Annual National Report 2009

Pensions, Health and Long-term Care

Finland

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Equal Opportunities

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1 Executive Summary

Pensions: 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. 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. There have been no remarkable changes in the system's characteristics since 2005. From 2010 onwards, national pensions will be financed solely by the state, and the employers' contribution will be ceased. The change will reduce the costs of private employers by EUR 700 to 800 million per year. In turn, during 2011-2014 contributions to the earnings-related pension system will be raised annually by 0.4 percentage points. Recent political debates concern the increase of the minimum retirement age. Two working groups were established to discuss this issue. It is also debated to introduce a minimum guaranteed pension above the level of the national pension, as the income gap between national pensioners and other pension recipients is increasing.

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 a complementary one. Development of primary health care is on top of the agenda of the Finnish Government. Development of health services by implementing national programmes continued throughout 2008. These programmes were funded by the state and by municipalities. A legal act to combine primary health care and specialised hospital care into a comprehensive health care was prepared, and relevant stakeholders were asked their opinions. Citizens` opportunities to choose services were stressed. Many municipalities had problems to recruit physicians. The development of primary health care services was one major topic in the Ministry of Social Affairs and Health, and several working groups collected ideas in order to save the welfare service model in primary health care.

Long-term care: Municipalities are responsible for organising and providing long-term care to their residents. In 2008, the Ministry of Social Affairs and Health and the Finnish Association of Local and Regional Authorities gave recommendations to municipalities about the quality and quantity of care of the aged. Development of home care was stressed by the Ministry of Social Affairs and Health. The possibilities of old citizens to choose services were increased by extending the service voucher programme into home nursing. The provision of long-term care services for the aged increased through. The status of long-term care of the aged was criticised in mass media, and a specific legislation to ensure care of the aged was proposed by non-governmental organisations.

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

2.1 Pensions

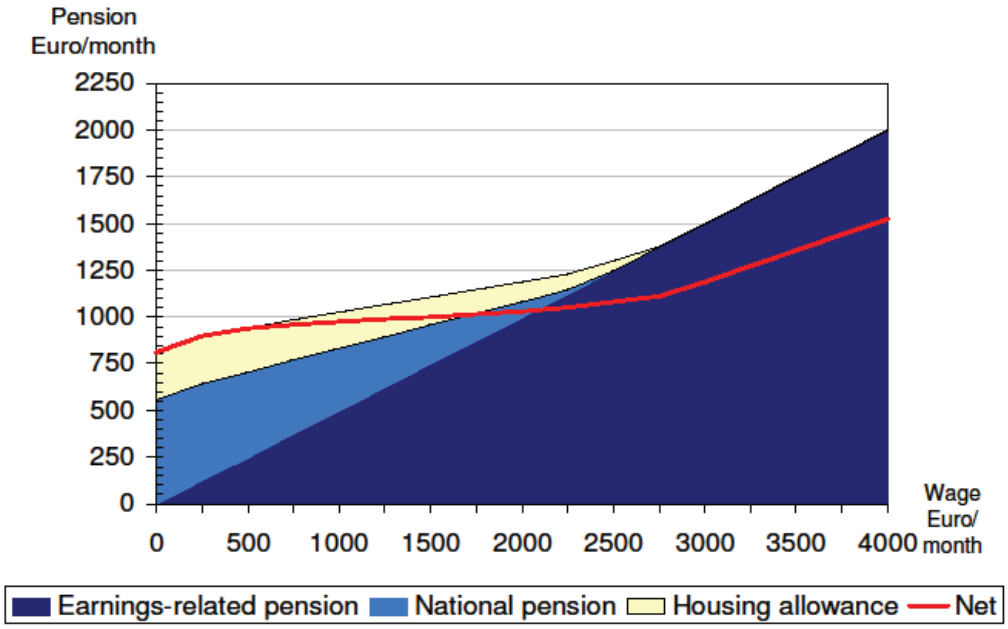
2.1.1 Overview of the system's characteristics

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. 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.

The statutory schemes are linked together, with the amount of the national pension benefit depending on the size of the earnings-related pension benefit. Earnings-related pensions reduce the national pension by 50%. If the amount of the earnings-related pension of a given individual is above a defined level, no national pension is payable. Expenditure for statutory pensions amounted to 10.8% of GDP in 2008, of which the employment based earnings-related pensions accounted for 86% and the national pensions for the rest. In the future, the role of the national pensions in the total pension income will diminish, as the level and the coverage of earnings-related pensions will rise (cf Figure 1 in chapter 2.1.1).

Figure 1: Earnings-related pension, national pension and pensioners' housing allowance 2008



Source: Finnish Centre for Pensions

In 2007, statutory earnings-related pensions were received by about 94% of all pension recipients, and national pensions by about 48%. About 8% of the pensioners received a full national pension. From those, 60% received disability pensions (mainly middle-aged men) and 40% old-age pension (mainly old-aged women). About 6% of the pensioners did not receive any other but the national pension.

National pensions are administered by the Social Insurance Institution supervised by the Parliament, subject to pay-as-you-go (PAYG) funding. The full national pension is granted on the basis of 40 years of residence in Finland. In 2009, the full national pension has been EUR 584.13 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 early before the age of 65, and the reduction is permanent.

National pensions were financed by contributions of employers (49%) and by the state (51%). As from 1 January 2010 they are financed solely by state. The purchasing power of national pensions is retained by annual indexation based on the consumer price index.

The earnings-related pension scheme covers all gainfully employed people, including the self-employed. Statutory pension coverage of the private sector is handled by authorised non-state

pension institutions. Employers' and employees' organisations have a strong position in their administration. The Finnish Centre for Pensions is the central body for the earnings-related pension schemes. The Ministry of Social Affairs and Health is in charge of the general supervision of the earnings-related schemes. Central and local government employees have their own earnings-related schemes. In principle, the pension benefits are similar for all sectors.

The financing of earnings-related pensions is a combination of a PAYG system and a pre-funded system based on pension contributions from both employers and employees. The PAYG system covers approximately three quarters of the earnings-related pension outlays, with the pre-funded scheme covering the rest. Despite being partially funded Finland's earnings-related pension scheme is of defined-benefit type.

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 ("carrot"). Study periods and periods of child care accrue for the pension within certain limits. If the insuree takes the pension at the age of 62, it is permanently lower than the normal old-age pension. The pension is reduced by 0.6% for each month the pension is taken early before the age of 63.

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 multiplier' 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 life-expectancy coefficient adjusts the pensions to be paid to the changes in longevity as of 2009. It is an automatic stabiliser. When the old-age pension starts it is multiplied with the life expectancy coefficient, which reduces the monthly payable pension in circumstances of increasing life expectancy, but does not reduce the accumulated pension payable over the pension recipient's whole time in retirement if the pension recipient reaches the age foreseen by the increase in life expectancy. The underlying idea is to eliminate the extra burden for the pension system due to increased longevity. Broadly speaking, if life expectancy increases by four years, one must work two years more between 63 and 68 (when the pension accrues at the rate of 4.5% per year) to compensate the impact of the life-expectancy coefficient, i.e. to keep the replacement rate.

The financial position in the earnings-related pension schemes is fairly good as the system is running on surpluses. The annual surplus has been 3% in relation to GDP. The market value of the pension fund's assets was 55.3% of GDP in 2008.

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.

Part-time pension can be granted to an insured 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% to 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 pension accrued until the start of the part-time pension. In the national pension system part-time pension regulations are absent.

Unemployment pension may be awarded to a long term unemployed 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.

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 pension to the age of 63. The requirement for the entitlement to a pension for the projected pensionable service is that insured has at least a minimum amount of earnings 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 funds of the national pension scheme.

Special assistance for immigrants may be awarded to claimants over the age of 65, and between ages 16-64 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.

2.1.2 Changes in the system's characteristics since 2008

There have been no remarkable changes in the system's characteristics since 2005. The most remarkable ongoing change is the considerable increase in the number of private non-statutory pension insurance. In 2000, the number was just over 300,000, and, in 2009, it was 800,000. Two thirds (62,000 in 2008) of new policies sold are own personal policies. One third (32,000 in 2008) is insured by employer. The premium income of private non-statutory pensions today is about 5% of all pension premiums, amounting to about 5% of total pension expenditures. So their role is yet by no means decisive but the increase may reflect a coming major change in the Finnish pension system.

One reason for the increased number of private pension insurance is that premiums of such pensions are tax-deductible up to the amount of EUR 5,000 per year, providing that the pension is not payable before of age 62. The tax treatment of different kinds of personal capital investments are under preparation and will be decided upon end of 2010. There have been expressed opinions that all alternative capital investments should have similar tax treatment and the preferential treatment of private pension insurance should be abolished. On the other hand, a preferential treatment for lifelong private non-statutory pension insurance has been proposed. Life long private non-statutory pension insurances are lacking today in Finland. Nearly all private non-statutory pension insurances are for a limited term of years, typically for five or 10 years and at a maximum for 15 years.

The increase in non-statutory pensions may partly be caused by the discussion that statutory system should be changed into a defined-contribution system and the contribution should have a ceiling instead of the prevailing defined-benefit system without any ceilings of contributions. In addition, the adoption of the life expectancy coefficient, as explained above, has weakened faith in adequate pensions. There is a desire to have extra pensions to

supplement statutory pensions. On the other hand, the Finns are confident of their future pensions. According to interviews 67% of Finns are confident about the future of their pensions. The figure is second largest among European countries (European Commission. European Social Reality, Report 2007. Special Eurobarometer 273).

There are signs – even if this does not yet remarkably reflect in statistics – that non-statutory pension policies offered by employers are increasing because of their positive influence as part of a recruiting policy. Some pension policy experts assume that this development has only just started and that it will have a remarkable position in the future. On the other hand, some experts presume that the prevailing statutory Finnish pension system is so strongly embedded in the Finnish system and in vested interests that its position is very stable. The result might be their coexistence.

As from the beginning of 2008, municipalities have no longer had an influence on the national pensions. Until then municipalities were divided into two categories, and in the "cheaper" communities pensions were lower. Nowadays, everyone gets pensions according to the "first" category. From the beginning of 2008, those living in institutions have received the same amount of national pensions as the pensioners living in their own homes. Until 2008, pensions of pensioners living in institutions had been reduced.

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.

From the beginning of 2009, 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.

The level of disability pensions will increase starting in 2010. Broadly speaking, the new life-expectancy coefficient coming into effect in 2010 and the old accrual rates will weaken the relative position of disability pensions and this is compensated by higher accrual rates for the projected pensionable service and some other changes.

The lower age limit for the part-time pensions will be raised from currently 58 years to 60 years. The change will take effect on 1 January 2011. 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. The reason of weakening the part-time pension were its popularity and alleged effects. The original idea of the part-time pension was to reduce the early exit from the labour market. Both experience and research results have indicated that the favourable terms of part-time pension tempted working people to move into part-time pension, and there was no significant evidence of postponing the retirement age.

As mentioned above the contributions of employers for national pension will cease on 1 January 2010. Until 2008, their contribution was 49%. From 2010 on , national pensions will be financed solely by the state. The change will reduce the costs of private employers by EUR 700 to 800 million per year. At the same time, it was agreed between the employers' and employees' organisations and the state that during 2011-2014 contributions to the earning-related pension system will be raised annually by 0.4 percentage points. It is likely that the agreed increase in contributions would have been inevitable in any case because of the prevailing scheme of earnings-related pensions. The calculated need for the increase of the contributions in the coming years is about double compared to the agreed 1.6 percentage points. So, the logic of the agreement is to postpone the discussion of the change of the prevailing defined-benefit earning-related pension system and of its financing.

The recession has deflationary consequences. The national pension benefits may decrease as a result of prevailing index linkages. It was assured by a governmental source that the pension benefits will not decrease even if it should be the result of the prevailing indexation scheme.

Another result of the recession is the decrease in returns of the capital investments of insurers. To avoid loss-making sales of capital investments, the regulations of financial solidity of financial investments were loosened in 2009.

2.1.3 Reforms under discussion

Employers' associations and trade unions made an agreement on 21 February 2009, commonly called “social package”. An important part of it dealt with unemployment benefits which were under preparation in a state committee reforming the social protection. But the pension policy played also a remarkable role in the package. The above mentioned changes in part-time and disability pensions and changes of the financing systems were agreed in the package.

The Government on 24 February 2009 informed about its intention to increase the regular minimum retirement age gradually to 65 years. This gave rise to heated discussions and, as a result, it was agreed between the Government, employers' associations and trade unions on 11 March 2009 that the Government gave up its intention, but two working groups were established. The pensions negotiation group of employers' associations and trade unions prepares the outlines for the measures to increase the effective retirement age by 3 years by 2025. The other working group focuses on the well-being at work to contribute to the same target. The deadline of both working groups is 31 December 2009.

According to public discussion one of the major results of the package of 21 February 2009 and of the agreement of 11 March 2009 was to show the strong position of employers' associations and trade unions in social security and pension policy. At the same time, the agreement of 11 March 2009 guaranteed the active preparation of the measures to increase the retirement age. On the other hand, it is not easy to see any socially acceptable measures to support remarkably the extension of the retirement age by means of pension policy reforms. So much has already been done in the thorough reforms of 2005 and by tightening of the terms of early retirement since 2005. The major possibilities may lie in improving the working life conditions.

The above mentioned committee for social protection reforms has made its preliminary suggestions and they are under discussion and further preparation. There seems to be strong political support for a new form of pension inside the national pension system. It is called guaranteed pension, meaning that it is a minimum pension. Under discussion is a pension which is EUR 100 higher than the full national pension of today. The full national pension in 2009 has been EUR 584 per month and so the minimum pension could be EUR 684.

