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Analytical support on
social protection reforms and
their socio-economic impact

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Pensions, health and long-term care

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GVG

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1 Executive Summary

There have been no remarkable changes in the pension system's characteristics during 2012-2013. Earnings-related early retirement pension was abolished for persons born before 1952. Early retirement age for national pension was raised to 63 from the current 62. Also the eligibility age for part-time pension was raised from 60 to 61 for those born in or after 1954.

Major reform has been agreed to take place in 2017 and reform proposals from an expert group are to be published in October 2013. On the basis of these proposals the social partners together with the government start to explore further ways to rise the effective retirement age to the level of 62.4 years by 2025, for ensuring a sufficient level of earnings-related pensions and the financial sustainability of the earnings-related pension scheme as well as strengthening general public finances. The national indicator of effective retirement age has continued to rise even higher than expected and was 60.9 in 2012.

The Finnish health care system guarantees universal coverage, high quality services and on average good health outcomes, at moderate cost. Nevertheless, it faces several challenges: Outcomes in special fields are not improving fast enough, and the ageing population needs more resources and a higher efficiency of the health care system, even if the increase of health expenditure has slowed down during the last years. It will be especially important to address the fragmentation and the financing of the health care system. The ongoing reform debate concentrates particularly on overcoming the fragmentation of the system.

With the new "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People", which entered into force on July 1st 2013, not only the sustainability, but also the quality of long-term care in Finland probably will improve further. Recent assessments of the Finnish LTC system show already a positive development over the last years. According to the OECD, the depth and breadth of LTC coverage in Finland is large, with comparatively low user cost-sharing. During the next two years, the implementation of the new act by the municipalities is in the center of political efforts. Also the newest OECD policy recommendation point out, that Finland should monitor the ongoing LTC reform. Such a monitoring system is in place, carried out by the National Institute for Health and Welfare (THL) and the National Supervisory Authority for Welfare and Health (Valvira). During spring 2014 a next report is planned.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

In 1996 the national pension scheme became dependent on the person's other pension income (i.e. pension tested) as the basic amounts of the national pension were gradually abolished. The most recent structural reform in the national pension was the introduction of the guarantee pension which took effect on 1 March 2011[1].

Earnings-related pensions underwent the most extensive reform at the beginning of 2005. The aims of the reform was to postpone the average effective retirement age by 2-3 years and to adjust the pension scheme to the average increase in life expectancy with the establishment of life expectancy coefficient taking effect since 2010. Further amendments were made in 2007 and 2010. The most recent reforms were agreed in March 2012 when the labour market organisations agreed on measures for the extension of working careers by abolishing the early old-age pension, raising the age limit for the part-time pension and for the unemployment path to retirement. It was also decided to increase pension contributions by 0.4 percentage points in both 2015 and 2016.

2.1.2 System characteristics

In Finland, the statutory (1st pillar) pension provision consists of defined-benefit (DB) earnings-related pension, which aims to maintain the attained income level to a reasonable degree, as well as residence-based national pension and guaranteed pension, which ensure minimum security. The statutory earnings related pension scheme covers all wage and salary earners and self-employed persons. Due to comprehensive coverage of the statutory schemes and the absence of a pension ceiling (neither in income nor in pension), the significance of supplementary pension, i.e. occupational pensions or individual pension insurance, is negligible. The earnings-related pension and the national pension, together with the guarantee pension, ensure the income of the population in case of old age, disability or the death of the family provider.

The statutory pension schemes are linked together, with the amount of the national pension benefit and guarantee pension depending on the size of the earnings-related pension benefit (see Figure 1). Earnings-related pensions reduce the national pension by 50%. Pensioners who receive no earnings-related pension at all or whose earnings-related pension is less than EUR 1,302.30 per month (for single persons) are entitled to a national pension.

The full national pension is granted on the basis of 40 years of residence in Finland. In 2013, the full national pension is EUR 630.02 per month for single and EUR 558.83 for married persons from the age of 65. The full national pension is approximately 20% of the average wage.

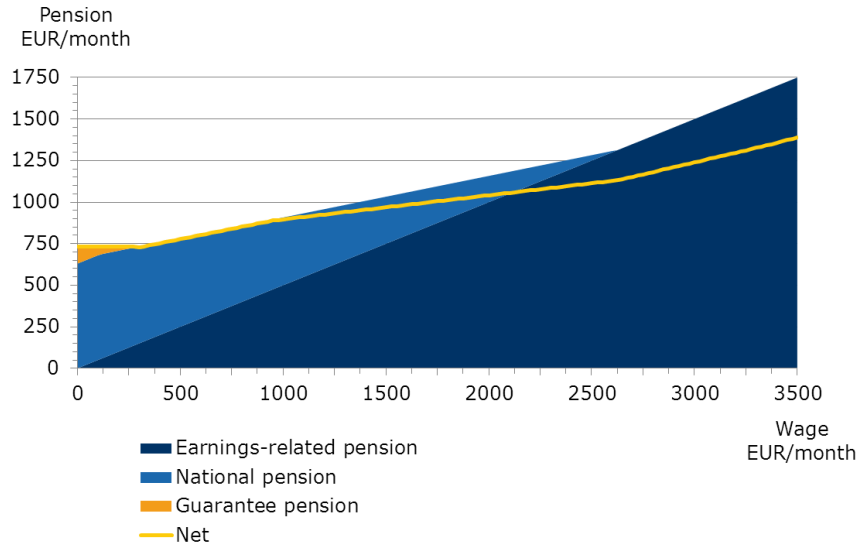
The national pension is supplemented with a guarantee pension as of March 2011. The guarantee pension is paid to pensioners whose national pension and earnings-related pension are less than a minimum income level defined in law. A single pensioner whose sole source of pension income is a full national pension would qualify for a guarantee pension of EUR 108.80 per month. Thus, the minimum pension in total is EUR 738.82 per month (2013),

[1] See the important milestones in the national pension's history: http://www.kela.fi/web/en/history

regardless of the pensioner's family status. The number of recipients of guarantee pension at the end of 2012 was 103,800, less than 8% of all pensioners residing in Finland (1,361,640).

The amount of the guarantee pension is affected by any other pension income (from Finland or abroad). Other pension income is deducted fully from the full amount of the guarantee pension. The guarantee pension is not reduced by care allowance, earnings, capital income or assets. The guarantee pension has some effect on the amount of housing allowance payable and the amount of income support paid to a family.

Figure 1: Earnings-related pension, national pension, guarantee pension in 2013.



Source: Finnish Centre for Pensions

The earnings-related retirement age is flexible between the ages 63 and 68. Within the national pension scheme, the retirement age is 65 years. An early old-age pension can be granted at the age of 62 only to persons born before 1952 with a permanent reduction. Persons born in or after 1952 are entitled to the early old-age pension only in the national pension scheme at age 63. The reduction for early retirement is 0.4% for each month that the pension is taken early before the age of 65.

Earnings-related pension accrue from the age of 18 to 52 at the rate of 1.5% of wages per year, from 53 to 62 at 1.9% and from 63 to 68 at 4.5% a year. Study periods and periods of child care accrue 1.5% for the pension within certain limits. The earnings-related benefit formula includes a life expectancy coefficient that reduces the pension in line with the increase in longevity. People need to work longer to compensate for the decreasing effect of the life expectancy coefficient on the pension.

The average total pension for persons who receive pension based on their own working career (in their own right) was EUR 1,486 a month in 2012, about 50% of the average income (EUR 2,974) in the said year. Share of earnings-related pension was EUR 1,317. For men pension was EUR 1,690 and for women EUR 1,320.

The taxation of statutory pensions is basically the same as the taxation of other earnings. However, due to pension income tax deduction persons who only receive national or guarantee pension get their pension tax-free (only the public service broadcasting tax of 0.68% is levied).

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

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

The implementation of statutory private-sector earnings-related pension provision has been decentralised to pension insurance companies (7), company pension funds (14) and industrywide pension funds (6). The pension insurance companies handled approximately 69% of all persons insured under the earnings-related pension acts. In the 2000s, the number of company pension funds has declined from 37 to 14 whereas the number of industry-wide pension funds has remained virtually unchanged.

In addition, farmers and seamen have their own funds. Central and local government employees have their own earnings-related schemes. In principle, the pension benefits are similar for private and public sector. Since the beginning of 2011, the handling of pension provisions for employees who work for the state, a local government or the Evangelical-Lutheran Church of Finland has been centralised to Keva (former Local Government Pension Institution).

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

The financing of earnings-related pensions is mixed, a combination of a PAYG system and a pre-funded system based on pension contributions from both employers and employees. Approximately four fifths of the earnings-related pensions are financed through PAYG, with the pre-funded scheme covering the rest. The market value of the pension funds' assets (€155 bn) amounted to 77% of GDP in 2012.

The average earnings-related pension contribution rate in the private sector (TyEL) for 2013 is 22.8% of wages. The employees’ pension contribution under the age of 53 is 5.15% and 6.5% for those aged 53–67. The average contribution rate for employers is 17.35% in 2013.

2.1.3 Details on recent reforms

Debate on substantial changes to the earnings-related pension scheme to extend working lives and increase the retirement age has been on-going during the last four years. In 2009, the government and the social partners agreed that additional measures must be taken to raise the average effective retirement age by at least three years by 2025, compared to the situation in 2008 (59.4 years). The focus in tripartite negotiations and in different working groups has been and continues to be on finding ways how to extend careers at the beginning, middle and end. The focus is on a multitude set of approaches instead of a single solution to rise the official retirement age, which on its own is most probably not a sufficient measure for

safeguarding the future pension adequacy. The timing of the next reform is scheduled for 2017.

Meanwhile, in 2012 the earnings-related early old age pension was abolished for persons born 1952 and after. Early retirement was possible earliest at the age of 62 with 0.6% abatement per month (7.2% maximum). This also meant that old age pension at the age of 62 for long-term unemployed was abolished for persons born in 1958 and after. As a consequence of the changes for earnings-related pension also early retirement in national pension scheme was raised to 63.

In addition, part-time pension eligibility age was raised from 60 to 61 for persons born 1954 and after.

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

An important part of the reform was to extend the right of tax deduction to other than insurance savings, i.e. to also include long-term savings covered by the legislation. Individuals' savings will be allocated to personal accounts and only taxed when benefits are paid, according to the EET system[2]. In order to take advantage of the tax relief on premium payments, contributions will be locked in until the upper level of statutory retirement age (age of 68), and benefits paid over a period of 10 years, excluding existing pension insurance products. The former law stipulates 63 years as the earliest age at which savers can withdraw their benefits over a two-year period.

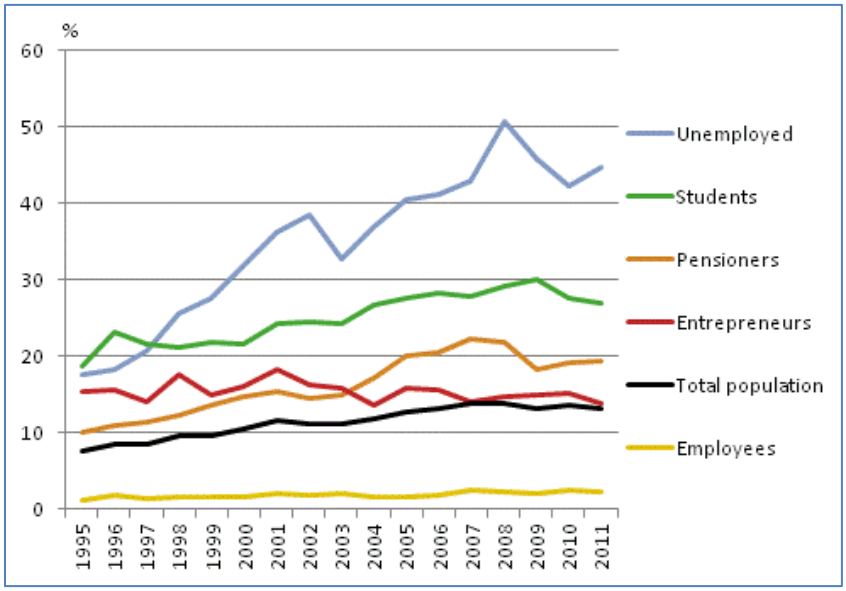
[2] "EET" is an abbreviation for "Exempt-Exempt-Taxed". The first "exempt" refers to the tax deductibility of employer and employee contributions. The second "exempt" refers to the investment earnings being exempt from taxation. The "taxed" refers to the eventual taxation of retirement pensions and other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

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

According to Statistics Finland's income distribution statistics, the at-risk-of-poverty rates (< 60% of median income) of both the whole population and population subgroups have remained unchanged in recent years. Pensioners' at-risk-of-poverty rate was 19% in 2011.

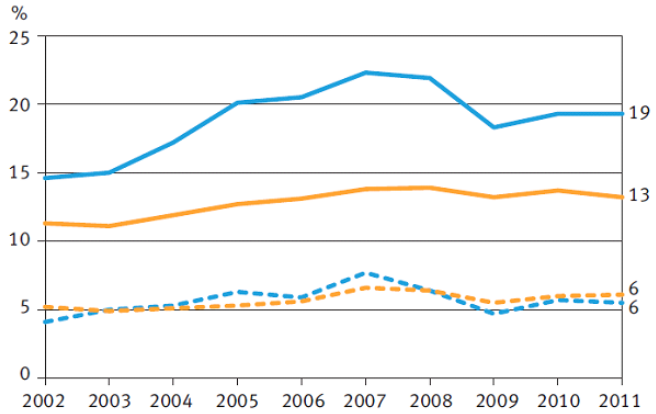
Figure 2: At-risk-of-poverty rates of the population aged 16 or over according to socio-economic group in 1995–2011.



Source: Statistics Finland 2013.

