDP plunged by 7.8%. During the previous recession in 1991 GDP fell by 6.0%. The economic situation is improving, but the recovery is still fragile. The Economics Department at the Ministry of Finance (MoF 2010) forecasts that output in the Finnish economy will start rising in 2010. In the medium term it is expected that the Finnish economy will recover from the deep economic crisis along with the rest of Europe. Driven by the recovery of private consumption and exports, GDP growth is expected to be slightly positive at 1.1% in 2010. Output growth in 2011 is expected to average just over 2%.

Figure 5: GDP change in volume, in%.



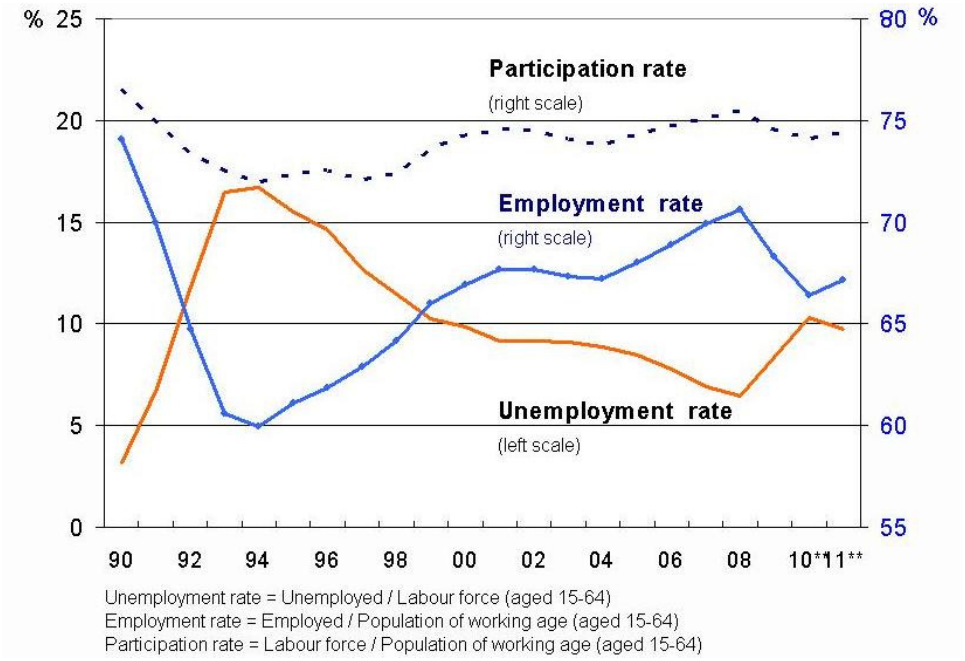
Sources: MoF, 2010.

Consumer prices did not rise at all in 2009 as measured by the national consumer price index. Inflation will accelerate to 1.5% in 2010 because of rising prices in energy and other raw materials. House prices and interest rates will also stop falling. In 2011 prices will continue to rise and the increase in energy taxes at the beginning of 2011 means that consumer prices are expected to increase by about 2.5%. Earnings increased very rapidly in 2009 relative to the cyclical environment. The earnings level rose by 3.9% and is anticipated to increase by 2.8% in 2010.

[86] Economic Survey Spring 2010, Economic outlook and fiscal policy for 2010-2014, Ministry of Finance, retrieved from: http://www.vm.fi/vm/en/04_publications_and_documents/01_publications/02_economic_surveys/20100329Econom/Taloudellinen_katsaus_kevaet_2010_netti.pdf.

Given the current business cycle, the rise in the unemployment rate has been moderate. This is mainly thanks to temporary lay-offs and the willingness of companies to retain their skilled labour. At year-end 2009 the number of employees classified as temporarily laid off, and therefore entered in the statistics as people in employment, was around 60,000, or just over 2% of the workforce. Anyway, the number of people out of work will continue to rise in 2010 despite the trend of output growth, and the unemployment rate is expected to climb to 10.3% from 8.4% in 2009. The highest monthly unemployment rates will probably be recorded in late spring. The situation will improve in 2011 when the employment rate is expected to edge up to 67% and the unemployment rate to fall to 9.8%. The unemployment rate is expected to fall to just over 7% by 2014 and the employment rate is projected to be close to 70%.

Figure 6: Employment indicators.



Sources: MoF, 2010.

The labour market situation looks set to improve over the medium term, and it is expected that the number of job vacancies will begin to rise sharply. At the same time the mismatch between labour supply and labour demand will get worse. The new jobs that are being created after the recession are not located in the same places and in the same branches where jobs were lost during the recession. This is hampering growth in employment. Population ageing will also begin to constrain the labour market during the present decade.

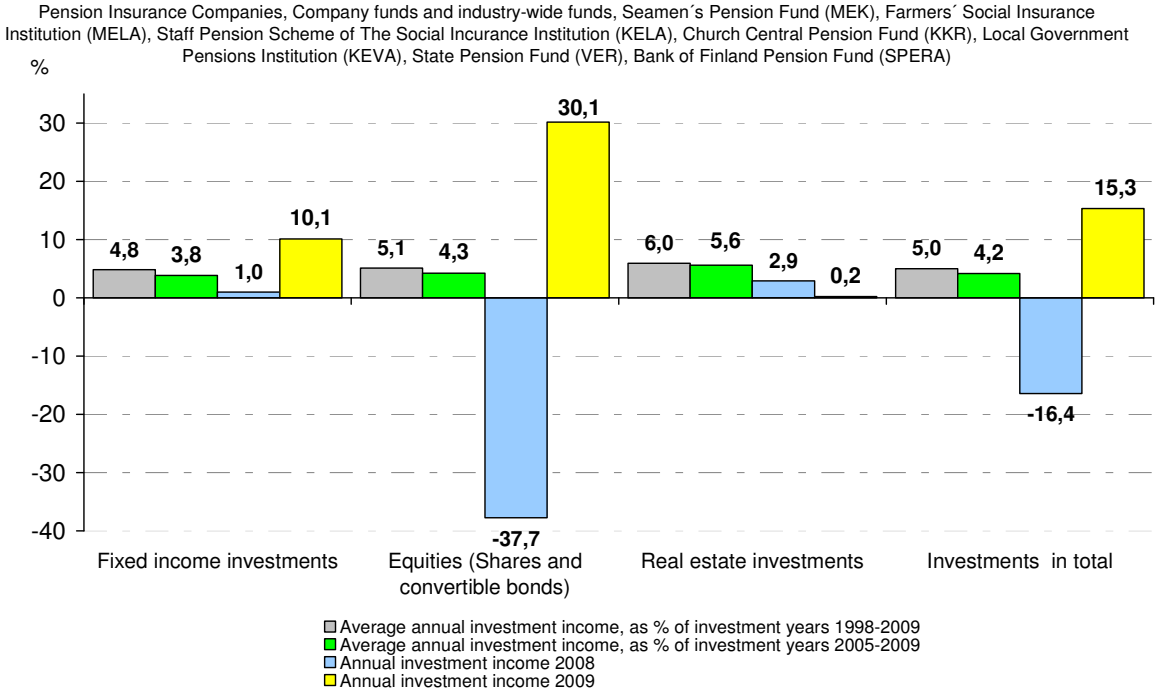
The legacy of the recession will continue to impact public finances for years to come. The deficit is estimated to slide from -2.4% in 2009 to 4% of GDP in 2010 and therefore clearly exceed the 3% budget deficit ceiling of the Stability and Growth Pact. This will only be a temporary breach, however, because in 2011 the deficit will narrow to 2% of GDP.

Although general government finances will continue to improve over the years ahead on the back of economic recovery, it is expected that without new measures to stimulate growth and consolidate public finances, they will remain firmly in deficit in 2014. Only social security funds will retain a surplus. The general government debt ratio began to rise in 2009. It rose up to 44% of GDP from the level of 34% year before. Debt ratio is projected to climb to 56.5% by 2014.

3.1.2 Impact on pensions

For earnings-related pensions the result of the crisis was a decrease in the capital investments of insurers. Here, 2008 was particularly difficult. Total investments lost 16.4% of their value. In the first quarter of 2009, the drop came to a halt. In 2009 pension funds returned an average 15.3% on investments, and have been able to return to levels seen before the financial and economic crisis according to the Finnish Pension Alliance Tela (see Figure 7).

Figure 7: Nominal rate of return on investments for 2008 and 2009 and on average for years 1998-2009 and 2005-2009.



Source: Finnish Pension Alliance Tela, 2010.

The immediate impact of investment losses has been targeted at the solvency margin and solvency of the pension providers. To avoid loss-making sales of capital investments, the regulations on the pension institutions' investment operations and solvency have been amended on a temporary basis due to the international financial crisis. The temporary Act was to be in force from December 2008 to the end of 2010. The purpose of the Act is to ensure that pension providers will not have to give up their long-term investment policy and realise share investments in order to protect their solvency position. However, due to crisis the temporary legislation is continued for two years until the end of 2012. The Government decided on the contents of the bill on 11 February, and the President of the Republic presented the bill (HE 5/2010) to Parliament on 12 February. The Act will enter into force during spring 2010.

If the temporary act expired at the end of 2010, it would weaken the solvency of the authorised pension institutions and reduce their ability to retain more risky investments with higher expectations for return. A poorer price development for shares and other investments would potentially lead to reductions in the asset beta even before the temporary Act expires at the end of 2010. In practice this would mean that pensions institutions would be selling especially shares, including those of Finnish listed companies.

The bill reinforces the solvency of the authorised pension institutions in the private sector so that the pension institutions can pursue efficient financial activities that implement long-term goals in the current unstable market situation.

Another aim is to prepare for permanent revisions of the solvency regulations for the authorised pension institutions in the private sector. The Ministry of Social Affairs and Health has appointed two working groups to examine the necessary permanent changes. The temporary Act would enable a sufficiently long foreseeable transition period prior to the permanent revisions to the solvency regulations that are currently being prepared.

As a result, part of the provision for pooled claims contained by the technical provisions of the pension institutions continues to be considered equal to the solvency margin. Moreover, the minimum solvency margin of the pension institutions would be independent of the investment distribution of the pension institution during the period the Act is in force.

The crisis has no significant effect on the long-term financing outlook, since the earnings-related pension scheme adapts quite well to various financial developments: recession decreases aggregate pension contributions, but at the same time it decreases the aggregate pension accruals as well. However, the likely downturn in the economy over the next few years does add pressure to the negotiations surrounding the earnings-related pension contribution. Before the recovery of the funds it was estimated that the lowered value of investments would have caused a pressure to raise the contribution level by approximately one percentage point (in addition to the level agreed earlier).

The crisis did not have any immediate impact on pension levels. For the national pension it would have had deflationary consequences, e.g. the national pension benefits would have decreased as a result of prevailing index linkages. However, as was mentioned above, the pension benefits will not decrease due to a separate statute which fixed the benefits to the 2009 level. For earnings-related pensions the impact would be indirect, based on the general development of the economy affecting thus the length of working careers.

The crisis has affected other areas of social protection more than pensions. Even for these, the assessment of social impacts is yet uncertain, but some recent information on social welfare offices' clients is worrying. Signals of growing demand for benefits and services emerge, e.g. recipients and expenditure of social assistance and unemployment benefits have risen.

