EIGHT PERIODIC REPORT
ON THE IMPLEMENTATION OF
THE REVISED EUROPEAN SOCIAL CHARTER

SUBMITTED BY THE GOVERNMENT OF FINLAND

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EIGHT PERIODIC REPORT ON THE IMPLEMENTATION OF THE REVISED EUROPEAN SOCIAL CHARTER

for the period from 1 January 2008 to 31 December 2011 regarding Articles 3, 11, 12, 13, 14, 23 and 30 made by the Government of Finland 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 (Finnish Treaty Series 78-80/2002), the instrument of acceptance of which was deposited on 21 June 2002.

In addition, the report contains answers to the conclusions made by the European Committee of Social Rights in 2009 on the basis of Finland's periodic reports. 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 Organization 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) and the Federation of Finnish Enterprises (FFE).

Contents:

ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

Article 3 para. 1: Health and safety and the working environment

Question 1

In respect of this Question the Government refers to its previous periodic reports.

Question 2

Fourth follow-up report on the occupational safety and health strategy

The Government notes that the Ministry of Social Affairs and Health adopted a national occupational safety and health strategy in 1998. The targets of the strategy are to promote employees' health, safety and working capacity and to reduce the number of accidents at work, occupational diseases and other losses of health related to work. The implementation of the occupational safety and health strategy has been evaluated every three years.

The previous follow-up report on the strategy was drawn up in 2008. The fourth and latest follow-up report, covering the years 2008–2010, was published in December 2010.[1] According to the report, no greater changes have taken place in working conditions in the past ten years. Partly for this reason the report concludes, among other things, that new outlines are needed for occupational safety and health activities in order to improve well-being at work.

Policies for the work environment and well-being at work until 2020

The policies for the work environment and well-being at work until 2020[2] clarify the strategy for social and health policies, *Socially Sustainable Finland 2020*[3], adopted by the Ministry of Social Affairs and Health in January 2011. The policies for well-being at work pay attention to those sectors of occupational safety and health which relate to the work environment and well-being at work.

One objective of the policies for well-being at work is to ensure people's ability to continue working longer than today. Achieving this objective requires a number of different measures. The target of the policies is that by the year 2020, compared to 2010;

- the number of occupational diseases should decrease by 10 per cent;
- the frequency of workplace accidents should decrease by 25 per cent; and
- the work-related harmful strain should decrease by 20 per cent in respect of perceived physical and psychic strain.

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[1] Työsuojelustrategian neljäs seurantaraportti. Sosiaali- ja terveysministeriön julkaisuja 2010:29. (The fourth follow-up report on the occupational safety and health strategy. Publications of the Ministry of Social Affairs and Health 2010:29). Available in Finnish at <http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-15357.pdf>.Summary in English on page 5 of the report.

[2] Policies for the work environment and well-being at work until 2020. Publications of the Ministry of Social Affairs and Health 2011:13, http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-16410.pdf

[3] Policies for the work environment and well-being at work until 2020. Publications of the Ministry of Social Affairs and Health 2011:13, <http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-16410.pdf>. Socially Sustainable Finland 2020. Strategy for social and health policy. <http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-15321.pdf>.

The means of improving the work environment and well-being at work include enhanced quality of leadership, more efficient cooperation with occupational health care, network cooperation for the work environment and well-being at work, enhanced communication between the interest groups involved in improving working conditions, up-to-date occupational safety and health legislation updated jointly with the labour market organisations, and improved effectiveness evaluation of the occupational safety and health administration's supervision.

The achievement of the target state defined in the *Policies for the work environment and well-being at work until 2020* will be monitored systematically, jointly with the interest groups and other actors, by means of available indicators. The target state set for the year 2020 will be followed and specified when drawing up framework and performance agreements. When necessary, intermediate objectives will be set out.

Question 3

The following statistics on accidents at work are available concerning the years 2008 and 2009:

Employees' accidents at work in 2008–2009, reported by Statistics Finland			
Year	Sex		
	Total	Men	Women
2008	53 960	38 711	15 249
2009	42 979	29 471	13 508

Employees' accidents on way to or from work in 2008–2009, reported by Statistics Finland		
Year	Type of accident	
	Accidents on way to or from work	Fatal accidents on way to or from work
2008	10 684	18
2009	8 524	11

Answers to the Committee's conclusions

A number of actors are jointly responsible for occupational safety and health. In addition to the occupational safety and health administration, other authorities and their experts support occupational safety and health and the measures contributing to it. Such other authorities include the National Supervisory Authority for Welfare and Health and the Radiation and Nuclear Safety Authority of Finland in the administrative branch of the Ministry of Social Affairs and Health and the Finnish Safety and Chemicals Agency, the Consumer Agency and the Finnish Transport Safety Agency in other administrative branches. Occupational safety and health are also promoted by actors other than authorities, e.g. the Finnish Institute of Occupational Health, the Finnish Work Environment Fund, the Federation of Accident Insurance Institutions, the Centre for Occupational Safety, VTT: Technical Research Centre of Finland and the Finnish Standards Association SFS.

Article 3 para. 4: Occupational health services

Question 1

An amendment to Chapter 13, Section 5 (*1056/2010*) of the Health Insurance Act (*1224/2004*) concerning compensation for costs of occupational health care took effect at the beginning of 2011. By this amendment the compensation of 60 per cent payable to an employer for costs of preventive occupational health care was made conditional on an agreement between the employer and the occupational health care services on monitoring absence from work due to illness and on models of early intervention.

Amendments to the Health Insurance Act (*19/2012*) and the Occupational Health Care Act (*20/2012*) concerning an opinion on an employee's working capacity and reports on absence from work due to illness took effect on 1 June 2012. These amendments obligate employers to inform the occupational health care services if an employee's cumulative absence due to illness has continued for more than one month. The Act now requires that the occupational health care services issue an opinion consisting of their assessment of an employee's remaining working capacity and of an assessment made jointly between the employer, the employee and the occupational health care services concerning the possibility of adapting the employee's previous work (a plan for his or her return to work) when the employee has received sickness allowance in 90 days.

Questions 2 and 3

Implementation of the government programmes of Matti Vanhanen's second cabinet and Mari Kiviniemi's cabinet in the Ministry of Social Affairs and Health in 2007–2011

The Government Programme of Matti Vanhanen's second cabinet mentioned plans to develop occupational health services. According to the programme the goal of social and health policy is to promote health, functional capacity and initiative, and diminish the differences in the state of health between the individual segments of population. To achieve this goal the Government committed itself, among other things, to developing occupational health care services.[4]

[4] Government Programme of Prime Minister Matti Vanhanen's second Cabinet 19 April 2007. <http://valtioneuvosto.fi/tietoarkisto/aiemmat-hallitukset/vanhanenII/hallitusohjelma/pdf/en.pdf>.

Government resolution in 2015

In 2004 the Government adopted a government resolution entitled *Occupational Health 2015 – Development strategy for occupational health care*.[5] The resolution presents ten lines for developing occupational health care:

- legislation
- occupational health care content
- occupational health service system
- a funding and compensation system for occupational health care
- human resources in occupational health care
- ethics of occupational health care
- cooperation
- information management systems in occupational health care
- research and development in occupational health care, and
- monitoring and supervision.

According to the government resolution, developments in occupational health care will be pursued on the tripartite principle as part of Finland's social and health policy.

In addition, measures have been taken in 2010–2012 to improve the content of occupational health care so as to better support coping with work and working capacity. These measures have been based on proposals of different working groups appointed during the reporting period. Two of such proposals are described in more detail below.