The committee puts the idea as follows: “To guarantee a fair level of smallest pensions a minimum level 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 would be realised by raising the national pension of about 675,000 pensioners, the cost would be about EUR 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.

There has been a lot of discussion of how the relative position of the smallest pensions have deteriorated in the past decades in relation to other income earners. If the smallest pensions, i.e. the pensions of those who get only a national pension, had been increased proportionally as quickly as the earning incomes from the year 1985, the smallest pension today should be about EUR 843. If 1995 were taken as a starting point of the comparison, the smallest pension should nowadays amount to about EUR 669. So there is a remarkable social pressure to improve the position of the lowest pension groups. The fiscal difficulty to meet this social pressure is apparent. The increase of the minimum pensions should be remarkably higher than EUR 100 in order to bring back the proportional position of pensioners who have the lowest pensions compared to 1995 and even more so compared to 1985.

The old method of increasing all national pensions to meet the social pressure would be very expensive. On the other hand, it is obvious that in the future the raises of non-earnings-related pensions exceeding the indexation based on the consumer price index will be directed exclusively to minimum pensions. There will be a deterioration of the relative position of those who draw both earnings-related and national pensions. Until now, the "extra" raises exceeding the indexation based on the consumer price index have been directed to all national pension recipients. It is possible that the adoption of minimum pensions will, in the long run, supersede the national pension system. It has been speculated that it will result in a considerable change of the pension system. If the earnings-related pensions must be added to meet the minimum pension, the addition will be made by the institutions which take care of earnings-related pensions. According to this speculation the role of social insurance institutions in pension policy will be limited to those only who have no earnings-related pensions.

From the part of the employers' organisations the incentive function of the minimum pension system have been emphasised. If as a result of the minimum pensions there is a wide income range where the earned income has no effects on the pension, the incentive effect of the pensions system will be weakened. The critics refer to experiences made in Norway where a sizable special supplement guaranteeing the minimum level has lead to the need to reform the system. In the new system a "guaranteed pension" is determined so that earnings-related pensions may influence the total pension also at a low total pension level. In other words, from the point of view of the pension total the Norwegian system is adopting the system which Finland is now abandoning by adopting the new minimum pension system, giving away the incentive effect.

The incentive problem of the suggested minimum pension system will have effects on the insurance of self-employed persons and on the insurance of farmers. The level of income "should correspond to the work effort of a self-employed person" but is, in fact, to some degree discretionary. At the same time, the level is rather low so that 55% of those who are insured under the statutory insurance for self-employed persons belong to the groups that are entitled to supplement their pension by a national pension. That means that many of those insured in the self-employed and farmers' systems are expected to be eligible for a minimum pension in the future. For them the level of statutory earnings-related pensions insurance is of no matter. This might have two consequences. Firstly, they will try to negotiate the pension amount to be as low as possible. Secondly, they will be frustrated paying their pension premiums without them effecting their future pensions.

Another suggestion from the part of the employers' organisations has been to compensate for the minimum level pension system e.g. by housing allowances. There is no means-testing planned in the proposed minimum pension system. The only incomes which were to reduce the amount of the minimum pension are other pensions. Housing allowance and other respective social benefits compensating minimum pensions are actually means-tested and thus more effective in directing the benefits to those in need. In such a way the most acute income problems will be covered by less expenditure compared to the minimum pension system.

There is, it must be said, a certain inconsistency in the two criticisms explained above. The heavy leaning on means-tested social benefits creates incentive problems. That may be one reason why on the part of employees' organisations it has been suggested that the new minimum pension system could apply only to the disability pensions.

The idea of the new minimum pension system has been approved by the committee. That means that the parties represented in the Government are to some degree committed to the minimum pension system. The representatives of employers and unions did not voice dissenting opinions. The correct interpretation might be that social partners are not heavily against it. The recession might have strong effects. It might be advantageous to slowly and gradually implement the new minimum pension system. Any binding decisions have not yet been made.

One of the big issues dealt with by the above mentioned for social protection is the relation between disability and work. In November 2008, OECD published a report entitled "Disability and Work: Breaking the Barriers (vol.3): Denmark, Finland, Ireland and the Netherlands." It has had influence on the work of the committee. The committee is preparing a proposal 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.

Recipients of national disability pensions may set aside approved disability pensions for up to five years. This means the possibility to return to the position of disability pensioner at a later point in time. The idea is to encourage affected persons to work, without the fear of loosing the approved disability pension if working proves to be impossible. According to the committee this system will be adopted in the future in the earnings-related pension system as well.

There are some other suggestions trying to "break the barriers" between disability and work. The content of suggestions concerns mainly the rehabilitation but it is probable that the currently accepted levels of earned income and the alternatives of partial pensions of disability pensioners will be made more flexible.

About 40% of all new approved disability pensions are due to problems in mental health. The Ministry of Social Affairs and Health launched a well-equipped project to reduce depression-related inability to work in November 2007. The project will run until spring 2011. The above mentioned suggestions are partly results of the discussions contributed by the project.

The capital investments of the earnings-related pension funds, which are administered by the insurance companies but regulated by the Ministry, have been debated. As mentioned above the regulations for financial solidity of investments were loosened in 2009 because of the recession. The level of accepted risks and the possibilities to direct capital investments to certain targets are discussed in ongoing preparation work. For example, the possibilities to support the domestic production and employment were examined, and it was found that the possibilities are rather restricted. The interests are conflicting in many aspects and no clear result is on the horizon, but the trend has recently been towards more freedom of choice for the companies.

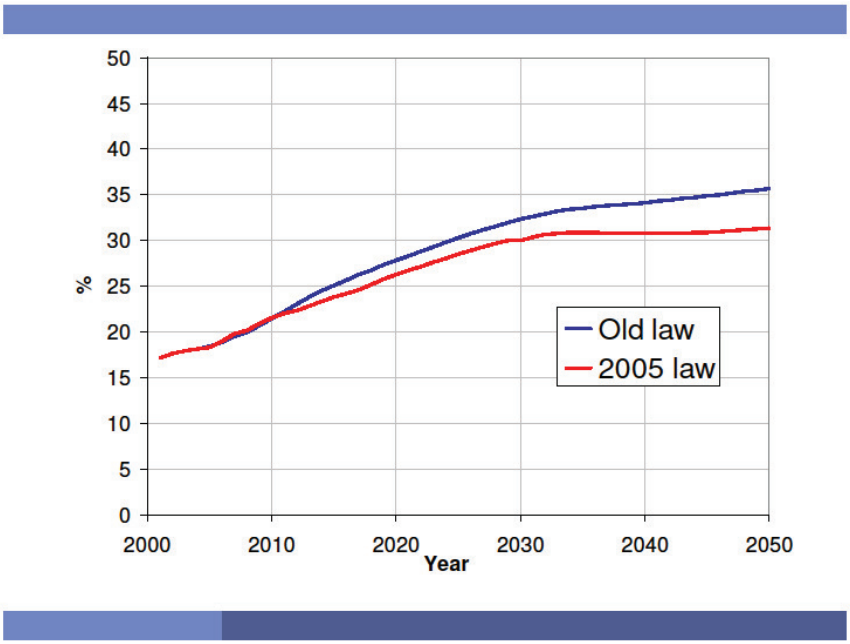
2.1.4 Impact assessments, debates and critical assessments

The discussion of pension policy in Finland focuses more on the calculations of economic sustainability than is the case in other Nordic countries.

When preparing the 2005 reform the estimates indicated that the effective age of retirement would increase by three years by 2050. According to most recent data Finland is well on the way to achieve the objectives of the reform. In 2004, the expected retirement age was 59.1 years. In 2007, it was 60 years in the public sector and 59.7 years in the private sector.

When the decisions of the 2005 reforms were made it was anticipated that the reforms would improve economic sustainability, but a need to increase the contributions in the future remained (see figure 2).

Figure 2: Projection of pension expenditure, % of wages in 2005-2050 private sector employees



Source: Finnish Centre for Pensions

As mentioned above it was agreed that in the period 2011-2014 pension contributions to the earnings-related pension system will be raised annually by 0.4 percentage units. This will probably be not enough and it is easy to foresee heated discussions of the ways to cover or to avoid the possibly needed extra contributions. From the employers' side it has already been suggested that a ceiling for the contributions and an automatic stabiliser with an effect on the level of pensions should be adopted. The employees' side underlined the measures to improve working life conditions in order to postpone the retirement age.

One theme in the discussion of economic sustainability of the pension system is the structure of powers. The "Ageing report", issued by the Prime Minister's office, included interesting discussion of the issue: "However, if changes in the cooperation between organisations result in the earnings-related pension scheme being unable to make the required decisions [to safeguard the economic sustainability] in the future, a window of opportunity may be open for transferring power. The earnings-related pension system and the national pension system may become a single system, decision on which will be made by the Parliament. […] If decision

making concerning the earnings-related pension system were transferred more clearly to the Parliament, the voter base influencing decision making would become distinctly older. Employers' associations and trade unions represent the working age population in particular, while the Parliament represents everybody of voting age. […] From the viewpoint of the sustainability of public finances, this would be a problematic development path. […]" So, there are no straightaway solutions to change the power structure of the earnings-related pension system from the viewpoint of economic sustainability.

The development of replacement rates in the national pension system has been poor – if one can speak about replacement rates concerning the residence-based minimum pensions. In the mid 1980s, the net of full national pension was about 45% of that of a full-time employed average productive worker. Nowadays, the comparable figure is about 30%. The gap between the national pensioners and the other pension recipients is still increasing at the same pace. The suggested guaranteed minimum national pension might improve the relative situation of the poorest pensioners for some time, but it may freeze the situation of those who get a small amount of earnings-related pensions. Their pension income consists mainly of the national pension and it is probable that the national pension benefits will be raised only by indexation based on consumer prices.

The income gap between the pensioners who have minimum and low pensions and those who have earned income or get earnings-related pensions is an interesting issue. In addition to changes based on consumer price indexation there has been, from time to time, a so called "level increase" of the national pensions. Usually, they have been included in the agreements made between the parties forming the new Government. In the 1990s and 2000s, the level increases were equivalent to 20% of the real increase of earned income.

There has been in fact no serious discussion of the possibility to peg the national pension to the earned incomes with some relation. The committee for social protection reform made a preliminary suggestion for a new model for the regular assessment of the adequacy of basic security benefits including national pensions. According to the suggestion the assessment should be effected once in the parliamentary term. Thus, the practice adopted in the 2000s will be continued.

The problem of the social sustainability of the national pensions is reflected in the manner it is manipulated in the long-term calculations. For example, in the long term calculations made in the government department of finance an index was adopted which has a weight of 50% on consumer prices and 50% on wages. The alternative to continue the prevailing development of the national pension in relation to other income earners leads in the long run to a situation which is socially so unfair and intolerable that the civil servants in the department of finance have manipulated its development even though they are known to be more interested in economic than social sustainability.

The aggregate replacement rate used for monitoring the overall Finnish pension policies is defined on the basis of the median pension of the pension recipients aged 65-74 related to the median earnings of the persons aged 50-59. According to these calculations, the Finnish replacement rate is about 48% which is pretty low for the EU countries. A similar figure is reached when comparing the average pension of all those who have retired on an earnings-related pension to the earnings of all economically active people. The level of new old-age pensions compared to the earnings of economically active people is higher, however, being about 61% in 2004. The reasons for the differences are the low level of national pensions and the late maturation of the earnings-related pension system.

What will be the results of the life expectancy coefficient? In describing above the characteristics of the Finnish pension system the result from the viewpoint of recipients can

be described as follows: If the 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. What if a person is too exhausted or not feeling well enough to continue their work? If the insured person is born in 1955, her or his pension will be 5-10 percentage points higher (in terms of the replacement rate) compared with that of a person born in 1985, provided they will retire at the same age and the expectations of economic and demographic development are as projected. The legitimacy of the difference is that the people born in the year 1985 live longer and they have more healthy living years than the people born in 1955. So, their relative position is equal. But from the point of view of the insuree this is cold comfort. Many insured may be afraid that they might not be willing or able to continue to work as long as is assumed by the calculations and will grant for themselves the possibility to retire earlier – especially because they have probably better economic possibilities to do so. There are thus good reasons to anticipate the increase in having personal non-statutory pension policies in addition to the statutory pension insurance. The threats concerning the prevailing defined-benefit schemes are presumably contributing to the trend. The result is a more arbitrary and less equal pension scheme than today.

2.2 Health care

2.2.1 Health: system characteristics

The Finnish legislation gives the task to organise health care services to the municipalities. The public municipal system covers primary health care and specialised health care.[1,2,3] Whilst the number of municipalities is rather large (348 at the beginning of 2009), the number of residents in a majority of municipalities is small (less than 10,000).[4] According to the legislation, each municipality has the responsibility to organise adequate health services for their permanent residents.[5]

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.[6]

In addition to the public health care system, health services are also provided by from 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 in the private sector on a part-time

1 Kuntalaki 17 March 1995/365, “Legislation about Municipalities and Tasks of Municipalities”, March 1995, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1995/19950365.

2 Kansanterveyslaki 28 January 1972/66, “Primary Health Care Act”, January 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1972/19720066.

3 Erikoissairaanhoitolaki 1 December 1989/1062, “Act on Specialised Medical Care”, December 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1989/19891062.