As a reaction to the weakening economic development and to combat unemployment, the Government launched an extensive package of measures in several stages, starting with the August 2008 budget session. According to MoF the scale of the stimulus measures in terms of national accounts was 1.8% in 2009 and 1.5% in 2010 in relation to total output. The stimulus provided by the Finnish budget is one of the largest in the Euro area. Moreover, taking into account the financial stimulus investments in 2009 and 2010, the estimated stimulus for 2009–2010 is just under 4½% in relation to total output.

3.2 Health

Tax revenues of municipalities decreased during 2009. Many municipalities had to take out loans and increase both the income-tax rate and real property-tax rate. All municipalities had to cut down public expenditures. At the same time they had to provide services for their residents.

Tax incomes of the state decreased, too. The state had to take out loans, but did not increase the income-tax rate.

In February 2009, the Association of Finnish Local and Regional Authorities drew up a concrete programme to make savings in municipal services. Cooperation between municipalities was stressed, and municipalities were asked not to lay off personnel. The experiences from the economic depression in the 1990s were used in preparing the programme. The State gave extra financial support to municipalities. Later in 2009, a concrete saving programme was prepared for the period 2010–2013. To control the increase of operational expenses and the increase of purchasing services from private companies is one of the main principles of the programme.

There are more than 300 municipalities in Finland, and all these municipalities make their own budgets independently. Published figures about cuts in the health care budgets from 2008 to 2010 in the whole country are not yet available. Neither are there published figures about produced health services and numbers of health care personnel in the whole country in 2009. The assessment of the impact of the economic and financial crisis is based on reports in mass media and on qualitative reports on the web pages of relevant institutions.

Some municipalities saved by laying off employees for some weeks, and these decisions were also taken in health care. Fewer employees were recruited, and some hospital wards were closed during summer holidays. The crisis has not yet strongly impacted on the availability of health care services. Health care workers reported about rising work loads, and an increase in sick leave among employees was reported in some institutions. The crisis led to fears of citizens about the maintenance of the welfare state model, which provides equal health services with reasonable fees, although all political parties stressed the importance of the survival of the welfare state.

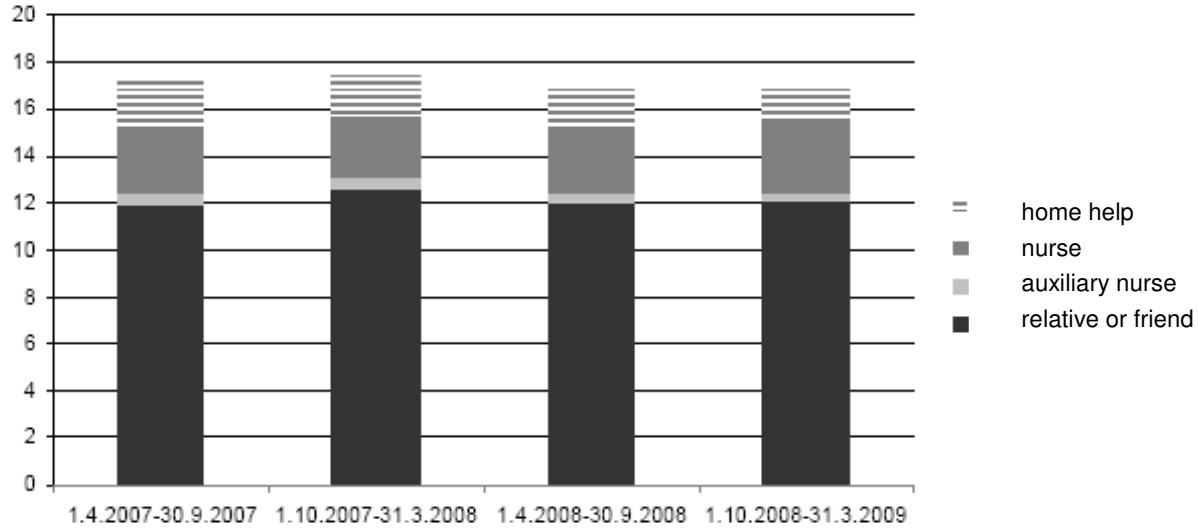
3.3 Long-term care

As mentioned in the previous chapter, there are no published figures about health and long-term care in municipalities in 2009. The assessment of the impact of the crisis on long-term care is based on reports in mass media and on qualitative reports on the web pages of the relevant institutions. The published figures extend only to the beginning of the year 2009.

The goal of the Ministry of Social Affairs and Health is to reduce the number of the aged in long-term institutions and to enlarge the number of the aged living at home by improving home care services. The figures about the development of home care from 2007 to 2009 show a contradictory development. The hours of care received by home care patients from their relatives have not changed during this period (Figure 8). However, the hours of care received from social and health care personnel have decreased, although home care patients are more disabled in 2009 than in 2007.[87]

[87] Heinola R, Finne-Soveri H, Noro A, Kauppinen S, Koskinen S, Martelin T, Sainio P. Vanhusten kotiin annettavat palvelut ja omaishoidon palvelut. Teoksessa: (In:) Kauppinen S (editor) Terveyden ja hyvinvoinnin laitoksen asiantuntijoiden arvioita peruspalveluiden tilasta. THL raportti 9/2010, Helsinki 2010, 189 p., retrieved from http://lib.thl.fi:2345/lib4/src?PBFORMTYPE=01002&TITLEID=51341&SQS=1:FI:1::10:50::HTML&PL=0, “Home-care of the aged and economically supported care by relatives”.

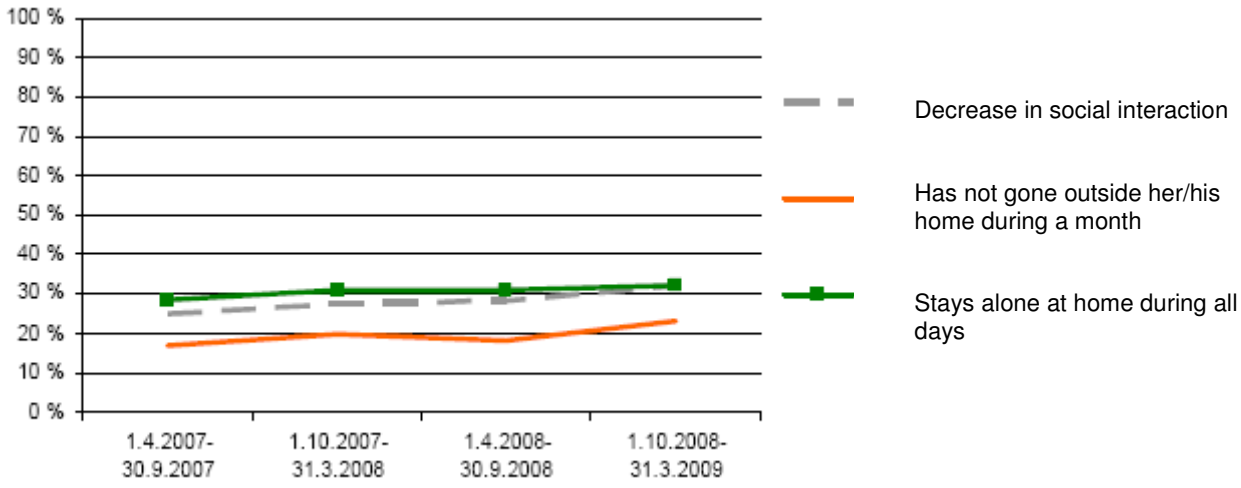
Figure 8: Amount of care (hours per week) to home care patients by caretaker.



Source: Heinola et al, 2010.

The figures show also that the quality of home care decreased from 2007 to the beginning of 2009 when the quality was measured as the maintenance of functional abilities and social interaction of the aged (Figure 9). In 2009, a greater proportion of home care patients were totally alone from days and nights to days and nights, and a smaller proportion of these patients went outdoors from their homes. Social isolation increased by 4% (28%–32%) during this period, and staying in one's home increased by 6% (17%–23%).[88]

Figure 9: Social isolation among the aged in home care 2007-2009.



Source: Heinola et al, 2010

The impact of the crisis on long-term care is more evident than on primary or specialised or occupational health care. There are several reasons for this. Negative attitudes towards the aged are common, and, therefore the development of long-term care is not considered to be

[88] Ibid.

important. At the beginning of the 2000s, the Government stressed the development of specialised health care, giving economic resources to municipalities for projects in specialised hospital care. The problems in primary care to recruit family physicians in the later half of the decade 2000–2010 led to the investment of economic resources in projects to develop primary care. The problems in long-term care, especially in long-term institutional care, were evident from the late 1990s onwards, but the development of long-term care was not a priority even during the period of economic growth. The strategic aim of the Ministry of Social Affair and Health is to decrease the amount of beds in long-term institutions and to give the aged possibilities to live independently at home. The poor economy in municipalities together with these aims led to the decrease in the amount of long-term beds in many municipalities, but the increase in the amount of home help or home nursing did not follow the development of the age structure.

Municipalities deliver a big amount of long-term care services by making contracts with private companies. They put more and more emphasis on the low price of services in selecting the private company with which they make contracts. A low price accounts for about 50% and a good quality of care only about 50% in criteria for selecting the company to deliver long-term care services. Competition has caused problems in the quality of care. Municipalities arrange competition tenders with intervals of three to four years. Some municipalities selected companies which promised to deliver services with a cheaper price than the companies with which the municipality made the contract previously. Disabled aged had to move from the comprehensive sheltered housing or group home where they lived for years.[89]

Some municipalities decided to transfer aged persons from single person's rooms in a group home to bigger long-term institutions to share rooms with other persons in order to save money.[90]

The municipalities have the right to decide the fees in group homes and in comprehensive sheltered housing. Many municipalities increased client fees. There were reports in newspapers telling that some old persons in these facilities had no resources to buy medications due to the high costs of the group home fees.

Municipalities made many kinds of decisions to decrease their costs in long-term care. The reduction of the quality of meals and even the withdrawal of certain meals, like midday coffee, in long-term care facilities and the reduction of the amount of incontinence nappies given daily to clients in home care or in long-term institutions were reported.[91]

Salaries of the personnel form the greatest proportion of costs of social welfare and health care services. There are municipalities which saved by employing less workers for long-term care.

Further education of social and health care personnel is stressed by the Ministry in order to guarantee the high quality of social welfare and health care services. Further education is guaranteed by an Act, and the State gives extra state subsidies to municipalities for further education. There were reports that in many municipalities, social and health care workers were not given opportunities to participate in further education organised by another institution than their own employer.

The poor economy of many municipalities led to a decrease in the financial support for relatives taking care of disabled persons at home, and fewer relatives were accepted as carers.

89 Helsingin Sanomat, 7.10.2009, "The Helsinki Newspaper".

90 Helsingin Sanomat, 25.3.2010, "The Helsinki Newspaper" and Helsingin Sanomat, 29.3.2010, "The Helsinki Newspaper".

91 Helsingin Sanomat, 7.10.2009, "The Helsinki Newspaper".

Every municipality makes its own decisions about delivering social welfare and health care services. There were differences in the quality of long-term care between the municipalities already before the crisis. There is reason to believe that differences are nowadays more evident than they were previously. The inequality of older and disabled citizens seems to have increased.

The amount of private group homes and sheltered housing not subsidised or paid by municipalities has increased. The average pension of old Finns is quite low, and the number of old persons able to afford totally private services in long-term comprehensive sheltered housing or group homes is small. Some old persons with small pensions and with no possibilities to get services in a sheltered house owned or subsidised by the municipality sold their own flats and moved to a private sheltered house. After some years, they had no resources to live in a private sheltered house, and they moved to a nursing home owned by the municipality where they reside. Older persons are accustomed to welfare services, and they cannot calculate the prices in open market.