The at-risk-of poverty rates drop significantly by using 50% of median income as a cut-off point. A large share of the elderly have an income between 50 and 60% of the median income.

Figure 3: At-risk-of-poverty rates (at 60 % and 50 % of median income) for pensioners in 2002-2011



Source: Statistics Finland 2013.

The at-risk-of-poverty rate of people aged 65 is higher than the EU average (18.3% vs. 15.9%) and higher than for the population under the age of 65 (12.1%). Moreover, the gender gap is large in at-risk-of-poverty rates of those over 65, and especially for those aged 75+.

Women's poverty rate exceeds men's by more than 10 percentage points and the gender poverty gap is clearly higher than the EU average.

The higher poverty risk of those aged 75 and over, whether compared to EU average or people aged under 65, is partly due to the gradual entry into force of the earnings-related pension scheme, low participation rate of older women in the labour market and a relatively low national pension. The risk of poverty is greatest for older women in receipt of a national pension with short or no working careers. Women also dominate the oldest age cohort, as – on average – women live longer than men. Two thirds in this age group are women and one third men (OSF 2013). Consequently, the period of retirement is longer for them and a major part of women live alone, thus facing a much higher risk of falling into poverty than older persons living as a couple.

Table 1: At-risk-of poverty rates by age groups.

Age	1995	2000	2005	2010	2011
under 18	4.3	8.8	9.7	11.8	11.1
18-24	21.0	20.1	24.2	26.5	24.8
25-44	5.2	7.7	8.8	10.3	10.3
45-64	6.7	8.3	9.6	11.2	10.7
65-74	9.8	11.4	16.5	12.9	11.2
over 74	15.6	23	29.0	26.9	27.6
Total population	7.6	10.5	12.7	13.7	13.2

Source: Statistics Finland 2013.

The relative pension level will begin to decrease in 2020. The most important reason for this decline is the life expectancy coefficient, which adjusts the benefit level to correspond to changes in life expectancy. The increase in life-expectancy has been more rapid than projected in the drafting of the 2005 reform. This is resulting in a situation where pensions will be significantly lower than it was projected, if working lives do not substantially extend.

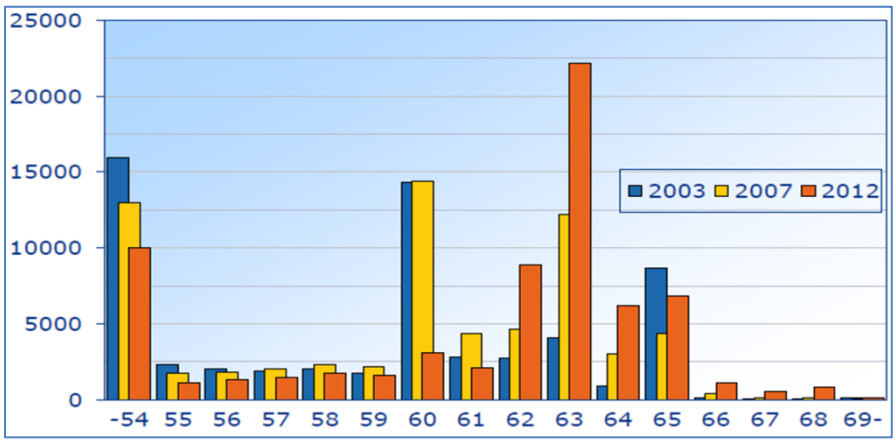
Table 2: Projected development of average pension and average wage 2012-2080.

	2012	2020	2040	2060	2080
Average wage, €/month	2,974	3,204	4,523	6,260	8,635
Average pension €/month	1,486	1,689	2,035	2,567	3,354
% of average wage	50,0	52,7	45,0	41,0	38,8

Source: Risku et. al 2013.

For future pension adequacy, one of the decisive elements is the effect of the life expectancy coefficient and people's reactions to flexible retirement. The question that arises is whether the life expectancy adjustment encourages long enough careers for decent living. It is still too early to answer this question, as the mechanism was only established in 2010. However, if people retire immediately when they reach the minimum retirement age, it is worth considering whether the level of minimum retirement age should be higher, in order to safeguard the adequacy of future pensions. People tend to retire at the earliest age when possible. This phenomenon can also be seen in the following figure.

Figure 4: Persons having retired on an earnings-related pension by age in 2003, 2007 and 2012.



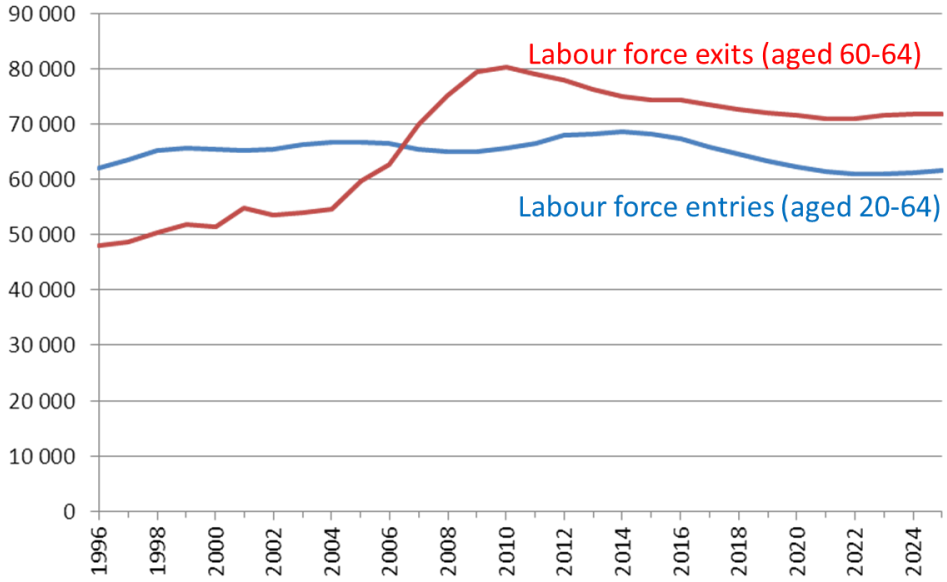
Source: Finnish Centre for Pensions

2.2.2 Sustainability

Pension expenditure is projected to increase at more than twice the EU average by 2060 according to EPC-AWG calculations: from 12% up to 15% of GDP by 2060 (European Commission and Economic Policy Committee 2012). According to recent national projections the growth of the pension expenditure is slower than previously projected. For the year 2012, the total statutory pension expenditure was slightly over 13% of GDP. At its highest, the share of pension expenditure is projected to increase to approximately 15% in the 2030s after which the share will stabilize at slightly less than 14% from 2040 onwards. One reason for this development is that the employment rate is projected to increase one percentage point more than in 2011 projection, from the current 68% to an ample 72% from 2020 onward. Also immigration is projected to increase slightly more than previously and decline in mortality is slower. (Risku et. al 2013.)

A significant challenge is the shrinking of the size of the working age population. Due to size differences in cohorts Finland is already in a situation where annual labour force exits will exceed the labour force entries. Thus, the success of active ageing policies and prolonging of working careers are decisive to counterbalance this ongoing structural development.

Figure 5: Potential supply of labour force in1996-2025.



Source: Population Statistics and Population Projection, Statistics Finland.

According to Eurostat the employment rate of the elderly (aged 55 to 64) has risen remarkably since 2000 (41.6%), reaching 58.2% in 2012, which was well above the EU average (48.8%)[3]. Even though the economic crisis led to a decrease in the overall (aged 15-64) employment rate, it did not have any serious effect on the employment rate of older workers. The employment rate of the aged has continued to rise.

Taking a closer look at the work activity in different age groups of seniors, we see that the employment rate for those aged 55-59 (73.9%) is even higher than the employment rate for the age group 15-64 (69%). The employment rate is considerably lower among the 60-64-year-olds. However, there is a clear rise in the employment rate for this group as well reaching up to 43% in 2012. Also for the age group of 65-69 the rate is higher compared to previous years. (see Table).

Table 3: Employment rate by age group and sex in 2002–2012.

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	15-64	67,7	67,3	67,2	68	68,9	69,9	70,6	68,3	67,8	68,6	69
	55-59	65,1	65,6	65,7	65,4	67,3	67,9	70,3	71,4	72,5	72,7	73,9
	60-64	26,1	27,3	29,2	33,5	37,2	39,1	41,2	39,3	40,8	41,8	42,9
	65-69	5,3	5,8	5,7	6,8	7,8	9,7	9,8	9,8	10,6	11,7	12,6
Male	15-64	69,2	68,9	68,9	69,5	70,5	71,3	72,3	68,8	68,7	69,8	69,8
	55-59	64,5	64,9	64,6	63,4	65,7	65,6	68,9	69,2	69,9	70,5	70,2
	60-64	28,8	31,1	31,3	36,3	39,5	41,5	43,5	39,4	41,8	43,3	43,6
	65-69	7,9	9	9,2	9,4	9,8	13,3	14,1	13,3	14,7	15,4	16,5
Female	15-64	66,2	65,7	65,5	66,5	67,3	68,5	68,9	67,9	66,9	67,4	68,1
	55-59	65,6	66,3	66,8	67,4	69	70,4	71,6	73,6	75	74,9	77,5
	60-64	23,4	23,7	27,2	30,8	35	37	39,1	39,2	39,9	40,4	42,1
	65-69	3	3,2	2,7	4,4	6	6,5	5,9	6,7	7	8,5	9,1

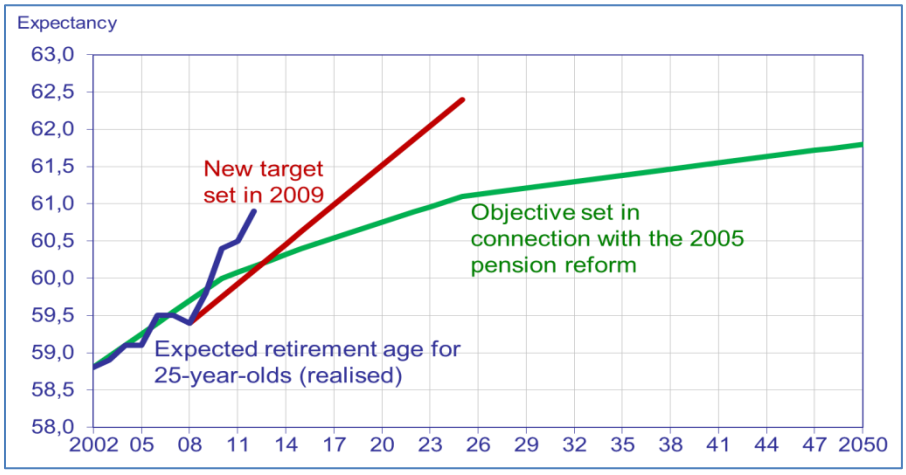
Source: Labour Force Survey, Statistics Finland.

[3] http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_unemployment_lfs/data/main_tables

So far, the expected effective retirement age has risen even more than predicted[4]. After the 2005 pension reform, the average retirement age has risen from 59.1 years to 60.9 years. Target is 62.4 by 2025. The increase in effective retirement age is mainly due to abolishing and narrowing pathways to early retirement. In future it is more likely that the effective retirement age increase more slowly and settle down to the previously projected line without further reforms.

In 2012, the effective retirement age was 60.9 years. In the above mentioned projection it is estimated to rise to 61.5 years in 2025 and 62.4 years in 2060. This is more pessimistic than the target set in tripartite negotiations in 2009 (see Figure 6).

Figure 6: Development of the expected effective retirement age.



Source: Finnish Centre for Pensions.

Currently, the Finnish statutory pension scheme is in a situation where private sector (TyEL) expenditure approximately equals the premium income. In the future, however, the expenditure will permanently exceed the contribution income. Investment returns play a key role in covering the difference between expenditure and contributions to avoid the risk of a sustainability gap. However, according to the latest projection (Risku et. al 2013) pressure to raise pension contributions is smaller than previously estimated. The according contribution level under the Employees´ Pensions Act (TyEL) of 25% is sufficient until the end of the 2050s. According to the previous projection, the TyEL contribution should have been raised to an ample 26% in the 2020s. A sustainable contribution level would be 25.6% starting in 2014. The labour market organisations have agreed to raise the TyEL contribution to 24.4% cent by 2016.

Pension funding alleviates the pressures to raise pension contributions with the ageing of the population and equalises the intergenerational income distribution (Finnish Pension Alliance Tela). The Finnish Centre for Pensions uses 3.5% as the assumption of real return in its long-term projection. In principle, if this level is not reached, the contributions must be raised or benefits need to be cut. In 2011, the real return was 5.9%, in the latest fifteen years (1997-2012) the annual real return was 3.9%. Return rate (nominal) was 2.3% in the first half of 2013.

[4] The expected effective retirement age describes the average effective retirement age for insured persons of a specific age on the assumption that the age-specific retirement risk and mortality rate for each age group remain at the level of the year of observation. The expectancy in Figure is calculated for 25-year-olds.

2.2.3 Private pensions

In 2013, the retirement age of individual pensions or long-term savings accounts was raised from 63 years to 68 years. As of the beginning of 2013, the pension contributions of new contracts are tax-deductible only if the retirement begins at the earliest at the deferred old-age retirement age as stipulated in the Employees Pensions Act.

The tightening taxation measures of voluntary supplementary pensions as of the beginning of 2013 also apply to group pensions. If the employee pays part of the insurance contributions, the contributions are tax deductible only if the pension begins at age 68 at the earliest.

Individual pension insurance policies have lost popularity in recent years; the number of new policies has declined compared to previous years and presumably the changes in taxation do not encourage individuals to engage in private pension provision.