4 TEPERI, J., PORTER, M.E., et al, “The Finnish health care system: A value-based perspective.”, *Sitra reports 82*, Sitra, Helsinki 2009, p. 115, retrieved from: http://www.sitra.fi/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

5 See fn 2, 3 above.

6 Ibid.

basis. Physicians` private practices located in shared facilities that are owned by private companies are the most common organisational model. During the 2000s, some new 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.[7]

There exists also a third system for the provision of health services: occupational health care. The Occupational Health Care Act from 1979 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. Employers pay two thirds of the costs, whereas the remainder is paid by employees.[8] 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.[9]

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 scope 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.[10] Health centre staff covers a wide range of professionals traditionally employed by municipalities. Physicians with a background of other specialties than family medicine (general practice) belong to the staff only in larger towns. In 1993, municipalities were given the freedom to buy services from private providers.[11] During the 2000s, some municipalities 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 largely interested in private sector and flexible contracts, and some municipalities have had problems to recruit physicians.

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

7 TEPERI, J., PORTER, M.E., et al, "The Finnish health care system: A value-based perspective.", *Sitra reports 82*, Sitra, Helsinki 2009, p. 115, retrieved from: http://www.sitra.fi/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

8 Työterveyshuoltolaki 21 December 2001/1383, "Occupational Health Care Act", December 2001, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2001/20011383.

9 KIMANEN, A., MANNINEN, P., et al, "Sairaanhoito työterveyshuollossa: toimintalukujen ja kustannusten vertailua", "Treatment of diseases in occupational health care", Suom, lääk.lehti 63:21:1965-1970, 2008.

10 Kansanterveyslaki 28 January 1972/66, "Primary Health Care Act", January 1972, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1972/19720066.

11 Laki kilpailunrajoituksista 27 May 1992/480, "Act on competition restrictions", May 1992, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/1992/19920480.

possibility of using service vouchers in the provision of home care services. In the beginning, the service voucher programme concerned mainly long-term services.[12] Patients who received a voucher could choose the provider of health care services of their own. At the beginning of 2007, a quarter of municipalities had been organising certain social and health care services by offering service vouchers.[13]

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 of the patient.[14]

The economic recession in Finland at the beginning of the 1990s 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 increased. Some small municipalities have had problems to ensure health care services in the quantities needed by residents. In January 2007, the Parliament introduced a law according to which primary health care services must be delivered in health centres covering at least 20,000 population. A transition period has been allowed to municipalities until 2012. The Government has been motivating municipalities to merge by means of extra state subsidies. In fact, the number of municipalities decreased from 453 in 2000 to 348 in 2009.[15]

During the 2000s, several local development programmes were 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 develop them.

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 amount of member municipalities varies from six to 58.[16] 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.

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.

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12 Laki sosiaali- ja terveydenhuollon palvelusetelistä 24.7.2009/569, “Service voucher legislation”, July 2009, retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569.

13 TEPERI, J., PORTER, M.E., et al, “The Finnish health care system: A value-based perspective.”, *Sitra reports 82*, Sitra, Helsinki 2009, p. 115, retrieved from: http://www.sitra.fi/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

14 Laki kansanterveyslain muuttamisesta 17 September 2004/855, “Hoitotakuulaki”, “Access legislation”, September 2004, retrieved from: http://www.finlex.fi/fi/laki/alkup/2004/20040855.

15 See fn 13 above.

16 Ibid.

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.[17]

2.2.2 Health reforms

The current Finnish Government has worked since the election in spring 2007. To strengthen health care, especially primary health care, has been its main goal.[18] 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. Another important goal is to increase the citizens' possibilities to choose services.

In order to implement the structural change mentioned above, a working group had been elaborating since 2007 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 proposed Act will be discussed in Parliament in the period 2009-2010.[19]

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; 5) 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.[20]

The citizens' possibilities to choose health care services will be increased by the comprehensive Health Care Act, giving citizens the possibility to visit any health centre in their hospital district. Patients have the right to choose together with their physicians any hospital in the tertiary care region (university central hospital region) to which the municipality of the residence of the patient belongs.[21]

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.

In 2008, the Government further stimulated the formation of bigger primary care areas by continuing the extra state subsidies programme and giving extra subsidies to municipalities willing to merge.

The service voucher programme was extended in 2008 to include home nursing. In addition, the Ministry of Social Affairs and Health prepared an Act to further extend the programme with the aim to introduce the new Act in August, 2009. New legislation will allow

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17 See fn 14 above.

18 Hallitusohjelma, "Pääministeri Matti Vanhasen II hallituksen ohjelma", "The Government Programme. Prime Minister Matti Vanhanen's second Cabinet", 19 April 2007, p.77, retrieved from: http://www.valtioneuvosto.fi/hallitus/hallitusohjelma/en.jsp.

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

20 Ibid.

21 Ibid.

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.[22]

The Ministry has set specific targets to municipalities to improve public health during 2008-2011. The targets cover both the targets for functions of health services and the targets for health of the population. As to the functions of health services, the goals are to decrease physician and dentist shortages in primary health care, to decrease geographical differences in the effectiveness of specialised health care, to shorten maximum waiting times, and to increase user satisfaction with health and social services. The latter group of goals include the aims to decrease alcohol consumption, the proportion of smokers, the proportion of overweight persons of working age, and the number of home and recreational accidents and to maintain functional abilities of the aged. A regular follow-up at the regional and municipal levels is intended. However, no external incentives are combined with this programme.[23]

In 2008, the Government continued to support the development of health care by providing partial funding to national development programmes. The overall goals and plans of national programmes are prepared by working groups at the Ministry of Social Affairs and Health, and municipal primary care regions and hospital districts make their own plans in line with the overall goals and their own needs. Several nationwide development programmes were operating during 2008.

One initiative to support municipalities to increase 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. The main goal is to improve access to primary care and to develop practices into health centres.[24]

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.[25]

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

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22 Hallituksen esitys laeiksi sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta, EV 67/2009 vp - HE 20/2009 vp, "Proposal of the Government to change the service voucher legislation", p. 5, retrieved from: http://www.eduskunta.fi/faktatmp/utatmp/akxtmp/ev_67_2009_p.shtml.

23 TEPERI, J., PORTER, M.E., et al, "The Finnish health care system: A value-based perspective.", *Sitra reports 82*, Sitra, Helsinki 2009, p. 115, retrieved from: http://www.sitra.fi/fi/Julkaisut/Julkaisuhaku/julkaisuhaku.htm.

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

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

differences and give better possibilities for unemployed and poor people to take care of their health, the Ministry has launched a project (2008-2011) tackling the issue.[26]

One example of 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.[27]

Medications used in outpatient care are partly reimbursed by the National Health Insurance scheme. Due to the rising reimbursement costs, the 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, reimbursement will be level with the cheapest generic alternative.[28]

Studies have shown that municipalities have reduced the amount of resources for preventive maternity services, child health and school health services during the mid and late 2000s.[29] The working group of the Ministry of Social Affairs and Health drafted a proposal to ensure these preventive services by means of a decree. The proposal was submitted in 2008, and the working group proposed that the decree should take effect in the mid of 2009.[30]

2.2.3 Health debates and political discourses

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 a sufficient number of physicians have raised discussions about possibilities to move the tasks of family physicians (general practitioners) to qualified nurses. In 2008, the debates included the idea of giving nurses with special trainings a permission to subscribe certain medications. Such a suggestion was made also by the Minister of Health and Social Services. The Finnish Medical Association strongly opposed to the proposal.

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

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

28 Laki sairausvakuutuslain muuttamisesta 5 December 2008/803, "Lääkkeiden viitehintalaki", "Act on prices of medications", December 2008, retrieved from: http://www.finlex.fi/fi/laki/kokoelma/2008/?_offset=2.

29 RIMPELÄ, M., HAPPONEN, H., et al, "Äitiys- ja lastenneuvoloiden sekä koulu- ja opiskeluterveydenhuollon käynnnit, teveystarkastukset ja voimavarat 2007 – 2008", "Visits to maternity, child health and school health services and resources for these services 2007–2008", *Raportteja 40*, Stakes, Helsinki 2008, p. 149, retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R40-2008-VERKKO.pdf.

30 Sosiaali- ja terveysministeriö, "Asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta", "Decree on welfare clinic services, school and student health services, and preventive oral health services for children and youth", *Working Group Report 37*, Helsinki 2008, p. 73, retrieved from: http://www.stm.fi/julkaisut/nayta/_julkaisu/1057173.

The problems to recruit family physicians have been evident in many municipalities, and quite many municipalities were obliged to "purchase" physicians for emergency services or health centres from private companies. Most of these "outside" physicians worked on the basis of short-term contracts in health centres, and the rapid fluctuation of physicians met with criticism in the mass media. The salaries of "outside" physicians were higher than those of family physicians employed by municipalities, which further fuelled discussions in the media.

Stakeholders commented on the proposal to the comprehensive Health Care Act to the Ministry during the second half of 2008. None of them voiced strong negative opinions in the mass media. It seems that the principles of the proposal are universally accepted, although comments on many details may be given. Some primary care experts have a suspicion that the new act will not strengthen primary health care. They suppose that the final result will strengthen specialised health care. Negative opinions about the value of the integration of specialists traditionally working in hospitals into primary health care were brought up by some primary care experts. The stakeholders' comments have been discussed in the Ministry of Social Affairs and Health since late 2008 and during 2009. The final proposal for the act will be submitted to the Parliament in late 2009 or in early 2010, and it will be discussed in Parliament presumably in 2010.

Many health care workers and experts have criticised the approach of developing health care by implementing new projects. The short duration, small scale and locality of many projects, and poor abilities to get financial resources to continue the developed functions have led to problems to integrate the good results of projects into real practical work. Health care workers reported in the mass media about their tiredness to continuously participate in new projects.

Some health centres and hospitals encounter difficulties in recruiting nurses. Possibilities to "import" nurses were discussed, and some municipalities tried to recruit foreign nurses. The number of foreign nurses and physicians is, however, rather small.

The coordinators of the "Kaste" programme (the National Development Programme for Social Welfare and Health Care) arranged meetings with leading workers in primary health care and professors of family medicine in 28 districts of the country in order to discuss problems and proposals for development. The coordinators published their report about the discussions in early 2009. The conclusions of this report show that there are several kinds of regional programmes aimed at the development of primary health care, and that regional cooperation is active.[31]

Even researchers have been actively discussing and making proposals for saving the welfare-based system in primary health care. Kuusi and Ryynänen published a discussion report, in which they propose that the functions of purchasing and delivering health care be separated; the responsibility for purchasing and funding should be given to five tertiary health districts (university hospital districts). Tertiary health districts should be financed by municipalities, state subsidies and patient fees. Primary care services should be delivered by establishing a limited company or a cooperative in every tertiary district. They are in favour of a paired working model (physic – nurse; physician - psychiatric nurse; physician – physiotherapist; physician – social worker; etc.), the use of the internet, cooperation between health centres

[31] KOKKO, S., PELKONEN, E., HONKANEN, V., (eds.), "Perusterveydenhuollon kehittämisen suuntaviivoja. Terveyden ja hyvinvoinnin laitos", "Proposals for developing primary health care", *Avauksia 13/2009*, Helsinki 2009, p. 94, retrieved from: http://lib.thl.fi:2345/http://lib.thl.fi:2345/lib4/src?PBFORMTYPE=01002&TITLEID=50503&SQS=1:FIN:1::6:50::HTML&PL=0.

and central hospitals by an integrated care pathway, and evaluations of effectiveness of health care.[32]

2.2.4 Overview of published studies

Systematic monitoring and evaluation of the Finnish health care system is not existent. The overview given here is based on selected reports published in 2008. A search for publications on 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 webpages of relevant institutions.

Stakes, which was the research institute under the Ministry of Social Affairs and Health in 2008, has reported on numerous studies about the influence of changes taken place in health care. The introduction of market principles in health care and the provision of services in an environment of open competition were in the focus of many studies published by the Research Centre of the Association of Local and Regional Authorities and the University of Kuopio. Other topics of published studies include the quantity and quality of preventive services and the quality of some other health services.

Hyvärinen and Lith collected empirical data from all regions in the country in order to assess the quality and background factors of competition in the provision of social welfare and health care services in municipalities. The results showed that the provision of social welfare services by introducing competition was more common than was the case in health services. The "political colour" of the municipalities was not associated with the provision of services based on competition.[33]

Kaarakainen asked the opinions of municipal leaders about the future of primary health care services. She found a significant pressure to restructure local governments and their roles in the service provision. Municipal leaders thought that primary health care would remain the responsibility of municipalities in the near future, although the forms of municipalities would change, and larger municipalities be formed. Municipalities will provide services organised by the municipalities themselves and partly purchased from the private sector, non-governmental organisations and/or other municipalities.[34]

Statistics of Kansaneläkelaitos (the Social Insurance Institution of Finland) show that nowadays private health care companies provide services for one third of the 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 a private system has taken place quite rapidly in the occupational health care sector.[35]

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[32] KUUSI, O., RYYNÄNEN, O.-P., "Hyvinvointipiirit ja kustannusvaikuttava terveydenhuolto", "Welfare districts and cost-effective health care", Valtion taloudellinen tutkimuskeskus, VATT-muistioita *79*, Helsinki 2008, p. 46, retrieved from: http://www.vatt.fi/julkaisut/uusimmatJulkaisut/julkaisu/Publication_6093_id/773.

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

[34] KAARAKAINEN, M., "Hajauttaminen, valtion ja kuntien välisissä suhteissa 1945–2015. Valtiollisesta järjestelmästä kohden kuntaverkostojen perusterveydenhuoltoa", "Decentralisation in state and municipal relationships from 1945 to 2015 from national primary health care towards municipality networks", Kuopion yliopiston julkaisuja E. Sosiaalitieteet 153, 2008, p. 196, retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml.

