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REVISED EUROPEAN SOCIAL CHARTER

4th National Report on the implementation of the European Social Charter (revised)

submitted by

THE GOVERNMENT OF FINLAND

(Articles 3, 11, 12, 13, 14, 23 and 30 for the period 01/01/2005 – 31/12/2007)

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CYCLE 2009

FOURTH PERIODIC REPORT ON THE REVISED EUROPEAN SOCIAL CHARTER

SUBMITTED BY THE GOVERNMENT OF FINLAND

OCTOBER 2008

REPORT OF THE GOVERNMENT OF FINLAND

for the period from 1 January 2005 to 31 December 2007, in accordance with Article C of the Revised European Social Charter and Article 21 of the European Social Charter, on the measures taken to give effect to Articles 3, 11, 12, 13, 14, 23 and 30 of the Revised European Social Charter, the instrument of approval of which was deposited on 21 June 2002.

In accordance with Article C of the Revised European Social Charter and Article 23 of the European Social Charter, copies of this official report in the English language have been communicated to the Central Organisation of Finnish Trade Unions (SAK), the Finnish Confederation of Salaried Employees (STTK), the Confederation of Unions for Academic Professionals in Finland (AKAVA), the Confederation of Finnish Industries (EK), the Employers' Confederation of Service Industries (PT) and the Federation of Finnish Enterprises.

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ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

Article 3, para. 1: Safety and health regulations

Regarding Article 3 paragraph 1 of the revised European Social Charter, the European Committee of Social Rights requests from Finland information on whether strategies have been developed in the field of occupational safety and health to incorporate the prevention of work-related health hazards into official activities at all levels. In addition, the Committee requests from Finland information on the government's role in research and training that aims at improving occupational safety and health.

The aim of Finland's national occupational safety and health policy is to protect all workers from work-related health hazards and risk factors, to control health risks arising from occupational accidents and work-related diseases, and to prevent detrimental workload and related health hazards and other losses. The Ministry of Social Affairs and Health is at present preparing a paper clarifying the contents of national occupational safety and health policy. The paper describes the background, contents and modes of operating within occupational safety and health policy.

The tools to implement national occupational safety and health policy include strategies and action plans in different sectors. The Ministry of Social Affairs and Health has, in 2008, confirmed a strategy for occupational safety and health, which defines the objectives, priority areas and needs to develop activities in the near future. The priority action areas include maintenance and promotion of work and functional capacity, prevention of occupational accidents and diseases, prevention of musculoskeletal disorders, mental wellbeing at work, coping at work as well as management of own work. The progress of the strategy is followed up every three years. At present the Ministry of Social Affairs and Health is preparing a 2007 follow-up report on the occupational safety and health strategy. The report is the third in order.

In 2006 the Ministry of Social Affairs and Health published a strategy covering the whole of social and health policy (Strategies for Social Protection 2015 – towards a socially and economically sustainable society), which presents the Ministry's views on the most important issues in social and health policy in the coming years. From the viewpoint of occupational safety and health, the most central priority action area in the strategy stretching to 2015 is wellbeing at work, and especially mental wellbeing at work. The strategy goals include for example the prevention of absence through sickness and incapacity for work by securing a good statutory minimum level of working conditions. The main responsibility for the concrete development of working conditions lies with workplaces, which receive support from occupational safety and health authorities, occupational health services and other expert services. The purpose of the monitoring carried out by occupational safety and health authorities is to make sure that workplaces adopt and introduce systematic safety management.

Strategic projects within occupational safety and health are supported through development activities. The Ministry of Social Affairs and Health decides the research and development objectives in the field and sets the performance targets for the research and expert institutions in its administrative sector in accordance with the strategy for occupational safety and health. The Ministry acts in a way that takes these goals into consideration even in other research and development activities. The Ministry also encourages the research institutes in the field to facilitate the utilisation of research results at workplaces. In particular, the Ministry follows the effectiveness of all research and development projects it has commissioned.

Article 3, para. 4: Occupational health services

According to the Occupational Health Care Act (1383/2001) all employers have a duty to arrange occupational health care for all employees working for them. The purpose of the Occupational Health Care Act is to ensure that all necessary measures, which help to detect and eliminate risks at work and protect the health and safety of employees, are adopted for the promotion of the safety and healthiness of work and working environments.

The employer is obligated to arrange occupational health care in order to promote the prevention of work-related illnesses and accidents, the healthiness and safety of the work and the working environment, the functioning of the workplace community, as well as the health, working capacity and functional capacity of the employees at different stages of their working careers.

Occupational safety and health authorities are obliged to ensure that the employer has arranged occupational health care as referred to in the Occupational Health Care Act. The authorities oversee that the activities and the organisation of occupational health care comply with the requirements laid down by law. The powers of the occupational safety and health authorities are defined in the Act on the Supervision of Occupational Safety and Health and Appeal in Occupational Safety and Health Matters (131/1973). These authorities are entitled to obtain the information necessary for the performance of their duties, including the employer's agreement concerning occupational health care services, its occupational health care plan and its survey of the workplace. The occupational safety and health authorities can, if needed, order an employer, under the threat of a fine, to take the necessary measures to rectify any failure to comply with the obligation.

ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH

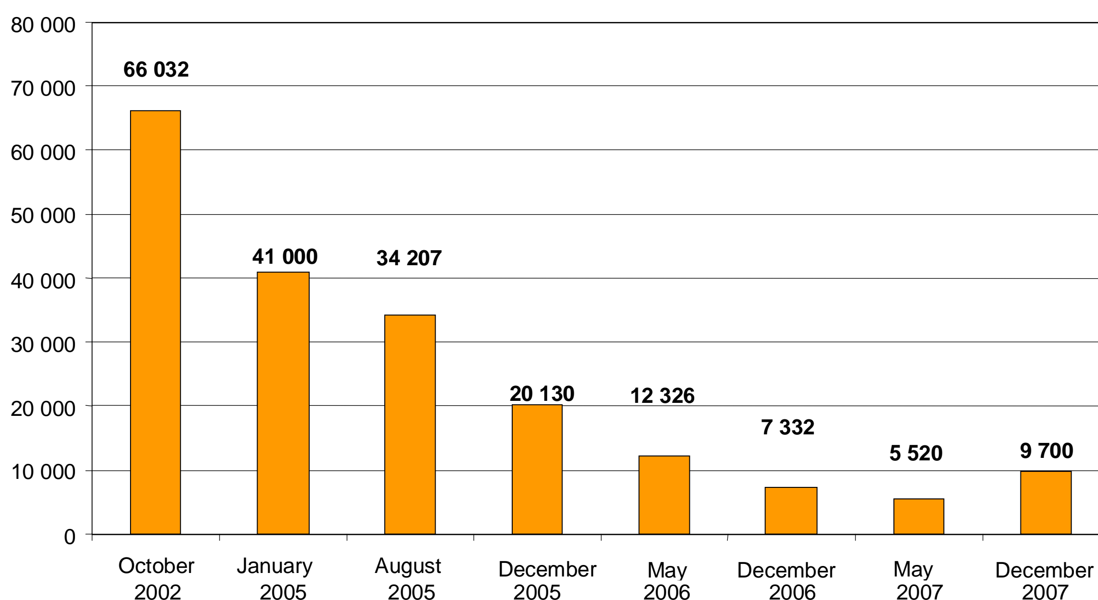
Article 11, para. 1: Removal of the causes of ill-health

Health care

Access to treatment

The Constitution of Finland (731/1999) ensures everyone living in Finland the right to adequate health services. The health care system is based on the principle of universalism. Every person is, without discrimination, entitled to the medical care he or she needs. All actors in society are responsible for developing society so that the needs of people with different functioning capacities are taken into account in planning, decision -making and implementation. The amended provisions of The Primary Health Care Act (66/1972), and the Act on Specialized Medical Care (1062/1989) and the Act on the Status and Rights of Patients (785/1992) concerning maximum waiting times for access to treatment entered into force on 1 March 2005. Since then the Ministry of Social Affairs and Health has monitored the implementation of the provisions on access to treatment. As a result, access to treatment is smoother and timelier than before across the country. In effect, the legislative revision has increased equal access to health services. The reform has also speeded up the modernisation of practices in different hospital districts.

Figure 1: Development in the number of patients queueing for over six months, October 2002–December 2007



The Ministry of Social Affairs and Health has examined access to specialised health care on four occasions since the relevant provisions entered into force, in August 2005 and in January, May and December 2006, by means of questionnaires addressed to the hospital districts. The reference point is October 2002, when the Government allocated the hospital districts extra financing for reducing the waiting times. At that time 66,000 persons had been on waiting lists for more than six months. In August 2005 (six months after the provisions entered into force) the corresponding number of patients had gone down to 34,000 and in December 2005 to around 20,000. In May 2006 around 12,000 patients had been on waiting lists for more than six months, and in December the number had further decreased to 7,000.

In specialised health care the waiting list situation had deteriorated somewhat by the end of 2007. At the turn of the year 2007–2008, 9,700 patients in specialised health care, i.e. nearly 13 % of all the patients on waiting lists, had been waiting for treatment over six months. Around 55 % were waiting for surgical procedures and around 22 % for ophthalmologic procedures.

Uniform criteria for access to treatment

There have been significant variations in the criteria for access to treatment across the country, and decisions on non-emergency care have been based on different grounds. The objective of the legislative reforms carried out has been to secure the population access to non-emergency care based on uniform grounds, irrespective of place of residence. Accordingly, uniform criteria for access to non-emergency care have been drawn up as a part of the National Health Care Project and of the securing of access to treatment. The goal has been to prepare criteria for around 80 % of all non-emergency care. The criteria have been developed on the basis of experiences. The hospital districts and the health centres assess and follow the effectiveness of the criteria. Everyone has free-of-charge access to the criteria through the webpages of the Ministry of Social Affairs and Health (www.stm.fi).

Doctors use these criteria when they decide on the treatment of their patients. In addition to the criteria, doctors always also consider the patient's individual need for care, as well as his or her

life situation. Doctors decide on the treatment in unison with the patient. However, the patient does not have the right to receive any treatment he or she wants. The provision of care is based on medical or odontological grounds.

The implementation of the criteria and the health economic effects of maximum waiting times for treatment will be evaluated within the next two years. According to the performance agreement for 2004–2007 between the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health (Stakes), Stakes will examine the effects that the reform securing access to treatment has on primary health care and prevention in municipalities. Stakes will also examine the development of the resources that municipalities allocate for primary health care and prevention.

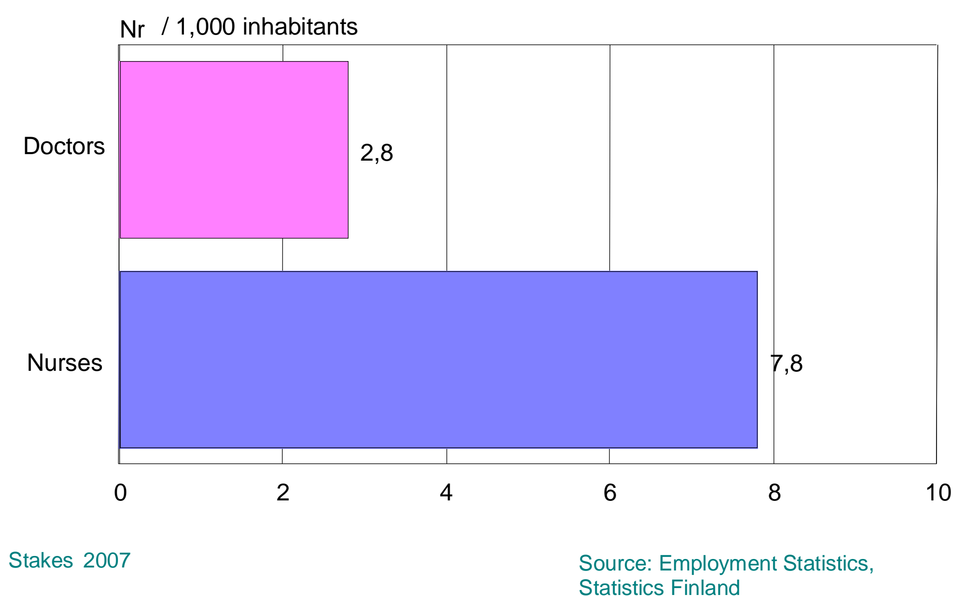
Since 2003 the state budget has included a separate appropriation for development activities in social welfare and health care. Municipalities may receive government grants for projects that develop and rationalise services and reform their practices. The priority action areas of the National Health Care Project include prevention and ensuring the effectiveness of health centres.

Health personnel trends

In 2006, in all 138,500 persons worked in municipal health services. In 2002 the number of municipal health personnel had risen to the level preceding the economic depression in the early 1990s. In 2000–2006 the number of this personnel grew by around 11 %. The growth was greatest in specialised health care; in 2000–2005 the number of personnel increased by 12 % in specialised health care and by 6 % in primary health care.