However, the government's proposal in spring to raise the age limit for withdrawal of savings as from the beginning of 2013 was instrumental to the increase in new agreements in 2012. By the end of 2012, about 28,500 long-term savings contracts had been signed, and the total value of investments was approximately EUR 47 million. Finnish households concluded just over 5,000 new long-term savings agreements in the fourth quarter of 2012. (Bank of Finland 2013).

2.2.4 Summary

Previous pension reforms have achieved positive development in employment and retirement indicators but pressures for further reforms still exist. The main driving force for further reforms is the increased longevity which according to latest population projections has increased even more than projected in drafting of the 2005 reform.

Another challenge for sustainability as well as adequacy of the pension system is the development of overall employment rate (15-64-year-olds) which has stagnated and was in 2012 less than 70%. For those aged 55 and over the employment has continued to increase for several years.

One challenge concerning the younger age groups in addition to unemployment is the inflow into disability benefit which continues to be high even though the number of new retirees on a disability pension has been decreasing for some time. By the end of 2011, those retiring on earnings-related disability pension were 23,000 new retirees, with total recipients of 203,000 (which is 8,000 less than previous year). People retire on a disability pension at the average age of 52,1 years. A total of 1,377,000 received earnings-related pension. (OSF 2013.)

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

2.3 Reform debates

In recent years, the prolongment of working life and the sustainability of public-sector economy in the future have been topics of extensive discussion. The general view is that 2005 pension reform will ease the ageing pressures on the labour market and pension financing but it will not be enough. A recent study (Uusitalo, Nivalainen 2013) argues that abolishment and

restriction of early retirement pension routes have had positive effect on employment - whereas flexible retirement has affected negatively. According to research the total impact of the 2005 reform has been smaller than projected in the drafting of the 2005 reform.

This kind of results have also been reported by some earlier studies. A study based on a dynamic macroeconomic model including the modelling of the pension schemes suggests that the 2005 reform would increase the effective retirement age by 1,5 – 2 years (Lassila and Valkonen 2005). Similarly a study based on stochastic life cycle model including pension rules, unemployment benefits and income taxation suggests that the effect of 2005 reform might be 0,7 – 1,5 years (Hakola and Määttänen 2007).

The EU Commission has in the country specific recommendations (2011, 2012, 2013) as part of Europe 2020 strategy encouraged Finland to align the minimal statutory retirement age with increased life expectancy. In addition it has been recommended to take further steps to increase the employment rate of older workers, including by improving their employability and reducing early exit pathways, implement and monitor closely the impact of on-going measures to improve the labour-market position of young people and the long-term unemployed, with a particular focus on the development of job-relevant skills.

Likewise the OECD (2012) also recommends rising the minimum and maximum retirement age and tightening early retirement routes by abolishing the unemployment pipeline.

According to the recent study by the Research Institute of the Finnish Economy (ETLA) retirement age must be tied to life expectancy (Lassila et. al 2013). The researchers assess that, as life expectancy is increasing, raising the retirement age is desirable for two reasons. The first reason concerns pension adequacy. If people live longer but do not work longer, the monthly pensions reduced by the life expectancy coefficient may become too small in relation to the set targets of the earnings-related pension scheme. The second reason concerns the impact of the length of working lives on state and municipal finances - the longer the working lives, the higher the tax revenue.

The most heated topic under discussion is indeed whether the minimum retirement age should be raised from the current level of 63 years. For example, the Social Democrats joined the government in 2011 on condition that the minimum retirement age will not be raised during the present government term. However, discussion has been lively. Discussions around sustainability gap, increased public debt and need for structural reforms to strengthen public finances have fuelled the debate. This is also reflected by the fact that in most European countries retirement ages have been raised.

Among the population people are more willing than before to accept the raise in retirement age. For example, according to an opinion poll conducted by EVA, every second Finnish citizen would be ready to accept a raise in the retirement age of at least two years. A slightly smaller share (45%) oppose the raising of the retirement age. The attitude toward raising the retirement age is more positive among the highly educated. Politically, the majority of the supporters of the Coalition Party, the Centre Party, the Greens and the Swedish People's Party are in favour of raising the retirement age, while the majority of the supporters of the Social Democratic Party, the Finns Party, the Leftist Union and the Christian Democratics oppose it. (Haavisto 2013.)

However, the atmosphere seems to have changed and not such a definite opposition against the raise of the retirement age exist as was the situation e.g. in 2011. For example the chair of the Finns Party, currently in opposition, reveals in an interview with Talouselämä (6 September 2013) that the party would not walk away from a Government resolute in raising the retirement age by 6—12 months. However, he stresses, the party would only be prepared

to consider the raise "if the government programme is otherwise sensible and has the imprint of the Finns Party".

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The present Finnish healthcare system was developed throughout the 1960th and 1970th through important acts like the sickness insurance act (Sairausvakuutuslaki; 1964) with the introduction of statutory national health insurance, the primary healthcare act (Kansanterveyslaki; 1972) with the development of a nationwide system of health centers for primary health care, the act on occupational healthcare (Työterveyslaki; 1970), the act on specialized healthcare (erikoissairaanhoitolaki; 1989), which enforced the now existing system of 20 hospital districts, and the act on patient rights (Laki potilaan asemasta ja oikeuksista; 1992).[5]

3.1.2 System characteristics

The Finnish legislation stipulates that the provision of health care services is under the responsibilities of the municipalities. The public municipal system covers primary health care and specialised health care. Each municipality has the responsibility to organise the provision of adequate health care services for their permanent residents. Municipalities have the right to levy taxes. They cover the costs of health care services with municipal taxes, state subsidies and user fees. The amount of state subsidies depends on the municipality's population, population structure and morbidity, among other factors.

Municipalities can organise the provision of primary health care services independently or form joint municipal authorities. In addition, local authorities can outsource the provision of services to other local authorities, to non-governmental organisations or private service providers.

Specialised health care services are organised by 20 federations of municipalities, and the country is divided into 20 hospital districts for specialised health care. These districts are grouped into five tertiary care regions around the universities with medical schools. In these regions, central hospitals are called university central hospitals. Specialised health care services on the autonomous Åland Islands are provided based on the Act on the Autonomy of Åland.

The basic public health and specialised health care services that must be available in every municipality are defined by law. However, local authorities can decide upon the scale, scope and model of municipal service provision within the limits of legislation, so that the services available can vary from one municipality to another.

Occupational health care represents a third system of health service provision. Employers are obliged to provide preventive health care services (those necessary to address work-related risks) and first-aid services at work for their employees. Approximately 90% of wage- and salary-earners have access to occupational health care. Many big and medium-sized

[5] http://www.stm.fi/sosiaali_ja_terveyspalvelut/lainsaadanto

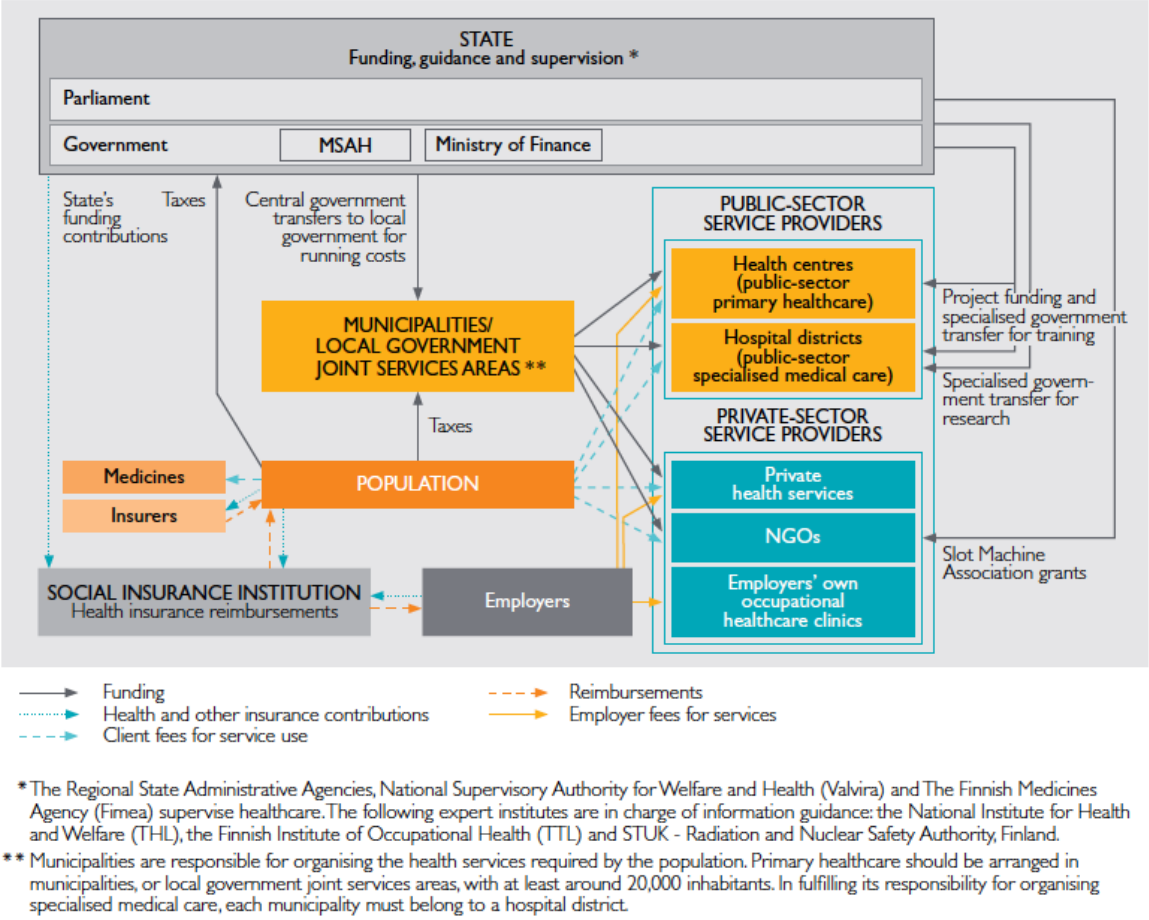
employers provide even basic outpatient treatment of common diseases for their employees. (Vuorenkoski 2008) In this context there are no patients' fees. Costs are covered by obligatory payments of employers and employees to the National Health Insurance Income Insurance Pool. Employers pay two thirds of the costs, whereas the remainder is paid by employees (Työterveyshuoltolaki 2001).

Health services are also provided by the private sector. Private service providers, i.e. enterprises, non-governmental organisations and foundations, can sell their services to local authorities, joint municipal authorities or directly to clients. When local authorities outsource the provision of health care services to the private sector, clients must pay for the services according to the Finnish Act on Client Fees in Social Welfare and Health Care. Users of private health care pay the fees themselves, but they receive a partial reimbursement through the obligatory National Health Insurance System. According to the Ministry of Social Affairs and Health, private-sector service providers account now for just over a quarter of all social welfare and health care services in Finland.

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

Government agencies and public bodies within the ministry's administrative branch are responsible for research and development, for guidance, supervision and statistics. These government agencies and public bodies include, among others, the National Institute for Health and Welfare, the Finnish Medicines Agency, the Radiation and Nuclear Safety Authority and the Finnish Institute of Occupational Health.

Figure 7: Organisation, funding, provision and supervision of healthcare services in Finland



* The Regional State Administrative Agencies, National Supervisory Authority for Welfare and Health (Valvira) and The Finnish Medicines Agency (Fimea) supervise healthcare. The following expert institutes are in charge of information guidance: the National Institute for Health and Welfare (THL), the Finnish Institute of Occupational Health (TTL) and STUK - Radiation and Nuclear Safety Authority, Finland.

** Municipalities are responsible for organising the health services required by the population. Primary healthcare should be arranged in municipalities, or local government joint services areas, with at least around 20,000 inhabitants. In fulfilling its responsibility for organising specialised medical care, each municipality must belong to a hospital district.

Source: Ministry of Social Affairs and Health: Health Care in Finland, Helsinki 2013

The Finnish statutory health insurance, which covers the entire population, is divided into medical care insurance and earned income insurance. The Social Insurance Institution of Finland (KELA) coordinates the health insurance. Medical care insurance reimburses clients for tests and treatments ordered by private doctors and dentists as well as for client charges according to statutory reimbursement rates. Clients pay costs in excess of the statutory reimbursement rate themselves.

Medical care insurance is financed almost solely by the State and the insured, each paying half of the costs. Medical care insurance contributions are deducted from the income, pension and benefits of all insured.

Reimbursement for outpatient prescriptions is determined as a percentage of the price or reference price of the medicine. Clients have a fixed deductible for travel expenses. A ceiling has been set on the maximum amount that clients have to pay for prescriptions and travel expenses per calendar year.

Earned income insurance covers sickness allowance, rehabilitation allowance, special care allowance as well as maternity, paternity, parental and special maternity allowance.

3.1.3 Details on recent reforms

The implementation of the Comprehensive Health Care Act in May 2011 gave new orientations and tasks to health care districts. Rules and regulations about the operation of health care and contents of services in the Primary Health Care Act and in the Act on Specialised Medical Care were brought together in the new act. The act did not include rules and regulations about financing services. The central aim was to reinforce the role of primary care. The key features of the act are

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

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

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

The new act improved also the mobility of patient records. All electronic patient registers and patient record archives in the health centres and hospitals in a hospital district now form a joint register of patient records. The personnel treating the patient have access to patient records in the joint register even without the patient's consent provided that the information is necessary for the treatment. The patient must be informed of the joint use of the patient register as well as of the possibility to forbid the joint use. The ban is valid until further notice and it can be cancelled any time. The patient records included in the prohibition are non-accessible even in emergencies. However, the patient can draw up a separate provision where he or she can allow the use of records included in the prohibition for example if he or she is unconscious and in need of immediate care.

3.2 Assessment of strengths and weaknesses

According to newest OECD publications the Finnish health system in some areas falls well behind its peers on equality and efficiency. The OECD states, that health inequalities are large across socio-economic groups and regions, and efficiency in health services has not increased as rapidly as it could. The most educated Finnish people at the age of 30 can expect to live 6 years longer than the least educated.