On 6 April 2010 the Ministry of Social Affairs and Health set up a working group to prepare proposals regarding improved occupational health care, nation-wide coverage of occupational health care and the procedure to be applied in cases of incapacity for work. The working group examined, among other things, the measures planned or already taken to follow up the proposals presented by the working group on working life. The mandate of the working group expired on 31 January 2011.

In its final report the working group proposed that occupational health cooperation is to be reinforced *inter alia* by improving cooperation between primary health care, specialised health care, occupational health care and rehabilitation. To improve the coverage of occupational health care the working group proposed that organisational models for purchasing health care services are to be designed for small workplaces and that, to ensure regional access to occupational health care services; these services must be taken into account in developing health service systems. Furthermore, the working group proposed measures to ensure the quality of occupational health care services, to improve training in occupational health care and to ensure the sufficiency of qualified personnel.[6]

[5] Government Resolution Occupational Health 2015 – Development strategy for occupational health care. Publications of the Ministry of Social Affairs and Health 2004:3. <http://www.stm.fi/c/document_library/get_file?folderId=28707&name=DLFE-3947.pdf&title=Government_Resolution__Occupational_Health_2015_en.pdf>.

[6] Työterveyshuolto ja työkyvyn tukeminen työterveysyhteistyönä. Työryhmän loppuraportti. Sosiaali- ja terveysministeriön selvityksiä 2011:6 (Occupational health services and support for work ability through occupational health cooperation. Final working group report. Reports of the Ministry of Social Affairs and Health 2011:4) Available in Finnish at <http://urn.fi/URN:ISBN:978-952-00-3132-9>. A summary in English is on page 6 of the publication.

On 7 April 2010 the Ministry of Social Affairs and Health set up the so-called Working Group on Wellbeing at Work to develop early intervention in cases of prolonged disability for work. The mandate of the working group lasted from 7 April 2010 to 31 January 2011. It was assigned to put forward proposals for amending the Health Insurance Act so as to support early intervention and cooperation of various actors. The working group also examined the need for regulating the activities to promote well-being at work carried out by the authorised pension institutions administering earnings-related pensions and considered methods to encourage in particular small enterprises to participate in these activities. Furthermore, the working group discussed how to develop health insurance and the sickness fund system of employees so as to ensure rapid access to specialised medical care in order to restore working capacity to a wider extent.

The Working Group on Wellbeing at Work submitted its report to the Ministry of Social Affairs and Health on 1 March 2011, proposing among other things that the payment of sickness allowance should be subject to a written opinion given by the occupational health service after 90 days of eligibility to the allowance. Because the employee pension legislation did not contain any provisions concerning authorised pension institutions' activities to promote well-being at work, the working group proposed that the legislative basis for these activities should be clarified. Moreover, the working group paid attention to the long waiting lists for specialised medical care, which entailed considerable costs to a number of actors.[7]

During the reporting period, measures were also taken to improve access to occupational health care services in small workplaces by developing new practices for purchasing such services. On the basis of the government resolution for the development strategy for occupational health care[8] the FUSK project, funded by the Ministry of Social Affairs and Health, has endeavoured to make occupational health care better meet the needs of small and medium-sized enterprises.[9] The project is based on the Government Programme of Prime Minister Katainen's cabinet, according to which the Government will look into the opportunities of small-sized workplaces to acquire occupational health care services by forming joint acquisition organisations.[10]

The purpose of the FUSK project is to develop a funding model for occupational health care to enable the development of well-being at work with the same multidimensionality and the same input in small and medium-sized enterprises, so-called micro enterprises and large enterprises. The project analyses the functioning of the occupational health care system from the standpoint of entrepreneurs associations and service producers representing small enterprises. Under the project, small enterprises purchase occupational health care services on the basis of a joint agreement through a local entrepreneurs association. The model tested under the project is being developed in cooperation between the Social Insurance Institution of Finland, the Finnish Institute of Occupational Health, the Ministry of Social Affairs and Health, the Finnish Association of Occupational Health Physicians, the Finnish Association of Occupational Health Nurses, enterprises providing occupational health care services and local entrepreneurs associations.

[7] Työhyvinvointityöryhmän raportti. Sosiaali- ja terveysministeriön selvityksiä ("Report of the Working Group on Wellbeing at Work. Reports of the Ministry of Social Affairs and Health 2011:4"). Available in Finnish at: <http://urn.fi/URN:ISBN:978-952-00-3130-5>. A summary in English is on page 5 of the publication.
[8] See footnote 5.
[9] <www.pyt.fi>.
[10] Government Programme of Prime Minister Jyrki Katainen's Cabinet 22 June 2011. <http://valtioneuvosto.fi/hallitus/hallitusohjelma/pdf/en334743.pdf>.

Answers to the Committee's conclusions

During the reporting period the occupational health of professional drivers in road traffic was improved in the context of implementing the Government Resolution for the Development Strategy for Occupational Health Care.

In 2008–2011, the Finnish Institute of Occupational Health and different actors in the transport sector carried out jointly the *Alert behind the wheel with healthy nutrition* - project, funded by the European Social Fund. The project was intended to promote professional drivers' alertness at work, working capacity and health by means of healthy dietary habits during working hours, and to increase their awareness of life habits that promote working capacity. The website of the project also contains practical information about how employers in the transport sector can support the healthy nutrition of their employees.[11]

Moreover, new ways have been searched for improving the health behaviour of professional drivers. In 2007–2010 the Finnish Institute of Occupational Health and the University of Oulu studied jointly a group instruction model for promoting healthy life habits and the usability of video conferencing technology in this context. The researchers found that distance instruction of groups by video conferencing was a useful method for instructing individuals to adopt healthy life habits. In addition, the Finnish Institute of Occupational Health has studied the occupational health care needs of lorry and taxi entrepreneurs in Southwest Finland and their current occupational health care. On the basis of the results, a new operating model of occupational health care will be developed for sole entrepreneurs and micro enterprises, to take account not only of the health care needs of drivers in traffic but also their access to related services.

During spring 2010, as part of the efforts to improve the occupational safety and health legislation, the Ministry of Social Affairs and Health arranged, in nine localities, training for enterprises and workplaces in the transport sector and for other target groups. The theme of the training was the risk of physical violence at work. The transport sector is dominated by small enterprises, and its health risks and risks related to the working conditions are reflected in the overall road safety. Safe professional transport was one of the partial effectiveness targets for the Finnish Institute of Occupational Health in 2006–2010. Against this background the Institute is developing a unit specialised in problems with driving capacity and coordinating a national network for research on assessing such problems. The purpose of the network is to improve and standardise the examination and assessment of problems with driving capacity. The unit serves the training of doctors working in occupational health care.

Since development projects in the transports sector, as in other sectors, require long-term efforts, it is often impossible to achieve rapid results. The Ministry of Social Affairs and Health supports, *inter alia* by training, the elaboration, piloting and putting into practice of occupational health care models designed for different actors in the transports sector, transport entrepreneurs and micro enterprises.

[11] <http://www.ttl.fi/en/research/research_projects/alert_behind_the_wheel/Pages/default.aspx>.

ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH

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

Questions 1, 2 and 3

In respect of these Questions, the Government refers to its previous periodic reports.

Answers to the Committee's conclusions

Life expectancy and main causes of mortality

The number of deaths caused by traffic and occupational accidents has been on the decrease lately. During the last years, also the number of deaths caused by home and leisure time accidents has decreased slightly. Nevertheless, 80 per cent of accidents happen at home and during leisure time.