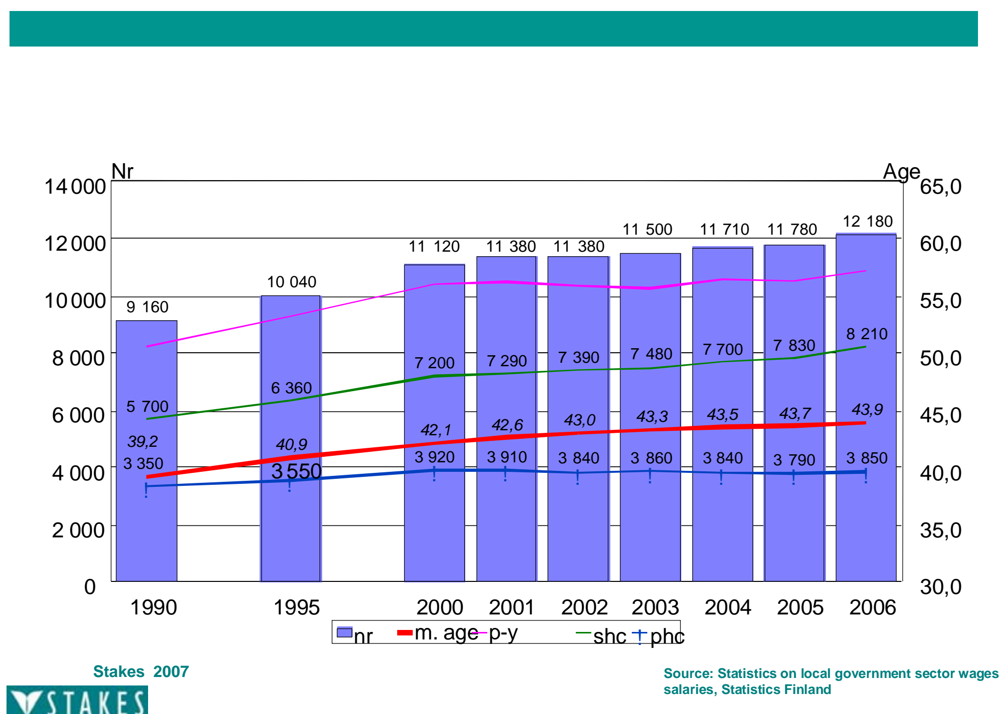
Although the personnel growth has been very moderate, several personnel groups have grown faster than the average. The growth can be explained by medical and technical developments as well as changes in care practices, personnel structures and the statutory obligations of municipal health services.

Figure 2: The number of doctors and nurses per 1,000 inhabitants in Finland in both the private and the public sector, 1 January 2005



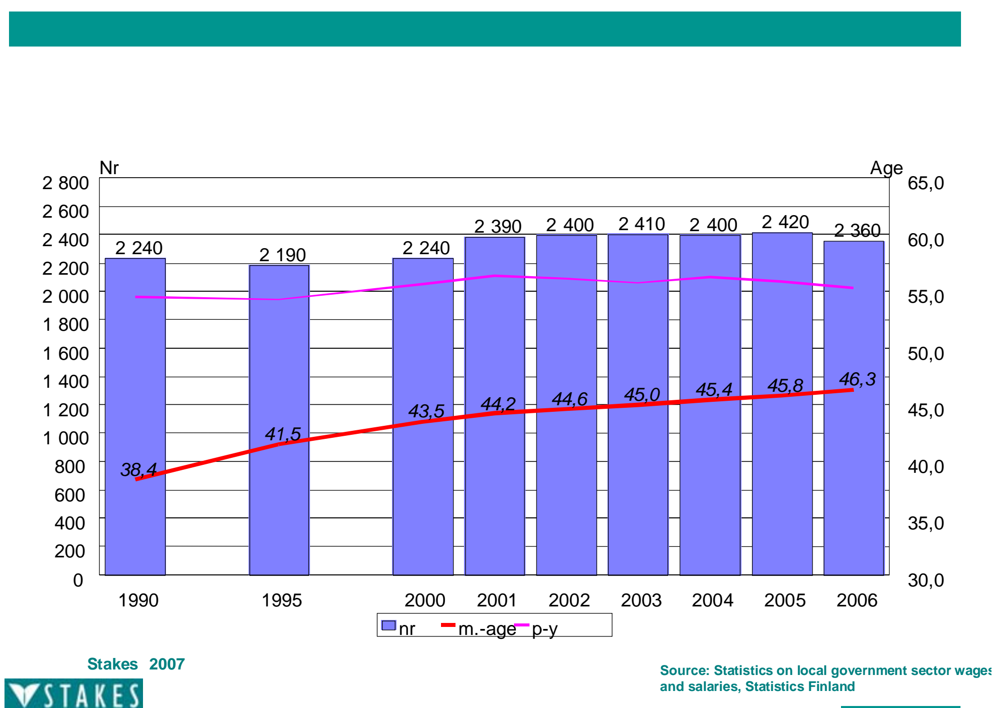
The number of doctors in the municipal sector grew by 10 % in 2000–2006 (see Figure 3 below). In 2006 there were nearly 12,200 doctors in the sector. The growth has concentrated on specialised health care. The increase in the number of doctors has not, however, curbed the growth of the doctor deficit. At the same time, securing doctor workforce by purchasing services has become more common, especially in primary health care. In 2006, the doctor deficit in health centres was nearly 16 %. Purchased services covered about a half (7 %) of the deficit, which was greatest in the eastern part of Finland. In municipal specialised health care, the doctor deficit was nearly 9 %. There were regions with no deficit, while others had a deficit that was as much as three times the average. The increases in university places for doctor training carried out in 2001 and 2002 will improve the availability of doctors from 2008 onwards.

Figure 3: The number of doctors in municipalities and joint municipal boards according to profession in 1990, 1995 and in 2000–2006



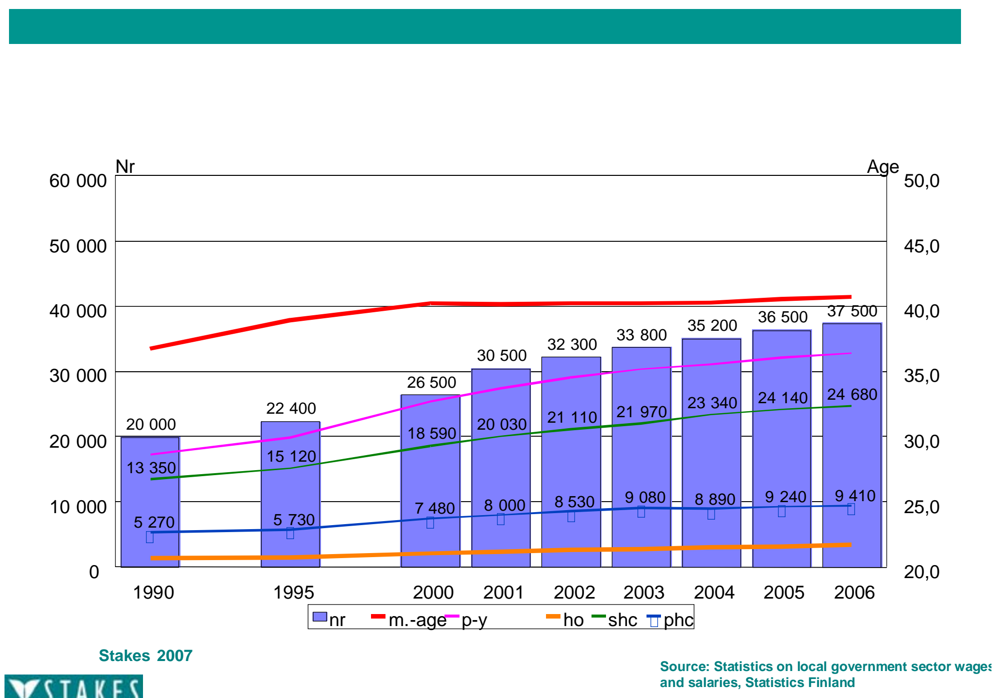
The number of dentists in health centres has not grown in the 2000s, despite an expansion of the municipal dental health care as well as a legislative reform on access to treatment carried out in the early 2000s. In 2006 there were nearly 2,400 dentists in the municipal sector (see Figure 4 below). In 2006 the deficit of health centre dentists was nearly 16 %, out of which purchased services covered around 3 percentage points. The deficit was greatest in the central eastern part of Finland and in areas with no private dentists. In specialised health care, 7 % of all dentist posts were vacant. The Ministry of Social Affairs and Health has proposed that the dentist training should be increased and that the training of dentists for the eastern part of Finland be reinstated in Kuopio.

Figure 4: The number of dentists in municipalities and joint municipal boards according to profession in 1990, 1995 and in 2000–2006.



The number of nurses and practical nurses in the municipal sector increased by 41 % and 54 % respectively in 2000–2006 (see Figure 5 below). In 2006, the municipal sector employed 37,500 nurses and nearly 35,800 practical nurses. In the last 15 years, the share of nurses of all personnel in specialised health care has grown from 19 to 33 %, and their share of all personnel in primary health care from 19 to 26 %. Correspondingly, the share of practical nurses of all personnel in specialised health care has decreased from 22 to 12 %, while their share in primary health care has increased from 24 to 29 %. The growth in the number of nurses has been greatest in specialised health care, where the personnel structure has been reformed in a more nurse-orientated way. Three out of four practical nurses in health care work in primary health care.

Figure 5: The number of nurses in municipalities and joint municipal boards in 1990, 1995 and in 2000–2006



The number of dental hygienists was increased by a half in 2000–2005 so as to implement the objectives set for preventive dental health care and to secure access to treatment. The goal of increasing the number of dental hygienists is to introduce an effective division of tasks in dental health care.

Also the number of other groups of health care personnel has grown. Their growth has, however, been less than that of the groups mentioned above.

The implementation of the proposals made by the Working Group on the development of child health clinic activities at national level

The Expert Working Group was assigned with the task to develop, on the national basis, the work of child health clinics so as to correspond to children's and families needs, to prepare a recommendation and, if necessary, other guidelines for the work, to put forward proposals for developing the relevant statistical and data systems, and to promote the co-operation between child health clinics and various interest groups.

The Working Group has prepared a guide for developing the activities of child health clinics, primarily meant for clinic personnel, their directors and municipal decision-makers (Child health clinics in support of families with children). The guide presents the aims of the work and specifies the tasks and principles guiding the activities of child health clinics. With a view to improving the municipal and sub-regional co-ordination, the Working Group proposes setting up a working group for planning and monitoring the wellbeing of families with children, which should report on the issue to the municipal decision-making bodies on a regular basis. It is recommended that the work of child health clinics and the work for families with children should be linked to the local childhood policy programme. This would at the same time promote the taking into account of the best interests of the child in decision-making and other activities.

It is necessary to strengthen skills of personnel in family-oriented work in order to help families in need of special support, to intervene in problematic situations as early as possible and to provide the necessary help without delay. With a view to strengthening the role of parents, the Working Group proposes supporting early interaction, parenthood and the relationship between the parents, intensifying peer support by means of parents' groups, increasing home visits and participation by parents in planning the services of child health clinics. The guide also contains proposals for adequate staffing and resources, as well as for developing knowledge and skills by means of further training.

The Working Group also proposes further development of the relevant data and statistical systems, organisation of further training, intensification of research and development, making use of the project financing scheme linked to State subsidies in development projects regarding child health clinics, as well as preparing a quality recommendation for the work of the clinics.

Detailed information on the reimbursement of pharmaceuticals

In accordance with the Health Insurance Act (1224/2004) there are three rates of reimbursement: basic reimbursement (42% of the price), lower special reimbursement (72 % of the price) and higher special reimbursement (100% of the price). The medicine must have been confirmed as reimbursable and as having a reasonable wholesale price by the Pharmaceuticals Pricing Board, which operates in affiliation with the Ministry of Social Affairs and Health.

Table 1 The compensation from health insurance

Benefit	Compensation %	Criterion	co-payment	Real compensation rate in 2005
Medicines subject to				
- basic reimbursement	42 %	sale price		42.1 %
- special reimbursement	72 %	sale price		69.9 %
- higher special reimb.	100%	sale price	3.00€/medicine	97.3 %

In respect of high medicine costs the annual out-of-pocket limit is in total maximum EUR 616,72 (in 2006). After this maximum is reached, the refund is 100 % of all refundable medicines, with EUR 1.50 excess per medicine.

Article 11, para. 2: School health care

According to the Primary Health Care Act (66/1972), municipalities are responsible for the maintenance of school health care. School health care includes monitoring and promoting healthy and safe school environments in schools that provide basic education in the municipality, monitoring and promoting pupils' health, cooperating with other student welfare and teaching personnel, and arranging special examinations necessary for determining pupils' health status.