High inequalities in health are caused in part by lifestyle factors. The percentage of adult smokers in Finland is below the OECD average and declining. The obesity rate among adults is also slightly below the OECD average. However, obesity rates are increasing; adult alcohol consumption is above average and Finland is one of the few countries where it is still rising. Smoking and drunkenness among 15-year olds and overweight and obesity rates among 11-15-year olds, are all high by OECD standards.

3.2.1 Coverage and access to services

Inequalities in health outcomes are according to the OECD partly due to inequalities in access to services, particularly primary care. In a comparison of 15 OECD countries, only Estonia and the United States showed greater inequality than Finland in access to doctors.

Also other reports see significant differences across municipalities in resource allocation for health care delivery. According to a SITRA report these differences are due to factors including the differing evolutions of care delivery structures over time in various regions, financial resources, availability of health professionals, and the way in which each population's health care needs are perceived by municipal decision makers.

A Stakes report on quality and access of the Finnish health care system from 2008 already stated, that in outpatient health services equity issues arise from the existence of several care pathways (i.e. public outpatient health services, occupational health services, and private health services) and different ways of financing these services as well as different out-of-pocket-payments in these three patient pathways. In public sector specialist care there is a relative lack of supply of outpatient services in relation to need and the impact of private sector outpatient services is thereby large in access to non-emergency specialist care and elective surgery.

Unequal access to care is a particular problem for primary care, which is provided by municipal health centers, but also by occupational or private sector providers. Regional inequalities have also been observed and are partly explained by difficulties for small municipalities, in remote areas where it is difficult to recruit qualified personnel (OECD 2013). The National Institute for Health and Welfare published a report about trends in health inequalities in the period 2007–2010 (Rotko, Tuulia / Terveyden ja hyvinvoinnin laitos 2011). They concluded that the worrying trend in social determinants of health may further intensify health inequalities. Poverty has increased and the level of basic social security has fallen far behind the general wage development. The review shows that many programmes, projects and working groups address health inequalities. However, inequalities persist despite efforts to reduce them. At the same time, some political decisions may have widened the health gap even further.

According to the National Institute for Health and Welfare (THL) in spring 2013 only 15% of all inhabitants lived in a municipality, in which they got access to a physician in a health centre within 2 weeks. For around one fifth of all inhabitants the waiting time for a physician consultation was 5 weeks or more. Both, smaller and bigger municipalities were characterised by long waiting times for a visit to a health center. Thus, the size of municipalities is not the only reason for unequal access to primary care.

The OECD recommended to continue the planned reforms to restructure municipalities (see 3.3 Reform debates), as they can be expected to result in improved efficiency and quality of care, and to consolidate care into fewer and larger organisations. SITRA recommended strengthening primary health care through the implementation of the integrated practice unit (IPU) approach. SITRA also criticises, that the parallel municipal and occupational primary care funding channels create obstacles to moving toward value-based care models.

3.2.2 Quality and performance indicators

In 1993 a first healthcare accreditation programme was introduced in Finland. The first Finnish National Recommendation on Quality Management was published in 1995. In 1998 a quality strategy was proposed for public services and in 1999 Recommendations on Quality Management for Health Services provided and purchased by municipalities were introduced.

In 1993 the Finnish act on patient's rights entered into force – as the first law of this kind in Europe (Legion-Quigley 2008). As Vuorenkoski states (Vuorenkoski 2008), apart from information about waiting times public information about quality indicators is not available. Honkanen (Juha-Pekka Honkanen, Laaturekisteri kertoo leikkaustulokset, Lääkärilehti 13.11.2012) shows that quality registers exist on a regional level, but nationwide quality registers are not available, due juridical obstacles to use such information outside the region, in which the respective patient was treated. According to a speech of Paula Risikko, Finnish Minister of Health and Social Services, in the opening of the OECD Health Care Quality Forum in Paris in October 2010, the Finnish discussion about quality and quality assurance in health care focus on local quality strategies and quality management systems in the health care units as well as in health technology assessment (HTA).

The Statistical Yearbook on Social Welfare and Health Care 2012 (Helsinki 2013) contains in addition to many other data also different European health indicators. According to these indicators the standardised death rate due to ischaemic heart diseases per 100.000 persons in Finland for 2010 (120,7) is much higher than in the EU-15 (20,8) or the EU-27 (76,5), even if the standardised death rat is lower than 2008 (128,8) or 2009 (122,5). Also the standardised death rate due to suicides per 100.000 persons in Finland in 2010 (16,8) is higher than in EU-15 (9,0) or EU-27 (10,2).

On the other hand, the number of patients who have been waiting for admission for more than 6 months has decreased throughout the country. While at the end of 2008, 4.3 patients per 10.000 inhabitants had been waiting for admission for more than 6 months, the same number was only 2.2 patients at the end of 2011. There were, however, regional differences in the number of patients waiting for admission for more than 6 months.

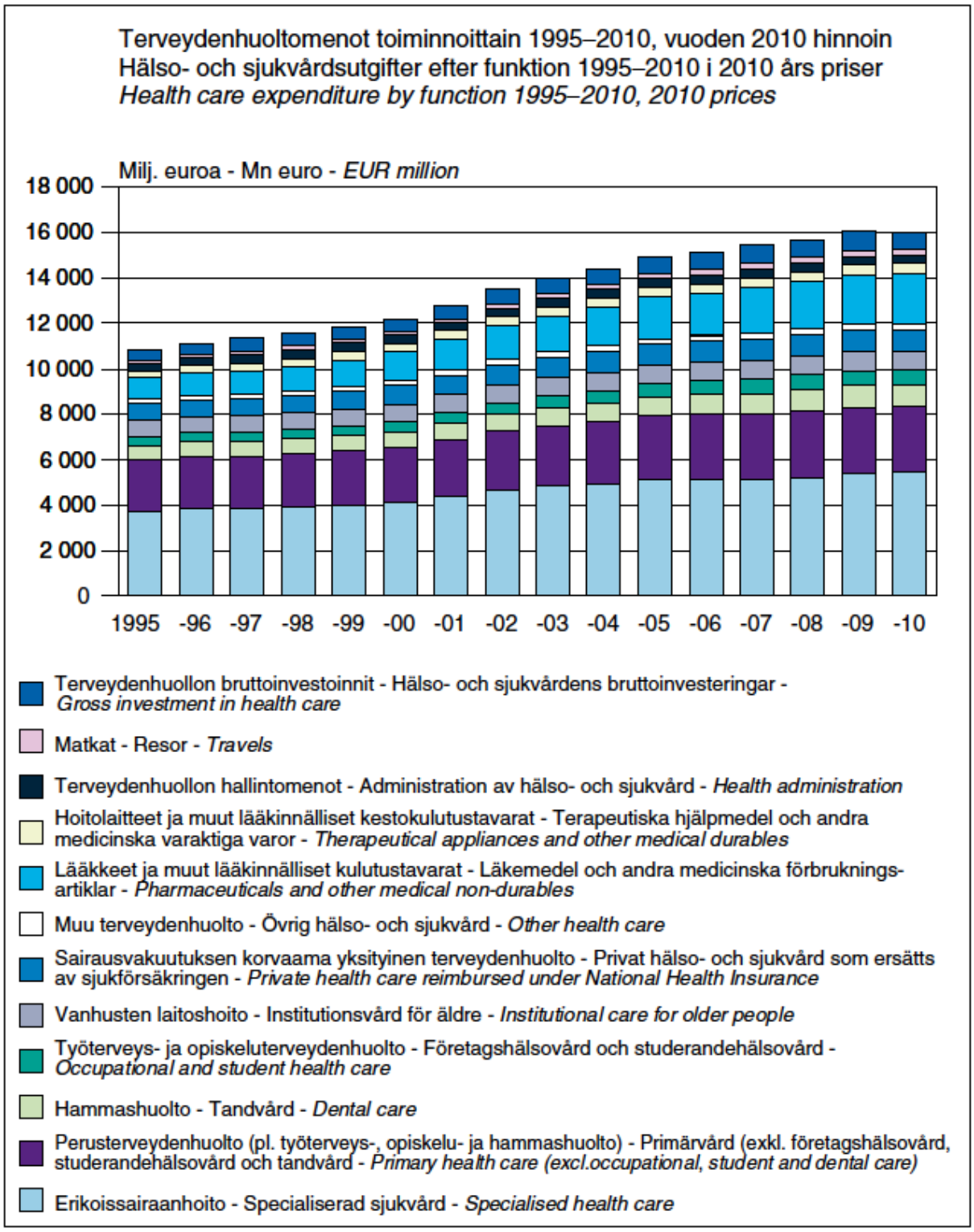
The five-year relative survival rate for breast cancer in Finland is very high in international comparison. It was 86,3% for the period 2004-2009 (1997-2002: 84,2). Only Norway has a higher survival rate for the period 2004-2009 (86,5%). Also breast cancer mortality (age-standardised rates per 100.000 females) in Finland is very low (2000: 23,0; 2010: 21,2) in international comparison.

3.2.3 Sustainability

According to the OECD Economic Surveys Finland (02/2012) productivity in the health sector has been falling and Finland underperforms the most efficient OECD countries on some indicators of the population's health status. As the OECD report states, ageing will put further pressures on public health spending, underlining the need for significant and lasting efficiency gains.

The Statistical Yearbook on Social Welfare and Health Care 2012 (Helsinki 2013) shows that health expenditure in Finland in 2010 amounted to EUR 16.0 billion. In real terms, total health expenditure decreased by 0.1% on the previous year. Per capita expenditure was EUR 2.986. Health expenditure as a proportion of GDP was 8.9% in 2010, which is 0.2 percentage points less than in the previous year. Expenditure in specialised health care (EUR 5.5 billion) and primary health care (EUR 3.3 billion) together accounted for slightly over half of the total in 2010. Specialised health care expenditure increased by 2.0% in real terms. This was especially due to an increase in the costs for inpatient care in somatic specialised health care. Outpatient care costs for somatic specialised health care, by contrast, decreased. Expenditure on primary health care decreased by 2.1% in 2010, which was principally due to a decrease in inpatient care costs in primary health care. Health expenditure in 2011 amounted to 9,0% of GDP according to OECD Health Data 2013.

Figure 8: Health care expenditures by function 1995-2010



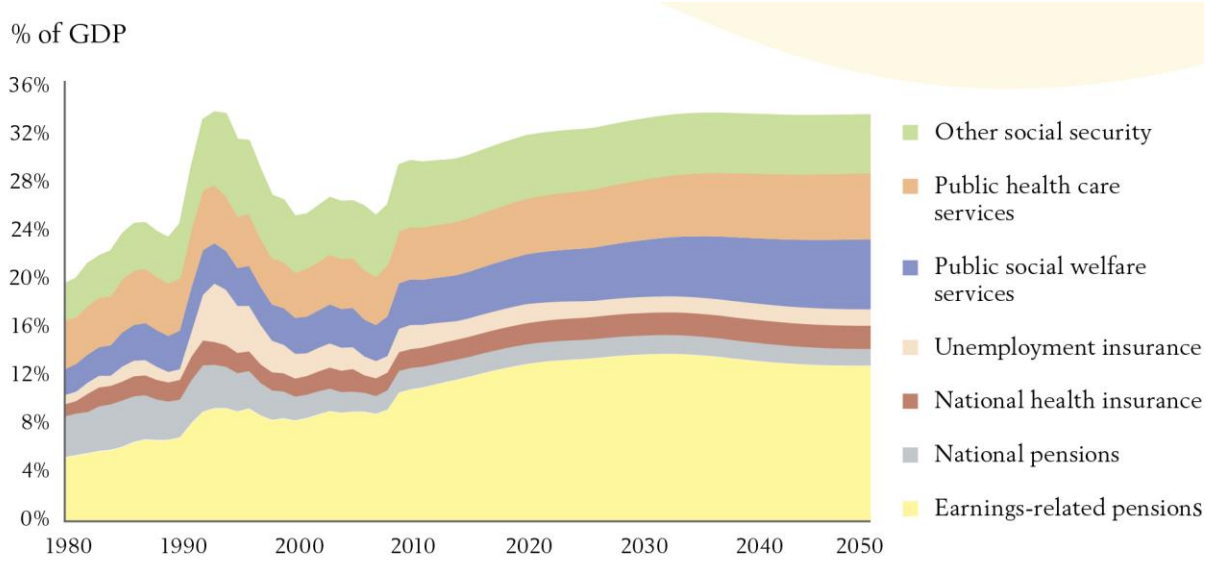
Source: Statistical Yearbook on Social Welfare and Health Care 2012

The OECD warns that health expenditures already account for a sizeable share of general government spending. Increasing cost of medical technology, rising patients' expectations and a rapidly ageing population will strain resources, unless productivity improves, and may require raising taxes or restricting supply of public services significantly. To achieve long-term sustainable growth and preserve the country's comprehensive welfare state arrangements in the face of demographic ageing, Finland has to implement forcefully a series of structural reforms, so the recommendation of the OECD.

The Finnish government sees also certain risks in the development of health and social service costs, as shown in the graph.

But an even bigger challenge is the fact that there are huge regional differences in access to and quality of health care due to the different financial resources of municipalities. The OECD recommendations reducing the number of municipalities and thus building bigger municipalities, will not result in an improvement of the situation, in case the financial situation of the municipalities will not alter and a financial reform aiming at less financial burden and/or better tax income for the municipalities is missing. Thus, regional reform of municipalities, a financial reform (which has not yet started) and the reform of the health care structure only jointly can lead to a sustainable situation.