The promotion of safety has been strengthened and has become more efficient as a result of the adoption of the Internal Security Programme by the Government in 2004.[12] The Programme covers all sectors of safety: accidents and violence, improving the safety of immigrants, promoting the security of business operations, and prevention of crime. Its main objective is to make Finland the safest country in Europe by the year 2015. A new Internal Security Programme will be drawn up each time a new Government begins its term of office and the Programmes are a permanent part of the Government's strategic work. They are drafted in co-operation between the authorities, non-governmental organisations and the business sector and are implemented in wide co-operation. The Second Internal Security Programme was adopted by the Government on 8 May 2008 and the Third Internal Security Programme was adopted on 14 June 2012.

During the reporting period, the Government also adopted Finland's national action plan for injury prevention among children and youth[13], which is implemented effectively. Moreover, the prevention of falling accidents among elderly people has been set by the Government as a priority area of accident prevention.

During the reporting period, the number of suicides has been on the decrease and is currently the lowest for 40 years. A national plan for mental health and substance abuse work (*MIELI*)[14] defines the core principles and priorities for the future of mental health and substance abuse work until 2015. For the first time, the plan outlines also common national objectives for mental health and substance abuse work.

Infant and maternal mortality

Infant mortality has continued to decline slightly. In 2010 the rate of infant mortality in Finland was 2 per 1,000 live births, whereas the rate of 2009 was 2.7.[15]

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[12] A Safer Community. Internal Security Programme. Ministry of the Interior 2004. A summary available in English at <http://www.intermin.fi/intermin/images.nsf/files/7E16BE52F11364AEC2256F47002D6874/$file/internal_security_programme_summary_en.pdf>.

[13] Providing a Safe Environment for Our Children and Young People. Finland's national action plan for injury prevention among children and youth. Report 8/2010. National Institute for Health and Welfare. <http://www.thl.fi/thl-client/pdfs/bcda07c2-aa23-4faa-a59d-55a60fdc6764>.

[14] More information on the national plan in English is available at: <http://www.thl.fi/en_US/web/en/research/programmes/mieliplan>. Reports on the implementation of the national plan are available in Finnish at: < http://www.thl.fi/fi_FI/web/fi/tutkimus/ohjelmat/mielijapaihde/julkaisut>.

[15] National Institute for Health and Welfare. Newborns 2010. Official Statistics of Finland. <http://www.stakes.fi/tilastot/tilastotiedotteet/2011/Tr42_11.pdf>. The statistics in English start from page 13.

The most important causes of infant mortality are perinatal causes (e.g. congenital structural defects; nearly half of all infant deaths), congenital malformations and chromosomal anomalies (approximately one third of all infant deaths), and cot deaths (slightly less than one tenth of all infant deaths).

In 2009 the rate of maternal mortality was 1.6 per 100,000 live births (one death).[16]

Access to care

In recent years the waiting times for care in hospitals of the different hospital districts have stabilised. Since 2010, 22 per cent of all patients have waited for access to care in more than 3 months. The percentage of patients waiting for care in more than 6 months has varied between 1.2 and 1.7 per cent. In specialised health care units maintained by primary health care services, the percentages have varied slightly more.

At the end of April 2012 nearly 70 500 patients were waiting for access to care in hospitals of hospital districts and in specialised health care units maintained by primary health care services. Of these patients, 2 per cent had been waiting for care in more than 6 months. Of all patients waiting for access to care in hospitals of hospital districts, 1.4 per cent (almost 900 persons) had been waiting in more than 6 months, and of those waiting for care in health care units maintained by primary health care services 6.7 per cent (almost 600 persons) had been waiting in more than 6 months.

Since the beginning of 2012 the situation in the hospital districts has remained nearly unchanged. At the same time, however, the situation in specialised health care arranged by primary health care services has slightly worsened. Among the whole population, the numbers of patients having waited in more than 6 months were highest in the Kainuu hospital district and in specialised health care units in Kuopio, Lahti and Pori. The waiting times for the first consultation and the processing times for referrals shortened during the reporting period.

In recent years, the assessment of patients' need for care has started more rapidly than before. The situation has improved most regarding eye diseases. In January–April 2012 the hospital districts and the specialised health care units maintained by primary health care services processed approximately 391 000 referrals, 86 per cent of which were processed by the hospital districts.

The waiting times for the first consultation have shortened considerably compared with the previous years. This is visible in almost all special fields, and most in the fields of surgery and eye diseases. At the end of April 2012, nearly 8 700 persons (10 per cent of all patients) had been waiting for the first consultation in a hospital district in more than 3 months. This was one thousand persons less than at the end of December 2011.

The waiting times for the first consultation were longest in the special fields of cardio thorax surgery, eye diseases and dental, oral and maxillofacial surgery. Proportionally the highest numbers of patients were waiting for the first consultation in the hospital districts of Kanta-Häme and Päijät-Häme and the lowest numbers in the hospital districts of Central Finland, Helsinki and Uusimaa, Central Ostrobothnia and North Karelia.

At the end of April 2012 approximately 2 900 persons (17 per cent of all patients) in the specialised health care arranged by primary health care services had been waiting for the first consultation in more than 3 months. The number of patients waiting for the first consultation had declined by nearly 500 persons since August 2011.

[16] Official Statistics of Finland: Causes of death in 2009.
<http://www.stat.fi/til/ksyyt/2009/01/ksyyt_2009_01_2011-02-22_kat_002_en.html>.

Supervision of care guarantee

The National Supervisory Authority for Welfare and Health (Valvira) is the authorising and supervisory authority in the social welfare and health care sector. Valvira supervises the fulfilment of the care guarantee jointly with the Regional State Administrative Agencies. Valvira and the agencies have partly parallel competences and duties in the supervision of health care. The agencies and Valvira each supervise the realisation of access to health in individual cases, e.g. on the basis of complaints. Cooperation groups between the agencies and Valvira agree on a more systematic division of work in supervising the care guarantee. The supervision is based on information collected by the National Institute for Health and Welfare[17]. The Institute collects information from the field about access to care, at least twice a year regarding oral health care and primary health care and three times a year regarding specialised health care.

Division of work between the National Supervisory Authority for Welfare and Health and the Regional State Administrative Agencies in supervising access to care

The Regional State Administrative Agencies supervise access to care in health centres. The National Supervisory Authority for Welfare and Health (Valvira) supervises the overall situation of access to specialised health care, including mental health care services for children, young persons and adults. Valvira also monitors the information provided by hospital districts to their residents regarding access to care, e.g. the length of waiting lists and the assessed waiting time.

The Regional State Administrative Agencies supervise access to care in individual special fields and monitor the processing time for referrals in these fields. The agencies also supervise some activities of health centres, e.g. oral health care, and the information provided to residents regarding access to care in health centres. A different division of work may be agreed on in individual cases. Valvira and the agencies have jointly agreed on criteria for intervening in the activities of a health centre or a hospital by requesting an account of their situation. The authorities decide the cases on the basis of the accounts. If necessary, they may order that the defects be corrected either under penalty of a fine or without the penalty of a fine.

Intervention in problems with access to primary health care

Jointly agreed criteria for intervening in problems with access to health care:

- Continuous problems with immediate contacts with a health centre and / or less than 80 per cent of all telephone calls are answered; or
- Daily situations where a patient's need for care is established but consultation with a doctor cannot be arranged.

Criteria for discretionary intervention in problems with access to health care:

- Occasional problems with immediate contacts;
- Assessment of the need for care within three working days; or
- Publishing of waiting times for access to care.