A definition of school health care is included in the Quality Recommendation for School Health Care (Handbooks of the Ministry of Social Affairs and Health 2004:8). Regular health examinations in school health care and the required ratio of personnel to pupils are defined in the Guide and Quality Recommendation for School Health Care. It is recommended that three comprehensive health examinations be carried out during basic education. In addition, each pupil should have an annual meeting with school health staff. A comprehensive health examination includes the teacher's assessment of the pupil in the school community, a meeting with the pupil and his or her guardian, an interview with the pupil, and the guardian's description of the situation of the pupil and the family, examinations by a school health nurse and a doctor, as well as a summary and feedback. In reality, however, regular health examinations of pupils are not carried out in accordance with the Quality Recommendation, and there are variations in practices among municipalities.

A school health survey conducted by Stakes at two years' intervals provides nationally uniform information about the living conditions, school experiences, health and health habits of persons aged 14–18 years. The school health survey aims at supporting the promotion of the health and wellbeing of young people and especially the development of student welfare in schools and school health services. Stakes has also examined access to services through a 2005 health centre survey and a 2007 survey on preventive health services for children and young people. According to the Stakes reports, the organisation of school health services at health centres varies and no uniform practices exist. Moreover, there are variations in the sufficiency of personnel.

With regard to guidance centre activities, school health care and student health services, it is important that the different services be able to work in seamless cooperation with other municipal actors. The intention is that preventive health services for children and young people should be a part of all the municipal social welfare and health services.

Article 11, para. 3: Prevention of diseases

Food Safety

Please see Finland's second report concerning the Revised Social Charter.

Health promotion

The Government Programme of Prime Minister Matti Vanhanen's second Cabinet includes a Policy Programme on Health Promotion. Its objective is to improve the population's state of health and to narrow health inequalities. The Policy Programme will continue the efforts launched under the National Health Care Project to promote health and prevent health related hazards.

The Government Programme is further supplemented with a Policy Programme for the Wellbeing of Children, Youth and Families. It focuses especially on reducing differences in the state of health of children and the youth across social classes, and on promoting healthy lifestyles and mental health.

The Primary Health Care Act (66/1972) was revised in early 2006 by specifying municipalities' tasks with regard to health promotion. The revision was intended, for example, to ensure by means of goal-oriented management and activity assessment that municipalities follow the health status trends by population groups and that health is taken into account in all municipal activities. In addition to health promotion and prevention, public health work also incorporates medical care.

The aim of public health work is to guarantee that each municipal resident has the best possible health and as equal opportunities as possible to attain it. While several indicators show that the population's health continues to improve, the health differences between different social groups and the genders remain great. In the 1990s, many municipalities cut down their resources for prevention, and all obligations under the Primary Health Care Act were not duly fulfilled.

The best way to promote the population's health and prevent illnesses is to ensure that all administrative sectors take into account the health implications of their decisions. Important decisions that have implications on wellbeing and health are made for instance in planning, construction, planning and implementation of housing, traffic planning, education, labour policy and, naturally, social welfare and health care. The implementation of health promotion requires effective local and regional structures and practices as well as cross-sectoral cooperation for realising the health promotion goals. The necessary requirements also include access to information about wellbeing, related data systems and management systems covering even cross-sectoral activities, as well as defined management practices.

Applying the 2006 Quality Recommendation for Health Promotion, which was drawn up to help municipalities, is still rather uncommon in municipalities. The key message of the Quality Recommendation is that the promotion of health and wellbeing requires management, cooperation structures and resources. Only some municipalities have included goals related to health promotion in their municipal plans or financial and action plans or implemented other policies defined in the Recommendation.

The ongoing restructuring of local government and services enables municipalities to reinforce the promotion of health and wellbeing that is being carried out either by social and health care services or in cooperation with different administrative sectors.

Finnish life habits

The National Public Health Institute has, since 1978, followed the health behaviour and health of people of working age through an annual survey based on questionnaires sent by post. The objective is to monitor changes in the health behaviour of the population as a whole and of different population groups. The survey is used for example for assessing health policy effects and the effectiveness of health promotion programmes. The survey is also used widely in different research projects.

The health behaviour survey provides information about for example smoking, dietary habits, alcohol consumption, physical exercise and overweight among Finns. The extensive Health 2000 survey showed that the health and functional capacity of adults in Finland has improved significantly during the last two decades. Also their perceived health is much better than before. Cholesterol levels have decreased, blood pressure levels are significantly lower, and coronary disease has become more rare. However, certain diseases and health risk factors have become more common. A large share of Finnish adults still has an increased risk of developing diabetes and diseases of the circulatory system. Despite a decrease in musculoskeletal disorders, they still constitute key public health problems, and attention should be paid to the prevention on such disorders. At present, public health risks include for example diabetes, asthma, mental disorders and psychiatric symptoms.

Positive trends in dietary habits continue. The consumption of high-fat milk and butter continues to decrease, and the use of vegetable oil in cooking has become more common. In the Health 2000 survey, 58 % of men and 65 % of women reported engaging in physical exercise at least twice a week. Engagement in commuting exercise has remained fairly unchanged.

Life habits, such as smoking and eating habits, play a key role in health promotion and the prevention of chronic diseases. According to the survey on health behaviour and health, smoking among men has decreased in Finland. Alcohol use has increased and abstinence decreased during the last two decades.

Smoking ban

In Finland, smoking has been prohibited in bars and restaurants from the beginning of June 2007 by an amendment of the Act on Measures to Reduce Tobacco Smoking (693/1973). The amendment allows setting up a special smoking room with separate ventilation system so that tobacco smoke cannot spread from the smoking booth to smoke-free area. There is a transition period of two years for those bars and restaurants that have arranged the separate smoking areas, for which the amendment will become binding from the beginning of June 2009. The Act is primarily aimed at protecting personnel in bars and restaurants from tobacco smoke.

Programmes for the prevention of smoking

Smoking trends among the Finnish children and adolescents have developed into a positive direction. According to the Adolescents Health and Lifestyle Survey 2007, smoking is experimented in an increasingly older age and also regular smoking habits are adopted at an older age than before. The objective of the Health 2015 - Programme (to curb regular smoking among 16-18 year olds to 15 %) is getting closer, but nevertheless still every fourth person under 18 years of age smokes cigarettes. In Finland, the trend in particular among the 7th to 9th graders is alarming; less than 10 % of the 7th graders smoke, but two years later one third of them is likely to smoke regularly. Also the socio-economic differences in the smoking habits of adolescents are considerable. The positive trend, however, has been contributed by several factors, among other

things the prohibition of smoking in restaurants, which serves as an important message in favour of non-smoking, in addition to which it reduces the exposure to cigarette smoke.

The selling of tobacco to persons under 18 years of age is prohibited by law. In order to reinforce the prohibition, the Government submitted a Bill[1] to Parliament in the summer 2008 proposing that selling tobacco products should be subject to a licence. The purpose of this proposal is to, in particular, prevent the adolescents from smoking.

Alcohol consumption

In 2006, the total consumption of alcoholic beverages amounted to 10.3 litres of pure alcohol per capita. The long-term trend in alcohol consumption has been upward. Among other things, this has been due to the changes that took place in the availability and prices of alcohol in 2004. The growth in alcohol consumption has increased the demand for services for substance abusers and the number of alcohol-related periods of hospital care. In 2006, A-clinics had approximately 44,400 clients. Detoxification and rehabilitation centres had approximately 11,200 clients.

The Government will continue to pursue the National Alcohol Programme during the period 2008-2011 with the objective of reducing the harmful effects of alcohol consumption. The Government supports the alcohol programme through the Health Promotion Policy Programme.

Abuse of drugs

In 1995–2001, all indicators (experimentation, problem use, health detriments, morbidity, mortality, criminality and seizures) suggested that the drug situation was aggravating. However, in 2001–2006 this trend showed clear signs of weakening. According to the 2006 population survey, 13% of 15–69-year-olds had experimented with cannabis sometime in their life. The level was nearly the same as in the 2002 survey and three percentage points higher than in 1998. The number of problem drug users is estimated in Finland based on the number of problem users of amphetamines and opiates, which was 14,500–19,100 in 2005; this accounts for 0.5–0.7% of 15–54-year-olds among the entire population. Nearly four fifths of problem drug users used amphetamines. The proportion of men was 80%. The majority of problem drug users belonged to the 25–34-year age group.

The numbers of hepatitis C, B and A cases and HIV infections among intravenous drug users have either decreased or remained at a low level. Buprenorphine is becoming the most common finding in drug-related deaths by poisoning. The victims of buprenorphinerelated deaths have been mainly young people. Especially low-threshold treatment services play an important role in preventing and reducing infectious diseases related to drug use. Developing peer group activities, among other things, has reduced the spread of infectious diseases related to intravenous drug use.

The harm associated with drug use cost the public sector 180 million euros in fiscal year 2005. The state paid 107 million euros and municipalities 73 million euros of the overall expenditure. Harm reduction and enforcement of safety and order comprised approximately 70 per cent of the expenditure. Noticeably lower funds were spent on drug treatment and the prevention of harm. Young Finns have a stable living environment in the sense that we do not have residential areas characterised by an accumulation of social problems. The worrying aspects include the rising number of child welfare cases and the fairly high number of children living in unstable conditions. Child welfare measures are often taken due to parental substance abuse, which can increase a young person's risk of developing substance abuse problems in adulthood. The increase of mental

[1] HE 101/2008 vp.

health problems among young people is also worrying because it has been seen that these problems are linked to drug experimentation. The measures taken in Finland are not primarily directed at risk groups. Instead, it is believed that drug prevention is linked to the comprehensive improvement of the living conditions of children and young people. Within the service system, the provision of emotional support, for instance, should be developed.[2]

Among the drug clients who sought treatment in 2006, opiates (41 %) were the most common drug, while stimulants (21 %), poly drugs (17 %), cannabis (14 %) and sedatives (7 %) were less popular. The opiate buprenorphine was the principal drug leading to treatment for 31 % of all the clients. Nearly two thirds of the clients reported abusing at least three substances. The average age of the drug clients was 28 years. Drug abuse is associated with societal, social and individual factors.

As drug abuse has increased, more attention has been paid to the abusers, the prevention of addiction and the development of treatment facilities and methods for those suffering from addiction. One key to successful treatment is familiarity with the basic mechanisms of addiction.

The National Public Health Institute is monitoring the trends of drug use. The objective is to produce data that promotes the health and functional ability of especially young people and facilitates the prevention and reduction of exclusion, and the management of the drug and alcohol situation. As part of its drug research the Institute also develops drug analytics for official use.

HIV/Aids

Statistics by the National Public Health Institute show the HIV/Aids situation in Finland. Statistics on HIV in Finland, Aids in Finland and mortality in HIV infected patients in Finland in 2004–2007 are given below. The statistics also include 2008 data, i.e. all cases reported by 20 April 2008.

[2] the 2007 National Report (2006 data) to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Table 1: HIV in Finland, all cases reported by 20 April 2008, according to date of diagnosis

All cases			Principal transmission categories			Cases by gender		Sexual contact			Injection drug use		Rare transmission categories	
Year	Total	Abroad	Sexual contact	Injection drug use	N/A	M	F	Male-to-male	Hetero-sexual, M	Hetero-sexual,F	M	F	Blood	Peri-natal
All since 1980	2301	661	1633	332	309	1708	593	765	472	395	248	84	13	14
2008	34	10	19	1	14	25	9	10	3	6	1	0	0	0
2007	189	59	142	10	37	138	51	70	40	32	7	3	0	0
2006	193	63	154	10	28	134	59	61	47	46	6	4	0	1
2005	139	59	101	16	21	98	41	32	37	32	15	1	0	1
2004	126	36	101	10	14	102	24	46	37	18	9	1	0	1

Source: National Public Health Institution, Department of Infectious Diseases Epidemiology

Table 2: Aids in Finland, all cases reported by 20 April 2008, according to date of Aids diagnosis

All cases			Principal transmission categories			Cases by gender		Sexual contact			Injection drug use		Rare transmission categories	
Year	Total	Abroad	Sexual contact	Injection drug use	N/A	M	F	Male-to-male	Hetero-sexual, M	Hetero-sexual, F	M	F	Blood	Peri-natal
All since 1980	502	106	423	43	22	415	87	269	89	64	36	7	9	5
2008	9	3	8	0	1	7	2	5	1	2	0	0	0	0
2007	33	11	24	8	0	22	11	13	4	7	5	3	0	1
2006	26	12	23	1	2	20	6	8	9	6	1	0	0	0
2005	26	4	18	7	1	25	1	10	7	1	7	0	0	0
2004	21	6	16	5	0	14	7	8	2	6	5	0	0	0

Source: National Public Health Institution, Department of Infectious Diseases Epidemiology

Table 3: Mortality in HIV infected, all cases reported by 20 April 2008, according to year of death

All cases			Principal transmission categories			Cases by gender		Sexual contact			Injection drug use		Rare transmission categories	
Year	Total	Abroad	Sexual contact	Injection drug use	N/A	M	F	Male-to-male	Hetero-sexual, M	Hetero-sexual, F	M	F	Blood	Peri-natal
All since 1980	447	281	307	94	35	387	60	207	70	30	77	17	9	2
2008	1	0	1	0	0	1	0	0	1	0	0	0	0	0
2007	22	8	6	11	5	16	6	3	1	2	8	3	0	0
2006	27	3	10	14	3	20	7	3	6	1	10	4	0	0
2005	26	6	8	15	3	25	1	5	3	0	14	1	0	0
2004	19	8	13	6	0	17	2	6	5	2	6	0	0	0

Source: National Public Health Institution, Department of Infectious Diseases Epidemiology

MASTO Project: 2007-2011

In 2007 the Ministry of Social Affairs and Health in Finland launched a project designed to reduce the amount of depression-related disability. Depression is a major cause of early retirement, prolonged sick leave and leave due to work incapacity.