Figure 9: Development of social expenditure (excluding user fees) under current legislation, as a ratio of GDP, 1980 to 2007 and projection 2050



Source: Finnish Social and Health Ministry, Socially Sustainable Finland 2020 - Strategy for social and health policy, Helsinki 2010

3.2.4 Summary

The Finnish health care system guarantees universal coverage, high quality services and on average good health outcomes, at moderate cost. Nevertheless, it faces several challenges: Outcomes in special fields are not improving fast enough, and the ageing population needs more resources and a higher efficiency of the health care system, even if the increase of health expenditure has weakened during the last years. Especially the fragmentation of the health care system and the financing of the system have to be dealt with. The ongoing reform debate concentrates especially on changing the fragmentation of the system.

3.3 Reform debates

The government is at present preparing a local government and service structure reform, which involves revising the local government structure and the Local Government Act, social welfare and health care service structures and financing as well as re-evaluating the statutory duties of local authorities.

The government's aim is to keep local authorities principally in charge of the provision of social welfare and health care services. The government states that in order to be able to provide these services, municipalities need a sufficient population base, adequate human resources and competence as well as ability to finance the infrastructure needed for the provision of services. The objective of the governmental reform plans is to divide the provision of services between larger regions serving a higher number of citizens.

According to the proposal of the SOTE working group for the reform of the social welfare and health care service structure (SOTE), published early in 2013, responsibility for social welfare and health care services should be shifted from municipalities to new social welfare and health care regions (SOTE region). It is also proposed that joint municipal authorities of hospital districts and special welfare districts for the mentally ill should be re-organised. According to the plan of the SOTE working group, a total of 34 social welfare and health care regions / municipalities would be established in Finland.

But the government disagreed with the recommendation of the SOTE working group. Background is that the government does not want a model that in the end would lead to only 34 strong municipalities in Finland. Therefore the government on March 21st 2013 decided about new guidelines for the SOTE reform, which aim at an integrated social and health system structure with two levels. The new law shall come into force in the beginning of the year 2015. The central idea behind the reform is called the "responsible-municipality-model" (vastuukuntamalli). The central cities of 18 regions as well as economically robust municipalities with sufficient financial capacity and based on natural commuting areas will act as responsible municipalities.

Medium-sized municipalities with 20,000–50,000 inhabitants will arrange primary level services themselves, but a social and health services region administered on the responsible municipality model will be responsible for arranging more demanding services. Municipalities with fewer than 20,000 inhabitants will be responsible for the funding of services, but the responsibility for arranging services will rest with the appropriate social and health service region. Five specific catchment areas, which will coordinate the extensive primary level, will be formed for demanding social and health care services. The nowadays health-care regions (sairaanhoitopiirit) shall be abandoned until 2017.

As the structural reform of social and health care services is directly connected to the local government reform, the central decisions of both reforms have to be taken simultaneously. In April 2013 this led to the implementation of a new governmental coordination committee, which has to ensure that the central decisions of both reforms are taken simultaneously.

In June the preparatory committee for the act on the arranging of social welfare and health care services submitted its interim report to the Ministry of Social Affairs and Health. The interim report defines the duties included in the responsibility of organising social welfare and health care services. It also defines the central characteristics of the model of municipalities with primary responsibility (MPRs) and arrangements between municipalities in the funding of social welfare and health care services. In addition, the interim report contains an account of the duties of specific catchment areas (SCAs) and the organisation of the administration of

university hospitals. The interim report does not anticipate the number of SOTE regions or primary-level areas that could be formed in Finland.

Municipalities and other actors could state their opinion concerning the interim report until October 11th. The final report in the form of a government proposal should be completed until the end of 2013. The proposal will be considered by the parliament in spring 2014 and, if approved, would come into force at the beginning of 2015. The aim is for social welfare and health care (SOTE) regions to begin their activities by latest at the start of 2017.

In the reform, the responsibility for arranging social welfare and health care services will be allocated principally to social and welfare and health care (SOTE) regions and, in some aspects, to primary-level areas. The SOTE regions and primary-level areas each will have a municipality with primary responsibility (MPR) that is responsible for arranging the services for the municipalities in the region. Upon specific special grounds, municipalities within a SOTE region may agree on the adoption of a joint municipal authority model.

The preparatory committee proposes certain central characteristics for the MPR (municipality with primary responsibility) model. Decisions concerning the services provided by primary-level areas would be made in a joint organ of the member municipalities. The SOTE regions, too, would have a joint organ, in which the member municipalities and the primary-level organ would be represented. The composition of the organ would also account for the power relations between the municipalities. The number of votes held by the representatives of the municipalities would be determined based on the population size of the municipalities.

SOTE regions formed by municipalities would be responsible for all statutory duties of municipalities regarding social welfare and health care services (so-called extensive primary and specialised level). Primary-level areas could be formed by municipalities with 20,000 to 50,000 residents. They would arrange primary-level services for their residents, currently provided by health centres and social services departments. Specialised services would be arranged by the SOTE region.

Municipalities with less than 20,000 residents would not arrange services themselves. Services for their residents would be organised by a SOTE region or a primary-level region. The duties of small municipalities would still include promoting the well-being and health of their residents, as this is also the duty of other sectors within municipalities.

In the future, the activities of SOTE regions and primary-level areas would be coordinated by five specific catchment areas. These have been named specific catchment areas in social welfare and health care services (SOTE-SCAs) by the preparatory committee, as their duties would now also include the steering of social welfare services. A SOTE-SCA would be a body corporate and a joint municipal authority, with SOTE regions as its members.

The SOTE-SCAs would have to ensure equality particularly as concerns centralised services requiring cooperation between SOTE regions (e.g. emergency services, demanding social welfare services and specialised medical care). They have to guide purposeful use of resources in their area so that no overlaps or shortages in services are created. The specific catchment areas would also be responsible for the regional coordination of research, development and teaching.

In the case the reform will be adopted by parliament, hospital districts will cease to exist as administrative organisations at the end of 2016. To manage the duties of SOTE regions, the staff, property and responsibilities of hospital districts would, as a general rule, be transferred to the ownership and control of the MPR or joint municipal authority of the SOTE region.

Part of the actual reform plan is, that all municipalities will continue to be responsible for the funding of the services. The preparatory committee recommends that the costs of the primary-level areas and SOTE regions would be divided between municipalities using the capitation model, in which the age structure and morbidity of the population would be weighted.

In the capitation model, the cost to a municipality can be anticipated and differences between municipalities are evened out over longer time periods. However, a shift to the capitation model would require a transition period of several years. Applying the model to established services may cause significant changes to current expenses in some municipalities. In most municipalities, the changes required would be small.

Primary-level areas would obtain the majority of the services required by them from the SOTE region and would pay for these services on performance basis. The capitation model would be applied to the funding of SOTE-SCAs provided by SOTE regions. Central government transfers to local government would still be paid to municipalities.

The Finnish debate about the SOTE reform is very controversial. Especially the fact that the recommendations of the working group where overruled by the new guidelines of the government only a few days after publishing of the recommendations has been seen critically. Most of the health-care experts criticize that the government model will not lead to the expected result as stated by the government, because the new structure has to many different players with different responsibilities.

In addition experts also discuss about positive and negative results of concentrating health-care in bigger regions, because in many cases this leads to longer distances to health centers and hospitals, especially during nights and weekends. On the other side a pilot project for a bigger health-care region in South Carelia (South Carelian Social and Health-care district) shows good results in cost-effectiveness and better access to high quality healthcare [4)].

The now planned reform does not directly tackle the problem of multi-channel financing of health-care, which led to a primary health-care system, which is divided into three different parts for different groups of the population: Public health-care, financed by the municipalities, occupational health-care, financed by the employers and re-financed partly through the Finnish Social Insurance Institution KELA, and private health-care, financed out of the pocket, but partly also re-financed by KELA. The public primary care system, based on health centers, is more and more used mostly by pensioners and groups, which are not covered by occupational health-care or can not afford private health-care.

Partly as a result of the controversial discussions about the reform plans THL, the Finnish National Institute for Health and Welfare, in October 2013 announced a seven-point initiative to strengthen primary health care. The goals of the THL initiative are access to elective care without queuing and genuine opportunities for patient choice.

THL proposes, first, that primary health care should be financed with public funds, but that the services under predetermined uniform criteria can be provided by public, private, or third-sector service providers.

Secondly, money should follow the patient. That means that the service provider will get a predetermined, partly fixed, reimbursement according to the patient's choice of service unit. THL sees that this will give service providers incentives to attract patients with good access, high quality, and a client-oriented approach. At the same time, free choice of provider for the patient has to be guaranteed, and the service fee is the same for all providers. In the moment, the city of Espoo in southern Finland is going to introduce this model for the health centers in Espoo.

Thirdly, occupational health care should concentrate on its primary task - to prevent work-related diseases, promote return to work, and develop work communities.

THL also proposes, that the public funding of social welfare and health care should be channelled to regional actors, and that the number of regional actors responsible for the organisation of social and health services should be reduced to, less actors.

According to the THL proposal the necessary restructuring of services and funding should progress in stages. Access to elective care could be improved fairly quickly through temporary earmarking of health-insurance reimbursements. A preliminary estimate of THL is that this temporarily earmarked funding should be EUR 250–350 million per year. According to THL this would require both a raise in the health insurance contributions and a review of other ways of redistributing the reimbursements of medical expenses.

Cross-border health care

The Finnish government has proposed new legislation to put into effect the European Union's Directive on cross-border healthcare. According to the reform plans of the government, the costs of a patient travelling from Finland abroad for treatment would be reimbursed in two different ways depending on whether or not the patient seeks the treatment in another country or if the treatment involves a medical necessity that emerges during travel abroad. In both cases the patient would always pay for the cost of the treatment to the caregiver and could later apply for reimbursement from the Finnish Social Insurance Institution (KELA). The patient would not need to apply for advance permission for seeking treatment.

According to the proposal the patient would be entitled to reimbursement for health care (KELA compensation) in the same amount, as KELA compensation is available for treatment by private care givers in Finland, when he seeks treatment in an EU or EEA country or in Switzerland. Also travel costs to the nearest place of treatment in the home country where equivalent treatment is available would be reimbursed.

When a person needs medically necessary treatment while abroad, the treatment costs would be reimbursed on a clearly higher level: by an amount according to the costs of public health care in Finland. Only the heath care client fee would be deducted from reimbursement to be paid to a person. The state would pay for these costs.

In addition, patients would only have the right to reimbursement for the kind of treatment that is part of the selection of services of Finnish healthcare. The National Contact Point for cross-border healthcare, whose main task would be to provide information on seeking treatment by Finnish residents in other countries and by foreign residents in Finland, would be set up in the Social Insurance Institution KELA.

Patients coming from other EU countries would also be entitled to seek healthcare services in Finland.

It is also proposed that instead of the municipality providing the treatment, the state should meet the costs of the treatment more extensively in cases in which treatment is given in Finland to a person whose treatment costs Finland is responsible for, but who does not have a home municipality in Finland. In addition it is proposed that this state compensation should be extended to situations in which a person without a home municipality is given urgent treatment in accordance with the Healthcare Act, when the cost of treatment could not be collected.

The Government has presented a bill to Parliament proposing an Act on Cross-Border Healthcare on September 12th. The new legislation also includes existing regulations on

procedures and reimbursement for treatment costs. The legislation is to take effect on January 1st 2014.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Finland adopted a "National Memory Program 2012-2020" in 2013. The overall goal is to create a "memory-friendly" Finland on the basis of the following activities:

1. Promoting brain health
2. Fostering a more open attitude towards brain health, treatment of dementing disease and rehabilitation
3. Ensuring a good quality of life for people with dementia and their families through timely support, treatment, rehabilitation and services
4. Increasing research and education

The background reported in the program brochure is the rising number of people with a memory disorder: Approximately 13.000 people are diagnosed with a memory disorder every year in Finland. Also the number of people diagnosed with progressive memory disorders is growing rapidly. Just over 95,000 people had been diagnosed with at least a moderate dementia and approximately 30,000–35,000 people with a mild memory disorder in 2010. Approximately 130,000 people are estimated to be suffering from at least a moderate dementia in 2020.

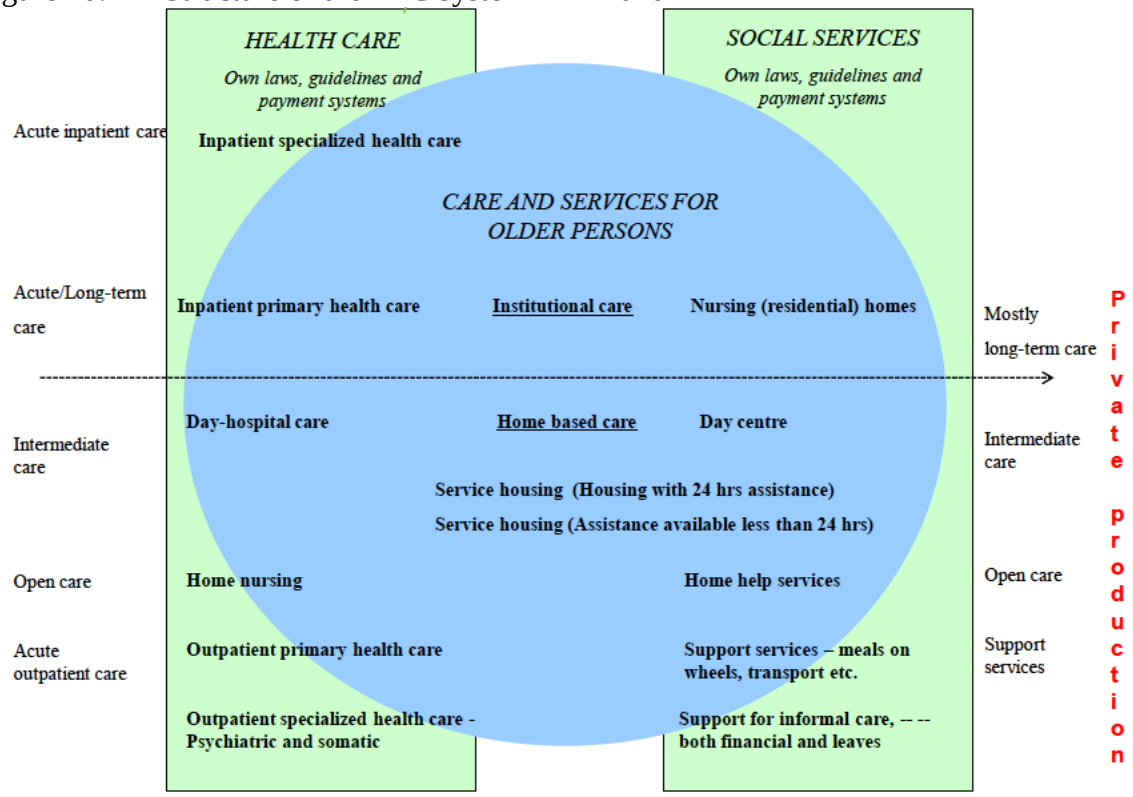
The majority of costs result from the need for 24-hour care. Approximately 80% of patients in 24-hour care have cognitive decline or a diagnosed progressive memory disorder. In 2010, the average cost of 24-hour care was EUR 46,000 per person per year. The average cost of home care was EUR 19,000 per person per year.