Finnish citizens do not actively demonstrate. The problems in long-term care have, however, activated citizens to fight for better long-term care. The financial and economic crisis increased the fears of citizens about poor care or lack of care when they themselves are old. Citizens insisted in mass media that long-term care must be developed. Old persons, relatives of old persons and owners of private companies (providing high-quality long-term care) which lost in competitive tenders wrote in newspapers, spoke in radio and TV, collected lists of names, organised demonstrations and even established new voluntary organisations in order to prevent the destruction of long-term care services. In some municipalities, politicians had to withdraw and change their decisions about minimising the costs of long-term care.

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MSAH, MINISTRY OF SOCIAL AFFAIRS AND HEALTH (2009b). Sosiaaliturvan uudistamiskomitean (SATA) ehdotukset sosiaaliturvan uudistamiseksi, Sosiaali- ja terveysministeriön selvityksiä 2009:62, Helsinki. Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-10834.pdf "Proposals of the SATA Committee for reforming social protection"

OECD (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 from: http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2010/oecd-elakearvio-08032010/fi.pdf

RISKU ISMO & KLAAVO TAPIO (2009a). Työkyvyttömyys- ja perhe-eläkkeen muutosten vaikutus eläkemenoihin. "Effect of the changes to disability and survivors' pensions on pension expenditure". Muistio (memorandum), 25.6.2009. Eläketurvakeskus (Finnish Centre for Pensions), Helsinki. Retrieved from: http://www.etk.fi/Page.aspx?Section=63974

RISKU ISMO & KLAAVO TAPIO (2009b). Osa-aikaeläkkeen ikärajan ja karttumamuutoksen menovaikutus. " Effects on the expenditure for part-time pensions". Muistio (memorandum), 25.6.2009. Eläketurvakeskus (Finnish Centre for Pensions), Helsinki. Retrieved from: http://www.etk.fi/Page.aspx?Section=63974

STATISTICS FINLAND (2010). Structure of Earnings statistics. Helsinki. Retrieved from: http://www.stat.fi/til/pra/2008/pra_2008_2009-11-06_tie_001_en.html

THE FINNISH PENSION ALLIANCE TELA (2010). Investments. Helsinki. Retrieved from: http://www.tela.fi/?pid=1181291056

WORKING GROUP ON WORKING LIFE (the so-called Ahtela group) (2010). Ehdotuksia työurien pidentämiseksi, Työelämäryhmän loppuraportti 1.2.2010. Helsinki. Retrieved from: http://www.ek.fi/www/fi/tutkimukset_julkaisut/2010/2_helmi/TEResitys010210.pdf
"Proposals for lengthening working lives – final report".

4 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

[R1] ELO Kalle, KLAAVO Tapio, RISKU Ismo, SIHVONEN Hannu, Lakisääteiset eläkkeet. Pitkän aikavälin laskelmat 2009., Eläketurvakeskuksen raportteja 2009:4, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64313
"Statutory pensions.Long-term projections 2009". (forthcoming in english)

The earnings-related pension expenditure for the whole economy was slightly over 22% of the wage sum in 2008. In the years 2009–2010, the pension expenditure will grow quickly due to the decrease in employment. The growth in expenditure will continue until the beginning of the 2030s, when earnings-related pension expenditure will account for a third of the wage sum. From the end of the 2030s onwards, the pension expenditure will decrease by a total of 3 percentage points by the end of the projection period. Total statutory pension expenditure currently corresponds to 11% of GDP. At its highest, the share is projected to increase to an ample 15% in the 2030s. From the end of the 2040s onwards, the share of pension expenditure in GDP will stabilise at 14%. The TyEL contribution rate will rise from the current level of 21% to approximately 27% by 2025. Following this, the contribution level will decrease by two percentage points.

[R1] SOSIAALI- JA TERVEYSMINISTERIÖ, Sosiaaliturvan uudistamiskomitean (SATA) ehdotukset so-siaaliturvan uudistamiseksi, Sosiaali- ja terveysministeriön selvityksiä 2009:62, Helsinki, retrieved from:
http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-10834.pdf
"Proposals of the SATA Committee for reforming social protection"

The Government set up the Committee in June 2007 to prepare a total reform of social protection by drawing up a proposal for adequate basic protection, earnings-related security with focus on active alternatives, improved incentives, clarification of social security, and ensuring the sustainability of social protection. The Committee submitted its proposal by the end of 2009. The Committee prepared the basic policy lines for the reform by the end of 2008 which were published in January 2009 (Reports of the Ministry of Social Affairs and Health 2009:10). A considerable part of the proposals included in the basic lines are concrete proposals for legislation, which are already subject to law drafting. Taken as a whole, the Committee's proposals outline the future

development of social protection. Many of its proposals aim at increasing the rate of employment in the future. The proposals can be realised only within the limits allowed by the sustainability of public finances.

[R2] HARJU Jarkko, "Voluntary pension savings: the effects of the Finnish tax reform on savers' behaviour", VATT Working Papers 7, Government Institute for Economic Research, Helsinki, retrieved from: http://www.vatt.fi/file/vatt_publication_pdf/wp7.pdf

This paper is an empirical study of changes in savers' behaviour as a result of the reform using individual level data. Many countries tax voluntary pension savings using the so-called EET model, based on tax-deductible savings and taxable withdraws. In Finland the tax reform of 2005 changed the tax rate schedule from progressive to proportional, while the basic structure of the EET model was retained. The economic estimates indicate that the reform altered pension saving behaviour by reducing the labour income and age effects on saving contributions in a statistically significant way. Also, the reform reduced the number of pension savers among high income-earners.

[R2] KAHRA Hannu, Osakemarkkinoiden näkymät ja haasteet eläkesijoittamiselle. Eläketurvakeskuksen raportteja 2009:3, Helsinki,
retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64310
"The outlook for the stock market and the challenges it creates for pension fund management"

This is a study of the literature and recent academic research on equity market risk premium. The equity risk premium is not a constant, but a time-varying random variable. In addition to the risk premium study the review provides brief guidelines to modern fund management from a pension fund's point of view. This is conducted by reviewing current practices and trends in institutional asset management. According to study, equity markets will recover in due course, but one cannot rely on equity returns to solve the pension funding problem. Modern approach in asset and risk management is required.

[R2] KARI Seppo, PEHKONEN Jaakko, EEROLA Essi (eds.), "Reforming taxation and social security in Finland – why and to what direction?", Government Institute for Economic Research Publications 54, Helsinki, retrieved from:
http://www.vatt.fi/file/vatt_publication_pdf/j54.pdf

A collection of articles examining and discussing needs for reforming taxation and social security. Articles have their basis in the framework of SATA Committee. Main focus is in the development of taxation. However, also the effects of the pension reforms to employment of the elderly are discussed.

[R2] KARISALMI Seppo, GOULD Raija, VIRTA Lauri, Työkyvyttömyyseläkeläiset eri järjestelmissä, Eläketurvakeskuksen raportteja 2009:2, Helsinki, retrieved from:
http://www.etk.fi/Binary.aspx?Section=42845&Item=64125
"Disability pension recipients in different schemes"

The study strives to analyse how disability pension recipients in the earnings-related pension scheme and the national pension scheme differ from each other. The results of the study firstly emphasise the disability pension recipients' remaining work capacity. Especially those who received a pension due to intellectual disability assessed their work ability as moderate. A second key observation was the perceived insufficiency of the income. A third conclusion related to the quality of life. Disability pension recipients defined their quality of life primarily through health and mental well-being. Improving mental well-being through treatment and rehabilitation would enhance disability pension recipients' quality of life and probably also the ability to work.

[R2] KAUTTO Mikko, JOENTAKANEN Kullervo, KLAAVO Tapio, LAMPI Jukka, LASSILA Aino, POUTIAINEN Eeva, SALONEN Janne, UUSITALO Hannu, VIDLUND Mika, Eläkekattoa koskeva selvitys, Eläketurvakeskuksen katsauksia 2009:14, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64348
"The assessment of the pension ceiling"

The assessment of the pension ceiling has been implemented at the request of the Ministry of Social Affairs and Health. The impetus for the assessment request was the media attention focused on executive bonuses in state-owned companies in April 2009. The assessment examines the foundation of the earnings-related pension system and the principles for determining pension security. It contains an international review and comparison of pension ceiling. The assessment presents the discussion previously held in Parliament regarding the pension ceiling, and it includes a statistical description, based on pension registers, of the level, prevalence and distribution of high statutory pensions. Effects of a possible pension ceiling have been evaluated from the perspective of insurance contributions, premium income, pension expenditure, the number of insured and the wage sum. On the basis of assessment pension ceiling was not seen recommendable.

[R2] KORKEAMÄKI Ossi, KYYRÄ Tomi, "Institutional rules, labour demand and disability programme participation", Working Papers 2009:5, Finnish Centre for Pensions, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=63976

Employer-employee data is used to model transitions out of work into sick leave and disability retirement. To identify the role of institutional factors study exploits a law change that made the medical requirements for disability pension eligibility tougher for a certain group, as well as partially experience-rated employer contributions that vary with the firm size. Evidence is found that employers exploit disability retirement as a way of adjusting their workforce at times when dismissals are difficult to justify. The paper also shows that the transition rate to disability retirement depends on the stringency of medical screening and the degree of experience rating applied to the employer.

[R2] NIEMELÄ Heikki, SALMINEN Kari, Kansallisten eläkestrategioiden muotoutuminen ja Euroopan unionin avoin koordinaatiomenetelmä, Kela, Sosiaali- ja terveysturvan tutkimuksia 104, 2009, Helsinki, retrieved from: http://helda.helsinki.fi/bitstream/handle/10250/8207/Tutkimuksia_104.pdf?sequence=2
"Making of national pension strategies and the European Union open method of cooperation"

This study analyses the making of pension strategy reports for the EU Member States of Spain, the United Kingdom, Germany, Sweden, Finland and Denmark as the outcome of the pathway dependencies of their history and institutional legacy, and of the liberal administration or open coordination method of the European Union. However, the main emphasis in the study is on historical-institutional analysis of pension policy in the reference countries. The study indicates that the European Union has exerted little influence over the pension systems of the reference countries, and that the workfare state paradigm provides a better framework than conventional integration theories for appreciating the pension reforms made in these countries. The question relates more to a new regulatory approach in capitalism as a whole than to the European integration process.

[R2] RISKU Ismo and KALIVA Kasimir. Sijoitusriskien ja rahoitustekniikan vaikutus TyEL-maksun kehitykseen. Eläketurvakeskuksen keskustelualoitteita 2009:6. Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64110
"Influence of the investment risks and financing technique on development of the TyEL-contribution (the Employees Pensions Act)."

The report studies an influence of the investment and financing reform in 2007 on pension financing under the Employees Pensions Act (TyEL). It also compares the reformed pension financing rules to alternative rules, where the contribution level is annually adjusted to match the expected long-term sustainable level. An influence of the investment and financing reform is investigated by integrating a new stochastic investment model to the ETK's long-term projection model. According to simulation results the reform probably will reduce the need to increase the pension contribution in coming decades without it significantly increasing risk of a high contribution level. However, the reform increases uncertainty of the contribution level. An alternative financing technique, where the contribution level is annually adjusted to match the expected long-term sustainable level, produces more predictable and stable contribution levels than the present technique.