The initiative, called the MASTO Project and led by a broad-based coordination group, aims to improve mental health in the working-age population by promoting mental wellbeing at workplaces and by directing measures at depression prevention, treatment and rehabilitation. It also aims to develop a range of best practices concerning people on sick leave due to depression and to facilitate their return to work.

The project seeks to promote strong collaboration between the numerous other initiatives underway nationwide to upgrade mental health and tackle depression. It is also a follow-up to earlier projects, which, in particular, have targeted the medical profession in order to provide better knowledge for early interventions and a rehabilitation-centered approach.

The coordination group responsible for carrying out the project comprises of high-level representatives from the health, labour market, municipal, business and research and development sectors. The project started in November 2007 and will run until May 2011.

Surveillance conducted by the radiation and nuclear safety authority

Surveillance of environmental radioactivity in Finland is one of the official obligations of the Radiation and Nuclear Safety Authority (STUK). This obligation is based on the national and the European Communities' legislation. The Finnish radiation protection legislation appoints STUK as the national authority responsible for surveillance of environmental radioactivity, and the Euratom Treaty assumes continuous monitoring of levels of radioactivity in the air, water and soil in the Member States. The surveillance is based on the Euratom Treaty Articles 35-35 and the Commission Recommendation of 8 June 2000 on the application of Article 36 of the Euratom Treaty concerning the monitoring of the levels of radioactivity in the environment for the purpose of assessing the exposure of the population as a whole (2000/473/Euratom).

The main objective of the surveillance of environmental radioactivity is to be always aware of levels of artificial radiation in the environment to which the public is exposed. Another objective is to detect all remarkable changes in levels of environmental radiation and radioactivity. Compliance with the basic safety standards laid down for protection of health of the general public against dangers arising from ionising radiation can be ensured with environmental radiation surveillance. Running of surveillance programmes on continuous basis also maintains and develops competence and readiness to respond to radiological emergencies.

The surveillance programme on environmental radioactivity contains continuous and automated monitoring of external dose rate in air, regular monitoring of radioactive substances and gross beta activity in outdoor air, radioactive substances in deposition, in surface and drinking water, milk, foodstuffs, and in human body. Also a summary of radioactivity surveillance of the Baltic Sea was added in this report since 2002.

Results of the environmental surveillance are reported in annual reports written in Finnish, Swedish and English. The reports summarise the results of environmental radiation surveillance in the preceding years. Surveillance of environmental radiation contains surveillance of artificial

radiation and artificial radioactive elements in the environment. Natural radiation and natural radioactive elements are not associated with the surveillance programme, although the greater part of the public exposure to radiation is caused by natural radiation. Exposure to natural radiation is controlled separately if there is reason to suspect, that natural radioactive elements cause unusual high exposure to the public (e.g. indoor radon and natural radionuclides in drinking water). Nuclear power plant licensees are responsible for environmental surveillance in the vicinity of nuclear power plants in Finland. Those results are reported elsewhere.

STUK has several partners in surveillance of environmental radioactivity. The partners are collecting and delivering environmental samples for laboratory analyses, or are participating in whole-body counting.

Environmental health care

Environmental health care is a part of preventive health care and of the official supervision of the human living environment. According to Section 1 of the Primary Health Care Act (66/1972), the legislation pertaining to environmental health care includes the following acts: the Act on Health Protection (763/1994), the Food Act (361/1995), the Act on Food Hygiene of Foodstuffs of Animal Origin (1195/1996), the Product Safety Act (914/1986), repealed and substituted by the Act on the Safety of Consumer Products and Consumer Services (75/2004), the Chemicals Act (744/1989), the Act on Measures to Restrict Tobacco Smoking (693/1976) and the Act on Veterinary Service (685/1990). In March 2006 the new Food Act (23/2006) entered into force, repealing the above-mentioned Food Act of 1995 and the Act on Food Hygiene.

Environmental health care is a part of public health work, which is important for people's health. All municipalities have a unit responsible for tasks relating to environmental health care. Organisationally, the unit works either as a part of primary health care or in cooperation with environmental protection and building supervision. This has been both practical and efficient in terms of resources.

Section 6 of the Primary Health Care Act enables municipalities to organise environmental health care separately from other forms of health care even if they are members of joint municipal boards for primary health care. It is important that there is cooperation between environmental health care and other municipal official duties (such as environmental protection and building supervision), due to the similarities in these fields.

ARTICLE 12: THE RIGHT TO SOCIAL SECURITY

Article 12, para. 1: Existence of a social security system

Social security reforms

Employee pension scheme

The Finnish legislation on employee pensions was reformed during the reference period. The reform was described in the first periodic report by Finland in respect of the revisions of pension benefits and pension accruals that came into effect in 2005.[3]

[3] For a more detailed description of the Finnish pension system, please see Annex II: The Finnish Pension System; Finnish Centre for Pensions, Handbooks 2007:6

The pension reform was finalised on 1 January 2007, when three separate acts on private sector pensions were merged into a single Employees Pensions Act (395/2006). The 2007 Employees Pensions Act replaced the earlier Employees Pensions Act (395/1961), Temporary Employees Pensions Act (134/1962) and Pensions Act for Performing Artists and Certain Groups of Employees (662/1985).

Also the amended Self-Employed Persons' Pensions Act (1272/2006), Farmers' Pensions Act (1280/2006), and Seamen's Pensions Act (1290/2006) entered into force at the beginning of 2007. The public sector pensions acts, i.e. the State Employees' Pensions Act (1295/2006) and the Local Government Pensions Act (549/2003), were not, however, merged, and they remained as separate acts even after the pension reform. These acts were amended only technically, as necessitated by the new Employees Pensions Act.

No new changes took place in pension policy in 2007. The reform of 2007 was largely related to legislation technique and had no significant impact on the level of pensions. Instead, the aim was to clarify the legislation and management regarding employees' pensions. Since 1 January 2007, the pension insurance of all employees falls under one single Employees Pensions Act irrespective of the level of income, length of employment relationship or branch. The employer is now able to centralise the management of pension security for all its employees under one pension provider. Additionally, the earnings limit for pension accrual was lowered so that employee pension accrues if the employee's salary is at least EUR 46.08 per month.

Since the beginning of 2008, all employees aged 18–67 years who live in Finland receive a pension record annually. The pension record shows the employee's pension data for the five preceding calendar years. It includes private sector earnings specified by employer, pension accrued during certain unpaid periods, such as child care and studies, and pension accrued up to the end of the previous year.

Persons entitled to Finnish pensions and living abroad can contact for example the Finnish Centre for Pensions to check the data on their pension record.

Health insurance scheme

The new Health Insurance Act (1224/2004) entered into force on 1 January 2005. The reform of this legislation, which was aimed to clarify and make it more precise, is described in the first periodic report submitted by Finland. The financing of the health insurance scheme was reformed as of 1 January 2006.

The main aim was to ensure the financial sustainability of the scheme by reinforcing the insurance principle, i.e. by defining more clearly the financial responsibilities of each party and by strengthening the links between premiums and expenditure. However, the reform was carried out in such a way that the actual financial burden of the parties is not changed at the outset.

The funding of the health insurance scheme is divided into two parts:
– earnings security insurance and
– medical care insurance.

The earnings security insurance covers benefits linked to work: daily allowances for sickness, maternity, paternity and parenthood as well as rehabilitation. It also finances refunds on the employer's part of the costs of occupational health and maternity leave[4].

[4] Employers can claim a refund on the costs of the annual leave of an employee accrued during maternity leave.

The medical care insurance covers refunds on pharmaceuticals and transportation costs in ambulatory care. Further, it covers refunds on doctors' fees, examinations in private care, some special benefits for special groups[5], and payments abroad in accordance with European Community legislation.

The earnings security insurance is funded by premiums paid by employers and employees and also by self-employed persons and farmers. The premiums are calculated as a given percentage of earned income (salaries for employees, and insured pension income for self-employed persons and farmers). The premiums have been set at a level that is needed to cover the expenditure. The state covers the costs for minimum benefits. At the outset of 2006, the employers' premium was set to cover 73 % of the (non-minimum) expenditure and the premium of employees (as well as self-employed persons and farmers) to cover 27 %. Future premium increases due to increased expenditure will be equal for both employers and employees.

The medical care insurance is funded by premiums paid by the insured and the state on a fifty-fifty basis.

Table 4: Health insurance premiums in 2005–2007:

Health Insurance Premiums	2005	2006	2007
Employers (% of payroll)	1.60	2.06	1.97
Pensioners (% of income subject to local government tax)			
Health insurance (for medical care)	1.50	1.50	1.45
Employees			
Health insurance total	1.50	2.10	2.03
For medical care (% of taxable income)		1.33	1.28
For earnings security (% of payroll)		0.77	0.75
Self-employed persons			
Health insurance total		2.35	2.19
For medical care (% of taxable income)		1.33	1.28
For earnings security (% of earnings)		1.02	0.91

Part-time sickness allowance

Part-time sickness allowance was introduced on 1 January 2007 as a voluntary arrangement between an employer and an employee. The allowance can be granted for an employee or a self-employed person who has been on sick leave for an uninterrupted period of at least 60 days and who has received sickness allowance.

The purpose of part-time sickness allowance is to facilitate an employee's gradual return to work and thus to integrate him or her back to work. It is thus possible to work part-time and, at the same time, to receive part-time sickness allowance paid by the Social Insurance Institution of Finland (SII). An employee or a self-employed person is entitled to part-time sickness allowance if his or her working time and salary decrease by 40–60 % from the earlier.

An employee can return to work only on the condition of a positive medical report, and the return must not risk the employee's health or recovery.

[5] E.g. farmers' special health care scheme.

Basic unemployment benefit for single persons complemented with supplements

In 2005 the basic unemployment benefit was supplemented by a child increase, which is EUR 4.40 for one child, EUR 6.46 for two children and EUR 8.34 for three or more children per day. In 2006 the equivalent child increases counted to EUR 4.45, EUR 6.54 and EUR 8.43 per day.

Single parents are entitled to a housing allowance. The housing allowance compensates for 80% of housing cost in excess of a basic own risk amount, which depends on family size, income and the location of the house.

It is to be noted that the child allowances are paid for all children on the basis of the Child Allowance Act (796/1992), which provides the benefit for all children resident in the country. Single parents are entitled to an additional increase of EUR 36.60 (2005 and 2006) per child.

In addition, social assistance is granted to a person (including single unemployed person), who is temporarily, for a shorter or longer period without sufficient means to meet the necessary cost of living. The statutory basis for social assistance is the Act on Social Assistance Act (1412/1997).

Activation reform of the labour market support scheme

The labour market support scheme for persons unemployed for more than 500 days was reformed in 2005. Accordingly, when a person has been unemployed for more than 500 days, labour market authorities are required to offer intensified activating measures (job offers, education, supported jobs, etc.) for at least 12 months during the ensuing 24 months. If the person refuses the offer, he or she will not receive labour market support. The aim is to intensify the efforts to prevent long-term unemployment and exclusion in cases where ordinary measures have been insufficient.

The funding of labour market support and social assistance has been reformed, too. The state and the municipalities finance both benefits on a fifty-fifty basis. Previously the state covered all costs for the labour market support, while municipalities funded the social assistance with the help of a government appropriation of 33 % on average. The state will continue to cover all costs for the activation period. The aim is to neutralise the funding incentives and to create a funding scheme where activation is always beneficial to all parties. The reform was estimated to increase somewhat the total costs for municipalities. To prevent this, an additional government appropriation was introduced.

Statistics

Statistics on social security in Finland are found in the following two publications: *Trends in Social Protection in Finland 2005–2006*[6] and *The Finnish Pension System* (Finnish Centre for Pensions, Handbooks 2007:6; Annexed).

Article 12, para. 2: European Code of Social Security

A report on the ratification of the European Code of Social Security is under preparation and should be finished during 2008.

[6] *Trends in Social Protection in Finland 2005–2006*. Ministry of Social Affairs and Health Publications 2006:17. Available at: http://www.stm.fi/Resource.phx/publishing/documents/7581/index.htx

Article 12, para. 3: Development of the social security system

Daily allowances

In 2005 the amount of minimum sickness, maternity, paternity and parental daily allowances was increased from EUR 11.45 to EUR 15.20 per day, which constitutes a total increase of EUR 94 per month. The minimum amount of the rehabilitation allowance was increased correspondingly.