The incidence of progressive memory disorders and dementia can be decelerated. By treating the prodromal stages of Alzheimer's disease, for example, the onset of the disease can be delayed by as much as five years. This could reduce the incidence of Alzheimer's disease by 50% in a single generation.

The "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People" was adopted by the Finnish parliament on December 28th 2012 and entered into force on July 1st 2013. The act concentrates on ensuring healthy ageing and good functional capacity at old age. Local authorities must offer health examinations, appointments and home visits that support wellbeing, health, functional capacity and independent living in particular for those members of the older population whose living conditions and life situations are on the basis of research results or general life experience considered to involve risk factors increasing their need for services. In addition, local authorities must draw up a plan on measures to support the wellbeing, health, functional capacity and independent living of the older population as well as to organise and develop the services and informal care needed by older persons. The plan also must underpin living in the own home and measures to promote rehabilitation.

4.1.2 System characteristics

Figure 10: Structure of the LTC system in Finland



Source: Quality Assurance and Quality Management in Long-Term Care – National Report Finland; Helsinki 2010

Entitlement to LTC services in Finland is based on residence. Social protection for older people consists of services and income security, arranged as a part of social and health care. Municipalities are responsible for arranging services. The municipality grants services on the basis of an individual service needs assessment. Municipalities may produce the services themselves or buy them from other municipalities or from private service providers.

Since the beginning of the year 2011 clients receiving LTC for more than one year have the right to change the municipality, in which they receive LTC. The municipality of origin then has to pay for the services arranges in the new municipality.

If an older person requires home services, informal care, institutional care, services for older people, social assistance or other social care services, for these to be granted a specialised group of municipal officials (vanhustenpalvelujen sijoitustyöryhmä (SAS=selvittää-arvioida-sijoittaa) assesses the client's service needs.

These services are benefits in kind, except informal care support, which is a cash benefit. So benefits in kind include institutional care for the elderly, home help services, support for informal care, day care for the elderly, the services of day and service centres, sheltered housing and family care. The Care Allowance for Pensioners, a cash benefit paid out by the Social Security Institution (KELA), intended to make it possible for pension recipients with an illness or disability to live at home, as well as to promote home care and to reimburse pension recipients for extra costs caused by illness or disability. The mean monthly allowance is around €100.

Home service and home nursing care assist when an older person requires help at home due to diminished functional capacity or illness. In many municipalities these are combined as home care, which is supplemented by support services.

If it is not possible for an older person to live at home or in service accommodation (service homes, sheltered housing), care can be organised in the form of institutional care. Institutional care is provided both in nursing homes and in the inpatient departments of health care centres (in international statistics sometimes referred to as hospital beds).

Informal care support is targeted towards families in which a family member is caring for an aged spouse or parent, for example. Decisions on granting informal care support are made by local authorities.

In the end of 2011, 6.777 clients aged 65 and over received institutional care in health centres and long-term care beds in hospitals, and 15.099 clients received institutional care in residential homes. So the number of clients with institutional care in the end of 2011 added up to 21.876 or 2,2% of all inhabitants aged 65 and over.

The number of clients in sheltered housing (also service housing; in Finnish: palvelutalo) amounted to 35.892 (ordinary sheltered housing: 6.147; sheltered housing with 24-hour assistance: 29.745) or 3,6% of all inhabitants aged 65 and over. This form of long-term care increased enormously during the last years (2005: 25.711). There are different ways of arranging sheltered housing depending on the basis of ownership and the arrangement of the services. The sheltered housing can be owned or co-owned by the state, municipality, organization or private persons, or it can be co-owned by these parties. The resident can live in the sheltered housing as a tenant or as the owner. The old person can buy the services they need from either the municipal or private service providers, or both. Sheltered housing can include different types of dwellings like sheltered dwellings, group homes or dwelling groups and different combinations of these. In addition, sheltered housing can also serve as temporary accommodation. Sheltered housing can be a part of, so-called, service centres which offer the elderly versatile services which support and rehabilitate the independence of the elderly. Finnish research data shows that a very high proportion of the clients living in sheltered housing are satisfied with their living conditions (Özer-Kemppainen: Alternative Housing Environments for the Elderly the Information Society – the Finnish Experience).

63.866 clients (6,5% of all inhabitants aged 65 or over) received regular home care (as of 30.11.2011 / as the data collection criteria have been revised, the data are not comparable with the statistical reports for previous years).

In the end of 2011 19.439 clients (2,7% of all inhabitants aged 65 or over) received support for informal care (as cash benefit). The number of clients which received support for informal care has doubled almost from 14.355 in 2000 to the number shown for 2011. Also the share of this group of population aged 65 and over has risen from 1,8% (2000) to 2,7% in 2011. The principle for informal care is, that a relative may provide care at home for an older person (or person with a disability or with a chronic illness) and receive payment. The minimum payment for the informal carer is 375,41€ per month and 749,01€ for difficult care conditions. The informal carer has the right for a minimum of 3 free days per month. During this time the municipality has to organize the care. There over the informal carer is insured against occupational accidents and diseases, and the municipality has to pay the pension contributions.

The development during the last years reflects that more and more elderly people with need for long-term care receive sheltered housing with 24-hour assistance: The number of recipients has grown from 10.007 in 2000 to 29.745 in 2011. In the same period the number

of residents in health centres and long-term care beds in inpatient institutions has lowered substantially from 12.164 (2000) to 6.777 in 2011.

Table 4: Care and Service for older people 2005-2011 (aged 65 and over) in absolute numbers

Year	Support for informal care	Regular home care	Ordinary sheltered housing	Sheltered housing with 24-hour assistance	Residential homes	Health centres, long-term inpatients
2005	19.796	53.149	10.072	15.639	18.899	11.325
2010	24.656	60.432	6.675	27.711	15.656	7.598
2011	26.055	63.866	6.147	29.745	15.099	6.777

Source: Statistical yearbook on Social welfare and Health Care 2012

Table 5: Care and Service for older people 2005-2011 (aged 65 and over) in % of all aged 65 and over

Year	Support for informal care	Regular home care	Ordinary sheltered housing	Sheltered housing with 24-hour assistance	Residential homes	Health centres, long-term inpatients
2005	2,4	6,3	1,2	1,9	2,2	1,3
2010	2,6	6,4	0,7	2,9	1,7	0,8
2011	2,7	6,5	0,6	3,0	1,5	0,7

Source: Statistical yearbook on Social welfare and Health Care 2012

LTC services are financed by tax money from the municipalities, by state subsidies and user fees. The user fees in residential homes and health centres are 85% of net income of the recipient. A minimum of 97 € per month has to remain for own use of the recipient. In the case, that the recipient of long-term care in such an institution is married with a person with better income, net income of both persons is counted together, and the fee for LTC then is 42,5% of the net income of both persons. A second principle states, that the fee for LTC shall not be higher than the cost of LTC for the municipality.

In home care and sheltered housing the principal is fee for service. The maximum fee for LTC in these cases is 35% of monthly net income above 520€.

In 2011, the total expenditure for LTC in Finland (benefits in kind) amounted to 2.197 Million Euro. The state financed 809 Million Euro, the local authorities 1.388 Million Euro. The clients had to pay 502 Million Euros fees to the municipalities.

Table 6: Expenditure on LTC (benefits in kind) 2011, Million €

	Total expenditure	Financing by state	Financing by local authorities	Transfer from client fees
Benefits in Kind together	2.197	809	1.388	502
Institutional care of the elderly	722	261	462	203
Home help services	536	193	342	100
Support for informal care	107	39	68	0
Other	832	316	516	199

Source: THL/SVT Tilastoraportti/FOS Statistikrapport/OSF Statistical Report 5/2013

The share of the expenditure for Institutional LTC amounted to 32,9% of the total expenditure on LTC, the expenditure for home care was 24,4%, and the share of support for informal care was 4,9%. The share of public LTC expenditure as share of GDP amounted to 2,5% in 2010 and is expected to rise to 5,4% of GDP in 2060.

The number of professional carers in LTC in Finland amounted to 73.500 in 2010. This means a substantial rise by 26,1% or 16.400 persons since 2000, when the number of professional carers in LTC in Finland was 57.100. In the same time the number of social and health personnel in Finland rose by 2,3%.

Table 7: Professional carers in LTC in Finland 2000-2010

Year	2000	2005	2007	2008	2009	2010
Professional carers in LTC	57.100	69.600	64.500	68.100	72.000	73.500

Source: Terveyden ja hyvinvoinnin laitos: Sosiaali- ja terveyspalvelujen henkilöstö 2010

That means, that in 2010 in Finland worked 78,1 carers per 1.000 population aged 65 an over (2000: 73,5). Most of the personnel belonged to public services (48.500) and non-profit organizations (12.500), while the number of personnel working for private for-profit organizations amounted to 12.400. 24.000 carers worked in the field of residential homes, health centres and other long-term inpatient institutions, 23.500 in the different forms of sheltered housing, and 21.400 in home care. 32.760 or 44,6% of carers in LTC had training as Practical Nurse (lähihoitaja), 17.535 as home aid (kodinhoitajat).

4.1.3 Details on recent reforms in the past 2-3 years

Partly as a consequence of long during discussions about sometimes poor quality, but also to ensure good LTC service in the future, the Finnish government suggested a reform for LTC in 2012. The "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People" was adopted by the Finnish parliament on December 28th 2012 and entered into force on July 1st 2013.

Two groups are in the centre of the new act:

- older population, defined as population aged 63 and older, and
- older persons, defined as: person whose physical, cognitive, mental or social functional capacity is impaired due to illnesses or injuries that have begun, increased or worsened with high age or due to degeneration related to high age

Central objectives of the new act are:

- precedence to services provided at home („In order to prevent other service needs attention must be paid in particular to services promoting Rehabilitation and services provided in the old person‘s own home.“)
- Institutional long-term care can be provided only if it is medically justified or if it is otherwise appropriate to ensure a dignified life and safe care for an older person.

Further on, the act guarantees older persons the right to a comprehensive evaluation of service needs without delay. The evaluation will then be used to draw up an individual service plan. Options must be discussed with the older persons themselves, and their opinions must be recorded in the service plan. A case worker must be assigned to each older person in case they need help in matters related to the provision and coordination of services.

Local authorities are required to draw up for each electoral period of the municipal council a plan for supporting the wellbeing of the ageing population and the availability of social welfare and health care services for older people. Moreover, the sufficiency and quality of the services has to be evaluated on an annual basis. Local authorities must allocate sufficient resources to the support of wellbeing and the providing of services. Local authorities are obliged to consult the local council for older people in the planning, preparation and monitoring of any activities concerning older residents in the municipality.

Local authorities must offer health examinations, appointments and home visits that support wellbeing, health, functional capacity and independent living in particular for those members of the older population whose living conditions and life situations are on the basis of research results or general life experience considered to involve risk factors increasing their need for services.

The Act also provides for a standard of quality for services for older people provided by service providers. The number of personnel and their qualifications and job duties must be consistent with the number of older persons being provided services by the service provider and the level of service that their functional capacity requires. Service providers must engage in self-monitoring in order to maintain and further develop the quality of their services. Self-monitoring will involve obtaining regular feedback from employees.

Some important regulations in the new act in respect to quality are:

- The number of personnel and their qualifications and job duties must be consistent with the number of older persons being provided services by the service provider and the level of service that their functional capacity requires.
- Local authorities must appoint an employee responsible for an older person if the older person needs help in matters regarding the provision of services and their coordination.
- Service providers must engage in self-monitoring in order to maintain and further develop the quality of their services.
- The service provider must draw up a self-monitoring plan, which must be kept on public display. The implementation of the plan must be monitored.
- Self-monitoring must be developed on the basis of the feedback gathered on a regular basis from the older persons obtaining services of the unit, their family members and other persons close to them as well as from the staff of the unit.

The implementation of the new act on LTC is overseen by the National Institute for Health and Welfare (THL) and the National Supervisory Authority for Welfare and Health (Valvira). A first report a month before the new act came into force, showed, that already most of the Finnish municipalities had prepared for the different aspects of the new act. For example,

already 91% of all municipalities had a local council for older people. The complete results of the report are published on the internet.[6] During spring 2014 a next report is planned.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The assessment of the Finnish LTC system shows a positive development. According to the OECD, the depth and breadth of LTC coverage in Finland is large, with comparatively low user cost-sharing, and Finland has increased competition across providers of care services through publicly-funded vouchers that can be used to pay for the services produced by competing providers certified by the municipality. It has also encouraged productivity improvements through the use of remote technologies, assistive devices, and voice systems to link care users to their caregivers in nursing homes. The OECD policy recommendation 2012 says, that Finland should monitor the ongoing LTC reform.