[R3] KANNISTO Jari, HILTUNEN Maija, "Effective retirement age in the Finnish earnings-related pension scheme." Eläketurvakeskuksen tilastoraportteja 2/2009, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=63760

One of the main objectives set in connection with the 2005 pension reform is 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. In 2008 the expected effective retirement age was 59.4 years, i.e. 0.1 years lower than the year before. However, over the 2000s the expectancy has increased by a good six months. The small changes in effective retirement age cannot be discerned from ageing people's employment rate, however, since the employment rate continued to increase in 2008.

[R3] OECD, "Increasing the effective retirement age in Finland", Report by the OECD to the Prime Minister of Finland, Directorate of Employment, Labour and Social Affairs, 2 March 2010, 11 p., retrieved from:
http://www.valtioneuvosto.fi/tiedostot/julkinen/pdf/2010/oecd-elakearvio-08032010/fi.pdf

The OECD's assessment of Finland's proposals to lengthen working lives and reform the pension system. Prime Minister requested the OECD to assess the proposals that the working group on working life (the so-called Ahtela group) had put forward to reform Finland's pension schemes:

[R3] PENSOLA Tiina and GOULD Raija. Ammatit ja masennusperusteiset työkyvyttömyyseläkkeet, Eläketurvakeskuksen keskustelualoitteita 2009:7, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64138
"Depression-related disability pensions in different occupations"

Study examines the incidence of depression-related disability pensions in different occupations over the years 1997–2006. The registry-based data comprised 272,000 persons. The average incidence of depression-related disability pensions per 10,000 person years was 22 for women and 16 for men. In five of the largest occupational groups for women, four showed a higher than average incidence of depression-based pensions. Also in many female-dominated human service occupations the incidence was

high for both sexes. In professional occupations, depression was a relatively more significant cause for work disability than other diseases. In blue-collar occupations other illnesses also often caused incapacity for work, and the overall incidence of disability pensions was high.

[R3] POLVINEN Anu. Koulutuksen, terveyden ja työn vaikutus työkyvyttömyyseläkkeelle siirtymiseen, Eläketurvakeskuksen keskustelualoitteita 2009:4, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=63935
"The impact of education, health and work to retirement on a disability pension"

The study examines the risk of retiring on a disability pension as posed to the working population aged 30 and over. The aim is to clarify the impact that various factors such as education, income, health and capacity as well as factors relating to work, endurance, and attitudes to work have on the probability of retiring on a disability pension. Retirement on a disability pension was based on the Cox model. Factors relating to health and capacity, such as long-term illness, physical condition as well as mental illness, significantly impacted retirement on a disability pension. Additionally, education and exhaustion in particular seemed to affect the risk of disability pension.

[R3] UUSITALO Hannu, KAUTTO Mikko and LINDELL Christina (eds.) Myöhemmin eläkkeelle – selvityksiä ja laskelmia, Eläketurvakeskuksen selvityksiä 2010:1, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64589
"Later to retirement – clarifications and calculations"

This report contains the background material (memorandums, projections etc.) that was made for the use of tripartite working group (the so-called Rantala group) in 2009 which considered means by which the effective retirement age might be raised by at least three years by 2025.

[R3] VALKONEN Tarmo and MÄÄTTÄNEN Niku, "Wealth and Retirement." Finnish Centre for Pensions, Helsinki, Reports 2010:1; The Research Institute of the Finnish Economy ETLA, Helsinki, Serie B 243, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64625

The aim of the study is to find out whether wealth affects a person's decision to retire. The wealth of many persons approaching retirement age has grown to such amounts that they could afford to retire early. This possibility may play an important role for the success of the policy that strives to achieve a postponed retirement age. The connection between wealth and the retirement decision is not straightforward. Nevertheless, wealth is of significance from the point of view of the incentive effects of various pension reforms. In simulation models raising the old-age retirement age will prolong careers but, on average, clearly less for those that have a substantial amount of liquid wealth when approaching retirement age. This is due to the fact that it is easier for wealthier persons to finance an early retirement by using their own savings. Therefore, wealth makes it more difficult to postpone the retirement age by raising age limits.

[R4] PALOMÄKI Liisa-Maria, TUOMINEN Eila. Työssä käyvät eläkeläiset – erot muihin työssä käyviin ja eläkkeellä oleviin. Eläketurvakeskuksen keskustelualoitteita 2010:4, Helsinki, 34 p., retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64711
"Working pensioners – differences to other workers and those in retirement"

The purpose of this study is to explain how both working pensioners younger than the general retirement age (55−62 years), as well as working old-age pensioners (between 63−70 years), differ from other workers and those who are already in full-time

retirement. Working old-age pensioners are better educated and have working spouses more often than other workers. Less than a third of them report financial reasons as having an effect on their decision to continue at work, in contrast to other workers, who are particularly motivated by a greater pension accrual in the future. The research is based on the ad hoc 2006 survey data of Statistics Finland, collected in connection with the Labour Force Survey.

[R4] HYTTI Helka, "Disability policies and employment Finland compared with the other Nordic Countries", The Social Insurance Institution, Finland (Kela) Research Department, online working papers 62/2009, retrieved from: http://www.kela.fi/in/internet/liite.nsf/NET/050608123720PN/$File/Selosteita62.pdf?openElement

Despite the problems observed, our neighbouring countries can teach us how to build up disability policy to support the social participation of people in a weak position on the labour market and how to give them the opportunity to utilise their remaining working capacity. The danger is that the necessary changes will not be implemented fully, resulting in contradictions in the relationships between various schemes and incentive structures. Besides the policy measures discussed above, this package of necessary changes includes strengthening the social security and labour market policy service structures and providing for unemployment security for the partly incapacitated in cases where no suitable employment is available to augment the income of the partly incapacitated benefit recipient.

[R4] HYTTI Helka, VALASTE Maria, "The average length of working life in the European Union", The Social Insurance Institution, Finland (Kela) Research Department, Helsinki, online working papers 1/2009, retrieved from: http://helda.helsinki.fi/bitstream/handle/10250/8369/The%20average%20length%20of%20working%20life%20in%20the%20European%20Union.pdf?sequence=1

According to the authors a life table-based indicator combining information on total life expectancy and labour market participation is considered the best measure for monitoring the duration of working lives in Finland and in other European countries. As a final conclusion from the results it may perhaps be argued that efforts to extend working lives should to a large degree be considered as part and parcel of policies aimed at health promotion, better reconciliation of family and working lives, flexible working arrangements especially for elderly workers and, in general, supportive institutional structures combining social security and labour market regulations in a coherent way that allows for individual adjustments in different phases of life.

[R4] HAKOLA Tuulia, MÄÄTTÄNEN Niku, "Pension system, unemployment insurance and employment at older ages in Finland", Prime Minister's Office Publications 2/2009, Helsinki, retrieved from: http://www.vnk.fi/julkaisukansio/2009/j02-pension/pdf/en.pdf

The study analyses the labour supply and retirement incentives of the Finnish social security system with a numerical life cycle model with endogenous labour supply and retirement decisions. The model features a detailed description of the benefit rules of the pension and unemployment insurance systems and takes into account various early retirement options. The main aim is to find policy reforms that would postpone labour market withdrawals and reduce the fiscal cost of the social security system without having too regressive distributional effects.

[R4] TENHUNEN Sanna. "Employment and accrued pension rights among the elderly – a peek into the pension registers", Finnish Centre for Pensions, Working Papers 2010:1, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=64578

Economic incentives behind retirement decisions come up in discussions around pension reforms. The 2005 pension reform in Finland was designed to also encourage longer working careers. While the relationship between pension accrual and employment decision is a complex issue, this study aims to take the first steps on the path towards considering this question in light of the register data on earnings-related pensions. The study considers development in the employment of the elderly and explores the possibility of linking pension accrual and employment from an empirical point of view.

[R5] AHONEN Antero, Kansaneläkkeen saajan indeksiturva ja tuloasema. Mikrosimuloinnin sovellus pitkävaikutteiseen ilmiöön, Kela, Sosiaali- ja terveysturvan selosteita 65, 2009, Helsinki, retrieved from:
http://helda.helsinki.fi/bitstream/handle/10250/7984/Selosteita65.pdf?sequence=1
"Indexation and Incomes in the National Pension Scheme. Application of Micro Simulation."

The alternative indexations of national pensions are examined. The main approach is micro simulation. The severe problem of the national pension in comparison to the earnings-related pension is the level of the pension in the beginning and its indexation. Alternative ways of the indexation of the national pension in both dimensions – in the beginning of the pension and during the pension – are formulated and the results are compared using micro simulation. The treatment of the amount of the pension in the beginning, i.e. its indexation, proves to be an important factor in determining the subsistence of the pensioners in the national pension scheme.

[R5] AHONEN Kati, BACH-OTHMAN Jarna, Vanhuusköyhyyden jäljillä – kotitalouden rakenteen merkitys sukupuolten välisiin köyhyysriskieroihin kahdeksassa EU-maassa., Eläketurvakeskuksen keskustelualoitteita 2009:8, Helsinki, retrieved from:
http://www.etk.fi/Binary.aspx?Section=42845&Item=64557
"Tracing old-age poverty – the significance of the household structure on gender differences in the poverty rate in eight EU countries" (forthcoming in English)

In the study gender differences in poverty rates among the elderly are examined in eight EU countries. The aim of the study is to find out how gender differences vary from one country to the next, and what causes the differences in each country. Special focus is on the weak connection between the high female labour force participation rate and the small gender differences in the risk of poverty. The empirical part of the study is based on EU-SILC 2006 (European Community Statistics on Income and Living Conditions). According to study, the higher risk of poverty among elderly women is strongly related to difficulties regarding the means of support in single households and to the higher share of single households among women. In addition, the differences in the risk of poverty between the genders are affected by the gender differences in the household composition.

[R5] LAESVUORI Arto, RISKU Ismo, KNUUTI Juha, KESKI-HEIKKILÄ Sari and UUSITALO Hannu, Työeläkkeiden indeksisuoja TEL:stä TyEL:iin, Eläketurvakeskuksen raportteja 2009:1, Helsinki, retrieved from:
http://www.etk.fi/Binary.aspx?Section=42845&Item=64123
"Indexation of earnings-related pensions from the Employees' Pensions Act (TEL) to the Employees Pensions Act (TyEL)"

From the viewpoint of pension provision indexation is an important issue. If pensions were not index-linked, already an annual inflation of 2% would eat up 40% of the purchasing power of the pension in 25 years. A comparison of the indexation of statutory pensions in 31 countries indicates considerable variation between the countries. The general trend seems to be a weakening of indexation. The Finnish earnings-related pension index and wage coefficient may be considered as taking a position roughly midway on the variation range. In the 2005 pension reform a solution was sought in between the extremes by improving the indexation for the earnings during the working career and weakening the indexation of pensions in payment for pension recipients aged under 65. The reduction was, however, compensated by the lump-sum increase payable to disability pensions after five years of payment.