[35] Kansaneläkelaitos – The Social Insurance Institution of Finland, "Lääkärikeskuksista tullut suurin työterveyspalvelujen tuottaja", "Private companies produce the majority of occupational health services",

2.2.5 Critical assessment of reforms, discussions and studies

Great reforms of health care were performed in the 1960s, 1970s and early 1980s. From the middle 1980s onwards, health care services were developed mainly by national development programmes and by minor, specific Acts dealing with one topical problem. The Comprehensive Health Care Act with the goal to combine primary care and specialised health care will lead to a large-scale reform. Thus, the Government has embarked on a historical reform.

Finnish people have traditionally had equal possibilities to get preventive and curative services, but they have not had the possibility to choose. Client and patient fees have been small, although they have been rising during the 2000s. At present, "possibilities to choose" belong to the main goals of the Government and the Ministry of Social Affairs and Health. Reforms in the health care sector are a prerequisite for achieving this goal. The Government has opted to increase the possibilities of municipalities to offer service vouchers and, thus, use competition in providing services. Service vouchers are practical means to increase the possibilities of citizens to choose. It is further believed that open competition will lead to services of a higher quality and at a lower price. Economic aspects seem to be of great importance in this respect. The municipalities have the responsibility to organise and provide health care services, but the provision by purchasing services from private companies may become more common in the future. The development of the private sector has not been rapid, and international companies are not yet common service providers in primary and specialised health care. In the occupational health care sector, at least one international private company delivers services.

The problems have been evident in primary health care for many years, but previous governments have supported specialised health care more than primary health care. From this viewpoint, the main goal – the development of primary health care – of the Government is crucial. Discussions about severe difficulties in the provision of primary care services due to the lack of physicians in many municipalities started in the mid 2000s. It took some years before the Ministry started to collect ideas to overcome these problems. Discussions are now in the phase of collecting ideas and making proposals to the Ministry. The future will show how the welfare state model in primary health care will be saved. The majority of the citizens stress the importance of the issue, and the principle of the welfare state model makes part of the programmes of all political parties.

The number of published studies is quite large, but they do not cover the totality of health care. Changes in health care and in the provision of services and the impact of these changes form a majority of the topics of the studies. In addition to these modern trends in the health care system, problems in health care and problems of citizens to get health services have interested researchers.

2.3 Long-term care

2.3.1 Long-term care: system characteristics

The main responsibility to organise and provide 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

Kela, tilastokatsaus 2009, retrieved from: http://www.kela.fi/in/internet/suomi.nsf/NET/210901101350TL?OpenDocument.

health care services for their residents. In fact, municipalities have the possibility to form federations in order to provide primary health care services, but there exist no federations of municipalities to provide long-term social welfare services for the aged. Thus, social welfare and primary health care services may be delivered by separate organisations, and this distinction has hindered cooperation between the 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. Home nursing and care in health centre hospitals 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 have been established originally in the 1980s by non-governmental, not-for-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 uncommon 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 uncommon 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 have been financially supported since the mid 2000s. 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 caretaker.[36] However, due to the poor economy of many municipalities, the expansion of this kind of caretaking has been slow, and many municipalities have even cut down on the financial support to caretakers 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 care 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 decreased, and the proportion of the aged in informal, economically supported care by relatives has increased.

In order to increase citizens´ possibilities 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, all

[36] Laki omaishoidon tuesta 2 December 2005/937, “Act of supporting care by relatives”, retrieved from: http://www.finlex.fi/fi/laki/ajantasa/2005/20050937.

municipalities do not organise services offering service vouchers.[37] Auxiliary home help, home help, comprehensive sheltered housing and care in group homes are the most common services for which service vouchers are offered.[38]

Non-governmental, not-for-profit organisations belong to the supporters of many older persons. They cover their functions partly by funds from the Slot Machine Association (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.[39]

The poor quality of long-term care, especially care in health centre hospitals, had been a major topic of critics during many years in the 2000s. In 2006, the Minister of Health and Social Services appointed an administrator to make proposals for the development of care of the aged and of gerontology 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 official 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.[40]

2.3.2 Long-term care: reforms

Developing long-term care of the aged does not belong to the goals ranking in high place on the Government's agenda. In this sector, the policy goals of the Ministry of Social Affairs and Health include the goals to increase access to home-based care, decrease the amount of the aged in long-term institutional care in health centre hospitals, develop new models to take care of the aged, and expand informal care by relatives.[41]

In February 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. The recommendations include proposals concerning the quantity and quality of services, and the numbers and professional background of personnel. In addition, proposals for the development of management and care environments were given in a booklet. Municipalities may decide about the scope and quality of services, and the municipalities are not obliged to follow these guidelines.[42]

To increase citizens´ possibilities to choose services belongs to the political goals in long-term care. In 2008, the Government expanded the service voucher programme to include

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37 Laki sosiaali- ja terveydenhuollon palvelusetelistä 24 July 2009/569 July 2009, "Service voucher legislation", retrieved from: http://www.finlex.fi/fi/laki/alkup/2009/20090569.

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

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

40 Ibid.

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

42 Ibid.

home nursing. In addition, the Ministry of Social Affairs and Health prepared an act aiming to extend the service voucher programme to nearly all social and health care services in 2009, as described in the section 2.2 (Health: reforms).[43]

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.

2.3.3 Long-term care: debates and political discourses

In 2008, the poor quality of long-term care of the aged was among the most popular topics of discussion about social and health care in the mass media. Relatives of old persons and old persons themselves reported about several problematic cases in newspapers, and editors produced numerous articles and broadcasts on radio and TV programmes. Examples of group homes delivering high-quality care were also shown. The number of citizens´ complaints about poor care to official control organisations increased. Non-governmental organisations addressed the importance to ensure high-quality long-term care of the aged by legislation and by appointing an official 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. The Minister of Health and Social Services has not yet signalled a positive answer to these proposals in 2008 or in early 2009.

The attractiveness of long-term care is quite poor among health care and social welfare care professionals. Some municipalities encounter problems to recruit physicians and nursing staff for long-term care. The possibilities to "import" foreign long-term care workers were discussed in the mass media. The opinions of politicians about the need for professionals with a foreign background to work in long-term care are ambiguous. The number of workers with a foreign background is quite small.

Citizens, editors and experts have discussed in the mass media the privatisation of long-term care services. The amount of services provided in open competition in municipalities has increased, and municipalities set store by low prices in this competition. Citizens apprehend that low prices will lead to low-quality services. Political parties have, however, not been very eager to partake in these discussions.

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 care and long-term care services in Great Britain and in Sweden from the 1980s onwards, and gives proposals to save the equality of these services in Finland without dividing services and citizens into two classes ("services for poor people" and "services for rich people").[44] The changes in other European countries and the proposals by Koskiaho were discussed in several TV and radio programmes.

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 webpages of relevant institutions. Only few empirical studies

[43] Hallituksen esitys laeiksi sosiaali- ja terveydenhuollon palvelusetelistä sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain 12 §:n muuttamisesta. EV 67/2009 vp - HE 20/2009 vp, "Proposal of the Government to change the service voucher legislation", p. 5, retrieved from: http://www.eduskunta.fi/faktatmp/utatmp/akxtmp/ev_67_2009_p.shtml.

[44] KOSKIAHO, B., "Hyvinvointipalvelujen tavaratalossa", "A welfare service market", Osuuskunta Vastapaino, Tampere 2008, p. 272.

were found. The topics covered some important, actual trends and problems, as the provision of long-term services for the aged by competition, cooperation between services and the quality of long-term services.

A report about the quality of nursing care in long-term institutions was published by Isola, Backman, Voutilainen, and Rautsiala. The data were collected by interviewing the nursing staff in the health care division of a Finnish city in 2001. Thus, the results do not show the actual quality at the end of the 2000s. The findings indicated that care of the aged mostly aims to respond to their physical needs.[45]

The empirical data collected by Hyvärinen and Lith from all regions in Finland showed that the provision of social welfare services by competitions was more common than the provision of health care services. An older age structure of the municipality was related to purchasing private services, because long-term care of the aged was provided by competition in many municipalities. Greater municipalities/towns provided more social welfare services based on competition than smaller ones.[46]

Kähkönen and Volk assessed the impact of competition on costs of long-term care services for the aged. Their results showed that the costs of care in sheltered housing and the costs of auxiliary home help had decreased in over a half of the cases. The results regarding other services varied.[47]

2.3.5 Critical assessment of reforms, discussions and studies

The Ministry tries to guarantee the quality and quantity of long-term care for the aged by giving recommendations to the municipalities. Municipalities decide on the amount and quality of long-term care, and they are not obliged to follow those recommendations. The decentralised information guidance system together with ageism may lead to great differences in the long-term care between municipalities. There are no plans for any larger reforms, although problems in long-term care have been evident since the middle 1990s, and non-governmental organisations proposed a reform by new legislation which would guarantee high-quality long-term care for the aged. These are the only concrete proposals, because problems have been the main focus of discussion in the mass media.

The Ministry of Social Affairs and Health has not launched any big national programme to develop long-term care of the aged. The development is based on small programmes many of which are implemented by non-governmental organisations and partly funded by the Slot Machine Association.

The distances from the centres of municipalities to the homes of aged residents are long in many municipalities. Severely disabled old patients may need help by professionals many times a day. The provision of home nursing and home help needs a reasonable amount of financial resources from municipalities. Thus, the economic problems have led to the lack of development of home care services in some municipalities. The good goal to offer

[45] ISOLA, A., BACKMAN, K., et al, "Quality of institutional care of older people as evaluated by nursing staff", J Clin Nurs, 17 September 2008 (18):2480-9, Epub 11 February 2008.

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

[47] KÄHKÖNEN, L., VOLK, R., "Kuntien vanhuspalvelujen kilpailuttamiskokemuksia", "Experiences in the provision of long-term services for the aged by competition in municipalities", Kunnallisalan kehittämissäätiö, Kunnat ja kilpailu-sarja Nro 4, Helsinki 2008, p. 102, retrieved from: http://www.polemiikki.fi/files/library/attachments/KunnatJaKilp_4.pdf.

possibilities to live at home to nearly all aged Finns stressed by the Ministry may not be achieved.

The discussion in the mass media show that the majority of citizens stress the survival of the welfare state model to provide equal services with reasonable fees to the aged. In this respect, there do not seem to be great differences in the political programmes of the parties, either.

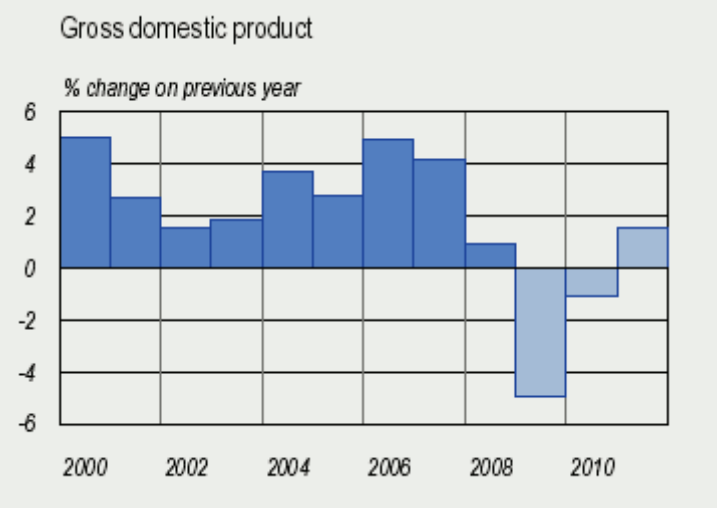
There are some active research teams, but the amount and the scope of studies about long-term care show the minor interest of many research institutes in long-term care of the aged.

3 Impact of the Financial and Economic Crisis on Social Protection

World economic growth contracted in an unprecedented fashion during the final quarter of 2008. The world economy is now in a deep recession with no prospect of a rapid recovery. The Bank of Finland forecast does not expect the world economy to recover until the first half of 2010. By that time, the massive monetary and fiscal policy support measures will have begun to have an effect and the financial market crisis will gradually begin to ease. Small open economies like Finland have benefited considerably from growth in international trade and the deepening international division of labour. If international trade declines, the international capital markets would fragment and protectionism would increase and Finland's productivity growth would slow down for a prolonged period (Liikanen, 2009).

Finland's GDP volume grew 0.9% in 2008. First-half growth was still relatively brisk, but in the last quarter there was a decline in GDP. The growth outlook for the Finnish economy has deteriorated sharply in a very short period of time. While the forecast of the Bank of Finland in September 2008 envisaged cumulative growth in real GDP of a full 5% in the years 2008-2010, the current estimate predicts a decline by the same amount (Bank of Finland Economic Outlook 1/2009).