Since 1 January 2007 it is possible to choose the time of paternity leave more flexibly. The levels of maternity and parental allowances have also been increased. The more flexible use of the so-called paternity month and the increase of the parental allowances are meant to motivate fathers to use more parental leave.

The paternity month has to be used before the child has reached the age of 14 months. The calculation of the time is individual, as it depends on the beginning of the payment of maternity allowance.

The maternity allowance is higher for the first 56 weekdays, i.e. for a little more than nine weeks. During this time, the daily allowance is increased from 70 to 90 % of the earned income. The parental allowance is increased from 70 to 75 % of earned income for the first 30 weekdays. For an income of more than EUR 45,221 per year, the accumulation rate is 32.5 % for maternity allowance and parental allowance. The paternity allowance paid for the paternity month may also be increased. If both parents use the parental leave and apply for parental allowance, they are both entitled to an increased allowance for the 30 first weekdays at most.

The raise in the daily maternity allowance will also increase the compensation the employer receives for the expenses of the employee’s maternity leave. The employer will also be better compensated for the employees’ annual leave with pay.

The special rate for child disability allowance and the special disability allowance were increased as of 1 January 2007. Child disability allowance is paid at a special rate if the treatment and rehabilitation of a child imposes an extreme strain on the family. The special child disability allowance is intended for children with severe disabilities who are considered to need nearly constant outside help and supervision in everyday activities. Special disability allowance can be granted for a person with an illness or injury, which reduces his or her functional capacity for a period of at least 12 months. The special rate for child disability allowance and the special disability allowance were increased to EUR 361.21 per month in 2007 (EUR 340.03 in 2006).

Pensions

In March 2005 an index adjustment was made to the national pension, and the pension was raised with EUR 7. The next increase was made in September 2006, and the level of national pension was further increased with EUR 5. On 1 January 2007 national pensions were raised by an index adjustment of 1.7 %.

From the end of October 2006 it has been possible to apply for old-age pension also electronically. Persons with web banking codes or a chip-based ID can apply for old-age pension either through the webpages of their pension providers or through the Internet service www.tyoelake.fi.

Labour subsidy for young people (18-24 years)

Based on the information provided in the previous periodic reports, the Committee asks whether there is an initial period where jobseekers may refuse to take up an offer of a job on the grounds that it does not meet his/her occupational requirements or experience without risking losing his/her unemployment benefits. There is no such initial period for young people in receipt of labour market subsidy.

Adjustment of social security benefits

Social security benefits are generally annually increased. Earnings-related pensions are indexed with the TEL-index (20% wage index and 80% inflation). National pensions are tied to the cost of living index. Unemployment basic benefit, labour market subsidy and child increase are tied to the cost of living index. Child allowances are not index-linked.

Article 12, para. 4: Social security of persons moving between states

The Finnish legislation retains the accrued benefits related to work. The earnings-related pensions are exported to all countries and irrespective of the nationality of the recipient. In a similar way the accrued benefits from the employment accident insurance scheme are exported to all workers where ever they choose to reside. In addition, the pension scheme and the employment accident insurance scheme do not require a minimum insurance period. Thus the accumulation of insurance periods is not relevant.

In regard with the residence based benefits the idea of universality prevails as the basic principle. For the residence based system it is characteristic that the benefits are not dependent on the socio-economic status of the person concerned or his/her status as a family member of an employed person, but the scheme is built on the premises that the system provides an even and fair social security coverage to all persons resident in the country.

The residence requirements for non EU/EEA citizens' entitlement to national pension have been reduced. According to the revised legislation, in order to qualify for a national pension, a person has to have lived in Finland for a minimum of three years in all after the age of 16. From 1 January 2008 onwards the residence requirements have been similar for all persons applying for national pension.

Bilateral and multilateral agreements

A list of bilateral and multilateral social security agreements is attached to this report.

In 2007 Finland restarted negotiations with Australia regarding social security. An administrative arrangement to implement an Agreement on Social Security was finalised and signed in May 2007. The Agreement on Social Security between Finland and Chile entered into force on 1 January 2008.

ARTICLE 13: THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

Article 13, para. 1: Persons without adequate resources

Social assistance

According to Section 2 a of the Act on Social Assistance (1412/1997), a person aged 17–64 years, who is applying for social assistance has to register as an unemployed job seeker at the local employment office. The Section also lists life situations where this obligation does not apply. Social assistance applicants who are currently employed, full-time students, ill or incapable to work do not have to register at the employment office. Moreover, the obligation does not apply to persons, who are incapable of accepting a job due to an obstacle comparable to the afore-mentioned situations. Such a situation may emerge, for example, when the person applying for social assistance is caring for his or her small child or other family member in need of care.

According to statistics on social assistance in 2006, less than a tenth (8 %) of the persons receiving social assistance did not have any other income. A total of 92 % of the recipients had some earned income or social security income and therefore did not need to register at an employment office, or were already clients at an employment office when applying for social assistance. Of all social assistance recipients, 46 % received unemployment benefit, 10 % earned income, 15 % pension, 5 % sickness allowance, 7 % financial aid to students, and 4 % child home care allowance. Ultimately, a social worker assesses whether an unemployed person aged 17–64 years applying for social assistance should be obligated to register as a client at an employment office.

According to Section 10 of the Act on Social Assistance, the size of the basic social assistance benefit can be reduced by up to 20 %, if the recipient’s need for social assistance is caused by his or her having refused work specifically and demonstrably offered or an employment policy measure that would secure a living for a reasonably long period, or by his or her having acted, through negligence, in such a way that work or an employment policy measure could not be offered. If the recipient acts repeatedly in this way, the size of the basic benefit can be further reduced up to 40 %. If the basic benefit is reduced, a plan has to be drawn up with the recipient and other actors concerned in order to promote the independent coping of the client. Further, an assessment has to be carried out in order to ascertain that the reduction does not endanger a living essential in providing security needed for a life of human dignity and that it cannot otherwise be considered unreasonable. Moreover, the reduction cannot last more than two months at a time from the refusal or negligence in question. A social worker draws up the reduction plan with the recipient. The social worker assesses the recipient’s life situation as well as different opportunities to support him or her in seeking education or treatment, if for example inadequate training or competence obstructs employment or if the person is incapable to work. The recipient’s right to appeal also applies to decisions to reduce the size of the basic benefit.

Level and duration of social assistance

The amount of social assistance is equal to the difference between the recipient's disposable income and assets and the expenses specified in accordance with Section 6 of the Act on Social Assistance. Social assistance is calculated by month. If necessary, it can be granted and paid for a period shorter or longer than a month, even for one single day.

According to the Act on Social Assistance, the expenses to be taken into account include (i) expenses to be covered by the basic benefit (EUR 399.10 per month for one adult in 2008), (ii) other basic expenses, such as rent or service charges, household electricity and home insurance as well as health care costs that are higher than minor, and (iii) expenses covered by the supplementary benefit, including child day care expenses, housing expenses other than those mentioned above and expenses arising from special needs or circumstances and regarded necessary for ensuring a person’s or family’s living and helping them to cope independently. According to the statistics on social assistance in 2006, the average social assistance per household was EUR 346 per month. The statistics do not show to what extent each client's expenses per month have been taken into account and how much other income and assets each

client has had for covering the expenses. On the basis of various statistics it has been assessed that the amount of the expenses specified in the Act on Social Assistance is around EUR 900 per month per adult living alone. Out of this amount the basic benefit covers more than 40 %. Also the share of housing expenses that the client has to pay him- or herself is more than 40 %, and the rest are other expenses. The above-mentioned average amount of social assistance per month can vary by household; that is, it can be higher or lower according to the housing expenses and other relevant expenses.

In 2006 around 70 % of all households receiving social assistance were single households. A total of 42 % of all households in receipt of social assistance were single male households and 28 % single female households. The average social assistance in 2006 for a single male was EUR 319 per month and the average duration of the assistance was 5.8 months. Correspondingly, a single female household received EUR 325 per month for an average of 5.3 months. Single parent households accounted for 12 % of all social assistance clients, receiving on average EUR 358 per month for an average of 5.2 months per year. Of all social assistance clients, 10 % were two parent households, and they received social assistance worth an average of EUR 466 per month for an average of 6.0 months per year. The remaining 8 % of social assistance recipients were households of two adults without children, and they received social assistance worth an average of EUR 394 per month for an average of 5.3 months.

The number of households receiving social assistance went down by approximately 3 % from 2005 to 2006. The average duration of social assistance has changed little in recent years and was 5.6 months in 2006.

Right of appeal

The right of appeal applies to all decisions concerning the level or contents of social assistance, including decisions on reducing the basic benefit.

Nationals of EU/EEA States

Citizens of EU/EEA States have the right to reside in Finland for three months without registering their residence. A prerequisite for the residence is that the person's subsistence is secured. During the three months, EU/EEA citizens are comparable to tourists with regard to social assistance. Here, a tourist refers to a foreign citizen who arrives in Finland for a short stay (three months at the most) for travelling or other comparable purpose. Such a person cannot be considered to live permanently in Finland in the manner referred to in Section 14.1 of the Act on Social Assistance[7]. Therefore, social assistance can be granted only in urgent cases in accordance with Section 14.3. of the Act[8].

Citizens of EU/EEA States have to register their residence permit if their stay in Finland lasts more than three months. In connection with the application for a residence permit a report on secured subsistence may be required. If a person continuously relies on social assistance in order to cover normal living expenses, it is possible that secured subsistence is no longer considered as a precondition for the residence permit. When citizens of EU/EEA States apply for social assistance, the validity of their residence permit is examined, if necessary, by contacting the police. EU/EEA citizens with a residence permit valid in Finland can, in principle, be granted social assistance on the same grounds as Finnish citizens in a similar situation. Questions important for the assessment

[7] Section 14.1 of the Act on Social Assistance (1412/1997): Social assistance shall be granted on application by the body in the municipality where the person or family lives regularly.
[8] Section 14.3: If the need for support is urgent, social assistance shall be granted by the body in the municipality where the family or person is living when the application is submitted.

of a person's need for social assistance include the questions how permanently he or she resides in the municipality in question and what other case-specific circumstances exist.

Another group of foreigners eligible for social assistance in Finland consists of job seekers from EU/EEA States that have the right to seek employment for three months in another EU/EEA State and to receive unemployment security, which is covered by their home country. In order to receive unemployment security, the job seeker has to have registered as a job seeker in accordance with the legislation of his or her home country prior to leaving that country. As the job seeker arrives in Finland he or she has to register as an unemployed job seeker within seven days of the arrival. Job seekers are still covered by the social security of their home country, and their stay in Finland can be considered as temporary until they find employment and start to work. Job seekers are expected to live on the unemployment benefit from their home country, so that they will not have the need to rely on Finnish social security. In terms of social assistance, job seekers are comparable to tourists until they find employment. Citizens of EU/EEA States can stay in Finland even after the three months have lapsed, if they are still looking for a job and if they have real possibilities to find employment. The right of a job seeker to social assistance is assessed in each specific case on the basis of how permanent the stay is.

Tourists as recipients of social assistance

The basic assumption is that a tourist arriving in Finland has the necessary means for the stay and for the journey home. If a foreign citizen lacks these means, he or she can be turned back at the border. A foreign citizen in need of social assistance has the right to it only if he or she cannot gain the necessary subsistence in any other way. If foreign tourists have money problems during their temporary stay in Finland, they should first and foremost be instructed to take care of their affairs themselves. In such cases, if it is deemed necessary, the tourist should be reported to the police, so that he or she may be sent back to his or her home country.

Social assistance may be granted only as a last resort, if a tourist's need for urgent assistance cannot be met in any other way. The purpose of social assistance is not, however, to enable tourists to continue their stay in Finland. A tourist with financial problems has to return immediately to his or her country of residence, even if his or her visa is still valid. This being the case, the social assistance granted can at most cover the cost for the return journey and the food and other necessary expenses incurred by the tourist before he or she returns home. According to Section 15.1. of the Act on Social Assistance[9], social assistance may, if necessary, be granted and paid for a period shorter than a month and even for one single day.

If a special cause exists, social assistance can be paid to cover a tourist's living expenses by, for example, issuing the person a travel ticket or a food voucher (Section 16.2. of the Act on Social Assistance[10]). A special cause can, for example, be a situation where the person applying for social assistance has been proven incapable of ensuring the sufficiency of the means, which he or she had on arrival and which should have financed his or her stay in the country.

Right to social assistance and responsibility of the municipality of residence

Section 19.1 of the Constitution of Finland (731/1999) provides that all those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. This basic right applies to all persons residing in Finland irrespective of their citizenship.

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[9] Section 15.1: Social assistance is specified by the month. If necessary, it can be granted and paid for a period shorter or longer than a month.
[10] Section 16.2: If special cause exists, social assistance can be paid to a member of the applicant's family or to a person caring for the recipient for use in maintaining the recipient, or used otherwise to pay the person's living expenses.

According to Section 13 of the Social Welfare Act (710/1982) municipalities are obliged to provide social assistance to their residents. The provision does not require that the municipality providing social assistance is the recipient's municipality of residence referred to in the Municipality of Residence Act (201/1994). A person's staying in a municipality gives him or her the right to receive social assistance from that municipality.