[R5] LAINE Veli, SINKO Pekka, VIHRIÄLÄ Vesa, "Ageing report. Overall assessment of the effects of ageing and the adequacy of preparation for demographic changes.", Prime Minister's Office Publications 4/2009, Helsinki, retrieved from:
http://www.vnk.fi/julkaisut/julkaisusarja/julkaisu/en.jsp?oid=258437

The ageing report reviews developments in the ageing of population, the effects of ageing and Finland's ageing policy, on which basis it assesses the adequacy of the preparations for this, and the need for new policy measures. In addition to the established fiscal sustainability, social and political sustainability forms the perspective of this assessment. If successful, various structural measures should prove capable of substantially alleviating the threats and restrictions presented by fiscal sustainability to welfare promises concerning pensions and services. Sound policy will facilitate attending to these promises, while partly even improving safety nets, without raising the overall tax ratio.

[R5] MAUNU Tallamaria, "The distribution of pension wealth in Finland", Finnish Centre for Pensions, Helsinki, Working Papers 2010:3, retrieved from:
http://www.etk.fi/Binary.aspx?Section=42845&Item=64708

This paper studies the effect of pensions on the distribution of wealth in Finland. A combination of survey and register data is used, including register information on earned pension rights. The discounted value of the stream of future pension benefits is calculated. Adding pensions to net wealth makes the distribution of wealth somewhat more even. Inequality is reduced within all subgroups studied. The subgroups whose relative situation improves, compared to other subgroups, are the highly educated, singles, and part-time pensioners.

[R5] SALONEN Janne, Palkansaajien ansiot ja eläkkeet. Yksityisen ja julkisen sektorin palkansaajan ansiokehitys 1964–2004, Eläketurvakeskuksen keskustelualoitteita 2009:3, Helsinki, retrieved from: http://www.etk.fi/Binary.aspx?Section=42845&Item=63904
"Employees' wages and pensions. Private and public sector employee's wage history between 1964 and 2004"

The publication examines the working careers and pensions realised in the age groups born between 1905 and 1975, based on the earnings development data and pension registers of the Finnish Centre for Pensions. The sample data, unique for Finnish conditions, has been used to monitor the work and wage histories of those covered by pension insurance between 1964 and 2004. Reviews of the earnings development are of a general nature, with a focus on wage development in relation to age and gender differences. Particular attention has been paid to the end of the working career and the change in income caused by the transfer to retirement. The results show how the systems

of early retirement affect the length of a working career. The income distribution of the pension recipients during the period under review has remained very even.

[H] Health

[H2] FREDRIKSSON Sami, HYVÄRINEN Olli, MATTILA Mikko, WASS Hanna. Kilpailuttaminen poliittisena päätöksenä. Kunnallisalan kehittämissäätiön Kunnat ja kilpailu-sarjan julkaisu nro 14, Helsinki 2009, 170 p,
retrieved from: http://www.kaks.fi/node/37/?julkaisuid=109&src=dr
"Competition as a political decision"

The study is part of to the research project about municipalities and competition. It consists of four parts: 1. the ideological basis of competition, 2. competition and power of municipal politicians and administrators, 3. working of competition in practice, and 4. opinions of residents and politicians in municipalities.

[H2] JOENSUU Tiina. "Cumulative costs of caries prevention and treatment in children – with special reference to work division and cohort effect." Annales Universitatis Turkuensis D 848, Turku 2009, 104 p, retrieved from: https://oa.doria.fi/handle/10024/45156

The aim was to calculate the cumulative costs of caries prevention and treatment in children by comparing two operational models of caries management in the public health centres of Kemi and Tornio. In addition, the dental health of children was observed. The study was carried out from the viewpoint of the public provider. Data were collected from the files of the Public Health Centres. In Kemi, the cohorts born in 1980, 1983 or 1986 (n = 600), and in Tornio, the cohorts 1980 and 1992 (n = 400) represented the conventional operational model. The cohorts 1989, 1992 and 1995 (n = 600) in Kemi represented the new model. The cohorts and towns were compared in relation to dental health and resources used. The operational model had a major effect on the cumulative costs of caries treatment in children. Early prevention and control of caries carried out by dental hygienists was associated with lower cumulative costs and better or equally good dental health as conventional prevention with less work division. The cost-effectiveness in caries treatment of children in the Public Health Centres significantly improved during the study years. The early risk-based approach for control of caries enables cost-effective use of personnel resources.

[H2] KALAVAINEN Marja, KARJALAINEN Senja, MARTIKAINEN Janne, KORPPI Matti, LINNOSMAA Ismo, NUUTINEN Outi. "Cost-effectiveness of routine and group programmes for treatment of obese children". Pediatrics International 2009; 51(5): 606-11, retrieved from: http://www3.interscience.wiley.com/journal/122295387/abstract?CRETRY=1&SRETRY=0

The aim was to compare the cost-effectiveness of group treatment with routine counselling in obese children. A prospective 6-month intervention assessed family-based group treatment (15 separate sessions for parents and children) and routine counselling (two appointments for children). Children's weights and heights were measured at baseline, at the end of the intervention and at follow up 6 months later, and the changes in weight for height and body mass index standard deviations scores (BMI-SDS) were calculated and used as main outcome measures. The mean costs and effects of the programmes were analysed to produce the incremental cost-effectiveness ratio, which is an estimate of the additional costs per 1% decrease in weight for height or 0.1 decrease in BMI-SDS. Cost-effectiveness analysis was performed from the perspective of the service provider. At the end of the intervention, group treatment costs were 1.4-fold when counted per 1% weight for height decrease, and 3.5-fold when counted per 0.1 BMI-SDS decrease. Incremental cost-effectiveness ratio estimates were EUR 53 when

calculated for 1% weight for height decrease, and EUR 266 when calculated for 0.1 BMI-SDS decrease. Family-based group treatment is more costly compared with individual routine counselling. Salaries form most of the total costs.

[H2] KANKAANPÄÄ Eila, LINNOSMAA Ismo, VALTONEN Hannu. "Public health care providers and market competition: the case of Finnish occupational health services." The European Journal of Health Economics 2010,
retrieved from: http://www.springerlink.com/content/cv221026448qpr03/

The study assessed possible differences in public providers' performance (price, intensity of services, service mix-curative medical services/prevention, productivity and revenues) according to the competitiveness of the market. The Finnish Institute of Occupational Health (FIOH) collected data on clients, services and personnel for 1992, 1995, 1997, 2000 and 2004 from occupational health services (OHS) providers. Employers defray the costs of OHS and apply for reimbursement from the Social Insurance Institution (SII). The SII data was merged with FIOH's questionnaire. The unbalanced panel consisted of about 230 public providers, totalling 1,164 observations. Local markets were constructed from several municipalities based on commuting practices and regional collaboration. Competitiveness of the market was measured by the number of providers and by the Herfindahl index. The more competitive the environment was for a public provider the higher were intensity, productivity and the share of medical care. Fixed panel models showed that these differences were not due to differences and changes in the competitiveness of the market. Instead, in more competitive markets public providers had higher unit prices and higher revenues.

[H2] KANKAANPÄÄ Eila, SUHONEN Aki, VALTONEN Hannu. "Does the company's economic performance affect access to occupational health services?" BMC Health Services Research 2009; 9:156, retrieved from: http://www.biomedcentral.com/1472-6963/9/156

In Finland like in many other countries, employers are legally obliged to organise occupational health services (OHS) for their employees. We explored whether economic performance was associated with the companies' expenditure on occupational health services. A prospective design to predict expenditure on OHS in 2001 by a company's economic performance in 1999 was used. Data were provided by Statistics Finland and expressed by key indicators for profitability, solidity and liquidity and by the Social Insurance Institution as employers' reimbursement applications for OHS costs. The data could be linked at the company level. 19% of the companies (N=6 155) did not apply for reimbursement of OHS costs in 2001. The profitability of the company represented by operating margin in 1999 and adjusted for type of industry was not related to the company's probability of applying for reimbursement of the costs in 2001. Profitability measured as operating profit in 1999 and adjusted for type of industry was not related to costs for curative medical services nor to OHS cost of prevention in 2001. No relationship between the company's economic performance and expenditure on OHS was found in Finland.

[H2] KOIVUNEN Marita. "Acceptance and use of information technology among nurses in psychiatric hospitals". Annales Universitatis Turkuensis D 837, Turku 2009, 74 p, retrieved from: https://oa.doria.fi/handle/10024/43661

The use of information technology (IT) has not played a very significant role in psychiatric nursing although the development of IT applications has affected health care delivery and the work processes of nurses. The objective was to create recommendations on the best practices for improving the acceptance and use of IT among nurses working in psychiatric hospitals. The study consisted of five phases using a combination of

descriptive statistical and qualitative methods. The data were collected during the period 2003–2006 among health care staff working on nine acute psychiatric wards. The results showed that there are eight main factors which could improve the acceptance and use of IT among nurses working in psychiatric hospitals if these factors are taken account when new IT applications are implemented. The factors were divided into two groups; external variables (resource allocation, collaboration, computer skills, IT education, training, patient-nurse relationship) and usability and usefulness of the application.

[H2] KUOKKANEN Liisa, SUOMINEN Tarja, HÄRKÖNEN Eeva, KUKKURAINEN Marja-Leena, DORAN Diane. "Effects of organisational change on work-related empowerment, employee satisfaction, and motivation." Nursing Administration Quarterly. 2009; 33(2):116-24, retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/19305308

This article reports the results of a longitudinal quantitative study on nurses' views on factors promoting and impeding empowerment and examines the relationship between work-related empowerment and background variables in one hospital. Data were collected using a self-administered questionnaire. Nurses gave lowest assessments of promoting factors on the second measurement occasion, a time when the organisation was going through major changes. Both job satisfaction and motivation showed a positive relationship with factors promoting empowerment. Organisational changes have a direct effect on the work environment in terms of empowerment and job satisfaction. To cope successfully with changes, special attention must be paid to personnel management.

[H2] KUOTOLA Yrjö. Kunnan raja. Acta Universitatis Tamperensis; 1454, Tampere 2009, 315 p, retrieved from: http://acta.uta.fi/english/teos.php?id=11249
"Municipal border"

Finnish local government has always been based on municipalities which have authority, territory, residents and functions of their own. New duties, a weak economic situation and changes in the functional environment are changing the situation and setting new demands for local government. Municipal and regional cooperation has become more common and spread to almost all fields of service. The state has taken an active role and started a restructuring project. The aim of this project is to secure welfare state services in the future. The main reform is that health care and associated social services have to be provided by a local authority or partnership area with a population base of at least 20,000. The goal is to promote municipalities to merge voluntarily or to establish a partnership area. In the future the Government could force municipalities in a difficult situation to merge.

The main conclusion of this study is that municipal boundaries still have real significance. It seems that some of the municipality's essential elements such as community and accountability have lost some of their significance. Municipal boundaries indicate the authority of the municipalities, the area over which residents can exercise their democratic rights and the municipality's responsibility to offer basic welfare services to the citizens. Due to municipal cooperation and social changes, municipal boundaries have lost their relevance in a functional sense. Municipal boundaries are not entirely appropriate when carrying out tasks by the state. In some cases municipal boundaries are an obstacle to better or more appropriate services. This can be problematic from the point of view of citizens´ fundamental rights and in terms of realising the constitution. In order to enhance democratic factors, municipal boundaries should be constructed so that they form real communities of citizens in which people are directly able to influence the government and their living environment. One option

would be to change the juridical role of the municipality and stress the role of the district or region as a local actor and provider of welfare services.