Figure 3: GDP annual % change in Finland 2000-2011

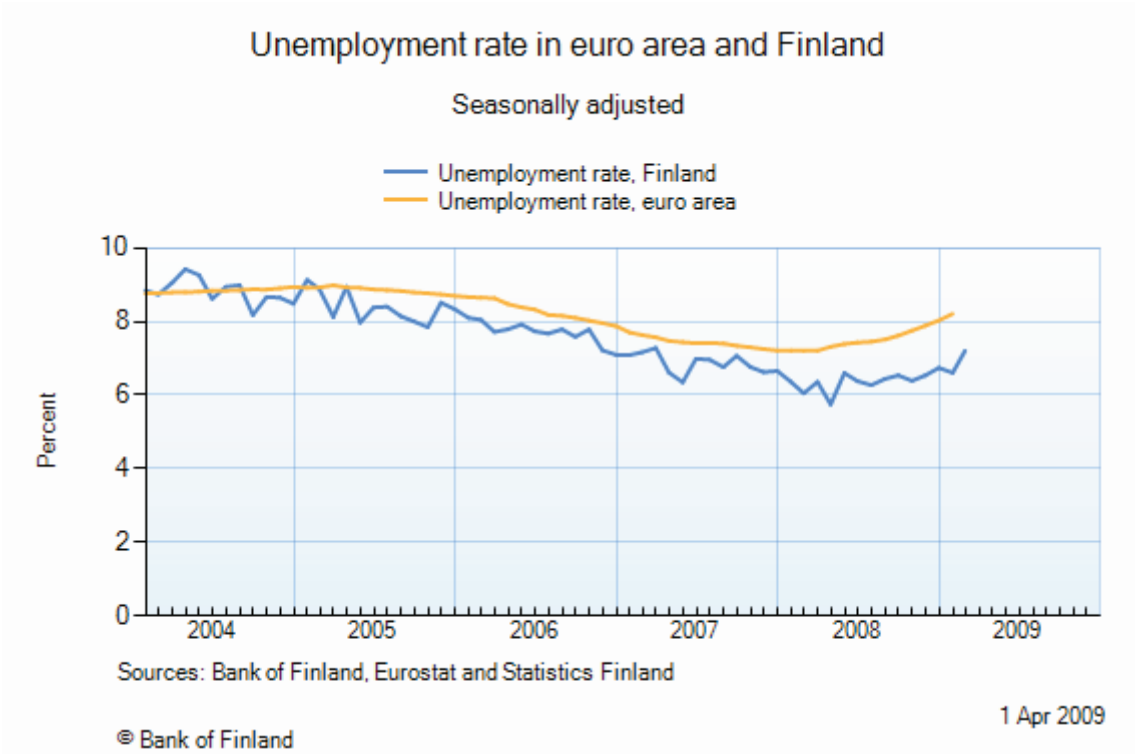


Source: Bank of Finland Economic Outlook 1/2009

In comparison to early 1990s economic recession the current recession is estimated to be not that bad. At that time the cumulative decline in GDP was around 15%. Now, the corresponding figure will be around half of that (Bank of Finland Economic Outlook 1/2009).

The prolonged period of growth in the number of employed came to an end in the second half of 2008, and there was a slight rise in unemployment in the final months of the year. The employment situation is expected to deteriorate, with the unemployment rate rising to around 10% in 2011. Employment will decline more than previously forecasted, with a total of 180,000 jobs being lost over the period 2009-2011. This is less than half of the number of lost jobs (550,000) in the early 1990's recession.

Figure 4: Unemployment rate in the euro area an in Finland



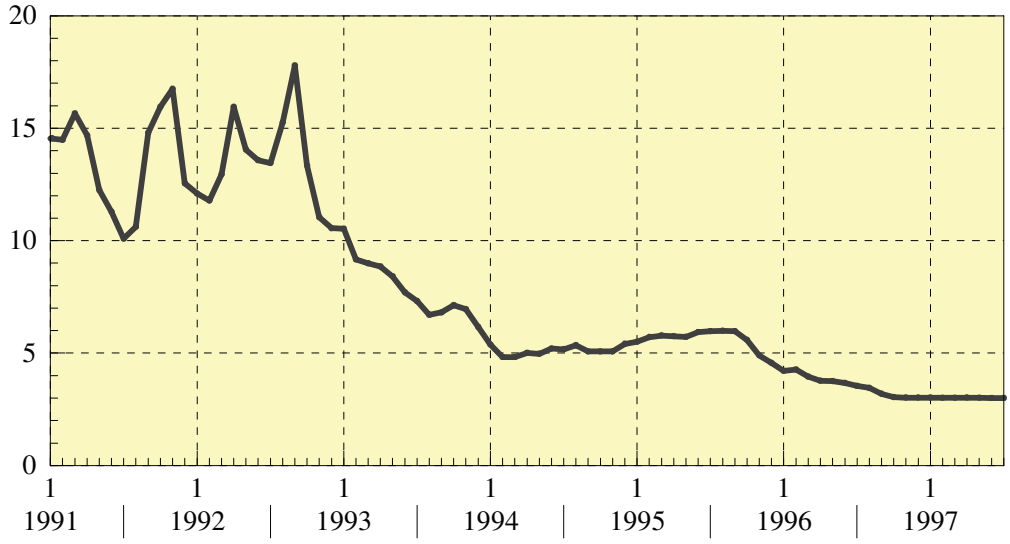
According to the labour force survey the number of unemployed persons was at 222,000 in March 2009, which was 42,000 more than a year before. Male unemployment increased by 34,000, while female increase was 8,000. At the same time, the number of laid off workers increased by 7,000 to 38,000 (Statistics Finland 4/2009). The increased unemployment mainly hit the construction sector. The unemployment rate was 8.3% in March 2009, which is 1.6 percentage points higher than a year before. In the early 1990s, the annual increase in the number of unemployed in Finland was 87,000 in 1991, 123,000 in 1992, and 113,000 in 1993. Overall, the unemployment rate increased during 36 consecutive months by 3.5 % to 16,5%. Statistics of the ongoing downturn during the first six months of 2009 are now available, and the increase in the number of unemployed persons is less than half of what Finland had in 1991 (the first year of the then recession). So the pace of the increase in unemployment parallels the trend in early 1990s.

What is a significant difference to the early 1990's situation are the interest rates. The state as well as households are rather indebted, but because of the low real interest rates the solvency is rather good. In the early 1990s, the monthly HELIBOR[48] interest rates had been constantly

[48] Helsinki Interbank Offered Rate

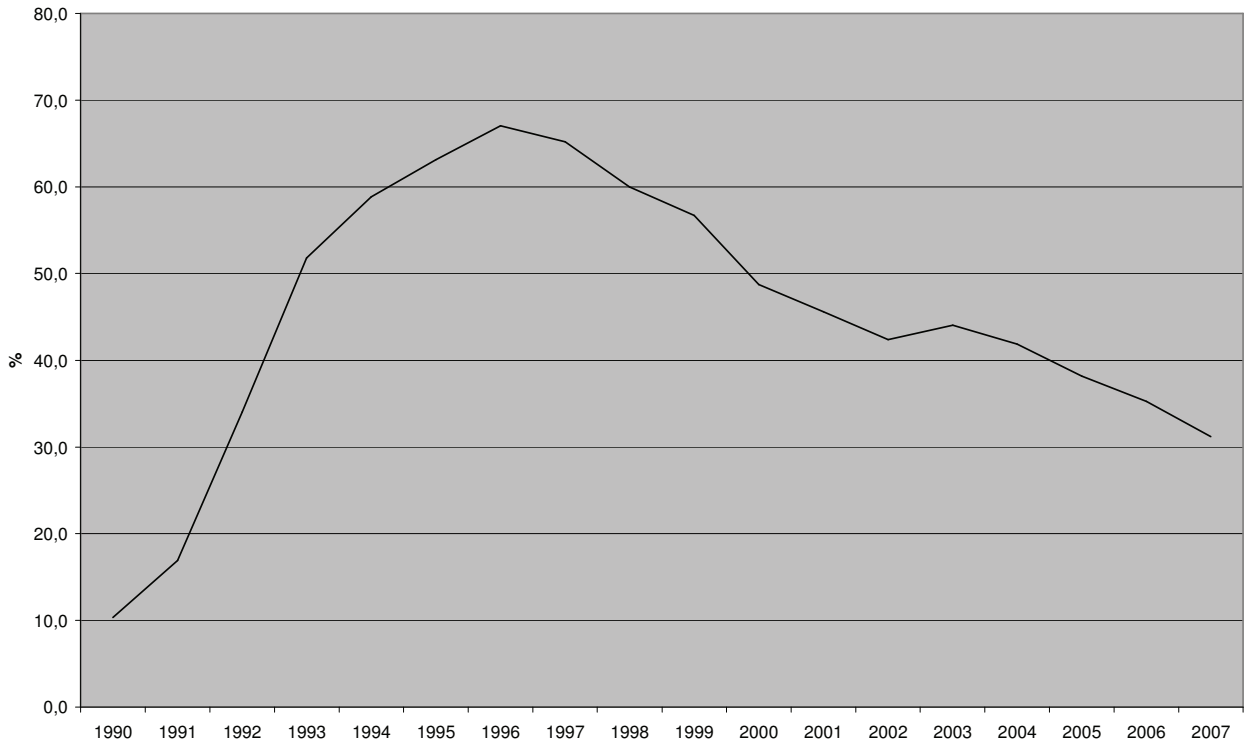
above 10% for several years whilst at present they are around 3.5% or less. So, even if the relative size of the current public debt is three-fold compared to the early 1990s, the costs for loan repayment are by no means higher. Also in cross-national comparison the central government's liabilities are rather low, 30% of the annual GDP.

Figure 5: Monthly HELIBOR interests rates in Finland 1991-97



SOURCE: BANK OF FINLAND (http://www.bof.fi/env/rhinden.htm)

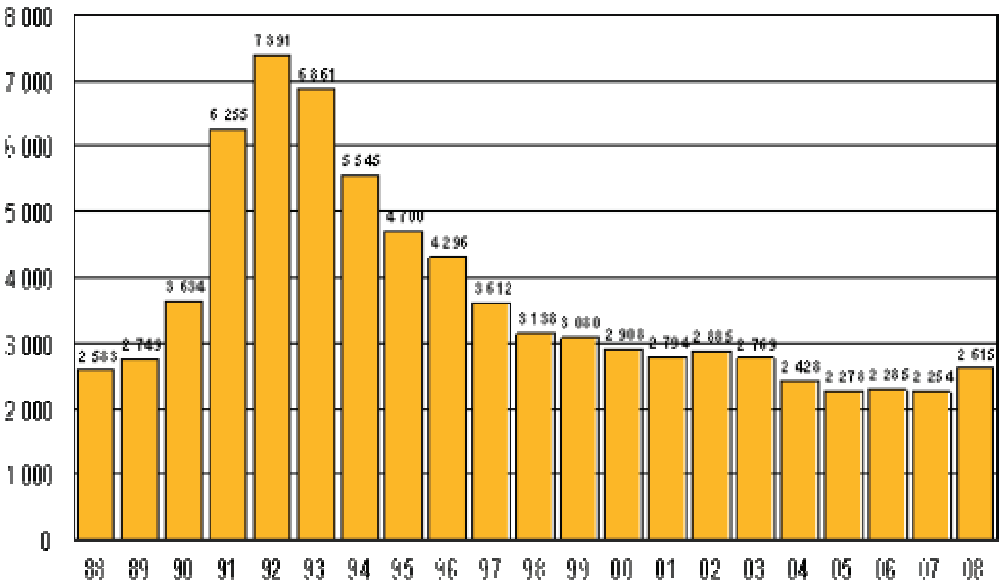
Figure 6: Central government debt % of GDP in Finland 1990-2007



Source: Statistics Finland, Statistical Yearbook 2008

In the early 1990s, expensive loans forced thousands of firms into bankruptcy, which, in turn, accelerated the economic downturn.

Figure 7: Bankruptcy claims filed to court 1980-95



Source: Statistics Finland

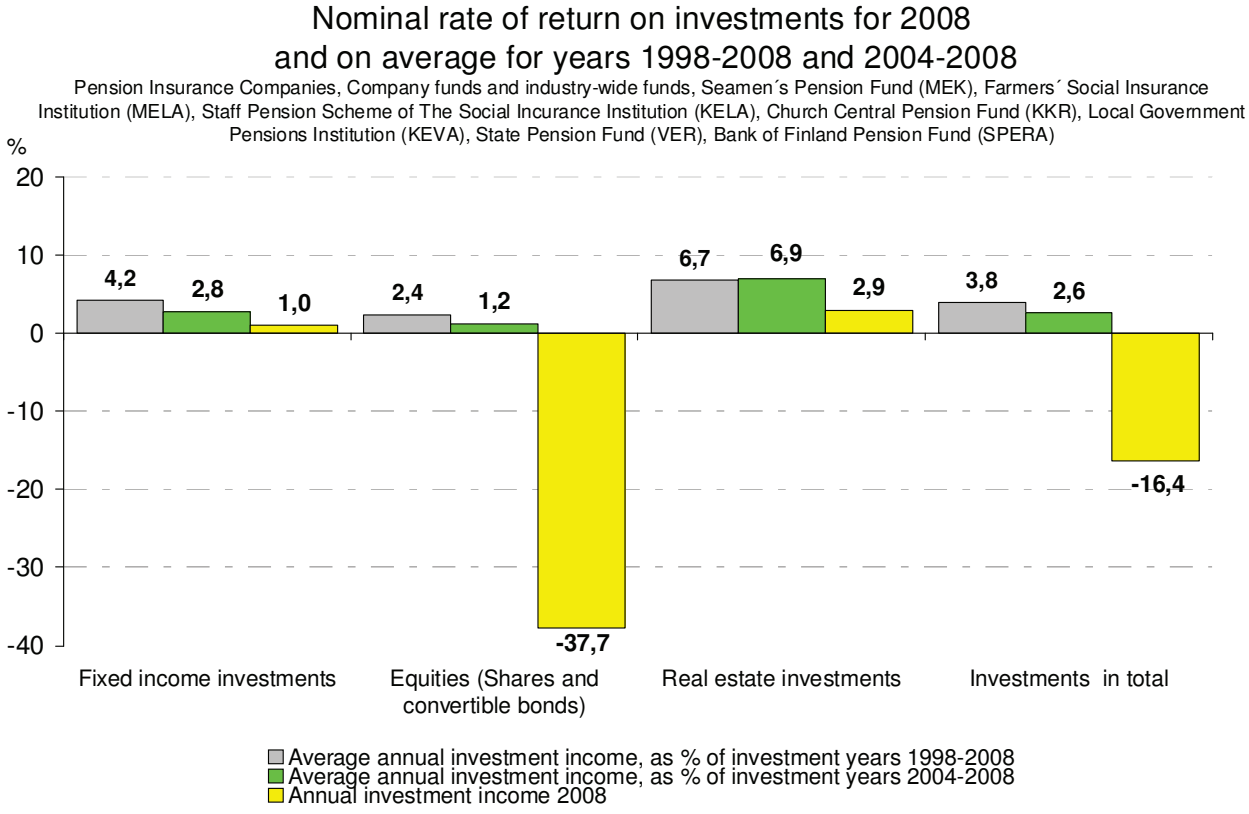
The ongoing economic depression has already lead to increased bankruptcies. In January and February 2009, 578 bankruptcy claims were filed with the courts, which is a 17% increase compared with the year before. The total number of employees in the affected firms was 2,630. Bankruptcies mainly hit small firms, i.e. the large number of bankruptcies added only a little to the increase in unemployment. This also differs from the situation of the early 1990s when also many larger companies went bankrupt.