Section 14 of the Act on Social Assistance deals with the mutual obligation of municipalities to grant social assistance, but it may have significance also when it is examined in which cases and to what extent an immigrant or a foreigner staying temporarily in Finland can be covered by the Finnish social assistance system.

The main rule is that social assistance is granted on application by the relevant body in the municipality where the person or family lives regularly. The preamble to the Act on Social Assistance states that a person's or family's permanent municipality of residence is usually the municipality where they have regular residence. Further, it is maintained that the regulation also means that the municipality of residence is specific to each applicant for social assistance. That is, members of one family may have different municipalities of residence.

Article 13, para. 4: Specific emergency assistance for non-residents

Urgent assistance for non-citizens

Only in cases where social assistance is needed urgently, a municipality can be obligated to grant it to a person residing temporarily in the municipality (Section 14.3. of the Act on Social Assistance 1412/1997). The provision is also applied to foreign citizens residing temporarily in the municipality. In such cases the purpose of social assistance is not to enable the foreign citizen to continue his or her stay in Finland. Instead, the granting of urgent social assistance is limited to immediate assistance, for instance for a return journey, the necessary food, and other expenses incurred prior to the start of the person's return journey. In such cases it can also be taken into account that, according to Section 15 of the Act on Social Assistance, social assistance can, if necessary, be granted and paid for a shorter period than a month and even for a single day.

Checking of travel documents in connection with application for social assistance

When foreign citizens apply for social assistance, they should be asked to present their travel documents. This is necessary primarily for verifying the applicant's identity. Moreover, the travel documents can give information that is necessary for assessing the applicant's need for social assistance. Such information includes the type of the applicant's residence permit or other grounds for staying in the country. According to Section 17 of the Act on Social Assistance, the applicant has to provide the body granting assistance with all essential information influencing social assistance. The information in travel documents can be considered as essential information referred to in the Act.

If a foreign person applying for social assistance cannot present any travel documents, or if such documents are difficult to interpret, the social welfare authority can seek executive assistance regarding the nature of the stay in Finland and the applicant's need for a residence permit or a visa. In such cases executive assistance can be sought from the police, passport control authorities and the Finnish Immigration Service. In questions relating to visas, executive assistance is provided by the Unit for Passports and Visas of the Ministry for Foreign Affairs.

A social services office can, in cooperation with passport control authorities, try to verify the amount of money that the applicant had upon arrival in Finland. Provisions on social welfare authorities' right to receive information and executive assistance from other authorities are included in Chapter 4 of the Act on the Status and Rights of Social Welfare Clients (812/2000).

ARTICLE 14: THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

Article 14, para. 1: Promotion and provision of social services

Legislative reforms

The Act on Support for Informal Care (937/2005) came into effect at the beginning of 2006. See the section discussing Article 23 for a more thorough description of the benefit system regarding informal care as well as the contents of the Act.

The revision of the Social Welfare Act (710/1982) regarding access to assessment of the need for social services entered into force on 1 March 2006. Accordingly, in urgent cases the need for social services has to be assessed without delay. In non-urgent cases, municipalities are responsible for providing persons aged 80 years or over and persons with severe disabilities access to a service needs assessment within a certain time limit. For more information on the legislative reform see the section dealing with Article 23.

On 1 January 2007, the provisions concerning interpreter services for persons with disabilities were included in the Services and Assistance for the Disabled Act (380/1987). Accordingly, persons with severe hearing or visual impairment are guaranteed the right to interpreter services in order to facilitate work, studying, errands and social participation, among other things. The minimum number of interpreter service hours for persons with hearing or visual impairment was raised from 120 to 180 hours and for persons with both hearing and visual impairment from 240 to 360 hours.

At the same time, provisions on day activities for persons with particularly severe functional impairments were included in the Services and Assistance for the Disabled Act. Day activities include activities organised outside home and aimed at supporting independent coping and promoting interaction.

Organisation of services

According to the Social Welfare Act (710/1982) the Ministry of Social Affairs and Health is responsible for general planning, guidance and supervision concerning social welfare. State Provincial Offices are responsible for the corresponding tasks within each province. The National Research and Development Centre for Welfare and Health (Stakes) acts as the expert government agency concerning social welfare matters.

Municipalities see to the planning of social welfare and the organisation of social services. The Social Welfare Act was revised as of 1 January 2007 so that functions related to the implementation of social welfare can be assigned to one or several multimember organs appointed by a municipality. Before, the tasks had to be centralised to one organ only.

According to the Act on Planning and Government Grants for Social Welfare and Health Care (733/1992), municipalities can organise their tasks relating to social welfare and health care in different ways: by providing the services themselves, by entering into agreements with some other

municipality/municipalities, by joining a relevant joint municipal board, by purchasing the services from another municipality or other public or private service provider, or by providing the clients with service vouchers.

The Social Welfare Act further provides that each municipality shall have professional staff to deal with tasks related to the implementation of social welfare. The Act (272/2005) and Decree (608/2005) on Qualification Requirements for Social Welfare Professionals entered into force on 1 August 2005. The aim of the Act is to promote the right of social services clients to good quality social services and to good treatment by requiring that the professionals employed in social services have the necessary education and familiarity with the work. A basic requirement for good quality services is completed education that responds to the demands of the work.

The qualification requirements for social services staff laid down in the relevant Act and Decree have to be followed in all local government and regional and central government sectors, as well as in private social services governed by the Act on the Supervision of Private Social Services (603/1996). The Act lays down qualification requirements for social services professions by occupational title, as well as minimum requirements for education for other professional posts within social services. The Act also lays down qualification requirements for management posts in social services. The Act does not include provisions on the task structure of social services staff or on staffing.

Social services are mainly funded by municipal tax revenues, government transfers for social welfare and health care, and client fees. The annual central government transfers to municipalities are based on calculatory grounds that reflect factors influencing service expenditure. The central government transfers to municipalities are equal to the difference between the calculatory expenses and the proportion of municipal financing. In 2005 the central government transfers amounted to around EUR 3,728,300,000 (32.99 %), in 2006 around EUR 4,022,300,000 (33.32 %), and in 2007 around EUR 4,309,800,000 (31.77 %).

The Act on Restructuring Local Government and Services (169/2007) entered into force in February 2007. It will be in force until the end of 2012, and its objective is to create prerequisites for a restructuring of municipalities and services. The goal is to reinforce municipal and service structures, develop ways of providing and organising services, reform municipal financing and government transfer systems, and revise the division of tasks between municipalities and the state in order to create a sound structural and financial basis for organising and providing municipal services as well as for developing the municipalities. The municipal structure will be reinforced mainly by merging municipalities, while the service structure will be strengthened by aggregating services that require a greater population base and by increasing municipal collaboration.

The Act also provides that municipalities or cooperating municipalities/regions responsible for primary health care and for closely related tasks of social administration should have a population base of at least 20,000. Further, in order to safeguard services requiring a larger population base, the country is divided into joint municipal boards that are responsible, for example, for the provision of specialised health care and special care for mentally handicapped persons to the extent required by the member municipalities. Each municipality is obliged to join one joint municipal board. Moreover, each municipality has, by the end of August 2007, issued the Government a report on the measures required by law and the implementation of the restructuring.

Access to services

According to the Constitution of Finland (731/1999) all those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Further,

public authorities are obliged to guarantee everyone adequate social, health and medical services and promote the health of the population as provided in more detail by law.

The Social Welfare Act prescribes which social services are to be organised by municipalities. These include social work, child guidance and family counselling, home-help services, housing services, institutional care, family care, and activities supporting access to employment and specific work for persons with disabilities. The Social Welfare Act also describes in more detail the contents of the services and the grounds for granting different benefits. Some of the services mentioned in the Social Welfare Act and intended for specific client groups are more precisely regulated by special acts. These include child welfare, child day care, social welfare for persons with disabilities or intellectual disabilities, support for informal care, and social work with alcohol and drug abusers.

Municipalities are obliged to see to it that social services are provided for permanent municipal residents, and in urgent cases, or when circumstances otherwise so require, also for other persons staying in the municipality.

A need for services is a basic criterion for access to any social service. The legal provisions regarding each service define more or less precise criteria for a client's access to an assessment of his or her service needs. The economic situation of the client or his or her family does not affect the access to services, but it can be taken into account, within legislative confines, when the client fee is determined.

The right of a client to certain of the social services is subjective. That is to say that municipalities have to deliver these services to all those eligible. Such services include for example child day care and certain services and support for persons with severe disabilities. For the majority of social services, however, access is, in the end, determined on the basis of the sufficiency of municipal appropriations for providing the service.

All social services organised by municipalities have to be based on a decision by an authority. Decisions to grant or deny social services or decisions on sizes of client fees are usually taken by an authority appointed by the responsible organ. If a person is dissatisfied with such a decision, he or she is, on his or her demand, entitled to have the decision reviewed by the organ in question within 14 days of being notified of it.

Remedies available to clients

Decisions of the organ can be appealed to an administrative court within 30 days of notification of the decision. As a main rule, an administrative court's decision on the provision of a social service or on the amount of a fee charged for it cannot be appealed against to the Supreme Administrative Court. However, an appeal to the Supreme Administrative Court is possible in the case of services to which persons with severe disabilities have a subjective right. Further provisions on the appeal procedure are laid down in the Administrative Judicial Procedure Act (586/1996), which also includes provisions on means of extraordinary appeal applicable to administrative decisions that have become final.

If a social welfare client is dissatisfied with the way in which the social service provider has treated him or her, the client can make a claim with the official responsible for the unit in question or the leading social welfare official in accordance with the Act on the Status and Rights of Social Welfare Clients (812/2000). An officer for social affairs assists the client in making the claim. The client can also lodge a complaint with the State Provincial Office supervising social welfare in the

municipality in question or with the supreme guardians of the law, i.e. the Parliamentary Ombudsman and the Chancellor of Justice.

Fees

According to the Act on Client Fees in Social Welfare and Health Care (734/1992), a fee can be collected for municipal social services from the service user unless otherwise stipulated in law. The free-of-charge social services are listed in Section 4 of the Act. These include social work, child guidance and family counselling, activities supporting access to employment and specific work for persons with disabilities, with certain exceptions services for persons with intellectual disabilities, in certain cases day care for children with disabilities, child welfare services with the exception of foster care, institutional care and housing services, certain services for persons with disabilities such as rehabilitation counselling and adjustment training, interpreter services and day activities for persons with severe disabilities as well as special services in connection with service housing.

For certain services, the Act and the Decree on Client Fees in Social Welfare and Health Care lay down more specific rules regarding the maximum amounts for fees and the effect that a person's ability to pay has on the size of a fee. The client's ability to pay influences the size of the fees for child day care, long-term institutional care, family care, as well as continuous and regular home-help services and 24-hour care within child welfare. A maximum amount in euros is defined by law for fees for short-term institutional care, temporary home-help services and care delivered during statutory leave of an informal carer. For transportation services for persons with severe disabilities, a fee corresponding to the public transportation rates can collected. In the case of other social services, a fee determined by the municipality can be collected. The fee should not exceed the costs for providing the service. If the service fee threatens to endanger the subsistence of a person or his or her family, the fee has to be lowered or left uncollected.

The Committee has also requested information on the number of beneficiaries of social services.

Services for children and families, clients 2006

Child day care	
- Municipal day care	189 312
- Private day care	16 352
Child welfare	
- Foster care	5 506
- Residental care and other care	10 122
- Children and young people receiving community care	59 069
Child guidance and family counselling, mother and baby homes and shelters for battered family members	
- Child guidance and family counselling	73 306
- Mother-and-baby-homes	736
- Shelters for battered family members	3 675

Care and services for older people, clients 2006

Support for informal care	5 466
Regular home care (2005)	18 478
Sheltered housing for older people	11 331
Residential homes	9 261
Health centres, long term	5 018

Services for people with disabilities, clients 2006

Services under the Services and Assistance for the Disabled Act	
- Transport services for people with serious disabilities	84 064
- Personal assistant services	4 548
- Interpreter services	3 791
- Housing alterations and housing equipment and facilities	3 883
- Sheltered housing for people with serious disabilities	3 088
Support to employment of disabled people and support for informal care	
- Day and sheltered work centres for people with intellectual disabilities (2005)	12 005
- Sheltered work centres for disabled people (2005)	2 993
- Activities to support employment of disabled people	3 521
- Day and sheltered work centres for people with various disabilities	11 716
- Support for informal care, under 65 years	10 446
Institutional care and housing services for disabled people	
- Institutions for people with intellectual disabilities	2 496
- Housing with 24-hours assistance for people with intellectual disabilities (2005)	4 874
- Housing with part-time assistance for people with intellectual disabilities (2005)	2 649
- Group housing services for people with disabilities, staff also available at night	5 355
- Group housing services for people with disabilities, no staff available at night	2 341
- Sheltered and supported housing for people with disabilities	1 758
- Family care for people with intellectual disabilities	1 253

Article 14, para. 2: Participation of individuals

In December 2007 the Government issued a Decree on the Advisory Board for Private Social and Health Services (1181/2007). The Advisory Board’s tasks include for example the promotion of cooperation between the private and the public sector in order to secure access to and good quality of social and health services. The Advisory Board operates under the lead of the Ministry of Social Affairs and Health, and it has representatives from, for example, NGOs and enterprises providing private social and health services, labour market organisations, service users as well as authorities supervising private service provision.