The new LTC legislation is to be explained by the political goal of Finnish governments to reduce the number and the proportion of elderly people living in long-term institutions and to increase the number and the proportion of elderly people living at home or in sheltered housing. In addition, during the last years long during discussions about partly poor quality in LTC took place. With the new act the Finnish government reacts on the demographic development to ensure good LTC service for a substantially increasing number of elderly. Nevertheless, also after implementing the new act, there will be clear regional differences in access to and quality of LTC, because the financial strength of municipalities varies a lot. This variation represents a challenge both for LTC as well as for health care. The OECD recommendations reducing the number of municipalities and thus building bigger municipalities will not result in improvements unless it is accompanied by a structural financial reform.

4.2.2 Quality and performance indicators

Across municipalities in Finland a considerable variation in the type of services provided can be found. Additional in a couple of municipalities there have been on-going discussions about a poor level of quality in long term care, especially in institutional care. To address this concern, already in 2001 the first national quality guidelines for elderly care were published by the Ministry of Social Affairs and Health. In the center of the guidelines were quality indicators for service needs, service structure and of health and welfare promotion. Part of the quality guidelines was also indicators related to staffing. It was recommended, that municipalities should define the number or ratio of personnel per client needed for each service. As a consequence of the "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People" (more details in section 5), which was adopted by the Finnish parliament on December 28th 2012 and entered into force on July 1st 2013, a new quality recommendation was published in 2013 by the Ministry of Social Affairs and Health Care together with the organisation of Finnish municipalities.

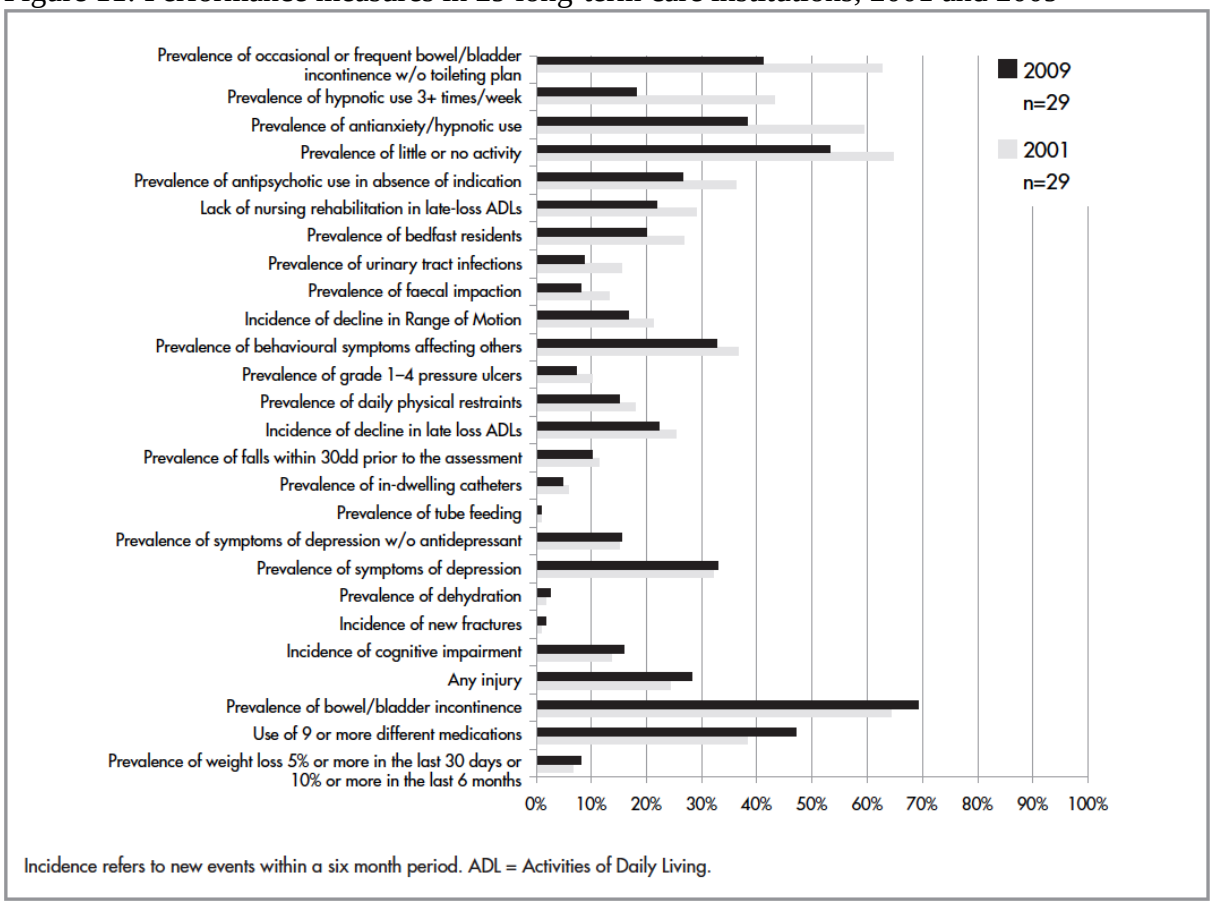
The assessment by the OECD shows, that Finland has developed reporting quality indicators on care effectiveness and safety and strengthened the use of standardised care-need assessment instruments in care homes in order to measure care needs and generate indicators of quality of care. On the basis of OECD findings, with the 2001 guidelines Finland was one

[6] http://www.thl.fi/fi_FI/web/fi/aiheet/tietopaketit/vanhuspalvelulain_toimeenpanon_seuranta

of the few OECD countries to have a national quality framework for care of older people. In this framework key dimensions of quality of care such as prevention and early intervention, comprehensive assessment, workforce and standards to be met are specified.

Since 2001 the interRAI Long-Term Care Facilities Assessment System (interRAI LTCF), which enables comprehensive, standardized evaluation of the needs, strengths, and preferences of persons receiving short-term post-acute care in skilled nursing facilities as well as persons living in chronic care and nursing home institutional settings, is voluntarily used in Finland. 2012 nearly 80% of all Finnish municipalities used interRAI LTCF in institutional and home care. The data is collected by THL (Finnish National Institute for Health and Welfare). THL also holds RAI-registers for R&D purposes. Two times annually a feedback report is sent to the users of interRAI LTCF in Finland.

Figure 11: Performance measures in 29 long-term care institutions, 2001 and 2009



Source: Harriet Finne-Soveri, Teija Hammar and Anja Noro: Measuring the quality of longterm institutional care in Finland; Eurohealth Vol. 16, No. 2

4.2.3 Sustainability

With the "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People", which entered into force on July 1st 2013, also the sustainability of the Finnish LTC system should improve further. A central goal of the new act is a shift to outpatient care instead of long term inpatient care. On the other hand, it concentrates on prevention and rehabilitation to prevent the necessity of inpatient long-term care.

According to the Statistical Yearbook on Social Welfare and Health Care 2012 (Helsinki 2013), support for informal care has clearly increased in the 2000s: client numbers are up

more than 80%. The proportion of people aged 75 and over who are cared for with the help of this type of support has increased from 3.0% to 4.4%. On the other hand, residential homes for older people had some 15 520 clients at the end of 2011; this number has been declining steadily since the beginning of the 2000s, being currently some 5800 lower than in 2000. The new act probably will improve these developments.

4.2.4 Summary

With the new "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People", which entered into force on July 1st 2013, not only the sustainability, but also the quality of long-term care in Finland probably will improve further. Recent assessments of the Finnish LTC system show already a positive development over the last years. According to the OECD, the depth and breadth of LTC coverage in Finland is large, with comparatively low user cost-sharing. During the next two years, the implementation of the new act by the municipalities is in the center of political efforts. Also the newest OECD policy recommendation point out, that Finland should monitor the ongoing LTC reform. Such a monitoring system is in place, carried out by the National Institute for Health and Welfare (THL) and the National Supervisory Authority for Welfare and Health (Valvira).

4.3 Reform debates

The debate about the LTC reform is directly connected to the reform of the local government and service structure reform, which involves revising the local government structure and the Local Government Act, social welfare and health care service structures and financing as well as re-evaluating the statutory duties of local authorities.

On the other hand, the municipalities are now concentrating on implementing the new "Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older People". The Ministry for Social Affairs and Health together with the Association of Finnish Local and Regional Authorities have prepared an information material package about the new act and its interpretation and especially about the duties the new act brings for the municipalities. In addition, the ministry and the Association of Finnish Local and Regional Authorities have prepared a joint quality recommendation as a consequence of the new act.

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This report evaluates the effectiveness of the institutional structure and governance of Finland's pension institutions. This is a companion study to that of Prof. Nicholas Barr of the London School of Economics, who was invited to do a similar evaluation of the broader design elements of Finland's pension system as a whole. The purpose of these evaluations is to get a forward-looking external view of the Finnish pension system from an international perspective, including recommendations. Institutional elements include the design of the institutional structure of Finland's pension system, the roles of co-operation and competition between pension services providers, the governance structures and decision-making processes of Finnish pension institutions, the cost-effectiveness of their investment and benefit administration functions.

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This report evaluates the design of the pension system in Finland from the perspective of adequacy, sustainability and design. Report evaluates strengts and weaknesses of the current pension system as well as gives recommendations for development of the system. This is a companion study to that of Prof. Keith Ambachtsheer.

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"Development of length of working lives in the 2000s"

This report offers information on the duration of working life and on the methods of its measurement. The focus is on the duration of Finnish working lives in the first decennium of the 2000s. The report has a review of the history of social debate on prolonging working life. Estimates on the length of actually realized working lives are based on the Finnish Centre of Pensions' register data. The estimates on the duration data from the Finnish Labour Force Survey are utilised to gain estimates of expected times in employment, unemployment and

outside the labour force. The estimates of working-life expectancies are given first by age and gender, then by level of education.

The different measurement methods provide with reasonably coherent results: working lives have been prolonged during the first decennium of the 2000s. However, the development has not been equally favourable in all population groups. The working lives of men have been prolonged at a slower pace compared to those of women. Time spent unemployed continues to consume a considerable share of potential working lives. Progress in the duration of working life has been divergent at different educational levels. Women with an upper-secondary education have been particularly successful in prolonging their working lives.

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

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

In 2012, the expected effective retirement age was 60.9 years. This was an increase of 0.4 years from the previous year. The expectancy has now risen by approximately two years from the level prior to the pension reform, in other words, even faster than predicted. Slightly over 69,000 persons retired on an earnings-related pension in 2012. The number was roughly 3,000 less than the previous year and more than 10,000 less than in the record year of 2009, when nearly 80,000 retired on an earnings-related pension. It now looks as though the retirement of the large age cohorts has peaked, and that on an annual basis, the number of people that retire is dropping.

LASSILA, Jukka, MÄÄTTÄNEN, Niku and VALKONEN, Tarmo, Eläkeiän sitominen elinaikaan – miten käy työurien ja tulonjaon?, Finnish Centre for Pensions, Reports/ The Research Institute of the Finnish Economy (ETLA) Series B 258, 2013, Helsinki, retrieved from:
http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/raportit/elakeian_sitominen_elinaikaan_miten_kay_tyourien_tulonjaon_7.pdf

"Tying retirement age to life expectancy – what happens to working careers and income distribution?"

This study analyses how pension policy reforms that aim at lengthening working careers impact working careers, income distribution, and fiscal sustainability of both the earnings-related pension system and overall public finances. The research focuses on the economic outcomes of increasing the statutory retirement age and establishing a link between the retirement age and life expectancy. Increasing the eligibility ages for old age pensions, part-time pensions and the unemployment pathway to retirement by two years would lengthen the

average working careers by about six months. Another reform example increases the statutory retirement age initially by 10 months and in the future by about two thirds of the increase in life expectancy, resulting in an increase of one month per year, if the most recent population projection would come true. The reform also eases the current life expectancy adjustment of pensions, and translates the current high accrual rate from age 63 to an increase for deferred retirement. This reform would lower the pension contribution rate by one and a half percentage points on average and reduce the sustainability gap of public finances by 0,9 percentage points.

MYRSKYLÄ, Mikko, LEINONEN, Taina and MARTIKAINEN, Pekka, Life expectancy by labor force status and social class: Recent period and cohort trends and projections for Finland, Finnish Centre for Pensions, Working Papers 02/2013, Helsinki, retrieved from:

http://www.etk.fi/en/service/home/770/publications?contentPath=en/julkaisut/research_publications/working_papers/life_expectancy_by_labor_force_status_and_social_class

Finnish register data for the years 1989–2007 is used to analyze period and cohort trends in life, work and retirement expectancies at age 50 by social class. The period and cohort perspectives complement each other as the period perspective describes what would happen to a cohort if it were exposed to a certain year's conditions throughout life, and the cohort perspective describes what in reality happens to a cohort as it ages over time. The Lee-Carter method is used to complete mortality and linear extrapolation to complete the labor force participation of partially observed cohorts.

Both the cohort and period approaches show that upper non-manual men are likely to work about four years and live about five years longer than manual men after age 50. For cohorts born in the 1940s, upper non-manual men can also expect to spend in total about 20 years in retirement, this is about 2 years more than manual men. Among women, the work and life expectancy advantage for the upper non-manual classes are about three and two years respectively and the total retirement expectancy among the 1940s cohorts is the same, 25 years, for all social classes. However, old-age retirement expectancy is about 4–5 years longer among upper non-manual men than manual men with the corresponding difference being three years among women. These are counter-balanced by opposite differentials for disability retirement.