On household level expensive loans were an important factor resulting in economic hardship in the early 1990s (Ritakallio, 2001), while currently heavily indebted households manage with low interest rates. Selling prices of dwellings is another factor which distinguishes the ongoing economic depression from the one of the early 1990s depression. In the early 1990s, the average selling prices halved during a three years period. Currently, statistics show that the price level has not decreased, or has decreased by a maximum of 5%. The purchasing periods have, however, prolonged. The question of interests and prices of dwellings is important in Finland because of the common home-owning tradition. Typically, active aged people have high housing mortgages, and old-age pensioners are outright owners of their dwellings.

From the point of view of the economic sustainability of the pension system an important factor is the change in the value of investments of the employees' pension funds. One quarter of the employees' pension liabilities in Finland is funded. 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. There has been neither increase nor decrease. However, the long-term investment output is rather good. Average annual investment revenues as a percentage of investment was 3.8% in the period 1998-2008. The Finnish Centre for Pensions has estimated that there is a pressure to raise employees' pension contributions by one to three percentage

points to maintain the economic sustainability of the system. This is mainly due to the population ageing, not because of the economic recession.

Figure 8: Nominal rate of return on investments for 2008 and on average for the years 1998-2008 and 2004-2008



Source: The Finnish Pension Alliance Tela

To summarise: There is reason to argue that the consequences of the current economic depression in the case of Finland is much less severe than was the case in early 1990s. However, the Finnish economy is largely dependent on foreign trade. So, eventually, the impacts of the crisis do largely depend on the trend of the global economy and the duration of the global economic depression.

During the 1990's recession the relative economic state of pensioners improved, when pensions were not cut down and the incomes of active aged population decreased. The same is expected to happen with regard to the ongoing recession. Long-term effects concern adequacy of pensions. For those hit by unemployment the accrued pension right will decrease. The longer the unemployment lasts the greater the loss. The pay-as-you-go strategy guarantees the economic sustainability of the pension system. The system is rather self-stabilising: Recession decreases aggregate pension contributions, but at the same time it decreases the aggregate pension accruals as well. According to many analayses and estimates the biggest problem in the Finnish pension system is the inadequacy of the minimum pensions. Minimum pensions are financed through public tax revenues. The recession will decrease such resources. So, the positive intentions of the Government (SATA-Committee) to make a marked increase to the minimum pensions may be threatened by the economic depression.

Regarding care systems the social and economic sustainability is not as well organised as in the pension system. The economic downturn scales down public revenues, while the demand for public spending decreases in no way. In fact, population ageing is constantly straining the public economy. In Finland, local authorities are in charge of the care systems. Already before the current recession the economy in most of the municipalities was in bad condition. Now, the decline in local tax revenues will bring extra difficulties. It is already reported that municipalities will cut down their health care budgets contrary to the actual need.

The impact of the financial and economic crisis on health care services is shown by cut-offs in the budgets of municipalities. Municipal politicians and administrators are obliged to cut budgets of health services. Some municipalities spare by laying off employees for some weeks, although these decisions have not been common in health care. Fewer employees are recruited, and some hospital wards are closed during summer holidays. The crisis has not yet affected the availability of health care services. Health care workers tell about rising work loads, and an increase in sick-leaves among employees has been reported in some institutions. The crisis has led to common fears about the possibilities to maintain the welfare state model, which provides equal health services with reasonable fees, although all political parties stress the survival of the welfare state.

The impact of financial and economic crisis on long-term care is more evident than on primary or specialised health care. In many municipalities, the cut-offs of budgets have led to a decrease in financial support of care by relatives, and to a decrease in the quantity of auxiliary home help and home help. Some municipalities are planning to reduce the number of the aged in group homes and in comprehensive sheltered housing and to transfer aged persons from single person rooms to long-term hospitals to share rooms with two or three other persons. Client and patient fees have increased in some municipalities. Reducing quality of meals and even taking off certain meals, like midday coffee, are reported from long-term care facilities. Fewer employees are recruited, and some municipalities aim to spare by laying off even workers in long-term care. The low-quality of long-term care of the aged has been discussed for some years, but they have not produced concrete programmes in the political level. The financial crisis seems to have increased the fears of citizens about their old age and produced several writings in mass media.

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.

[R5] AHONEN Antero, «Kansaneläkkeen saajan indeksiturva ja tuloasema. Mikrosimuloinnin sovellus pitkävaikutteiseen ilmiöön.», Helsinki: Kela, Sosiaali- ja terveysturvan selosteita 65, 2009, retrievable at: 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 the 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 result are compared using micro simulation. The treatment of the amount of the pension in the beginning, i.e. its indexation, prove to be an important factor in determining the subsistence of the pensioners in the national pension scheme.

[R1] BISTRÖM Peter, ELO Kalle, KLAAVO Tapio, RISKU Ismo, SIHVONEN Hannu, «Statutory pensions in Finland. Long-term projections 2007», Helsinki: Eläketurvakeskuksen raportteja 2008:1, retrievable at: http://www.etk.fi/Binary.aspx?Section=42845&Item=62077

The earnings-related pension expenditure for the whole economy increases relative to the wage sum, from the current level of nearly 23% to 34% by 2030, after which pension expenditure decreases by four percentage points of the wage sum by the end of the projection period. The increase in earnings-related pension expenditure is a consequence of the growth in old-age pension expenditure. Total statutory pension expenditure currently corresponds to 11% of GDP, and is projected to increase to 15% in the 2030s. Thereafter, the share of pension expenditure in GDP will decrease by two percentage points by the end of the projection period. The contribution rate for the pensions of the Employees Pensions Act will rise, from the current 21%, by four percentage points by the beginning of the 2030s, after which the contribution rate will be stable.

[R2] HILLI Petri, KOIVU Matti, PENNANEN Teemu, «Työeläkkeiden rahoitus ja sen riskienhallinta», Helsinki: Sosiaali- ja terveysministeriön selvityksiä 2008:19, retrievable at: http://www.stm.fi/c/document_library/get_file?folderId=39503&name=DLFE-8409.pdf
"Financial Risk Management in the Statutory Occupational Pension System"

During the research project many features were found that considerably complicate strategic risk management in pension institutions. For example, the solvency border as defined in the new law may encourage irrational investment behavior. Another serious complication results from the definition of the technical interest rate which depends on the overall solvency ratio of the whole pension system. This may lead to a complex situation where a pension institution is lead to consider secondary game theoretic problems instead of covering its liabilities.

[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, retrievable at: 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.», Helsinki: The Social Insurance Institution, Finland (Kela) Research Department, online working papers 1/2009, retrievable at: 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.*

[R2] KARISALMI Seppo, GOULD Raija, VIRTA Lauri, «Työkyvyttömyyseläkeläiset eri järjestelmissä», Helsinki: Eläketurvakeskuksen raportteja 2009:2, retrievable at: 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.

[R3] KARISALMI Seppo, TUOMINEN Eila, KALIVA Kasimir, «Eläkeaikomukset ja eläkkeellesiirtyminen », Helsinki: Eläketurvakeskuksen tutkimuksia 2008:2, retrievable at: http://www.etk.fi/Binary.aspx?Section=42845&Item=63415

"Retirement intentions and actual retirement"

> *Retirement was postponed from the planned timing. The retirement intentions were realised the better, the later the retirement occurred. The intentions of staying on at*

work were in the statistical models most consistently connected to gender, work ability, mental strain, and the employer's attitude to ageing employees. Intentions of staying on at work were commoner when the person was a male, the work ability was good, mental strain did not occur, and the employer supported ageing employees' staying on at work until retirement age. Coverage by supplementary pension provision arranged by the employer, an estimated good income in retirement, information about the size of the future old-age pension, and work in a company with a large number of employees were, on the other hand, factors connected to plans of earlier retirement.

[R5] LAESVUORI Arto, RISKU Ismo, KNUUTI Juha, KESKI-HEIKKILÄ Sari, UUSITALO Hannu, «Työeläkkeiden indeksisuoja TEL:stä TyEL:iin», Helsinki: Eläketurvakeskuksen raportteja 2009:1, retrievable at: 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, retrievable at: 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 ration.

[R2] NIEMELÄ Heikki, SALMINEN Kari, «Kansallisten eläkestrategioiden muotoutuminen ja Euroopan unionin avoin koordinaatiomenetelmä», Helsinki: Kela, Sosiaali- ja terveysturvan tutkimuksia 104, 2009, retrievable at: 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 co-operation"

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.

[R3] RANTALA Juha, «Varhainen eläkkeelle siirtyminen», Helsinki: Eläketurvakeskuksen tutkimuksia 2008:1, retrievable at:
http://www.etk.fi/Binary.aspx?Section=42845&Item=63147
"Early Retirement"

The study investigates the development in early retirement over the past decade. In addition to full disability pension, partial disability pension, individual early retirement pension, early old-age pension and unemployment pension, the analysis includes the part-time pension and the period of unemployment preceding the unemployment pension. In 1997, the profiles of early retirees were fairly similar to those in 2002. The exception to this is the part-time pension, the use of which was clearly more disparate in 1997. At that time those who took a part-time pension instead of working full-time were especially well-off, highly educated women who worked in other jobs than in the industrial sector. Five years later the popularity of this pension in different population groups was clearly more evenly distributed. Studying the effects of the pension reform will be possible from the end of this decade, when there will be enough data on the period after 2005.

[R1] SOSIAALI- JA TERVEYSMINISTERIÖ, «Kansallinen sosiaalisen suojelun ja osallisuuden strategiaraportti vuosille 2008-2010», Helsinki: Sosiaali- ja terveysministeriön selvityksiä 2008:38, retrievable at:
http://www.stm.fi/c/document_library/get_file?folderId=39503&name=DLFE-8300.pdf
"National Strategy Report on Social Protection and Social Inclusion 2008–2010"

The European Union Member States prepare national reports for the promotion of social inclusion in 2008–2010. The report has three separate sections. These sections present the strategy report on social inclusion, the pension strategy report and the report on strategies for health care and long-term care. The report ends with a relatively extensive set of appendices with information on social development indicators agreed within the EU as well as some of the tables and figures of the report. The key messages of the report can be summarised as:

• The general overview of the social situation is positive.
• Low income and problem prevention pose challenges to the strengthening of social inclusion.
• The growth pressure of pension expenditure is under control – small pensions pose a challenge.
• Diminishing health differences is the most important health policy challenge.

[R1] SOSIAALI- JA TERVEYSMINISTERIÖ, «Sosiaaliturvan uudistamiskomitean (SATA) esitys sosiaaliturvan kokonaisuudistuksen keskeisistä linjauksista», Helsinki: Sosiaali- ja terveysministeriön selvityksiä 2009:10, retrievable at:
http://www.stm.fi/c/document_library/get_file?folderId=39503&name=DLFE-7508.pdf
"Proposal of the Committee for reforming social protection (SATA Committee) for the main policy lines in the total reform of social protection"

The Government set up the Committee on 14 June 2007 to prepare a total reform of social protection. The Committee shall submit a proposal for the total reform by the end of 2009, except that a proposal for the most important policy lines shall be given by the end of January 2009. The proposal for basic policy lines includes an evaluation of the adequacy of social protection and foreseeable challenges. In practice the proposals cover almost the whole range of social protection: the adequacy of basic protection, social protection supporting active alternatives and attaining longer working careers, incentives and simplification of social protection. Further examination of details and calculation of expenditures is needed. When determining the order of priority of its proposals and the time schedule for their implementation the Committee should take into account the limitations posed by the sustainability of the public economy.

[R3] TAKALA Mervi, HIETANIEMI Marjukka (ed.), «Osa-aikaeläke ja eläkeuudistuksen tavoitteet», Helsinki: Eläketurvakeskuksen Raportteja 2008:2, retrievable at: http://www.etk.fi/Binary.aspx?Section=42845&Item=62962
"Part-time pension and the objectives of the pension reform"

This report evaluates the part-time pension from the viewpoint of the pension reform. The objective of the 2005 pension reform is to extend people's working careers by two to three years. Part-time work has been considered one means of extending people's careers. Both when assessing the costs for different alternatives and when comparing the total costs for full-time work and for the part-time pension, the calculations indicated that taking a part-time pension at the age of 58 is a more expensive alternative from the viewpoint of the earnings-related pension scheme than full-time work in the corresponding age bracket, when age-related disability and unemployment risks are taken into account and the person retires on an old-age pension at the age of 63.