Fees for services of non-state providers

The Act and the Decree on Client Fees in Social Welfare and Health Care apply to municipal social and health services that municipalities may provide themselves or purchase from private service providers. If a client acquires services directly from a private provider, the service fee is based on an agreement made between the client and the provider.

Supervision of services

The supervision of private social and health services has been emphasised in the performance negotiations for 2008–2011 between the Ministry of Social Affairs and Health and the State Provincial Offices. Accordingly, specific attention has to be paid to supervision in advance. This ensures the provision of appropriate and high-quality services to meet the population's needs. According to the performance targets, supervision activities should be focused especially on long-term institutional care and service housing with 24-hour assistance.

The supervision of private social services is based on the Act on the Supervision of Private Social Services (603/1996). The Act applies to social services where a private person or a community, in return for compensation, provides services through trade or professional activities. The general supervision and control of private social services belong to the domain of the Ministry of Social Affairs and Health. Supervision of the services is the responsibility of the relevant State Provincial Office and the municipality where the service is provided. Private service providers providing 24-hour services need an authorisation from the responsible State Provincial Office. In the case of other services, the service provider has to notify the municipal authority responsible for social welfare of its operations.

The supervisory authorities are obliged to arrange the guidance, counselling and monitoring necessary for services providers. The supervisory authorities have the right to receive any information necessary for the supervision and to carry out inspections at service providers' operating units. An authorised service provider is obliged to issue an annual report to the responsible State Provincial Office.

If a service provider has not fulfilled the obligation to notify the authorities of its operations or to apply for authorisation, or if fault is found in the provision of services, the State Provincial Office has to issue the service provider an order to conform to its obligations or to rectify the fault. The State Provincial Office has the right to suspend the operations entirely or partially or forbid the use of the operating unit, if services have been provided against provisions or regulations. A State Provincial Office may cancel an authorisation if the Supervision Act, or the provisions or regulations issued by virtue of it, have been substantially violated in the operations.

A revision of the Act on the Supervision of Private Social Services entered into force on 1 January 2006. The revision concerned national registers on private service providers that are maintained jointly by the National Authority for Medicolegal Affairs and the State Provincial Offices to facilitate the management of the authorisations and notifications, the supervision of operations and the compilation of statistics.

Municipal services are under democratic control at the local level. As state authorities, State Provincial Offices assess and supervise municipal social services. At the national level the Ministry of Social Affairs and Health is responsible for the supervision. Also the supreme guardians of the law (the Parliamentary Ombudsman and the Chancellor of Justice) participate in the supervision of social services by investigating individual complaints or conducting inspections, which they can carry out on their own initiative.

Private service providers (NGOs and enterprises) deliver over 25 % of all social services measured in the number of social service staff. The share of private services has grown considerably in the 2000s. The private social services that households buy are mostly child day care and home-help services. Households may receive public financial support for purchasing such services.

ARTICLE 23: THE RIGHT OF ELDERLY PERSONS TO SOCIAL PROTECTION

Legislation on non-discrimination

According to the Constitution of Finland (731/1999), everyone is equal before the law. No one shall, without an acceptable reason, be treated differently from other persons on the basis of sex, age, origin, language, religion, conviction, opinion, health, disability or other personal characteristics. In addition to the Constitution, discrimination is also prohibited by virtue of the Non-Discrimination Act (21/2004), the Employment Contracts Act (55/2001), the Act on Equality between Women and Men (609/1986) and the Penal Code (39/1889).

The Non-Discrimination Act also prohibits discrimination on the basis of age. Both direct and indirect discrimination is prohibited, as well as harassment and an instruction or order to discriminate. A reform of the Non-Discrimination Act is underway. The committee preparing the reform has also been commissioned to assess the status, tasks and jurisdiction of the existing special ombudsmen. The term of the committee on the Non-Discrimination Act will last until September 2009.

Furthermore, according to the Constitution of Finland, those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the wellbeing and personal development of the children. The public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.

The Act on the Status and Rights of Social Welfare Clients

The Act on the Status and Rights of Social Welfare Clients (812/2000) lays down the key legal principles regarding the participation, treatment and legal protection of social welfare clients, including elderly people in institutional care. The purpose of the Act is to promote client-orientedness and the confidentiality of client-service provider relationships, as well as clients' right to good quality social welfare services and good treatment. The Act further defines issues related to confidentiality, professional secrecy and submitting of confidential information. It deals with clients' status and rights in social welfare services, whether delivered by public authorities or the private sector.

The Act does not contain guidelines or criteria on the use of physical restraints on elderly persons. Drafting of legislation regarding such restraints has been initiated at the Ministry of Social Affairs and Health.

Social protection and the social services

The social protection system for elderly persons consists of two key elements: social services and income security (pension security). Municipalities are responsible for delivering social and health services for elderly persons as a part of universal social and health services. In Finland there is no separate legislation regarding services for elderly persons. Municipal authorities deliver social services for elderly persons on the basis of individual service needs assessments; the law does not specify the extent to which they should be provided. Such an assessment is based on one or more

expert evaluations and on the client's own views. From elderly persons' viewpoint, two significant legislative revisions took place in 2005–2007 with regard to social services legislation.

The Act on Support for Informal Care (937/2005) came into effect at the beginning of 2006. The Act replaced the provisions of the Social Welfare Act (710/1982) concerning informal care. The support for informal care is a statutory social service. Municipalities are responsible for organising the support within the limits of their resources. The support for informal care encompasses the services necessary for the person being cared for, a care fee (compensation) for the informal carer as well as leave and support services for the carer. An informal carer can be a next-of-kin of the person cared for or someone else close to him or her. The minimum care fee payable to the informal carer is EUR 317.22 per month. If the carer is prevented from gainful employment during a transition period involving exceptionally intensive care, the care fee is at least EUR 634.43 per month. The care fee index is readjusted annually. The care fee is taxable income. An informal carer who has entered into an agreement with the responsible municipal authority earns pension during the care.

The municipal authority also takes out an accident insurance for the carer. The purpose of the new Act is to promote the realisation of informal care in the interests of the person cared for by securing sufficient access to care services and by safeguarding the continuity of care. In 2007, more than 30,000 persons were cared for by means of support for informal care, of which 16,000 were aged 75 years or over.

In March 2006, provisions on a service needs assessment were added to the Social Welfare Act. According to section 40a of the Act, the need for services in urgent cases must be assessed without delay. This right applies to all people irrespective of their age. In non-urgent cases, the municipality must organise, for those over 80 years and recipients of the highest care allowance paid by the Social Insurance Institution, access to a service needs assessment on the seventh weekday at the latest from the contact with the authority responsible for social services in the municipality. The person him/herself or his or her legal representative, relative, other person or an authority can ask the municipality to carry out a service needs assessment. The right to a service needs assessment applies to both new clients and those already covered by services.

The purpose is to extend the right to a service needs assessment in regard to social services to those over 75 years from the beginning of 2009. The government bill regarding the issue has been submitted to Parliament this autumn (2008).

The right to a service needs assessment comprises all services under the Social Welfare Act and the special acts regarding social welfare. The most important social services for older people are home and housing services, services of old people's homes, and support for informal care. The right to a service needs assessment also applies to e.g. disability services and services for substance abusers.

The provision of services is still based on the client's application and the decision of the municipal authority. When the service needs assessment has been made the client must be given, if he or she so wishes, a written decision on provision of services or rejecting the application. The client may appeal the decision. The municipality must also draw up a care and service plan for the client according to section 7 of the Act on the Status and Rights of Social Welfare Clients, if the municipality organises the services needed by the client.

The reform has not meant a change in the municipality's responsibility for organising services, and neither does it involve a stronger right for clients to receive services. The reform, however, specified the procedures by means of which clients obtain access to services and promotes the

timely provision of services. The new provision also supports ensuring the necessary care for older people as laid down in the Constitution. The purpose of the reform is also to harmonise the procedures used by different municipalities. By carrying out service needs assessments the municipalities also obtain information on the actual need for services, which will help the municipal authorities to plan their service systems and also to draw up their budgets based on a realistic picture of the situation.

The subsistence of elderly persons continues to rest on the statutory pension cover, which consists of national pension and earnings-related pension. A *reform of the earnings-related pension scheme* entered into force on 1 January 2005. It introduced flexible retirement ages and rewards for longer careers.[11]

No changes took place in 2005–2007 regarding the care allowance for pensioners paid out by the Social Insurance Institution of Finland.

National Framework for High-Quality Services for Older People

The Government Programme 2007 - 2011 includes a number of measures aiming to develop services for older people. The focus is on strengthening home care and informal care and developing services in support of them, as well as improving the functional capacity of older people. The Government Programme also incorporates a revision of the National Framework for High-Quality Services for Older People with the aim of raising the level of commitment to it.

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued a new National Framework for High-Quality Services for Older People (a quality recommendation) in February 2008. The former quality recommendation was from 2001. The recommendation defines the ethical principles guiding the services for older people. The most important of them are the right of self-determination, inclusion, justice, security, resource-orientation, and individuality. The objective of the recommendation is to promote the health and wellbeing of older people, and to improve the quality, effectiveness and availability of services. It is intended, in particular, for municipal decision-makers and civil service management.

The recommendation presents strategies for three sub-areas: 1) promotion of wellbeing and health, and the service structure, 2) staff and management, and 3) housing and living environments. The quality recommendation sets objectives for the coverage of the most important services for older people by 2012. Table 1 shows the development of the coverage in this century and the objectives of the quality recommendation for the coverage.

The Ministry of Social Affairs and Health monitors and evaluates systematically the implementation of the quality recommendation. If the objectives defined in it are not achieved, the necessary additional measures will be undertaken to guarantee the quality and availability of services.

The Ministry of Social Affairs and Health has also set up a working group to develop services promoting the wellbeing and health of older people. The working group shall discuss establishing the services promoting health and wellbeing and preventive services as an integral part of the service provision for older people. Its work is a part of the implementation of the National Framework for High-Quality Services for Older People and the Policy Programme for Health Promotion. The working group also considers measures to apply working methods enabling prevention and early intervention on a larger scale than today. In addition, it shall put forward proposals for the structure of a counselling and service centre promoting wellbeing and health, for

[11] The changes in the pension scheme are described in more detail in earlier reports.

the content of the activity and national implementation. It should also discuss possible needs for amending the relevant legislation. The proposals are due by the end of March 2009.

Table 1. Coverage of services for older people 2000–2006, % of population aged 75+

	2000	2005	2006	2007	2012 *
People aged 75+ living in their own homes	89.8	89.6	90.1	**	91.0-92.0
People aged 75+ covered by regular home care on 30 Nov.		11.5		11.3	13.0-14.0
People aged 75+ covered by support for informal care during the year	3.0	3.7	3.7	3.9	5.0-6.0
Clients aged 75+ covered by intensified service housing on 31 Dec.	1.7	3.4	3.9	**	5.0-6.0
People aged 75+ in long-term institutional care in old people's homes or health centre wards on 31 Dec.	8.3	6.8	6.5	**	3.0

*The target levels according to the National Framework for High-Quality Services for Older People
**Data for 2007 are insufficient

The National Advisory Board on Health Care Ethics published in spring 2008 a report on old age and ethics of care ("Vanhuus ja hoidon etiikka"). The report is intended for social and health care professionals working with older persons, political decision-makers, and older people and their relatives and significant others. It is emphasised in the report that the treatment of older persons as individuals is an important basis for ethically sustainable care. Good care is based on the older persons' individual needs and hopes, respects their values and appreciates their opinions. An older person has the right to take part in the decision-making concerning his or her care and the place of care. He or she needs information about the different options and their impact.

Information on total public expenditure during the reference period on social protection and social services for the elderly

In 2005 old-age expenditure accounted for 32.6 % of the total social expenditure. Income security accounted for 89 % of the old-age expenditure, and social services for 11 %.

Table 2. Old-age expenditure in 2003–2005

Year	Total old-age expenditure, EUR million	Cash benefits out of old-age expenditure, %	Social services out of old-age expenditure ,%	Old-age expenditure out of total social expenditure, %
2003	12,448	89.4	10.6	32.1
2004	13,068	88.8	11.2	32.2
2005	13,697	89.0	11.0	32.6

Source: Statistical Yearbook on Social Welfare and Health 2007. Stakes.

Information on the number of elderly living in public and private institutions

Long-term institutional care is intended for persons, who can no longer be provided with the necessary round-the-clock care at home or in service housing. Long-term institutional care includes not only medical care but also full board, including food, medication, hygiene and clothing services and services that promote social wellbeing. Long-term institutional care services for elderly people are provided mainly by homes for the elderly and health centre wards. Also private service providers provide some institutional care services.