The application of the criteria is decided by discretion case by case.

[17] <www.thl.fi>.

When problems with access to care exist by the criteria above, some of the following measures are taken:

- an instruction letter to the health centre. Those local authorities whose telephone system does not produce information on the percentage of answered calls are obligated to correct the situation within a prescribed period of time.
- a written request for an account of the situation of the health centre, addressed to the board or a body of the local authority or the joint municipal authority for the hospital district in question. The request is sent for information to the medical director of the health centre. The account to be given must describe in detail the extent of the problem and the measures taken by the health centre to correct the situation.
- The Regional State Administrative Agencies inform the National Supervisory Authority for Welfare and Health about the measures taken and their own decisions.

Provision of care within three months

Any treatment considered necessary must be provided to the patient within three months of the assessment of the need. It is difficult to define an unambiguous criterion for establishing whether this obligation has been fulfilled. In many cases providing the treatment means that the patient can consult a doctor in primary health care within three months. However, providing the treatment may also mean something else, e.g. care in a hospital, provision of medical aids or physiotherapy.

The assessment of the situation of access to care is initially based on reports of the National Institute for Health and Welfare on those daily situations where the patient's need for care has been established but no consultation with a doctor has not been possible. Another criterion is that the health centre in question has not answered inquiries of the Institute.

Measures

The aforementioned written request for an account of the situation of the health centre is sent to the board or a body of the local authority or the joint municipal authority for the hospital district in question. The request is sent for information to the medical director of the health centre. The account to be given must describe in detail the extent and duration of the problem and the measures taken by the health centre to correct the situation.

The Regional State Administrative Agencies decide themselves what possible discretionary measures listed above they take.

Oral health care

Jointly agreed criteria for intervening in problems with access to oral health care:

- Continuous problems with contacts and less than 80 per cent of all telephone calls are answered; or
- Provision of care within six months.

Criteria for discretionary measures:

- Occasional problems with immediate contacts;
- Assessment of the need for care within three working days;
- Publishing of waiting times for access to care; or
- Provision of urgent care.

Measures

- an instruction letter to the local authority. Those local authorities whose telephone system does not produce information on the percentage of answered calls are obligated to correct the situation within a prescribed period of time.
- a written request for an account of the situation of the health centre, addressed to the board or a body of the local authority or the joint municipal authority for the hospital district in question. The request is sent for information to the medical director of the health centre. The account to be given must describe in detail the extent of the problem and the measures taken by the health centre to correct the situation.

Provision of oral health care within six months

Any treatment considered necessary must be provided to the patient within three months of the assessment of the need. In respect of oral health care the time limit may be exceeded by a maximum of three months if the treatment can be postponed on medical, therapeutic or other comparable justified grounds without jeopardising the patient's health. In this context, treatment refers to treatment given by a dentist or an oral hygienist.

Specialised health care

Jointly agreed criteria for intervention:

- Starting assessment of the need for care within three weeks; or
- Provision of care within the prescribed period of time.

Measures

The hospital district is sent a request for an account of the situation, requesting at least the following information:

- Average time of processing referrals, by special field;
- Reasons for the long waiting times;
- Whether the health centre contacts the patient if the waiting time is prolonged;
- How well the objective of assessing the patient's need for care is achieved within three weeks;
- What measures have been taken to shorten the patient queues;
- How the measures have succeeded;
- Whether treatment has been provided within the prescribed time;
- Whether treatment can be provided within the prescribed time more often than before; and
- How the health centre starts to assess the patient's need for treatment.

Any treatment considered necessary must start within six months of the assessment of the need. The mental health treatment of children and young persons must start within three months.

Intervention criteria

The National Supervisory Authority for Welfare and Health examines the situation of access to specialised health care in a hospital district at least if inquiries by the National Institute for Health and Welfare show that five or more of every 10,000 residents have waited for care longer than six months.

Measures

The hospital district is sent a request for an account of the situation, requesting at least the following information:

- The number of patients who have waited more than six months and more than three months regarding mental health services for children and young persons. The information about patient queues must be broken down by special field, local authority, hospital and operational unit;
- Waiting times and diagnoses of individual patients who have waited longer than the permitted delay;
- Reasons for the long waiting times;
- Whether the health centre contacts the patient if the waiting time is prolonged;
- What measures have been taken to shorten the patient queues; and
- How the measures have succeeded.

Article 11 para. 2: Advisory and educational facilities

Questions 1, 2 and 3

New Health Care Act

The new Health Care Act (*1326/2010*), regulating the content of health care services and activities, took effect on 1 May 2011. All local authorities and joint municipal authorities for hospital districts must ensure that services are available and universally accessible in their area to the residents for whom they are responsible for providing services. The authorities must make their health care services available to the residents for whom they are responsible for providing services locally unless regional centralisation of services is justified in order to ensure the quality of services. The substance and scope of the health care services provided must correspond to what the welfare, patient safety, social security, and health of the residents require, and what the estimated demand for the services is medically or based on dental records or the needs of health science according to existing data on the underlying factors.

Patients have access to health services according to a care plan even outside their home municipality. The Health Care Act allows patients access to health centre services even outside their municipality of residence, if they reside in another municipality on a regular or long-term basis, for example, because of work, leisure, a close relative or other comparable reason.

The patient must notify the health centre in the other municipality of his or her service needs at least three weeks prior to the first visit. Moreover, he or she must have a care plan, which is drawn up by the health centre of the home municipality: the plan defines the services the patient is entitled to at another health centre. The care plan is required for non-emergency services. In urgent cases it is still possible to use services in any municipality.

All long-term patients, especially those with multiple conditions, need a proper care plan for carrying out the necessary care and treatments. Health care professionals draw up the plan together with the patient. Some health centres may draw up health and care plans for everyone needing one already in the initial phase. Others prioritise care plans for treatments provided outside the municipality.

Mobility of patient records enables smoothly running care and better patient safety. The Health Care Act improves also the mobility of patient records. All the electronic patient registers and patient record archives in the health centres and hospitals in a hospital district form a joint register of patient records. The personnel treating the patient have access to the patient records in the joint register even without the patient's consent, provided that the information is necessary for the treatment.

The patient must be informed of the joint use of the patient register as well as of the possibility to deny the joint use. The denial is valid until further notice and may be cancelled any time. The patient records included in the denial are non-accessible even in emergencies. However, the patient may draw up a separate living will where he or she may permit the use of the records covered by the denial for example if he or she is unconscious and in need of immediate care.

The patient may change his or her health station within the home municipality or the cooperation area once a year. The patient must inform both the new health station and the old one of the change three weeks prior to the first visit. It is also possible to change the specialised health care unit within a so-called area of responsibility, which is formed by neighbouring hospital districts. The patient chooses the specialised health care unit in cooperation with the doctor issuing the referral to care.

From 2014 onwards the patient has the right to choose his or her health station and specialised health care unit from all the public health stations and hospitals in the country.

Answers to the Committee's conclusions

Promotion of health and well-being

Section 12 of the Health Care Act obligates local authorities to promote the health and welfare of their residents and to monitor the health and welfare and any underlying factors per population group. Local authorities must report regularly on the health and welfare of residents and identify, in their strategic plans, objectives for health and welfare promotion. They must assign coordinators for health and welfare promotion and cooperate with other actors on a broad basis.