[R5] TUOMINEN Eila (ed.), «Näkökulmia eläkeläisten hyvinvointiin – toimeentulosta kulutukseen ja ajankäyttöön», Helsinki: Eläketurvakeskuksen Raportteja 2008:4, retrievable at: http://www.etk.fi/Binary.aspx?Section=42845&Item=63553
"Aspects of pensioner welfare"

The report consists of three articles, which analyse older people's welfare from a different viewpoint. The first article surveys the research on the welfare of ageing people and its main focus is on the analysis of health and income. The second article describes changes in ageing people's consumption and consumption patterns from the mid-1960s to the beginning of the 2000s. The third article monitors the changes in the retired population's time use from the end of the 1980s to the beginning of the 2000s.

[H] Health

- [H_1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H_2] Public health policies, anti-addiction measures, prevention, etc.
- [H_3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H_4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H_5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H_6] Regulation of the pharmaceutical market
- [H_7] Handicap

[H4] ELLILA Heikki, SOURANDER Andre, VÄLIMÄKI Maritta, WARNE Tony, KAIVOSOJA Matti <<The involuntary treatment of adolescent psychiatric inpatients - a nation-wide survey from Finland>> J Adolesc. 2008 Jun;31(3):407-19. Epub 2007 Sep 27.

This national cross-sectional study investigates the prevalence rates, regional differences and factors associated with the involuntary inpatient treatment of adolescents in Finland on a chosen day in 2000. The proportion of inpatients with

involuntary legal status was 29.5% (n=82) giving a prevalence rate of 2.5 per 10,000/12–17 years old inhabitants. Regional differences were modest. Psychotic disorders, suicidal acts, and substance use disorders were associated with involuntary treatment.

[H2, H4] FREDRIKSSON Sami, MARTIKAINEN Tuomo <<Julkista vai yksityistä - kuntalaisten palveluita koskevat valinnat>> Kunnallisalan kehittämissäätiö, Kunnat ja kilpailu-sarja Nro 6, Helsinki 2008, 107 p., retrieved from: www.polemiikki.fi/files/library/attachments/Martikainen.pdf
”Official or private”

Opinions of Finnish citizens about competition in providing health care and other services in municipalities are described. The results showed that over a half of citizens accept changes, which increase competition and choice in social welfare and health services. Less than a quarter considers that public services are the best ones, and a quarter thinks that these kinds of changes will lead to problems.

[H3] HAKULINEN-VIITANEN Tuovi, *PELKONEN* Marjaana, *SAARISTO* Vesa, *HASTRUP* Arja, *RIMPELÄ* Matti <<Äitiys- ja lastenenuvolatoiminta 2007. Tulokset ja seurannan kehittäminen>> Raportteja 21, Stakes, Helsinki 2008, 80 p., retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R21-2008-VERKKO.pdf
”Preventive maternity and child care services 2007”

The report describes the amount and functions of preventive maternity and child health services in the year 2007.

[H4] HEPONIEMI Tarja, KOUVONEN Anne, VÄNSKÄ Jukka, HALILA Hannu, SINERVO Timo, KIVIMÄKI Mika, ELOVAINIO Marko <<Effects of active on-call hours on physicians' turnover intentions and well-being>> Scand J Work Environ Health. 2008 Oct;34(5):356-63. Epub 2008 Oct 14.

This study examined whether active on-call hours and the co-occurrence of lifestyle risk factors are associated with physicians' turnover intentions and distress. Cross-sectional survey data on randomly selected female (N=1571) and male (N=1081) physicians, aged 25 to 65 years, were used. The results showed that on-call duty and the co-occurrence of lifestyle risk factors may decrease physicians' well being and increase their intentions to leave their job.

[H4, H5, L] HYVÄRINEN Olli, LITH Pekka <<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”

The European background and the Finnish legislation for providing municipal services by competition are described. The empirical data collected from all regions in Finland showed that the provision of social welfare services by arranging competition was more common than the provision of health services by competition. Greater municipalities provided more social welfare services by competition than smaller ones. An older age structure of the municipality was related to purchasing private services, because long-term care of the aged was provided by competition in many municipalities. The “political colour” of municipalities was not associated with providing services by competition.

[H2] HYVÖNEN Juha <<Suomen psykiatrinen hoitojärjestelmä 1990-luvulla historian jatkumon näkökulmasta>> Kuopion yliopiston julkaisuja D. Lääketiede 330, 2008, 279 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml
"The Finnish psychiatric health services in the 1990's from a historical perspective"

The aim was to investigate the development of the Finnish psychiatric health services in the 1990's on the basis of available scientific and statistical data and especially through historical material. In Finland, the development of psychiatric services has mainly followed general Western tendencies. For centuries the direction was set and narrowed by a need for the hospitalisation of patients. The deinstitutionalisation process and subsequent transformation were initiated in the 1970's and 1980's by mental health professionals as a systematic reduction of inpatient care with a simultaneous increase in outpatient services. The changes during the 1990's include an interaction of psychiatric and somatic specialised health care systems. The Mental Health Act of 1991, the reform of the state subsidy and a severe economic recession modified the system. Mental health services scattered prominently.

[H2] HÄMÄLÄINEN Riitta-Maija <<The Europeanisation of occupational health services: A study of the impact of EU policies>> Finnish Institute of Occupational Health, People and Work Research Reports 82, 2008, 397 p., retrieved from: http://urn.fi/URN:ISBN:978-951-802-832-4.pdf

This study concerns Framework Directive 89/391/EEC on health and safety at work, which encouraged improvements in occupational health services (OHS) for workers in EU member states. The purpose was to analyse OHS within the EU context and then analyse the impact of EU policies on OHS implementation as part of the welfare state benefit. The main findings showed that OHS are a context-dependent phenomenon, which varies according to the development of the welfare state, and depends on each country's culture, history, economy, and politics. OHS as a concept is vaguely defined by the EU. The tasks of OHS have moved towards multidisciplinary and organisational development and the workplace health promotion sphere. OHS has developed differently in different EU member states.

[H3] JUNNILA Maijaliisa <<Toimiiko terveydenhuoltoalue? Tutkimus Mäntän seudun terveydenhuoltoalueen perustamisen taustoista ja vaikutuksista>> Tampereen yliopisto ja Stakes, Tutkimuksia 175, Helsinki 2008, 275 p., retrieved from http://acta.uta.fi/teos.php?id=11117
"Is the health care region a well functioning concept? A study on the background and effects of founding the Mänttä health care region"

New, innovative, well-functioning and financially sustainable options are sought to re-organise health care services. New operational models proposed by the National Health Project include health district and health care region models. The topic of this study was a new model adopted by the municipalities and the Pirkanmaa Hospital District, in order to re-organise regional health care services. The health care region model was a novel approach to re-organise services in the country.

[H2] JÄNTTI Satu <<Kansalainen terveyspalveluja valitsemassa. Kolmivaiheinen valintamalli julkisissa ja yksityisissä lääkäripalveluissa>> Kuopion yliopiston julkaisuja E. Yhteiskuntatieteet 154, 2008, 199 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml
"Citizens' choices of health services. The three-stage model of choice concerning physician services in the public and private sectors"

The aim was to examine citizens' health service choices. Insurance issues and previous experience of private health services increased the likelihood of choosing a private physician. Experiences of good quality private health services increased the likelihood of choosing a private physician. The factor that had the strongest effect on the likelihood of choice of private physician was that of the individual's own choice.

[H2] KAARAKAINEN Minna <<Hajauttaminen valtion ja kuntien välisissä suhteissa 1945–2015. Valtiollisesta järjestelmästä kohden kuntaverkostojen perusterveydenhuoltoa>> Kuopion yliopiston julkaisuja E. Sosiaalitieteet 153, 2008, 196 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml
"Decentralisation in state and municipal relationships from 1945 to 2015 from national primary health care towards municipality networks"

The purpose was to analyze decentralisation 1) between the Finnish state and municipalities from 1945 to 2015; and 2) in the internal administrative operations of municipalities. The primary care system has undergone a development process, moving from a centralised national welfare state to decentralised autonomous municipal services. To date, municipal primary health care remains the foundation of the Finnish health system, but there is significant pressure to restructure local government and its role in service provision. Municipal leaders have a vision that primary health care will remain the responsibility of the municipalities in 2015, although, the form of municipality will change. Larger municipalities will organise the primary health care services for their residents. Services will be organised partly by purchasing services from the private and third sectors and from other municipalities.

[H2] KANSANELÄKELAITOS – The Social Insurance Institution of Finland <<Lääkärikeskuksista tullut suurin työterveyspalvelujen tuottaja>> Kela, tilastokatsaus 2009, retriewed from:
http://www.kela.fi/in/internet/suomi.nsf/NET/210901101350TL?OpenDocument

Statistics show that private health care companies provide nowadays services for a third of employees, and the costs paid to these companies form a third of all costs of occupational health care. At the beginning of the 2000's the corresponding proportions were the fifth.

[H2] KAUHAVA Lea, IMMONEN-RÄIHÄ Pirjo, PARVINEN Ilmo, HOLLI Kaija, PYLKKÄNEN Liisa, KALJONEN Anne, HELENIUS Hans, KRONQVIST Pauliina, KLEMI Pekka J <<Lower recurrence risk through mammographic screening reduces breast cancer treatment costs>> Breast. 2008 Dec;17(6):550-4.

The objective was to evaluate treatment costs due to breast cancer recurrence in relation to patients' use of mammographic screening, consecutively collected in a defined population. The study included 418 women exposed to screening and 109 women unexposed to screening diagnosed with stage I-III breast cancer. The mean post-recurrence costs were comparable for both exposure groups irrespective of the detection method.

[H5] KIVINEN Tuula <<Tiedon ja osaamisen johtaminen terveydenhuollon organisaatioissa>> Kuopion yliopiston julkaisuja E. Sosiaalitieteet 158, 2008, 234 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml
"Knowledge management in health care organisations"

The aim was 1) to clarify the concept of knowledge management and 2) to describe the state of knowledge management and explain the influential factors in health care. Results information management was not planned nor were common ways of action

agreed on in all health care organisations. Insufficient comparison information from other organisations and shortage of information transfer between units inside organisations were the most significant deficiencies. Organisational culture and information technology skills explained the use of information systems and products. The creation of knowledge and personnel development focused mainly on individual level practices such as short-term training and appraisal and development discussions.

[H3] LAITINEN Arja, KOSKINEN Seppo, RUDANKO Sirkka-Liisa, MARTELIN Tuija, LAATIKAINEN Leila, AROMAA Arpo <<Use of eye care services and need for assistance in the visually impaired>> Optom Vis Sci. 2008 May;85(5):341-9.

The aim was to assess the use of eye care services and unmet needs for assistance in visually impaired people. Cross-sectional population-based survey on a sample representing the Finnish population aged 30 years and older formed the material. Of the 7979 eligible people, 6645 (83.3%) were interviewed and had their distance visual acuity assessed. One hundred forty-seven people were classified as visually impaired. Many visually impaired people, older persons in particular, have not had a recent vision examination and lack adequate low vision rehabilitation. This highlights the need for regular evaluation of vision function in elderly people and for actively supplying information about rehabilitation services.

[H2] NAUKKARINEN Eeva-Liisa <<Potilaan itsemääräämisen ja sen edellytysten toteutuminen terveydenhuollossa – Kyselytutkimus potilaille ja hoitavalle henkilöstölle>> Kuopion yliopiston julkaisuja E. Sosiaalitieteet 157, 2008, 148 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml

"Patient's self-determination and its prerequisites in health care. Survey on patients and staff"

The aim was to illustrate and explain how the care path of adult patients' self-determination and its conditions are implemented in health care centres and in surgical outpatient units. The patients considered that self-determination and its prerequisites were better implemented in the surgical outpatient units than in health centres. Women and younger patients regarded self-determination as more important and women were more willing to exercise self-determination than men and older patients.

[H3] NGUYEN Lien <<Dental service utilisation. Dental health production and equity in dental care>> Research report 173, Stakes, Helsinki 2008, 129 p. ISBN 978-951-33-2085-0.

This study describes factors affecting the utilisation of dental care, factors associated with dental ill-health, and the relationship between dental ill-health and use of dental care.

[H2] NIEMELÄ Mikko <<Julkisen sektorin reformin pitkä kaari Valtava-uudistuksesta Paras-hankkeeseen>> Helsinki: Kela, Sosiaali- ja terveysturvan tutkimuksia 102, 2008. 59 p., retrieved from: http://www.kela.fi/in/internet/suomi.nsf/NET/261108105640ML?OpenDocument&year=2008&cat=Tutkimus&navtdid=221208122816AK

"The long process of public-sector reform from the Valtava reform to the Paras project"

This study explores the history of reforms in the Finnish public sector. The analysis extends from the late 1970s to 2007. The main purpose is to explore the arguments of legislative reforms. The arguments in favour of reforms in the planning, steering and financial systems were, from the 1980s to the Local Government Act of 1995, mostly inspired by the idea of New Public Management. In the name of local self-government

and democracy, the aim was to give more responsibility to local governments and to strengthen their authority. Financial sustainability and the necessity of savings were stressed. Starting in the late 1990s, the debate on local government shifted towards change in local government structures. The aim of the reforms was to encourage municipal mergers with an explicit view to create larger local government units that would be able to function efficiently and provide municipal services productively and cost-effectively.