[H2] LEHTOMÄKI Leila. Valtakunnallisista suosituksista terveyskeskuksen talon tavoiksi. Acta Universitatis Tamperensis 1426, Tampere 2009, 250 p,
retrieved from: http://acta.uta.fi/english/teos.php?id=11222
"Implementation of national guidelines in health centres"

This research aimed at studying the implementation of national guidelines in health centres. The research phenomenon was approached multiprofessionally. The key aim of the research was to increase understanding of clinical guideline implementation. This research utilised the action research approach but also features of evaluation research. Although the common attitude towards national guidelines proved to be positive, several profession- specific and professional-group-specific factors hindered their introduction in health centres. The organisation structure and culture seemed to have a role in the introduction of clinical guidelines and harmonisation of care and operational practices. The large number of guidelines, combined with the forced pace of health centre work with insufficient possibilities to familiarise oneself with the guidelines, hindered their introduction. Even if multiprofessional cooperation and agreement on uniform operational practices were seen as important in the rhetoric concerning guideline implementation, they were quite rare in practice. It was more typical for the health centre culture to work independently, make decisions individually and cooperate with one's own professional group than to work multiprofessionally. The results give evidence to propose that health centres should develop multiprofessional cooperation culture and structures to promote reflective joint processing of the guidelines.

[H2] MARTIKAINEN Tuomo. Uudistaako kilpailuttaminen kuntia? Kunnat ja kilpailu -tutkimuskokonaisuuden loppuraportti. Kunnallisalan kehittämissäätiön Kunnat ja kilpailu-sarjan julkaisu nro 13, Helsinki 2009, 111 p,
retrieved from: http://www.kaks.fi/node/37/?julkaisuid=108&src=dr
"The final report of the research project. Municipalities and competition"

In 2005, the Association of Finnish Local and Regional Authorities and the Foundation connected to the Association started a research project for a wide assessment of competition in municipal health and social care services. The project consisted of 35 studies reported in 2009 or earlier, and 3 studies are in a reporting phase. This report gives an overview of the results, and considers the movement from welfare state to competition state in Finland. Results obtained with questionnaires show that the opinions of Finns are in a phase of change. There exist both uncertainty about changes and willingness to change. The opinions of politicians in municipalities seem to follow the traditional division into the left and right parties. The left parties stress the positive aspects of the welfare state. Population-based questionnaires give evidence that ageing citizens, those with lower education and lower income levels and those voting for the conservative party or the social-democratic party think quite positively about competition in services.

[H2] MIKKOLA Hennamari. Toimiiko kilpailu ulkoistuksissa riittävästi? Suomen Lääkärilehti 2010;65(9):794–795,
retrieved from: http://www.fimnet.fi/cgi-cug/brs/artikkeli.cgi?docn=000033617
"Does the competition work in outsourcing health care services?"

The article is a review about two studies performed by Mikkola. These studies showed that competition does not work very well in outsourcing, and outsourcing may lead to more expensive services in some cases.

[H2] PELTONEN Eija. Lääkäreiden ja hoitajien työpari- ja tiimityö vastaanottojen toimintamalleina perusterveydenhuollossa. Vertaileva tutkimus. Kuopio University Publications E 168, Kuopio 2009, 201 p, retrieved from: http://www.uku.fi/vaitokset/2009/index_tekija.shtml

"The doctor-nurse pair model and the admissions team model in primary health care: a comparative study"

The purpose was to describe the admission practices into primary health care from the point of view of doctors, nurses, health centre administrators, and patients. Specifically, the aim was to compare two admissions practice models – a doctor-nurse pairing and an admissions team. Ten health centres using either a doctor-nurse pair model or an admissions team model in admission practice were chosen to the study. The data were gathered during 2005–2006. For the health centres using the doctor-nurse pair model, it was typical that a patient would first contact directly their named nurses, who were responsible for setting appointments for those patients listed in their case load. Health centres using the admissions team model applied locally agreed clinical guidelines to direct admission practices. Health centres applying the doctor-nurse pair model dealt better with admission in unhurried matters. In health centres using the admissions team model, supervision of the admission practices of doctors and nurses had not been arranged. All the occupational groups felt that intensifying the planning and evaluation of the admissions practice is of highest importance. Common training for doctors and nurses, and joint access to software for arranging consultation times should be organised as part of implementing a new admissions model and reforming the work tasks.

[H2] SALONOJA Maritta, SALMINEN Marika, AARNIO Pertti, VAHLBERG Tero, KIVELÄ Sirkka-Liisa. "One-time counselling decreases the use of benzodiazepines and related drugs among community-dwelling older persons". Age and Ageing Advance Access published online on January 20, 2010, retrieved from: http://ageing.oxfordjournals.org/cgi/content/full/afp255v1?view=long&pmid=20089547

The study aimed to assess the persistence of one-time counselling by a geriatrician to reduce psychotropic drugs, especially benzodiazepines (BZD) and related drugs (RD). A prospective randomised controlled trial with a 12-month follow-up was conducted. Five hundred and ninety-one community-dwelling people aged 65 or older participated in the study. Instructions to withdraw, reduce or change psychotropic drugs were given to the intervention group. A 1-hour lecture about these drugs and their adverse effects was given later on. No changes in the drug therapy were suggested for the controls. The number of regular users of BZD and RD decreased by 35% (12/34) (in the intervention group while it increased by 4% (2/46) in the controls.

[H2] STENVALL Jari, AIRAKSINEN Jenni. Manse mallillaan – Tampereen mallin arviointi ja palveluinnovaatiot. City of Tampere and The Association of Finnish Local and Regional Authorities. Acta Publications No. 211/2009, Helsinki 2009, 136 p, retrieved from: hosted.kuntaliitto.fi/intra/julkaisut/pdf/p091116124624S.pdf

"Assessment of the Tampere Model and service innovations"

The implementation of the Tampere Model can be seen as one of the most radical reforms of the Finnish local government in the 2000´s. As a consequence of the reform the city of Tampere has implemented the mayor model, the purchaser/provider model and a client-centred process model. The aim was to assess how the Tampere Model works as a concept especially from the perspective of service innovations. This report is based mainly on material collected through interviews. The number of interviewees was 32. A distinctive feature of the Tampere Model is that the change has made the city open

up in several directions. Observations, influences and development impulses emerge from several directions and different operational levels. This kind of model may be considered particularly apt to operating environments that are complex and in need of continuous reforms. The Model opens up in so many directions that some actors perceive it as fragmentary, chaotic even, and the Model gives rise to strong demands and creates room for diverse interests. Progress has been achieved in regard to all the elements, but each element needs to be developed further. The Model enables promotion of innovation by using coordination based on interaction as the starting point.

[H2] VAAPIO Sari. Elämänlaatu ja kaatumisten ehkäisy. Annales Universitatis Turkuensis C 280, Turku 2009, 88 p, retrieved from: https://oa.doria.fi/handle/10024/44658
"Quality of life and fall prevention among the aged"

The study aimed to describe and assess fall prevention interventions as a quality of life indicator, and to describe the social dimension of health-related quality of life among the aged. In addition, it aimed to assess the effects of fall prevention intervention on quality of life among the aged. The study was implemented by using a methodological triangulation. The data in the systematic review was retrieved from the databases of medical and nursing sciences. Home-dwelling aged (n=19) participated in the qualitative study of a social dimension of quality of life. The quantitative multifactor fall prevention study comprised 591 older participants randomised into an intervention group or a control group. Follow-up measurements were carried out after a 12 month intervention. The systematic review showed that fall prevention produced positive effects on quality of life only in a few studies. Based on the thematic interview, the social dimension of quality of life consisted of three themes: personal values, personal milieu and personal daily life. The results of the fall prevention programme showed that depressive symptoms and distress decreased, managing in usual activities improved and sexual activity and phone contacts increased among men. In women, managing in usual activities improved, socialising increased and discomfort and symptoms decreased. Fear of falling and feelings of insecurity reduced among women in the intervention group. Multifactor fall prevention can affect positively some physical and psychosocial dimensions of quality of life among the community-dwelling aged.

[H2] 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.

[H3] GOEBELER Sirkka. "Health and Illness at the Age of 90." Acta Universitatis Tamperensis 1484, Tampere 2009, 95 p, retrieved from: http://acta.uta.fi/english/teos.php?id=11265

This study described the health and illnesses of 90-year-olds with the aim to obtain population level information from several perspectives. The target population was all people born in 1907–1910 and living in the city of Tampere at the age of 90. Sources of information were medical records, city hospitals' patient register and discharge database, a mailed questionnaire, testing for mobility and cognition, and population register data for mortality.

Four of five 90-year-olds were women (79%). More than two-thirds of the 90-year-olds lived in the community (72%). One-year mortality was nearly 20%. The surviving 90-year-olds men appeared to be healthier than women. The most common diagnosis groups in the patient history were cardiovascular diseases (78%), gastrointestinal diseases (59%), infections (54%), and injuries (50%). The diagnosis of dementia was mentioned in every fourth case (27%). One third (38%) were able to move using no support or a light support, 8% were bedridden. Of the community-living 90-year-olds, 78% reported their current health as good or average. During one year, 43% of 90-year-old men and 50% of 90-year-old women were admitted to hospital. The mean length of stay for men was 19 days, for women 46 days. Of the 90-year-olds, 7% were permanently in hospital. One third (36%) of the original population lived to age 94. Factors associated with survival were living in the community, no earlier history of certain diseases (heart diseases, cancer, diabetes, dementia, and infections), only a few co-morbidities, fewer than four medicines in daily use, a good cognitive state, and good mobility.

[H3] KIMANEN Annukka, MANNINEN Pirjo, RÄSÄNEN Kimmo, RAUTIO Maria, HUSMAN Päivi, HUSMAN Kaj. "Factors associated with visits to occupational health physicians in Finland." Occupational Medicine (Lond). 2010; 60(1):29-35, retrieved from: http://occmed.oxfordjournals.org/cgi/content/abstract/60/1/29

The aim was to analyse factors associated with visits to seek primary care from occupational health physicians (OH physicians) and to compare these factors with visits to physicians in municipal health centres, private clinics and hospital outpatient clinics. The subjects comprised 1753 randomly selected employed Finns aged 25–64 years covered by OHS including primary care. Provision of primary care in OHS was found to increase visits to OH physicians but to decrease visits to municipal health centre physicians. Among both genders, long-standing illnesses impairing work ability had the strongest associations with visits to all physicians. Among men, the factors associated with visits to OH physicians were long-standing illnesses without effect on work ability, requirement of sickness certificate from the first day of sickness, OHS arranged in private clinics and moderate stress symptoms. Among women, lower vocational level, OHS arranged in private clinics or joint-model OHS units, moderate stress symptoms and workplace harassment were associated with visits to OH physicians. In conclusion,

primary care in OHS enables OH physicians to reach workers with work-related health problems, thus enabling interventions on working conditions and work ability. Moreover, OHS seem to be a very important health care provider in Finland.

[H3] KINNUNEN Birgitta, MANNINEN Pirjo, TAATTOLA Kirsi. "Factors associated with farmers joining occupational health services". Occupational Medicine (Lond). 2009;59(4):273-6, retrieved from: http://occmed.oxfordjournals.org/cgi/content/abstract/59/4/273

The aim was to explore factors associated with farmers joining farmers' occupational health services (FOHS). In 2004, 1182 full-time farmers (aged 18–64), were chosen randomly from the register of the Information Centre of the Ministry of Agricultural and Forestry in Finland. They were interviewed in 2004–2005. Among both genders, chronic illnesses, farm size and opinion on whether membership of FOHS should be obligatory were predictors of farmers joining FOHS. Among male farmers, the production sector, the existence of a quality system on the farm and vocational education were associated with interest in joining. Among female farmers, interest was associated with physical activity. This knowledge is important for improving the coverage of FOHS and to motivate farmers to join.