Public information and awareness-raising

The provision of information and the awareness-raising on health by local authorities are based on the obligation imposed in Section 2 of the Health Care Act to promote and maintain the population’s health and welfare. Many local authorities provide information on health related issues at their own websites and in different publications. Some local authorities have arranged interactive programmes for their residents, e.g. health tests, health information and opportunities to ask questions. Such programmes are also being developed at national level. There are often television broadcasts dealing with healthy life habits, such as healthy nutrition, increased physical exercise and giving up smoking. In the field of sexual health, different organisations have carried out campaigns to promote the use of condoms.

Health education

Since 2001, providing health education at schools has been a statutory obligation. Health education is a separate subject in grades 7 to 9 of comprehensive schools, in the first and second grades of general upper secondary schools, and in vocational institutions. In pre-primary schools and in the lowest grades of comprehensive schools, health education is integrated into other subjects. Since 2007 health education has been included in the test in humanities and natural sciences in the matriculation examination. The content of health education in comprehensive schools essentially consists of 1) human growth and development (e.g. taking care of one's own health), 2) health in everyday choice situations (e.g. nutritional needs and problems in different situations, smoking, alcohol and other intoxicants, sexual health, the most common contagious diseases, traffic safety and behaviour); 3) resources and coping skills and 4) health, society and culture (e.g. national diseases).

By autumn 2012 teachers of health education are required to have specific qualifications of a subject teacher in health subjects.

Consultation and control: pregnant women

Section 15 of the Health Care Act provides that local authorities must provide within their area maternity and child health clinic services for pregnant women and families expecting a child as well as for children under school age and their families.

The services for pregnant women include regular checks to ensure the health of the mother and the foetus, foetal and infection screenings and other examinations. In addition, the services include family and health counselling. Mother and baby clinics provide their services free of charge.

Child health clinics and health care at school

The activities of child health clinics and school-based health care are regulated by the Health Care Act and the Government Decree on Maternity and Child Welfare Clinics, School and Student Health Care and Preventive Oral Health Care for Children and Young People (*338/2011*). Local authorities must arrange at least 15 health checks at child health clinics for all children before they start school. Three of these are extensive health checks. A child's both parents are invited to attend the extensive health checks, during which the clinics assess the whole family's well-being and possible needs for support. Health care at school, too, includes a health check every year.

Three of the health checks are extensive checks. In addition, the health services at clinics and school must include health counselling according to need and identification of children and families in need of particular support. The necessary support must be arranged without delay. Health care at school must also include monitoring and promoting the healthiness and safety of the school environment and community. The services of child health clinics and school-based health care are provided free of charge.

Monitoring reports show that the new legislation has considerably improved the implementation of health checks, although some deficiencies have still been found. In 2011, approximately four fifths of all health centres conducted extensive health checks. The National Supervisory Authority for Welfare and Health and the Regional State Administrative Agencies supervise the implementation of the above-mentioned Government Decree by means of a new supervision programme and intervene in the worst defects.

Article 11 para. 3: Prevention of diseases

Question 1

Environmental Health Care

Environmental Health Care is part of preventive health care and protects the health of individuals and their living environment. Section 21 of the Health Care Act contains a provision on environmental health care, according to which local authorities must provide environmental health care services within their area according to the provisions of the Act on Cooperation Areas in Environmental Health Care (410/2009).

According to Section 21(2) of the Health Care Act, the provision of environmental health care is governed by the Health Protection Act (763/1994), the Food Act (23/2006), the Chemicals Act (744/1989), the Tobacco Act (693/1976), the Veterinary Care Act (765/2009) and the Act on Safety of Consumer Goods and Consumer Services (75/2004). The latter has been repealed by the Consumer Protection Act (*920/2011*), which entered into force on 1 January 2012.

Environmental health care, which also constitutes public health care, important for public health, is organised by local authorities or in cooperation between local authorities, as stipulated in the Act on Cooperation Areas in Environmental Health Care.

Question 2

Masto project 2007–2011

In 2007 the Ministry of Social Affairs and Health set up the *Masto* project to promote practices increasing well-being at work, to enhance depression prevention, to improve effective treatment and rehabilitation, to promote staying on at work and returning to work in the context of depression, and to reduce depression-related work disability.

In addition to the actual project activities, *Masto* also served as an umbrella for many of the projects that the organisations involved had started before. In particular, the project promoted measures underpinning the cooperation among different actors and the dissemination of best practices at national level. The steering group of the project prepared an action plan for the years 2008–2011, comprising 20 sub-projects and measures which the participant organisations were responsible for carrying out.

In practice, the *Masto* project aimed at promoting well-being at work by taking up mental health themes in the training organised for occupational health and safety personnel and workplace supervisors. An important component related to the project was to develop good practices for occupational health services and, associated with it, to promote cooperation between the workplaces, occupational health services and psychiatry. An important element was to support the treatment of depression at its initial phases within primary health services.

The final report of the *Masto* project describes the activities in 2008–2011.[18] In addition, the steering group of the project, consisting of representatives from the most relevant branches of government, labour market organisations and the third sector, proposed follow-up measures to promote the objectives of the project.

[18] Masto-hankkeen (2008–2011) loppuraportti. Masennusperäisen työkyvyttömyyden vähentämiseen tähtäävän hankkeen toiminta ja ehdotukset. Sosiaali- ja terveysministeriön selvityksiä 2011:15. (Final report of the Masto project (2008–2011). Actions and proposals of the project to reduce depression-related work disability. Publications of the Ministry of Social Affairs and Health 2011:15.) Available in Finnish at:
<http://urn.fi/URN:ISBN:978-952-00-3151-0>. A summary in English is on page 5 of the publication.

Question 3

The HIV and AIDS situation in Finland and the mortality of HIV infected patients in Finland in 2008–2011 are demonstrated below by statistics of the National Institute for Health and Welfare. The statistics also include 2012 data, *i.e.*, all cases reported by 3 June 2012.

HIV in Finland during the reporting period: domestic cases reported by 3 June 2012, by date of diagnosis[19]

all			**main causes of contagion**			**breakdown by sex**		**contagion from sex**			**injected drugs**		**rare causes of contagion**	
year	**total**	**aliens**	**sex**	**injected drugs**	**no report**	**men**	**women**	**gay sex men**	**hetero sex men**	**hetero sex women**	**men**	**women**	**blood**	**mother-child**
all	2025	0	1525	313	166	1641	384	829	438	257	228	85	13	8
2012	36	0	26	0	10	31	5	14	9	3	0	0	0	0
2011	77	0	68	2	5	64	13	31	26	11	2	0	2	0
2010	108	0	91	3	13	83	25	34	37	20	0	3	1	0
2009	99	0	79	10	10	74	25	33	26	20	8	2	0	0
2008	87	0	70	2	14	73	14	38	22	9	1	1	0	1

AIDS cases and AIDS deaths reported in Finland by the end of 2011			
AIDS cases		AIDS deaths	
Year	Total	Year	Total
Reported AIDS cases 1980-2011	582	Reported AIDS deaths 1980-2011	299
2011	24	2011	5
2010	33	2010	8
2009	21	2009	7
2008	29	2008	11

[19] National Institute for Health and Welfare, < http://www.ktl.fi/ttr/gen/rpt/hivsuokotim.html >. More information on HIV in Finland is available at: <http://www.ktl.fi/portal/suomi/osastot/infe/yksikot/hiv-yksikko/tapaustilastot>.

Answers to the Committee's conclusions

Policies on preventing risks to be avoided

In 2011 Finland started to draft a national Water Safety Plan (WSP). The Finnish WSP covers the assessment of health risks and the organisation of water management in respect of both domestic water and waste water. The objective of the WSP is to ensure the safety of domestic water in all circumstances. The WSP should be available by the end of 2014.