At the end of 2006 municipal residential homes for elderly persons had 18,787 clients aged over 65 years, out of which 16,860 were over 75 years of age. Accordingly, 2.2 % of the population aged over 65 years and 4.1 % of the population aged over 75 lived in residential homes.

Long-term institutional care of elderly clients is also arranged at health centre wards. At the end of 2006, there were 11,004 clients aged over 65 years at health centre wards, out of which 9,547 were aged 75 years or over. Accordingly, 1.3 % of the population aged over 65 years and 2.4 % of the population aged over 75 lived at health centre wards.

Thus, at the end of 2006, a total of 3.6 % of the population aged over 65 years and 6.5 % of the population aged over 75 were in institutional care. The number and percentage share of persons aged 65 years or over in institutional care have decreased continuously.

Personnel of institutional care

At the end of 2005, there were 20,560 persons working in residential homes for elderly persons and 21,920 in health centre wards. There was a slight increase in this personnel in 2002–2003.

There are around 400 residential homes for elderly persons and over 200 health centre wards in Finland. In 2005 there were 44 private residential homes for elderly persons, and most of them were owned by the third sector. The private residential homes had a total of 2,300 residents.

In 2005 a total of 13,012 persons worked in public residential homes for elderly persons (a 11.4 % decrease from 2000) and 3,092 persons worked in private residential homes (a 5.8 % decrease from 2000). In 2005 there were 18,530 persons working in health centre wards (a 0.6 % increase from 2000). Although, as a whole, there has been a decrease in personnel in institutional care for elderly persons, the ratio of care personnel per patient has, however, somewhat increased in

residential homes and remained unchanged in health centre wards. This is explained by a decrease in the number of elderly persons in institutional care.

In the 2000s, the greatest personnel increase in services for elderly persons has taken place in service housing.

There are no national statistics or registers on the applications and waiting lists for residential care for elderly persons. Waiting lists exist in some municipalities. It is also noteworthy that the waiting list criteria are not uniform throughout the country. For example in Helsinki, with nearly 10 % of the population aged 65 years or over, more than 100 persons on average are waiting for admittance to institutional care at the moment. Less than half of them are admitted within a month. Moreover, approximately the same number is on the waiting list for service housing.

Persons receiving the minimum pension and their right to additional forms of assistance

There are two complementary pension schemes in Finland: earnings-related pensions linked to past employment and national pensions linked to residence in Finland. On 31 December 2006 the number of recipients of a full national pension was 83,000 persons. 32,600 of them were recipients of an old-age pension. Persons in receipt of a full national pension do not have any other pension income or that income is low.

In addition to national pension, the Social Insurance Institution can pay pensioners' housing allowance to pensioners. The allowance is paid for rented or owner-occupied dwellings located in Finland. The allowance covers 85 % of reasonable housing costs exceeding a deductible. Besides the housing costs, its amount depends on the claimants' family circumstances, the size of their family and their income and assets.

Pensioners' care allowance is 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. Eligibility is not dependent on any income or asset tests. The disability allowance is not taxable income. The care allowance for pensioners is subject to an annual indexation.

Table 3. The amount of pensioners' care allowance in 2008

Basic rate	54.80 euros/month
Middle rate	136.43 euros/month
Highest rate	288.49 euros/month

Social welfare and health care services provided for clients diagnosed with dementia

Dementia is diagnosed in specialised health care. Specialised health care authorities organise, throughout the country, special services for persons with dementia symptoms. Also an increasing number of municipalities have established dementia/memory clinics. Dementia clients are also a significant client group in all key municipal services for elderly persons.

At the end of 2005 around 32,500 persons with dementing illness were clients of regular services. That was over a third more than in 1999. Nearly half of all dementia clients live in residential homes for elderly persons or in service housing units with 24-hour assistance. Some of these have

group homes and/or special units (so called dementia units) specially designed for persons with dementia.

In 2005 every fifth client with dementia was in long-term institutional care at a health centre ward, and similarly, around every fifth dementia client received regular home care services. Since 1999 the number of dementia clients receiving regular home care services had grown by 45 %. Home care services are increasingly targeted at persons with dementing illness. The number of dementia clients among those living in service housing units with 24-hour assistance and in residential homes increased by 66 % between 1999 and 2005; the growth reflects also the growth in the number of group homes.

Table 4. Social welfare and health care services used by clients diagnosed with dementia in 1999, 2001, 2003 and 2005.

Clients at the end of the year	1999	2001	2003	2005	Change 1999–2005, Nr	Change 1999–2005, %
Regular home care	4,683	5,263	6,601	6,809	2,126	45.4
Ordinary service housing	2,138	1,325	1,695	1,599	-539	-25.2
Residential homes and 24-hour service housing	9,034	11,205	12,737	15,004	5,970	66.1
Primary health care, short term	1,654	1,904	2,181	1,869	215	13.0
Primary health care, long term	5,871	5,841	5,733	6,487	616	10.5
Specialised health care	621	670	712	722	101	16.3
Total	24,001	26,208	29,659	32,490	8,489	35.4

Source: National Research and Development Centre for Welfare and Health (Stakes). Care Registers for Social Welfare and Health Care

Private services

The supply of private services for elderly persons is on the rise. Private service providers in this sector sell most of their services to municipalities. In 2005 private social service providers accounted for 26 % of the total service expenditure, while the share of private health care providers was 23 %. In terms of personnel, the corresponding percentage shares were 27 and 17.

Regarding services for elderly persons, the share of the private sector is clearly greatest in service housing for elderly persons, where around half of all municipal services are purchased from private providers. Municipalities purchase increasingly home help support services, such as cleaning and meals on wheels services, from the private sector. Municipalities may also issue their clients service vouchers for acquiring home care services from service providers approved by the municipalities. The use of service vouchers is still fairly uncommon; in 2006 only every fourth municipality had introduced the service voucher and approximately 4,000 persons used it.

Elderly persons acquire services also privately to some degree. In such cases they can receive tax deduction for care services and also for housing conversions and repairs (the so-called domestic

help credit). Also children acquiring services for their parents or grandparents can receive the deduction.

By law, each municipality is responsible for ensuring that the quality of the services it purchases from the private sector corresponds to that of municipal services.

Supervision of private services

The supervision of private social services is based on the Act on the Supervision of Private Social Services (603/1996). The provisions of the Act have been explained in the previous chapters (see under article 14 para. 2).

The State Provincial Office can cancel an authorisation it has granted, if the Supervision Act or the provisions or regulations issued in virtue of it have been substantially violated in the operations. State Provincial Offices rarely withdraw authorisations already granted to service units (authorisations have been withdrawn in individual cases, but not every year). This is explained by the authorisation procedure, which rejects in advance most units that do not fulfil the necessary criteria. State Provincial Offices make inspections in municipal units usually only in cases of complaints. They caution service units or require them to correct certain faults in some ten cases per year.

ARTICLE 30: THE RIGHT TO PROTECTION AGAINST POVERTY AND SOCIAL EXCLUSION

In its Conclusions of 2007 regarding Finland's reports the Committee raised two issues in particular, in connection with Article 30. Firstly, the Committee requested further information about the impact of all measures in terms of reducing poverty and exclusion and secondly the Committee requested information about the participation of citizens and interest groups in reviewing anti-poverty measures.

Impact of measures in terms of reducing poverty and exclusion

The Government Strategy Document

A more detailed monitoring system has been included in the Government Programme 2007 - 2011. To ensure the effective implementation of the objectives defined in the Programme, the Government has prepared a Strategy Document in which the indicators used in the monitoring of the Programme are included[12]. Most indicators describe the development of themes essential to the Government policy. Some indicators are process indicators describing the progress of policy measures, while some are statistical indicators that can be used for the constant monitoring of the Government Programme. With the help of indicators, information on social development trends is gathered. Certain themes are monitored and assessed so that new or more efficient means can be introduced to affect these trends.

The Government Strategy Document and its indicators encompass, among others, the following themes: policy programmes, projects under the Government's special monitoring, developing sectoral research, legislative plan, the plan on reports to be submitted to Parliament and the plan on the decisions in principle by the Council of State.

[12] Government Strategy Document 2007. Prime Minister's Office Publications 4/2008, www.government.fi

In promoting well-being and reducing poverty, the main areas for action and monitoring are the social security reform, the restructuring of municipalities and services, the policy programme for health promotion, the policy programme for the well-being of children, youth and families, the policy programme for employment, entrepreneurship and working life, the gender equality programme and the service innovation project in social welfare and health care.

The Government Strategy Document lays the foundation for each ministry's action plan. The action plans of ministries and other documents required in steering are based on the Strategy Document. Its indicators are used for sector-specific monitoring.

Policy monitoring and assessment

The results of actions against poverty and social exclusion are to be assessed in separately organised events or occasions. In the assessment of practised policies, efforts will also be made to use the available qualitative descriptions on the development of Finnish welfare. The development of poverty and social exclusion will be assessed in connection with the follow-up of the government programme and in the annual reviews of various administrative sectors. The statistical authorities regularly publish information on changes that have taken place in citizens' living conditions, welfare, and poverty situation. In addition, organisations regularly publish reports on the development of people's welfare. Research institutes play a significant role in the provision of background information on the phenomena related to poverty and social exclusion. All available topical information is used in the preparation of political decision-making and when assessing the development of poverty and social exclusion in separate events.

The participation of individuals and organisations in reviewing anti-poverty measures

The basis for exerting an influence on decision-making affecting poverty is a functioning, democratic system, a solid judicial system, and good governance that takes citizens views into account. Most decisions that have a direct impact on the position of poor population groups are made at local level. Moreover, municipal democracy and initiatives support local influence in Finland. The administration will act close to citizens and be aware of the situation of various population groups. In Finland, the Administrative Procedure Act (434/2003) regulates the principles of good governance. It is important to guarantee that it is as easy as possible for a citizen to appeal to an administrative authority. The implementation of citizens' rights is monitored by special authorities, such as social ombudsmen appointed by the local authorities.

Non-governmental organisations (NGOs) form part of civil society, which is a key factor in functioning democratic societies. Non-governmental organisations build social cohesion and foster values. They accumulate social capital and have an influence on the direction of social development. Active citizenship and participation are also built through participation and learning in organisations. Such activities prevent the development and deepening of problems and support people's ability to cope in everyday life. Organisations often reach out to people who would otherwise be left alone and without support with their many problems.

The services provided by NGOs and partnerships between government and organisations have long traditions in Finland. These activities are important for prevention of poverty and social exclusion and with respect to opportunities for inclusion and participation of socially excluded people. Organisations have played an important role in meeting special needs in areas such as child welfare, services for substances abusers and the disabled, care of the elderly, and rehabilitation. In areas where organisations provide support and services, there are usually only a few other actors - in addition, special expertise has developed within the organisations. It is emphasised in the strategy document of the Ministry of Social Affairs and Health that the service

provision of the non-governmental organisations has added value with respect to other service providers. Added value is brought by the reliability of operations, which is based on the strong, committed, and sustainable value base of the organisations. These organisations operate in the long term. They contribute to building the connection between national policies against poverty and social exclusion and the local level in co-operation with local authorities, and create forums for expressing the needs of poor and socially excluded people.

Religious organisations and churches engage in social work and have taken part in the hearings. The pastoral and social work of the Evangelical Lutheran Church of Finland has some 800,000 client contacts each year. These operations prevent poverty and social exclusion via concrete measures, through the basic task of alleviating and removing distress and suffering. Solutions to overwhelming debt problems and looking after the rights of the unemployed constitute examples of the church's operations. In situations of over-indebtedness, good results have been gained through voluntary conciliation procedures, by improving networking with various quarters that would be of help, and by supporting peer activities. In order to improve the rights of the unemployed, the church has made efforts to have an impact on their situation, in terms of, e.g. the conditions of unemployment security, and has aimed to alleviate the psychological burden of unemployment by emphasising the value of people. In addition to other problems, mental health issues have gained in significance as a factor that heightens the risk of social exclusion.[13]

National Strategy Report on Social Protection and Social Inclusion

National Strategy Report on Social Protection and Social Inclusion[14] was prepared during 2008 and published in September 2008. The national strategy reports are a part of the EU open method of coordination. A similar report has been drawn up in 2006 and a concise version in 2001 and 2003. The Report has three separate sections, which present the strategy report on social inclusion, the pension strategy report and the report on strategies for health care and long-term care. During the compilation of the Report, a consultation process with non-governmental social welfare and health organisations and Association of Finnish Local and Regional Authorities and the representatives of the largest municipalities was arranged.

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[13] National Strategy Report on Social Protection and Social Inclusion 2008, Reports of the Ministry of Social Affairs and Health 2008:39 (Annex III)

[14] Reports of the Ministry of Social Affairs and Health 2008:39 (Annex III)

ANNEXES

List of bilateral and multilateral social security agreements (Annex I)

The Finnish Pension System, Finnish Centre for Pensions, Handbooks 2007:6 (Annex II)

National Strategy Report on Social Protection and Social Inclusion 2008 (Annex III)