[H4] Sosiaali- ja terveydenhuollon tilastollinen vuosikirja 2009. Terveyden ja hyvinvoinnin laitos, SVT Sosiaaliturva 2009, 228 p, retrieved from: http://www.stakes.fi/FI/tilastot/tilastojulkaisut/tilastollinenvuosikirja.htm
"Statistical yearbook on social welfare and health care 2009"

The Statistical Yearbook on Social Welfare and Health Care published by the National Institute of Health and Welfare provides the most important statistical information about welfare and health and the system of social welfare and health care services in Finland. The information is presented as time series. The National Institute of Health and Welfare was formed on 1 January 2009 through the merger of the National Research and Development Centre for Welfare and Health and the National Public Health Institute. Following the merger, the yearbook now also includes data on seasonal influenza vaccination coverage and the circumstances and sites of accidents requiring hospital treatment. The yearbook is a handbook suitable for day-to-day use in client work, administration and research in social welfare and health care.

[H5] HUOTARI Päivi. Strateginen osaamisen johtaminen kuntien sosiaali- ja terveystoimessa - neljän kunnan sosiaali- ja terveystoimen esimiesten käsityksiä strategisesta osaamisen johtamisesta. Acta Universitatis Tamperensis 1382, Tampere 2009, 212 p, retrieved from: http://acta.uta.fi/english/teos.php?id=11163
"Strategic knowledge management in municipal social welfare and health care services"

The importance of social and health care knowledge management will grow in the coming years because of the project to restructure local government and services, the challenges in getting a workforce and because of changes in services resulting from ageing of the population. The aim of this study was to formalise strategic knowledge management, describe how managers put it into practice and find central development areas in strategic knowledge management. In the first phase, data were collected through focus group interviews. In the second phase, a questionnaire was sent to 699 supervisors in social and health care in four municipalities. In the first phase five main categories in strategic knowledge management emerged: strategic management, strategic management of knowledge and competence, tangible capital management and research. All five categories were connected comprehensively and closely with each other. In the second phase, the model constructed in the first phase was defined with a

factor analysis. The main category was divided into four factors: knowing and recognition of the strategy, the competence to manage change, transforming the strategy into the work goals of their subordinates, and exploiting evaluation in strategic decision making.

[H5] MIKKOLA Hennamari. Toimiiko kilpailu lääkäripalveluissa? Kunnallisalan kehittämissäätiön Kunnat ja kilpailu -sarjan julkaisu nro 15, Helsinki 2009, 50 p, retrieved from: http://www.kaks.fi/node/37/?julkaisuid=538&src=dr
"Does competition work in medical services?"

The aim was to assess, how competition works in medical services. The material was collected with questionnaires sent to chief physicians in central hospitals and health centres. Altogether 110 (nearly 50%) chief physicians answered. The majority of chief physicians replied that competition had caused extra costs. Municipalities had had problems to get family physicians employed by municipalities to work in health centres, and they were obliged to make expensive contracts with private companies in order to provide medical services for their residents. Competition has worked poorly. The chief physicians reported that there had been a lack of knowledge about competition in municipalities. They assessed that competition will be a permanent way to provide medical services in future.

[H5] SAXÉN Ulla. Työhyvinvointi, koulutus ja toiminnan kehittäminen terveyskeskuksissa lääkäritilanteen näkökulmasta. Annales Universitatis Turkuensis C 278, Turku 2009, 62 p, retrieved from: https://oa.doria.fi/handle/10024/43662
"Job satisfaction, education and the operation development at health centres from the perspective of physician sufficiency"

Finnish health centres have suffered from a shortage of physicians in recent years. The objectives were to describe the situation of the physicians in the counties Satakunta and South-Western Finland at the time when the University of Turku started to decentralise its education to Satakunta and to describe the attitudes of the chief physicians in health centres towards training and research cooperation with the University of Turku; to gain information about the training programmes for physicians in specific training in general medical practice (STPG); to assess how the shortage of physicians affects the job atmosphere, the job satisfaction and the operation of the health centres; to assess health centre employees' opinions about their professional skills, their needs and interests in continuing education; to assess medical and nurse students' professional identity and their readiness to do multiprofessional teamwork. The material was gathered during 2003–2006 with three mail questionnaires and a questionnaire given to medical and nurse students who practised in the training health centre in Pori. In spring 2003, the shortage of physicians was more severe in Satakunta than in South-Western Finland. Attitudes towards training of medical students and research cooperation with the universities were generally positive. The guidance of STGP doctors in health centres improved during 2003–2005. A shortage of physicians had only a slightly negative impact on employee job satisfaction. The shortage of physicians had a positive impact on the operation of the health centres because it led to reorganisation of the operations. The personnel in health centres were willing to take more challenging tasks and to acquire appropriate further education or training. The medical and nurse students had strong professional identity and they understood the significance of teamwork for the health care service system.

[L] Long-term Care

[L] AARVA Kim. Hoivan ja hoidon lähijohtaminen. Acta Universitatis Tamperensis 1421, Tampere 2009, 225 p, retrieved from: http://acta.uta.fi/english/teos.php?id=11213
"First-line management of care and nursing"

This study addresses the concepts of caring and nursing care in elderly care. The study focuses on the similarities and dissimilarities in the management of care and nursing in elderly care in the city of Helsinki. Data were collected from employees and first-line managers working in the department of home nursing of the City of Helsinki Health Centre and at elderly services of the City of Helsinki Social Services Department. The qualitative data were collected by means of group discussions at the turn of the year 2006. The survey was undertaken in October–November 2007.

There appear to be no strong differences in construing care and nursing between the two organisational cultures, but the managers and employees of both departments tended to place highly divergent degrees of emphasis on the concepts. Perceptions of the activities and principles involved in the management of care and nursing did not differ according to the respondent's background department, nor were there differences between managers from the two departments. The way in which management activities were perceived by managers and their subordinates differed greatly from each other. Managers were more likely than their subordinates to place emphasis on almost all the care- and nursing-related management activities. Subordinates were more likely than managers to place emphasis solely on values as the starting point for nursing management.

Managers tend to emphasise professionalism, medical orientation, purposeful activities and care procedures in nursing care and the tangible aspects of care. Employees with social care qualifications stress the role of care in rehabilitation and the presence of everyday life in care. Those with social care qualifications are more likely to perceive care as a professional activity and emphasise its emotional aspects. Those with other than health care qualifications tend to view care as client-oriented and broad-based.

[L] ELONIEMI-SULKAVA Ulla, SAARENHEIMO Marja, LAAKKONEN Marja-Liisa, PIETILÄ Minna, SAVIKKO Niina, KAUTIAINEN Hannu, TILVIS Reijo S, PITKÄLÄ Kaisu H. "Family care as collaboration: effectiveness of a multicomponent support programme for elderly couples with dementia. Randomised controlled intervention study." The Journal of American Geriatric Society. 2009;57(12):2200-8, retrieved from: http://www3.interscience.wiley.com/journal/123206389/abstract

The aim was to assess whether community care of people with dementia can be prolonged with a 2-year multicomponent intervention programme and to analyse effects of the intervention on total usage and expenses of social and health care services. The trial was a randomised controlled one among community-dwelling couples with one spouse caring for the other spouse with dementia. Couples with dementia (N=125) were allocated at random to the intervention (n=63) or control group (n=62). Intervention couples were provided with a multicomponent intervention programme with a family care coordinator, a geriatrician, support groups for caregivers, and individualised services. At 1.6 years, a larger proportion in the control group than in the intervention group was in long-term institutional care. At 2 years, the difference was no longer significant. Intervention led to reduction in use of community services and expenditures. The difference for the benefit of intervention group was EUR -7.985. When the intervention costs were included, the differences between the groups were not significant. The intervention did not result in a significant difference in the need for institutional care after 2 years, but individualising services in collaboration with families may lead to reduction in use of and expenditures on municipal services.

[L] ELORANTA Sini. "Supporting older people's independent living at home through social and health care collaboration." Annales Universitatis Turkuensis D 869, Turku 2009, 88 p, retrieved from: https://oa.doria.fi/handle/10024/47133

The purpose was to increase understanding about the resources of older home care clients and to describe social and health care collaboration in home care provision. The data were collected among older home care clients and their professional carers in one municipality in Western Finland. Open-ended interviews were conducted with 21 older clients. In addition, 25 home care professionals – 13 home service workers, 11 home health care nurses and one medical doctor – described their experiences of multi-professional collaboration. A questionnaire was sent to 200 home care clients and to 570 carers: 485 home care workers, 81 home health care nurses and 4 doctors.

The older home care clients described their resources in terms of a sustained sense of life control and will. They derived strength in managing everyday life from their leisure activities and social networks, but they were challenged by the conditions imposed by outsiders on their everyday life, by their deteriorating health and loneliness. The care provided by professionals sometimes conflicted with older clients' expectations and did not always support the clients' resources. Professionals took care-related decisions and actions on behalf of their clients, even though the clients stressed the importance of retaining their sense of life control and will. Factors hampering multi-professional collaboration included difficulties that professionals had in identifying the resources of clients and threats to the resources, communication problems, the lack of clear goals and care professionals' contrasting views and ways of working. Clients' and care professionals' views on care provision differed. Clients had lower assessments than care professionals of the support provided for independence and the provision of physical, psychological and social care.

[L] FENG Zhanlian, HIRDES John P, SMITH Trevor F, FINNE-SOVERI Harriet, CHI Iris, DU PASQUIER Jean-Noel, GILGEN Ruedi, IKEGAMI Naoki, MOR Vincent. "Use of physical restraints and antipsychotic medications in nursing homes: a cross-national study." International Journal of Geriatric Psychiatry 2009; 24(10): 1110–8,
retrieved from: http://www3.interscience.wiley.com/journal/122253757/abstract

The study compared inter- and intra-country differences in the use of physical restraints and antipsychotic medications in nursing homes, and described aggregated resident conditions and organisational characteristics associated with these treatments. Population-based, cross-sectional data were collected using a standardised Resident Assessment Instrument (RAI) from 14,504 long-term care facilities providing nursing home level services in five countries: Canada, Finland, Hong Kong, Switzerland, and the United States. The prevalence of physical restraint use varied more than five-fold across the countries, from an average 6% in Switzerland, 9% in the US, 20% in Hong Kong, 28% in Finland, and over 31% in Canada. The prevalence of antipsychotic use ranged from 11% in Hong Kong, 26–27% in Canada and the US, 34% in Switzerland, and nearly 38% in Finland. Within each country, substantial variations existed across facilities in both physical restraint and antipsychotic use rates. In all countries, neither facility case mix nor organisational characteristics were related to the prevalence of either treatment. There exists large, unexplained variability in the use of physical restraints and antipsychotics both between and within countries. Since restraints and antipsychotics are associated with adverse outcomes, more studies about factors contributing to use rates are needed.