In 2008–2011 Finland also implemented Directive 2006/7/EC of the European Parliament and of the Council concerning the management of bathing water quality. The purpose of the Directive is to ensure safe bathing water in all circumstances during the bathing season.

Measures to prevent smoking, alcoholism and drug addiction

The total consumption of alcoholic beverages declined for three consecutive years from 2008 to 2010 to 10.0 litres of 100 per cent alcohol per capita. This is due to three increases in alcohol excise duties in 2008 and 2009. The detrimental effects of alcohol have also been declining. Until 2010, the police filed fewer cases of domestic disturbances, aggravated assaults, and drunken driving. These positive trends stopped in 2011 but the alcohol excise duties have been increased by the Government from 1 January 2012 onwards. For the year 2012, the total alcohol consumption is estimated to be 9.9 litres of 100 per cent alcohol per capita.

The Government has also agreed on continuing the Alcohol Programme[20], which is based on the joint efforts of the state, the municipalities and various associations and organisations. The National Institute for Health and Welfare is the principal authority in charge of co-ordinating the Programme and helping municipalities to implement the programme.

Finland has a state monopoly on retail off-sales of most alcoholic beverages. Only fermented alcoholic beverages containing a maximum of 4.7 per cent alcohol may be sold in private shops. The age limit for buying mild alcoholic beverages is 18 years and for strong alcoholic beverages 20 years.

The new Tobacco Act (*693/1976*, as amended by Acts *1731/2009*, *1538/2009* and *698/2010*) entered into force on 1 October 2010 with the objective of putting an end to the use of tobacco products in Finland.

Finland is thus the first country to lay down the aim of putting an end to smoking in a law. The purpose is to achieve this aim by preventing in particular children and adolescents from taking up smoking. Not only shops but also private persons may not sell or supply tobacco products to persons under 18. Persons under 18 are prohibited from importing and possessing tobacco products. Further, sellers of tobacco products must be at least 18 years old. There is a total ban on the sale of snuff in Finland, as the ban on import and sale has been extended to also apply to private persons. A maximum of 30 packets may however be imported for one's own use. In addition, the prohibitions against smoking have been extended in facilities used by children and young people, joint facilities of apartment house companies, outdoor events and hotel rooms. Since 2012 tobacco products or their trademarks may not be displayed in retail sale facilities. Furthermore, the sale of tobacco products from vending machines will be forbidden in 2015.

[20] More information available in Finnish at: <http://www.thl.fi/fi_FI/web/fi/tutkimus/ohjelmat/alkoholiohjelma>.

During the reporting period, smoking prevalence has decreased among both adults and youth. The rate of daily smoking was 21 per cent in 2007 and 19 per cent in 2010 among adults. Daily smoking among men was at 23 per cent and among women 16 per cent in 2010. The percentage of young persons aged 14–18 using tobacco products daily decreased from 19 per cent in 2007 to 17 per cent in 2011. In that year, the daily smoking rate among boys was 18 per cent and among girls 16 per cent.

Prevention of accidents

In this respect the Government refers to to the information given in connection with Article 11, paragraph 1 above.

General Questions from the Committee

According to the Act on Welfare for Substance Abusers (41/1986), municipalities must provide substance abuse services that are in accordance with the needs of the municipalities both in their content and coverage. All substances that are used for intoxication are considered intoxicants: alcohol, substitutes, pharmaceuticals and drugs. Units providing specialized services for substance abusers include outpatient care (A-Clinics, youth centres), short-term inpatient care (detoxification units), longer-term rehabilitative care (rehabilitation units) and support services (day centres, house services for substance abusers and supported housing) and peer support activities.

In addition to the units providing specialized services for substance abusers, increasing numbers of substance abusers are treated within primary social and health care services, including social welfare offices and child welfare services, mental health clinics, health centre clinics and wards, hospitals and psychiatric hospitals. The Finnish system emphasizes that drug treatment as such is often insufficient and the substance abuser should be assisted in solving problems related to income, living and employment.

In Finland, municipalities are in charge of organizing social and health services, but local government lacks monitoring systems that would help identify client group specific welfare deficits and service needs. In particular, the most socially marginalized substance abuse clients face an increased risk of exclusion from the service network.

A quality framework for substance abuse services (Ministry of Social Affairs and Health 2002) and Current Care guidelines (Duodecim 2006) for the treatment of drug abusers have been created in order to develop substance abuse work. The development policy for drug treatment services emphasizes developing low-threshold services and related training. The first health counseling centre intended for the exchange of needles and syringes was set up in Finland in 1997, and substitution and maintenance treatment was introduced as an official part of substance abuse services in 2000. As far as possible, the most difficult-to-treat substance abuse patients (multiple-diagnosis patients) are treated centrally in units providing specialized services.

ARTICLE 12: THE RIGHT TO SOCIAL SECURITY

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

Questions 1 and 2

National pension scheme

The National Pensions Act (*347/1956*) was reformed in 2007. The new National Pensions Act (568/2007) entered into force on 1 January 2008. The survivors' pensions paid by the Social Insurance Institution were also included in the Act. The main aim of the reform was to clarify and modernise the legislation regarding national pensions, but some changes had an impact on the level of pensions as well. The most important revision was that the pensioner's place of domicile no longer affects the amount of the national pension. As a result, the full amount of the national pension for those who live in municipalities of the second cost-of-living category rose by circa EUR 20 per month. In addition, the residential qualification period for the national pension was shortened from five years to three years. Non-EU citizens must have lived in Finland for at least three years after the age of 16 to qualify for the national pension.

At the beginning of 2008 also the Act on Disability Benefits (*570/2007*) and the Act on Housing Allowance for Pensioners (*571/2007*) took effect. The new Act on Disability Benefits comprises provisions on the child disability allowance, the disability allowance and the pensioners' care allowance. Some of the benefits were renamed in the new Act but the amount of the benefits remained unchanged. The benefits are now called disability allowance for persons under 16 years of age, disability allowance for persons aged 16 years and over, and care allowance for pensioners.

Guarantee pension

A new pension benefit was introduced in 2011. The Act on Guarantee Pensions (*2010/703*) entered into force on 1 March 2011. According to the Act, those with a very small pension may apply for a guarantee pension to ensure a reasonable level of income. The guarantee pension is financed by the State and administered by the Social Insurance Institution.

A resident pensioner is eligible for a guarantee pension if his or her total gross pension income is less than the full amount of the guarantee pension (EUR 714 in 2012). Immigrants who do not receive a national pension may receive a guarantee pension if they are at least 16 years of age and disabled within the meaning of the National Pension Act or have reached the age of 65. To qualify for a guarantee pension, the applicant must have lived in Finland for at least 3 years after reaching the age of 16. The guarantee pension has replaced the special assistance for immigrants, which was abolished when the Act on Guarantee Pensions took effect in March 2011.

The amount of the guarantee pension is affected by any other pension income that the beneficiary may receive. The other pension income is deducted from the full amount of the guarantee pension, which is about EUR 714 per month in 2012 (about EUR 688 in 2011). The guarantee pension is not reduced by earnings, capital income or assets, nor is it affected by the pensioner's marital status. In the end of 2011, about 105 000 persons received a guarantee pension. Roughly 44 000 of them were over 65 years old.