[H2] NYKÄNEN Irma <<Sepelvaltimotaudin prevention kehitys Suomessa vuosina 1996–2005>> Kuopion yliopiston julkaisuja D. Lääketiede 431, 2008, 158 p., retrieved from: http://www.uku.fi/vaitokset/2008/index_tekija.shtml
"Development the prevention of coronary heart diseases in Finland 1996-2005"

The purpose was to define developments in the prevention of coronary heart disease in Finland in 1996–2005. Between 1996 and 2005, significant overweight became more common, the level of serum cholesterol fell, the level of blood glucose increased, hypertension decreased, and the percentage of alcohol drinkers increased. Altogether 22 % of men and 16% of women did not exercise enough. In the 2005 study, the patients' eating habits were somewhat better than in most population surveys. Physicians and nurses did not adequately discuss self-care in alcohol consumption and smoking.

[H3, H4] PEKURINEN Markku, MIKKOLA Hennamari, TUOMINEN Ulla (eds.) <<Hoitotakuun talous. Hoitotakuun vaikutus terveydenhuollon menoihin, toimintaan ja sairausvakuutuskorvauksiin>> Raportteja 5, Stakes, Helsinki 2008, 70 p., retreived from: http://www.stakes.fi/verkkojulkaisut/raportit/R5-2008-VERKKO.pdf
"Effects of access legislation on costs and functions of health care and on social insurance reimbursements"

The effects of the access legislation implemented from March, 2005 onwards on costs of primary and specialised health care, on the amount of workers, and the access are described. In addition, regional differences are examined.

[H3] PEKURINEN Markku, RÄIKKÖNEN Outi, LEINONEN Tuija (eds.) <<Tilannekatsaus sosiaali- ja terveydenhuollon laatuun vuonna 2008>> Raportteja 39, Stakes, Helsinki 2008, 159 p., retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R38-2008-VERKKO.pdf
"An overview about the quality of social welfare and health care services in 2008"

This report is an overview about quality indicators and quality of social welfare and health care services in Finland in 2008.

[H3] RIMPELÄ Matti, HAPPONEN Hanna, SAARISTO Vesa, WISS Kirsi, RIMPELÄ Arja <<Äitiys- ja lastenneuvoloiden sekä koulu- ja opiskeluterveydenhuollon käynnnit, teveystarkastukset ja voimavarat 2007 – 2008>> Raportteja 40, Stakes, Helsinki 2008, 149 p., retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R40-2008-VERKKO.pdf
"Visits to maternity, child health and school health services and resources for these services 2007–2008"

A report about functions and resources of preventive health services for children, students and mothers.

[H2] SEPPÄNEN Johanna <<Mammographic mass-screening and future breast cancer burden in Finland>> Finnish Cancer Registry and University of Helsinki, Faculty of Medicine, Department of Public Health, 2008., retrieved from:http://urn.fi/URN:ISBN:978-952-10-4852-4

A population-based early detection program for breast cancer has been in progress in Finland since 1987. During 1987-2001, free of charge mammography screening was offered every second year to women aged 50-59 years. Recently, the screening service was decided to be extended to age group 50-69. The focus of this study was on assessing the effectiveness of mass-screening and on showing the estimated impacts of changes in the screening program on the short-term predictions. According to the predictions, the impacts of policy changes, like extending the program from age group 50-59 to 50-69, are clearly visible on incidence while the effects on mortality in age group 40-74 are minor. Extending the screening service would increase the incidence of localised breast cancers but decrease the rates of non-localised breast cancer. There were no major differences between mortality predictions yielded by alternative future scenarios of the screening policy. Any policy change would have at the most a 3.0% reduction on overall breast cancer mortality compared to continuing the current practice.

[H1] SILLANPÄÄ Matti, ANDLIN-SOBOCKI Patrik, LÖNNQVIST Jouko <<Costs of brain disorders in Finland>> Acta Neurol Scand. 2008 Mar;117(3):167-72. Epub 2007 Dec 12.

The aim was to calculate the costs of brain disorders on the national level. Any brain disorder was estimated to affect a fifth of the Finnish population. The three most common disorders were migraine, anxiety disorder and affective disorder. The total costs of brain disorders constituted 3% of the national gross product, or 45% of all the health-care costs. Of the total costs of brain disorders, 32% were for direct health care, 23% for indirect medical care and 45% for indirect costs. Dementia was the most costly brain disorder followed by addiction and affective disorders. Most costly per case were brain tumours and multiple sclerosis. Brain disorders constitute a costly part of health costs.

[H2] SNECK Timo, HANNULA Petri, SANDBERG Juha, TAIVASSALO Ville <<Kohti kuntajohtoista kilpailuttamisyhteiskuntaa>> Kunnallisalan kehittämissäätiö, Kunnat ja kilpailu-sarja Nro 8, Helsinki 2008, 95 p., retrieved from: www.polemiikki.fi/files/library/attachments/Sneck.pdf
”Towards a competitive society managed by municipalities”

A report about possibilities to arrange competitions in order to provide services in municipalities.

[H2, H4] 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”

This report of the Ministry of Social Affairs and Health is a detailed plan about goals for future development of social and health care and means to achieve those goals. Equality in health and wellbeing, better quality and effectiveness of services and decrease in regional differences of services belong to the main goals. Prevention of diseases and disabilities, good quality and adequate amount of workers and services with proven effectiveness are the main means.

[H2] STAKES <<Facts about social welfare and health care in Finland>> Series M252, Stakes, Helsinki 2008, 35 p.

The booklet provides information on social welfare services, alcohol and drugs, health care services and social assistance.

[H2] STAKES <<Sosiaali- ja terveydenhuollon tilastollinen vuosikirja 2008>> Tilastot Ti65, Stakes, Helsinki 2008, 222 p., retrieved from: http://www.stakes.fi/tilastot/ekirja/STV08.pdf
"Statistical yearbook on social welfare and health care 2008"

The yearbook includes a lot of statistics about social welfare and health care services.

[H2] TEPERI Juha, PORTER Michael E, VUORENKOSKI Lauri, BARON Jennifer F <<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

In this report, The Finnish health care system is described and assessed, and needs for changes are proposed from the value-based perspective.

[H2, H3, H4] TUOMOLA Seppo, IDÄNPÄÄN-HEIKKILÄ Ulla, LEHTONEN Olli-Pekka, PURO Markku <<Arviointiselvitys vuosina 2002–2007 toteutetusta Kansallisesta terveyshankkeesta. Terveydenhuollon tulevaisuuden turvaamista koskevan valtioneuvoston periaatepäätöksen toteutuminen>> Retrieved from: http://www.stm.fi/julkaisut/nayta/_julkaisu/1064959
"Assessment report on the National Health Care Project carried out in 2002–2007. Implementation of the Government Resolution on securing the future of health care"

The Government set up on 13 September 2001 a national project to secure the future of health care, the National Health Care Project. Its main objectives were to ensure the population's access to care based on their health needs, and to ensure the quality and adequate volume of care through the country irrespective of the clients' capacity to pay for services. In this report, the writers assess and make practical conclusions on how the objectives and related actions under the National Health Care Project have been realised.

[H3] WAHLBECK Ilkka, MANDERBACKA Kristiina, VUORENKOSKI Lauri, KUUSIO Hannamari, LUOMA Minna-Liisa, WIDSTRÖM Eeva <<Quality and equality of access to health care services. HealthQUEST country report for Finland>> Reports 1/2008, Stakes, Helsinki 2008, 77 p., retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R1-2008-VERKKO.pdf

[H1] WINBLAD Ilkka, REPONEN Jarmo, HÄMÄLÄINEN Päivi, KANGAS Maarit <<Informaatio- ja kommunikaatioteknologian käyttö Suomen terveydenhuollossa vuonna 2007>> Raportteja 37, Stakes, Helsinki 2008, 140 p., retrieved from: http://www.stakes.fi/verkkojulkaisut/raportit/R37-2008-VERKKO.pdf
"Health care ITC and Health in Finland 2007. Status report and future trends"

The survey describes the status and trends of health care information and communication technology (ICT) in Finland in 2007. It also delivers information about financial costs spent on health care ICT.

[H3] VÄÄNÄNEN Minna <<Community Pharmacies and the Needs of Mobile EU Citizens - A study on Finns living in Spain>> University of Helsinki, Faculty of Phramacy, Division of Social Pharmacy, 2008., retrieved from: http://urn.fi/URN:ISBN:978-952-10-4712-1

The aim was to understand medication use, the role of community pharmacies and the symptom mitigation process of mobile community residents. Finns living in Spain were used as an example to examine how community pharmacies in an EU member state meet the needs of mobile community residents. Community pharmacies had an important role in the health care of mobile community residents, and the respondents were mostly satisfied with these services. Several medication safety risks related to community pharmacy practices were identified.

[L] Long-term Care

[L] HAMMAR Teija <<Palvelujen yhteensovittaminen kotihoidossa ja kotiutumisessa>> Tutkimuksia 149, Stakes, Helsinki 2008, 196 p., retrieved from: http://acta.uta.fi/teos.php?id=11138
”Comprehensive co-ordination of home care and hospital care”

The aim of this study was to describe the need for help among home care patients and the effectiveness and cost-effectiveness of comprehensive co-ordination between home care and hospitals.

[L] HÄKKINEN Unto, MARTIKAINEN Pekka, NORO Anja, NIHTILÄ Elina, PELTOLA Mikko <<Aging, health expenditure, proximity to death, and income in Finland>> Health Econ Policy Law. 2008 Apr;3(Pt 2):165-95.

This study revisits the debate on the claim that population aging will not have a significant impact on health care expenditure, using a Finnish data set. According to results, total expenditure on health care and care of elderly people increases with age but the relationship is not as clear as is usually assumed. The results emphasise that even in the future, health care expenditure might be driven more by changes in the propensity to move into long-term care and medical technology than age and gender alone. The future expenditure is more likely to be determined by health policy actions than inevitable trends in the demographic composition of the population.

[L] ISOLA Arja, BACKMAN Kaisa, VOUTILAINEN Päivi, RAUTSIALA Tarja <<Quality of institutional care of older people as evaluated by nursing staff>> J Clin Nurs. 2008 Sep;17(18):2480-9. Epub 2008 Feb 11.

The aim was to report the quality of institutional nursing of older people as evaluated by nursing staff in 2001 and to compare the responses with those obtained in 1998. Data were collected from the health care division of one Finnish city. The findings indicated that care of the aged mostly aims to respond to the physical needs of older people.

[L] KÄHKÖNEN Liisa, VOLK Raija <<Kuntien vanhuspalvelujen kilpailuttamiskokemuksia>> Kunnallisalan kehittämissäätiö, Kunnat ja kilpailu-sarja Nro 4, Helsinki 2008, 102 p., retrieved from: http://www.polemiikki.fi/files/library/attachments/KunnatJaKilp_4.pdf.
”Experiences about providing long-term care of the aged by competition in municipalities”

The goal was to describe the effects of competition on costs of long-term care of the aged. The results showed that the costs of care in sheltered housing and the costs of auxiliary home help had decreased in over a half of the arranged competitions. The results about the costs of other services varied.

[L] SAARELA Tuula M., FINNE-SOVERI Harriet, LIEDENPOHJA Anna-Maija, NORO Anja <<Comparing psychogeriatric units to ordinary long-term care units - are there differences in case-mix or clinical symptoms?>> Nord J Psychiatry. 2008;62(1):32-8.

This study is a comparative analysis of long-term psychogeriatric and mixed-care unit patient characteristics in nursing homes and hospitals in Helsinki. Patients in psychogeriatric units and in ordinary, mixed-client settings were clearly distinguishable. The psychogeriatric residents were younger, had more comorbidity as to psychiatric diseases, and had more often psychiatric symptoms and psychotropic medications. The residents in psychogeriatric units did not differ in cognitive and

functional status from those in mixed-client units and had similar comorbidity as to somatic diseases.

[L] SALIN Sirpa <<Lyhytaikaisen laitoshoidon reaalimalli vanhuksen kotihoidon osana>>, Tampereen yliopisto, 2008, 105 p., retrieved from: http://acta.uta.fi/teos.php?id=11102
”Short-term institutional respite care as part of home care for the elderly”

The purpose was to develop a real model of short-term institutional respite care as a part of home care for the elderly. The carers described the periods of respite as either occupational therapy, resting periods or safe-keeping depending on how they viewed the condition of the recipient afterwards. The informal carers were shown to use creative methods of problem solving when encountering difficulties.

[L] 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”

Recommendations given by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities to municipalities for providing high-quality long-term care to the aged.

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 monitor 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 makes 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 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 the 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.

Lääkehoidon kehittämiskeskus ROHTO – The Centre for Pharmacotherapy Development ROHTO

Address: PB 55, FIN-00301 Helsinki, Finland
Phone: +358 9 4733 446
Webpage: http://www.rohto.fi/index_en.php

The centre collects and disseminates information to promote rational pharmacotherapy and supports implementation of this in practice.

Lääkelaitos – The National Agency for Medicines

Address: P.O.Box 55, FI-00301 Helsinki, Finland
Phone: +358 9 473 341
Webpage: http://www.laakelaitos.fi/index.html

Lääkelaitos regularly controls medical products, medical devices and blood products.

Kuntaliitto – The Association of Finnish Local and Regional Authorities

Address: Kuntatalo, Toinen linja 14, Helsinki
Webpage: http://www.kunnat.net/

The goal of the Association is to promote the opportunities for local authorities in order to support their work for the benefit of the residents. Its members consist of all cities and municipalities in Finland. There were 348 of them at the beginning of 2009. They provide lobbying services, research and development services and other expert services for local authorities.

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 amongst others services like training and information service. The Federation keeps under review developments in the 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.

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.

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 co-operation. 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.

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.

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.

For more information see:
http://ec.europa.eu/employment_social/progress/index_en.html