[L] FORMA Leena, RISSANEN Pekka, AALTONEN Mari , RAITANEN Jani, JYLHÄ Marja**.**
"Age and closeness of death as determinants of health and social care utilisation: a case-control study." The European Journal of Public Health 2009; 19(3): 313–318, retrieved from: http://eurpub.oxfordjournals.org/cgi/content/full/19/3/313?view=long&pmid=19286838

A case-control design was used to compare utilisation of health and social services between older decedents and survivors, and to identify the respective impact of age and closeness of death on the utilisation of services. Data were derived from multiple national registers. The sample consisted of 56,001 persons, who died during years 1998–2000 at the age of > or = 70, and their pairs matched on age, gender and municipality of residence, who were alive at least 2 years after their counterpart's death. Data included use of hospitals, long-term care and home care. Decedents' utilisation within 2 years before death and survivors' utilisation in the same period of time was assessed in three age groups (70–79, 80–89 and > or = 90 years) and by gender. Decedents used hospital and long-term care more than their surviving counterparts, but the time patterns were different. In hospital care the differences between decedents and survivors rose in the last months of the period, whereas in long-term care there were clear differences during the whole 2-year period. The differences were smaller in the oldest age group than in younger age groups. Closeness of death is an important predictor of health and social service use in old age, but its influence varies between age groups. Not only the changing age structure, but also the higher average age at death affects the future need for services.

[L] HARTIKAINEN Anne. Vapaaehtoiset vuodeosastolla: Etnografinen tutkimus vanhusten ja vapaaehtoisten kohtaamisesta. University of Helsinki, 2009, 151 p, retrieved from: http://urn.fi/URN:ISBN:978-951-806-133-8
"Volunteers at the inpatient ward – an ethnographic study on the encounters of older people and volunteers"

This ethnographic study investigates encounters between volunteers and older people at the Kerava Municipal Health Centre inpatient ward for chronic care. When this research began in 2003, nine of the volunteers came to the ward on set days per week or visited the ward according to their own timetables. The volunteers ranged in age from 54 to 78 years. Nearly all of them had been volunteers for more than ten years. The research questions are: How is volunteer work implemented in daily routines at the ward? How is interaction created in encounters between the older people and the volunteers? What meanings does volunteer work create for the older people and the volunteers? The core material is observation material, which is supplemented by interviews, documentation and photographs.

The volunteers open and create social arenas for the older people through chatting and singing together, celebrations in the dayroom or poetry readings at the bedside. Stimuli in daily life, such as handicrafts in groups, pass time but also give older people the experience of meaningful activity and bring back positive memories of their own life. The volunteers' identity is built up into the identity of a helper and caregiver. The older people's identity is built up into a care recipient's identity, which in different situations is shaped into the identity of one who listens, remembers, does not remember, defends, composes poetry or is dying. The results indicate that volunteer work is a meaningful resource in work with older people.

[L] KAUPPINEN Sari (editor). Terveyden ja hyvinvoinnin laitoksen asiantuntijoiden arvioita peruspalvelujen tilasta. Peruspalvelujen tila 2010 -raportin tausta-aineisto. Terveyden ja hyvinvoinnin laitos, THL raportti 9/2010, Helsinki 2010, 74 p,
retrieved from: http://www.thl.fi/thl-client/pdfs/0f7be8e6-0385-46a0-902d-c2f3602193a0
"Assessment of experts in the National Institute for Health and Welfare about the social welfare and health services in municipalities"

Data on social welfare and health services collected for the follow-up of the reforms in municipalities are presented in this report.

[L] MIKKOLA Tuula. Sinusta kiinni: Tutkimus puolisohoivan arjen toimijuuksista. University of Helsinki, 2009, 216 p, retrieved from: http://urn.fi/URN:ISBN:978-952-493-067-3
"Depending on you – a study of spousal care, everyday life and agency"

The purpose is to describe spouses as care givers and receivers and as home care service users. The data consist of interviews with 21 elderly couples. The results show that care changes the routines and actions of everyday life. The couples have to negotiate their duties and rights between each other. Care giving and receiving are both physical and emotional actions. In the end it becomes a part of the couples´ normal life. The purpose of couples´ action is to live together as long as possible. They want to strengthen both their own agency and their spouses´ agency. The living together depends on both of them. The spouses decided together what home care services they would like to use and on which conditions they have to use services. Services must support the elderly couples´ shared life at home. They cannot be against the conditions on the spousal care. In arranging services to elderly care-giving and care-receiving couples, the providers have to consider their own wishes and the meanings of their own relationship and shared life.

[L] NURMINEN Janne, PUUSTINEN Juha, KUKOLA Matti, KIVELÄ Sirkka-Liisa. "The use of chemical restraints for older long-term hospital patients: a case report from Finland." Journal of Elder Abuse & Neglect 2009; 21: 89–104,
retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/19347712

The purpose was to describe the use and concomitant use of psychotropics and other drugs as chemical restraints in the aged in long-term hospital care. The study consisted of 154 patients (42 men, 112 women) hospitalised in five long-term care wards in a primary care hospital in a Finnish town. Three or more psychotropics were regularly given to 33% of the patients and regularly or irregularly to 53% of the patients. Two or more benzodiazepine derivatives or related drugs were regularly given to 24% of the patients and regularly or irregularly to 46% of the patients. The very poor cognitive and functional abilities of the patients, the common concomitant use of psychotropic drugs, the use of psychotropics to control the behaviour of the patients, and the lack of documentation of the effects and side effects of the drugs give rise to the conclusion that psychotropics were used as chemical restraints in these long-term care wards.

[L] ONDER Graziano, FINNE-SOVERI Harriet, SOLDATO Manuel, LIPEROTI Rosa, LATTANZIO Fabrizia, BERNABEI Roberto, LANDI Francesco. "Distress of caregivers of older adults receiving home care in European countries: results from the Aged in Home Care Study." The American Journal of Geriatric Psychiatry 2009; 17(10): 899–906, retrieved from: http://www3.interscience.wiley.com/journal/123206389/abstract

The aim was to identify factors associated with distress of caregivers of home care patients in Europe and to evaluate whether caregivers response to distress varies between countries. The study is a cross-sectional study among older adults receiving

home care in 11 European countries with a total of 3,449 older adults receiving home care. Caregiver distress was assessed by asking whether the caregiver was distressed, angry, depressed, or in conflict because of caring for the participant. The mean age of home care patients was 82.4 years, and distress was detected in 7.5% of their caregivers. Amount of depressive symptoms, cognitive performance, amount of impaired Activities of Daily Living and amount of behavioural symptoms were associated with caregivers' distress, and these associations were consistent among caregivers in all countries. Overall, 295 caregivers (8.6%) felt that the patient would be better off in another living environment, and 1,444 (41.9%) caregivers were willing to increase help. Despite an elevated rate of distress, a low proportion of caregivers in Italy (3.0%), Germany (6.1%), and France (5.5%) felt that participants would be better off in another living environment. In countries with lower rate of distress, as Iceland and the Netherlands, this rate was higher. Distress of caregivers is associated with the long-term patient's cognitive and functional status, depressive, and behavioural symptoms, and there are national differences in the response to distress.

[L] SAARNIO Reetta. Fyysisten rajoitteiden käyttö vanhusten laitoshoidossa. Acta Universitatis Ouluensis D 1024, Oulu 2009, 122 p, retrieved from: http://herkules.oulu.fi/isbn9789514292088/

"The use of physical restraints in institutional elderly care"

The purpose was to describe and explain the use of physical restraints in institutional elderly care. Quantitative and qualitative approaches were used. The results showed that the use of physical restraints was quite common. The nursing staff considered the use of these restraints as an ethical conflict situation. There existed situations where family members demanded the use of restraints. The staff stated that the lack of legislation has an effect on the widespread use of restraints. 33% of the nursing staff reported that there are written instructions on the use of physical restraints in their work unit.

[L] SANERMA Päivi. Kotihoitotyön kehittäminen tiimityön avulla – toimintatutkimus kotipalvelun ja kotisairaanhoidon yhdistymisestä. Acta Universitatis Tamperensis 1458, Tampere 2009, 315 p, retrieved from: http://acta.uta.fi/english/teos.php?id=11261

"Developing home care work by teamwork. Action research on fusion of a home care work organisation and a home health care organisation"

The purpose is to describe fusion of a home care work organisation and a home health care organisation. Together they form home care organisation. The study was done as an action research in a municipal home care organisation during 2000–2003. The home care work organisation and home health care organisation were combined in 2000. Empirical data was collected by theme interviews of the personnel during the development interventions and after the project. As result a new model of home care was developed. The development model consisted of several processes: continuous common discussion forum, improvement of management and continuous evaluation and feedback process. Supporting processes are continuously working steering and planning group, networking and improving of learning process of the students. Development work advances via development cycles, which consist of five phases; diagnosis, planning, implementation, evaluation and learning.

[L] TEPPONEN Mirja. Kotihoidon integrointi ja laatu. Kuopio University Publications E 171, Kuopio 2009, 224 p, retrieved from: http://www.uku.fi/vaitokset/2009/index_tekija.shtml
"Integration and quality of home care"

The purpose was to explore the ways integrating home care and their interrelations, and the impact of these ways on the content and quality of home care in municipalities. Acts, policy documents and previous studies; interviews of directors; and interviews of clients were used in collecting data. The most common methods of integration in 43 municipalities were structural: home care units, boards responsible for home care, and combined health and social welfare departments. Integrative processes and tools served as other methods of merging. The organisation of home care changed in many municipalities from 2004 to 2007. The overall quality as rated by family members was better in unintegrated than in integrated home care, but no similar trend was found in the ratings of clients and employees.

5 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 Research Department 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.

Kela (Kansaneläkelaitos) – The Social Insurance Institution of Finland
Address: Helsinki (central administration)
Webpage: http://www.kela.fi/in/internet/english.nsf
Kela operates under the supervision of Parliament. Kela's mission is to secure the income and promote the health of the entire nation, and to support the capacity of individual citizens to care for themselves. Kela is a reliable, efficient and socially responsible actor. It has an active role in developing social security and its implementation. The social security provided by Kela is clearly understandable, reasonable in amount and delivered with a good standard of quality. Kela's service is the best in the public sector.

The Research Department of Kela undertakes research and development projects focusing on the social security and health provision of the Finnish population and on the benefit schemes, client service and other operations of Kela.

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 advices 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 do researches about 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 (THL) – The National Institute for Health and Welfare
Address: Mannerheimintie 166, Helsinki
Webpage: http://www.thl.fi/
The National Institute for Health and Welfare (THL) is a research and development institute under the Finnish Ministry of Social Affairs and Health. THL works to promote the well-being and health of the population, prevent diseases and social problems, and develop social and health services. THL is the statutory statistical authority in health and welfare and maintains a strong knowledge base within its own field of operations. THL is also responsible for the application of this knowledge. THL has a wide range of tools to carry out its responsibilities: research, follow-up and evaluation, development, expert influence, official tasks as well as international cooperation. THL seeks to serve the broader society in addition to the scientific community, actors in the field and decision makers in central government and municipalities.

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.

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
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.

Valtioneuvoston kanslia – The Prime Minister's Office

Address: Snellmaninkatu 1A, 00101 Helsinki
Webpage: http://www.vnk.fi

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

Valtion taloudellinen tutkimuskeskus – Government Institute for Economic Research

Address: Arkadiankatu 7, 00101 Helsinki
Webpage: http://www.vatt.fi/en/

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

Valtiovarainministeriö (VM) – Ministry of Finance

Address: Snellmaninkatu 1 A, Helsinki
Webpage: http://www.vm.fi/vm/fi/01_etusivu/

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

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

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