Disability

A provisional Act Promoting Return to Work from a Disability Pension (*738/2009*) is in force from 2010 to 2013. The Act makes it easier to suspend a disability pension and raises the maximum limit of earnings permitted during the payment of the disability pension. This offers better opportunities for low-income retirees on a disability pension to engage in and try gainful employment. In the earnings related pensions scheme a person receiving a full disability pension may earn a maximum of 40 per cent of the stabilised average earnings prior to retirement, and a person receiving a partial pension may earn 60 per cent of the earnings. Nevertheless, the maximum limit of earnings permitted is about EUR 714 per month (in 2012). In the national pension scheme the maximum limit of earnings permitted is about EUR 714 (in 2012) per month for everyone. When the earnings exceed the set limits, the pension payments are suspended for at least three months but for no more than two years. The impact of the provisional act will be assessed in 2013.

Employment accidents

A new Act on Sportspersons' Security against Accidents and Pension Security took effect on 1 May 2009 (*276/2009*). The right of sportspersons to security against accidents was improved by giving them the right to a permanent accident pension. A sportsperson is guaranteed reasonable income security until the age of 65 years, if a sports accident makes him or her permanently incapable also for work other than sports. A permanent accident pension is payable if examinations of the sportsperson's opportunities to recover show that the sports injury prevents the person's rehabilitation for a new work or occupation.

Reference price scheme for medicines

On 1 April 2009 a reference price scheme for medicines was introduced by amendments (*802/2008* and *803/2008*) to the Health Insurance Act (*1224/2004*) and the Medicines Act (*395/1987*). This scheme supplements the generic substitution scheme for medicines introduced in 2003. The generic substitution scheme makes it possible to replace a medicine prescribed by a doctor for a patient with a corresponding but less expensive alternative product. Doctors may prohibit such replacement for medicinal reasons or reasons of treatment. Pharmacy staff is obliged to inform patients that they may choose a corresponding less expensive medicine instead of the prescribed product. The staff must also explain the patients what the generic substitution means for them. The generic substitution scheme is cost-effective and guarantees the patients effective and safe medicinal treatment.

In the reference price scheme the medicines under the generic substitution scheme are classified in reference price groups. Interchangeable medicines of equal value containing the same active substance and reimbursable under health insurance are classified in the same reference price group. The reimbursement for medicines under health insurance is calculated on the basis of the least expensive alternative in the reference price group. If the price of the least expensive medicine in a reference price group, including value added tax, is less than EUR 40, the reference price is this price plus EUR 1.50. In other cases EUR 2.00 are added to the price of the least expensive price in a reference price group, including value added tax.

The reference price is the highest price on the basis of which the reimbursement for a medicine in the group in question is calculated. The reference price scheme makes both doctors and patients better aware of medicine prices, makes them choose alternative medicines that are less expensive but still have equal value in treatment, and promotes price competition between producers of medicines.

Question 3

The Government notes in this connection that detailed statistics and further information on the Finnish social security system can be found on-line at the website of Statistics Finland at <http://www.stat.fi/til/sos_en.html>.

Detailed statistics and further information on the Finnish pension system is available on-line at the website of the Finnish Centre for Pensions at <http://www.etk.fi/en/service/statistics/739/statistics> and <http://www.etk.fi/en/service/the_pension_system/1399/the_pension_system>.

Answers to the Committee's conclusions

Coverage of the social security system

Social security system in Finland by risk and target group		
	Whole population (legal permanent residents)	Employed people
Old age	-National pension (minimum 3 years of residence)	-Earnings-related pension (accrual starts after earnings of EUR 52.49/month or self-employed income of EUR 7000/year)
Sickness	-Minimum health insurance (16-67 years old) -Public health care	-Earnings-related sickness benefits -Occupational health care
Work incapacity	-National pension (rehabilitation)	-Earnings-related pension (rehabilitation)
Occupational disease or employment accident	-	-Accident insurance (almost 90% of all employed people are covered)
Unemployment	-Minimum daily allowance (fulfilment of the necessary working condition[21]) -Labour market allowance (those not meeting the working condition)	-Earnings-related unemployment benefit (voluntary membership in an unemployment fund and fulfilment of the working condition)
Family	-Minimum maternity, paternity and parental allowance	-Earnings-related benefits
Survivor	- Survivors' pension	- Survivors' pension -Group life assurance (voluntary)

Source: O. Kangas and M. Niemelä (2012): Riskit, vakuutus ja sosiaalivakuutus. In P. Havakka, M. Niemelä and H. Uusitalo (eds.) Sosiaalivakuutus. Sastamala: FINVA.

Social security in Finland is to a significant extent based on residence and mainly tax-financed. In other words, all legal permanent residents in Finland are entitled to certain benefits, such as the national pension, health insurance, labour market allowance, child allowance, maternity allowance, housing allowance, social assistance and student grant. Health care is organized by municipalities, and people have the right to free health care (a user fee with an annual maximum ceiling exists) based on their registered residence in a municipality. The benefits may be means-tested (the person's overall situation and need for support are examined), income-tested (the person's income affects the benefit) or universal (all residents receive the same benefit without any testing).

The universality principle is supported by comprehensive residence-based social security that guarantees minimum benefits. The right to social security is individual; *i.e.*, there are no separate benefits for family members based on their breadwinner's employment.

[21] Working condition = the person needs to fulfill all of the following criteria: 1) a period of employment of 34 weeks during the past 28 months, 2) more than 18 weekly hours of work, and 3) a minimum salary of EUR 1103/month or according to the collective agreement.

Some benefits are designed to compensate for lost earnings. These are based on earlier earnings, and all residents who fulfil certain conditions are entitled to these benefits. Insurance against employment accidents and occupational diseases are only based on employment.

While people without any previous work experience are entitled to a labour market allowance, it was agreed in 2012 that the work condition required for an earnings-related unemployment benefit or a minimum daily unemployment allowance would be reduced to 6 months from about 8 month as of 1 January 2014. To receive an earnings-related benefit a person needs to pay voluntary unemployment insurance contributions. All the unemployed people residing permanently in Finland are entitled to income security in some form. It is a right defined in the Constitution of Finland (*731/1999*).

More detailed discussion on coverage rates in Finland

The Committee has asked "for figures in percentage indicating the personal coverage of each branch of social security". Information on the coverage rates is given below. In 2009 the OECD jointly with the European Commission launched a project to analyse the trends in social benefit recipiency. One of the main goals of this project is to allow policy makers to assess to what extent social programmes effectively protect various groups from the loss of income, and how this protection has evolved over time. Finland has participated in the project by supplying data to the OECD. However, the project is still in progress, and so far the OECD has not published any reports including coverage rates for Finland.

The work involves several methodological challenges. Some of these challenges are related to those indicators which the Committee is asking about. The coverage rate indicator that the Committee is currently asking about would allow comparing the number of beneficiaries to the number of eligible persons for specific programmes. However, it is often very difficult to determine who are eligible persons (see also OECD document "*Design and build-up of database on social benefits recipients", DELSA/ELSA/WP1(2011)14*). Therefore alternative indicators are often used, such as participation rates (ratio of beneficiaries to the whole population) or pseudo-coverage rates (the ratio of beneficiaries to a given group *a priori* targeted by a programme).

Alternative indicators have obvious limitations that complicate interpretation. For example, we can compare the number of (old-age) pensioners to the number of persons who exceed a certain age limit. However, some persons may have chosen to continue working after this age limit and postponed their retirement (*i.e.*, pension recipiency). With ageing populations and an increasing life expectancy this may even be considered desirable from the policy perspective. In Finland the interpretation is further complicated by the flexible retirement age under the Finnish earnings related pension scheme.