MÄÄTTÄNEN, Niku and VALKONEN, Tarmo, Asunnot eläkkeiksi?, The Research Institute of the Finnish Economy (ETLA) Reports No 5, 2013, Helsinki, retrieved from:

http://www.etla.fi/julkaisut/asunnot-elakkeiksi/

"Housing equity into pensions?"

According to this study elderly people could markedly increase they standard of living by releasing their housing equity. Purchase of a single-payment life annuity would increase the benefits of this release. The tax treatment of these annuities is, however, very strict in Finland, because both yield and capital are taxed without deductibility of premiums. This study describes the wealth structure of households, assesses the options of taxing single-payment life annuities and analyses how launching of these products would influence tax receipts. Study recommends that a rate-of-return allowance should be applied, leaving risk-free interest rate and mortality bonus untaxed. Paper shows that adoption of this tax rule is likely to increase tax revenue, since it would reduce tax-preferred housing.

NURMINEN, Markku, Working-life expectancy in Finland: trends and differentials 2000–2015. A multistate regression modeling approach, Finnish Centre for Pensions, Reports 1/2013, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/raportit/working_life_expectancy_in_finland_trends_and_differentials_2000_2015_7.pdf

Working-life expectancy is the expected number of working years remaining in one's life. This report estimates expected times in employment, unemployment and outside the labor force. The research employs a modern statistical method. The multistate life table approach first estimates age- and year-specific probabilities of being in the different labor market states by stochastic regression modeling. Updated estimates of the probabilities, and subsequently of the expectancies, are given for the Statistics Finland's Labour Force Survey data of Finnish men and women aged 15–64 years in the period 2000–2010, along with mortality figures. Further, model-based predictions are projected for the years 2011–2015.

According to results, the length of working lives in Finland has extended favorably in the 2000s, and the trend is forecast to continue up to 2015 under the provision of economic equilibrium. During the past decade, the expected future employment time increased in all age groups and for both genders. In 2010, the estimated average length of working career up to age 64 was 34.6 years for 15-year-old males, while it tailed at 34.0 years for females of the same age. The results on educational differences support the anticipation that younger and better-educated cohorts are able to prolong their working lives as they grow older. There were conspicuous differences in the working-life expectancies between persons with tertiary vs. primary level of educational attainment.

RISKU, Ismo, APPELQVIST, Jukka, SANKALA, Mikko, SIHVONEN, Hannu, TIKANMÄKI, Heikki and VAITTINEN, Risto, Statutory pensions –long-term projections 2013, Finnish Centre for Pensions, Reports 04/2013, Helsinki, retrieved from:
http://www.etk.fi/en/service/home/770/publications?contentPath=en%2Fjulkaisut%2Fresearch_publications%2Freports%2Fstatutory_pensions_long_term_projections_2013

This report presents projections of the development of statutory pension expenditure and the average benefit level, as well as of the financing of private sector earnings-related pensions from 2013 to 2080. The current age structure and the continual increase in life expectancy will cause the dependency ratio to grow. The total statutory pension expenditure amounted to 13.1% of GDP in 2012. At its highest, the share is projected to increase approximately to 15% in the 2030s, after which it will decrease to slightly below 14% as of the 2040s.

By 2080, the purchasing power of the average pension will more than double. However, relative to the average wage level, the pension level will begin to decrease at the end of the 2010s. The contribution rate under the Employees Pensions Act (TyEL) will rise from the current level of slightly less than 23% to approximately 25% during the ongoing decade. The contribution will remain at approximately 25% until the latter part of the 2050s, after which it will rise moderately. In addition to baseline projection the report includes optimistic and pessimistic scenarios.

TAKALA, Mervi (ed.), Katsaus perhe-eläkkeeseen, Finnish Centre for Pensions, Reports 3/2013, Helsinki, retrieved from:

http://www.etk.fi/fi/service/julkaisut/440/julkaisut?contentPath=fi%2Fjulkaisut%2Ftutkimusjulkaisut%2Fraportit%2Fkatsaus_perheelakkeeseen&pageOffset=0&firstTime=false

"Review of the survivors' pension"

The report discusses the historical background to the survivors' pension, and provides an overview of the development of the surviving spouse's pension and orphan's pension. Recipients of survivors' pension are described in light of register data of the Finnish Centre for Pensions and Kela. The report also describes economic security following the death of the guardian and analyses the impact of surviving spouse's pension on the income.

Surviving spouse's pension is paid out for longer periods than previously, simply because surviving spouses today live longer. The average surviving spouse's pension in 2011 was EUR 519, and the median was EUR 434. The average surviving spouse's pension of men was less than half that of women. The level of statutory pension security among recipients of survivors' pension is the same as for other pension recipients.

The income of retired surviving spouses is approximately 85% of the total income of all retirees according to the income distribution research of Statistics Finland. In the income distribution of the population as a whole, retired surviving spouses have smaller incomes on average, and the poverty risk has increased. As a result of becoming widowed, a pensioner's income dropped on average 10%, while it remains roughly the same for surviving spouses who work.

TUOMALA, Juha and KYYRÄ, Tomi, Does experience rating reduce disability inflow? 2013, Helsinki, Government Institute for Economic Research (VATT), Working Papers 46, retrieved from:

http://www.vatt.fi/en/publications/latestPublications/publication/Publication_1345_id/949

This study explores whether the experience rating of employers' disability insurance premiums affects the inflow of older employees to disability benefits in Finland. To identify the causal effect of experience rating, study exploits a pension reform that extended the coverage of the experience-rated premiums. The results show that a new disability benefit claim can cause substantial cost to the former employer through an increased premium. Nonetheless, study finds no evidence of the significant effects of experience rating on the disability inflow. The lack of the behavioral effects may be due to the complexity of experience rating calculations and/or limited employer awareness.

TUOMINEN, Eila, Flexible retirement age in Finland: The evaluation of the Finnish flexible retirement scheme in light of employer and employee surveys, Finnish Centre for Pension, Working Papers 03/2013, Helsinki, retrieved from:
http://www.etk.fi/en/service/home/770/publications?contentPath=en%2Fjulkaisut%2Fresearch_publications%2Fworking_papers%2Fflexible_retirement_age_in_finland_the_evaluation_of_the_finnish_flexible_retirement_scheme_in_light_of_employer_and_employee_surveys

This comprised research report in English is a summary of the evaluation report of the Finnish flexible retirement scheme, published in its entirety in Finnish in November 2012. The study reviews the functionality of the flexible retirement age at workplaces, based on data from both employer and employee surveys. The aim of the study is to review simultaneously the views of both employers and employees on the flexible retirement age, the decision to retire on old-age pension, and factors that affect the decision to continue at work or to retire. Flexible retirement age puts more emphasis on the importance of working conditions. The employer

data was collected in tandem with the "Vacancies and recruitment" study carried out by Statistics Finland, by interviewing persons in charge of human resources at workplaces. The employee survey was carried out as a mail survey directed at employees who retired on old-age pension in 2010, directly from work. Both sets of data represent the target groups very well, and the response rates are high.

Employers and employees share a fairly similar view of the age limits for flexible retirement. The lower age limit is generally accepted. A majority of employers would like to limit upwards flexibility and lower the upper age limit. A significant share of wage earners is also in favour of limiting the degree of flexibility. According to both employers and employees, transition into old-age retirement has, in a majority of cases, taken place so that the individual in question has freely been able to decide when to retire. The employer, on the other hand, is most often involved in the decision to continue working when the individual in question has turned 63 years and wishes to continue at work.

According to the research, more years could be added to the end of careers by adopting more flexible working hours, decreasing the pace and pressure of work and by offering more employer support to continue working until retirement age. Results from the employer survey relating to the goal of extending working careers and the willingness of employers to employ the ageing to a greater extent than nowadays do not support the view that careers would be quickly extending.

UUSITALO, Roope and NIVALAINEN, Satu, Vuoden 2005 eläkeuudistuksen vaikutus eläkkeellesiirtymisikään, Prime Minister's Office, Reports 5/2013, retrieved from:

http://vnk.fi/julkaisukansio/2013/r05-elakeuudistus384891/PDF/fi.pdf

"The impact of the 2005 pension reform to the retirement age"

This research evaluates the impact of the 2005 pension reform and its effect on employment, unemployment and retirement decisions for those close to retirement, aged 55-64. Evaluation is based on the Finnish Centre of Pensions' register data. The total impact is relatively small. According to results abolishment and restriction of early retirement have had positive effect on employment whereas flexible retirement has affected negatively. Incentives to postpone retirement at the age of 63 and 64 diminished due to reform, whereas they increased for those aged 62 and over 65. Retirement increased clearly among 63 and 64-year-olds. The total impact of the 2005 reform has been smaller than projected in the drafting of the 2005 reform.

VAITTINEN, Risto and VANNE, Reijo, Pensions and public finances in Finland – A generational accounting perspective, Finnish Centre for Pensions, Working Papers 1/2013, Helsinki, retrieved from:

http://www.etk.fi/fi/gateway/PTARGS_0_2712_459_440_3034_43/http%3B/content.etk.fi%3B7087/publishedcontent/publish/etkfi/fi/julkaisut/tutkimusjulkaisut/keskustelualoitteet/pensions_and_public_finances_in_finland__a_generational_accounting_perspective_7.pdf

This paper evaluates generational incidence and sustainability of fiscal policy using the method of generational accounting (GA). Our attention is in the relative importance of earnings related pension on sustainability of public finances.

Two sustainability calculations is performed. Assuming the current structure of public income and expenditure, the sustainability gap in public finances, measured as a need to increase the

overall tax rate, is estimated to be 7.2% of GDP, when future taxes and benefits are discounted by a 3.5% interest rate. Due to the 2005 pension reform and recent labor market agreements, both contribution and benefit structures are changing. Using actuarial estimates of the impacts of the pension reform, the sustainability gap diminishes to 5.8% of GDP. Using an alternative discount rate of 5%, the respective figures would be 4.6 and 3.6%.

The contribution of earnings-related pensions to the sustainability of public finances, assuming the current structure of benefits, is 1.1% relative to GDP. Using actuarial estimates of pension expenditures, the pension system as a whole has a positive contribution to the sustainability of public finances, which is 0.3% relative to GDP. A significant proportion of the difference compared to a status quo calculation is due to the automatic adjustment as a result of the life expectancy coefficient that is reflected only in actuarial calculations. The diminishing size of public sector pensions liabilities is another major reason.

VALKONEN, Tarmo and LASSILA, Jukka, Työeläkejärjestelmän sopeuttaminen pysyvään kasvun hidastumiseen, The Research Institute of the Finnish Economy (ETLA), 17.6. 2013, ETLA Reports No 13, retrieved from:

http://www.etla.fi/wp-content/uploads/ETLA-Raportit-Reports-13.pdf

"Adjusting the earnings-related pension system to low growth"

This study analyses the adjustment of the Finnish earnings-related pension system to very low economic growth. The results show that a permanently lower growth rate of the wage bill would raise only moderately the pension contribution rates in the long term. This is because also the benefits are partially linked to wages. But if the rate of return on the pension fund investments would also go down, the contribution rates would increase significantly. External competitiveness and employment would weaken as well as the position of future generations. The study presents a pension reform that stabilizes the contribution rate by raising the retirement age and cutting pensions. These kind of specific reforms are not, however, optimal due to demographic and economic uncertainty. A better solution would be automatic adjustment rules that are designed to provide accepted redistribution of income between various generations.

[Health care]

ERHOLA, MARINA, JONSSON, PIA MARIA, PEKURINEN, MARKKU, TEPERI, Juha, Jonottamatta hoitoon - THL:n aloite perusterveydenhuollon vahvistamiseksi, Terveyden ja Hyvinvoinnnin Laitos, Helsinki 10/2013, http://www.thl.fi/thl-client/pdfs/344caaad-2793-4b73-a350-2fa3a00f192d

"Care without waiting – THLs initiative for improving basic health care"

THL has put out an initiative to strengthen primary health care services and ensure better access to elective care in Finland. The patient choice being the driving force, the initiative discusses the forms of funding and the number of regional actors responsible for organizing services. Benchmarking Sweden and Norway the initiative suggests that the reform in patient choice has paid off in better access to primary health care services and to the increasing number of service providers.

PAASIKOSKI, KIRSI ET. AL., Sosiaali- ja terveydenhuollon Järjestämislain Valmistelu-Ryhmän Väliraportti, Sosiaali- ja terveysministeriön raportteja ja muistioita 2013:15, Helsinki 2013

"Interim Report of the Preparation Group for the Social and Health Care Oganisation Act"

The report is the central paper for the preparation of the planned new act on the organisation of the social and health care system in Finland. On the basis of this report, the Finnish municipalities and other orhganisations are asked to reply tot he reform plans oft he government.

PÄÄKÖNEN, JENNI, SEPPÄLÄ, TIMO, Dimensions of health care system quality in Finland, Government Institute for Economic Research, working Papers 31, Helsinki 05/2012

The paper evaluates the determinants of quality - cost relationship in primary health care.

TERVEYDEN JA HYVINVOINNIN LAITOS: Statistical Yearbook on Social Welfare and Health Care 2012; Helsinki 2013; www.thl.fi

The Statistical Yearbook on Social Welfare and Health Care is a reference work for experts, policy planners and policy makers in the area of social welfare and health care. The Statistical Yearbook provides comprehensive statistical information on welfare and health and social and health services, personnel and expenditure in Finland. The data are presented in the form of comparable time series and they are mainly derived from the statistics and registers maintained by the National Institute for Health and Welfare (THL) and from surveys conducted by THL.

[Long term care]

Sosiaali- ja terveysministeriö, Kuntaliitto, Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi; Helsinki 2013;

"Quality Recommendation to insure good ageing and improve services"

The publication gives recommendations about the quality of LTC and the background of the new Finnish LTC act for the deciders in the municipalities.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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http://ec.europa.eu/progress