The population share of persons older than 65 years among all pension recipients in Finland is presented below. This population share is almost 100 per cent. The small decline in the population share since the late 1990s is related to the change in the pension income test of the national pension. Since the late 1990s, the national pension has been fully income tested against the recipient's earnings-related pensions and other permanent pension income. A person may continue to work and postpone his or her retirement (earnings-related scheme) after the age of 65 years. In this case the person may also postpone the national pension or apply normally for the national pension. In the latter case the pension income test of the national pension is carried out against the expected earnings related pension (as accrued by the age of 63). The person may also receive a pension from abroad, which is included in the pension income test of the national pension. The pension recipient figure does not include those recipients who receive a pension only from abroad, although pensions from abroad affect the income-test of the national pension.

Population share, persons over 65 years													
Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
%	100	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	99,9
Year	1999	200	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
%	99	99,8	99,8	99,7	99,3	99,7	99,8	99,6	99,4	99,3	99,3	99,2	99,1

Note: The population shares of pension recipients are calculated for all pension recipients residing in Finland, as a percentage of the population insured for national pension benefits. The population shares more or less cover the resident population of the country, but also include Finnish citizens residing abroad temporarily. Source: Finnish Centre for Pensions.

It is more difficult to create coverage indicators for other branches of social security. The definition of unemployment in the labour force survey (LFS) of Statistics Finland is different from the rules applied to different unemployment benefits. Therefore it would be very difficult to interpret the ratio of the number of unemployment benefit recipients to the number of unemployed people according to the labour force survey. For instance, persons receiving an unemployment benefit may not be considered unemployed in the labour force survey if they do not report that they are seeking work actively.

Somewhat similar problems arise if the number of registered unemployed job seekers is used (register data) instead of the labour force survey figures. The following examples are provided below:

- Registered unemployed persons do not include persons covered by different activation measures (e.g. training). However, these persons receive unemployment benefits during activation measures. It is possible to separate benefit recipients attending activation measures from the total number of benefit recipients. A recent reform abolished separate unemployment benefits for unemployed persons attending training etc. It is still possible to separate benefit recipients attending activation measures, but the reform may have affected the reliability of the time series.
- A person may receive an adjusted (reduced) unemployment benefit if he or she has incidental or part-time earnings while unemployed. Recipients of adjusted benefits are not necessarily classified as registered job seekers because the working time rules for their benefit recipiency differ from those for registered job seekers.
- Registered jobseekers may also include foreign nationals who are not covered by the Finnish social security system. In 2011, 7.8 per cent of all unemployed job seekers were foreign nationals. There is no information about how many of these foreign job seekers were not covered by the Finnish social security system.

As the examples above indicate, any indicator comparing the number of recipients of unemployment benefits to the number of registered unemployed persons must be interpreted with caution. Below, this ratio is presented for the years 2005-2011 (excluding benefit recipients attending activation measures).

Ratio of unemployment benefit recipients to all registered unemployed persons 2005-2011, %						
2005	2006	2007	2008	2009	2010	2011
92.4	92.9	90.0	88.4	88.7	86.9	85.8

Source: Ministry of Employment and the Economy. Note: Benefit recipients do not include immigrants receiving integration assistance.

There is no clear single explanation for the decline of the ratio. The 2006 reform of the labour market subsidy and other unemployment benefits (*1290/2002*) has probably contributed to the decline. The 2006 reform toughened the sanctions for long-term unemployed by increasing the periods without benefits (sanctions for resignation from work without a valid reason, dismissal for reasons attributable to the person himself or herself, refusal to take part in offered support programmes, decline of job offer). The increase of unemployment periods without benefits due to sanctions obviously changes the ratio of benefit recipients to all registered unemployed. However, it would be misleading to interpret the change in this ratio also as a change in coverage. The basic principle of the Finnish unemployment security system is that unemployment due to personal reasons, or prolonged unemployment caused by the unemployed person himself or herself, will result in withdrawing the unemployment benefit. The sanction system related to unemployment security must simultaneously meet a variety of requirements.

The system must steer job seekers to search for employment actively and to improve their personal capacities for finding work. The system must be clear in order to prevent activity regarded as inappropriate in terms of labour policy. The severity of the consequences must be in proportion to the degree of inappropriateness of the action in question. The rules governing the sanctions were recently revised (the new rules became effective on 1 June 2012). In this context the duration of the prescribed time limits was revised and the provisions concerning them were clarified. The reform will probably reduce the unemployment periods without benefits.

Currently, the labour market subsidy is income tested against the income of the beneficiary's spouse. This income test increases the number of registered unemployed persons without an unemployment benefit. The Government has agreed to abolish this income test in 2013. This will reduce the unemployment periods without benefits.

Employed persons who fulfil the employment requirement[22] and who are members of unemployment funds[23] may receive an earnings related benefit. According to the labour force survey of Statistics Finland, 83 per cent of all wage earners were members of unemployment funds in 2011. There has been no clear trend in this share during the 2000s. Unemployed persons who do not fulfil these requirements may receive a basic unemployment allowance[24] or labour market subsidy.

Share of wage earners who are members of unemployment funds, %									
2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
81.9	82.3	82.2	85.1	82.5	82.8	83.6	82.9	84.0	83.3

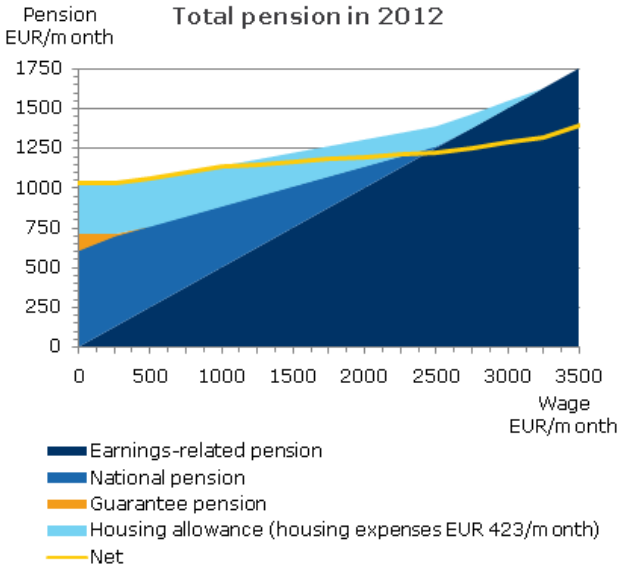
Source: Labour force survey, Statistics Finland

The Government observes that your Committee has concluded that the situation in Finland is not in conformity with Article 12 § 1 of the Revised Charter on the ground that the minimum national pension for single persons is manifestly inadequate.

The Government notes in this connection that the level of the minimum pension was increased during the reference period by introducing the guarantee pension, which is presented above in detail.

If a pensioner has no other pension income, he or she is entitled to the full amount of the national pension, which was about EUR 586 per month for single persons in 2011. Since March 2011 such a pensioner has also been entitled to a guarantee pension. In 2011 the amount of the guarantee pension for him or her was about EUR 101 per month (the full amount of the guarantee pension in 2011 was about EUR 688 per month). However, the amount of the housing allowance for pensioners is affected by their pension income, including the guarantee pension. If this effect on the housing allowance is taken into account, a single person’s pension income was raised with about EUR 96 per month when the guarantee pension was introduced.

[22] The employment requirement of a fund for wage earners is met if the person has been gainfully employed for 34 calendar weeks during his or her membership, with the minimum weekly working hours of 18 hours.
[23] The membership requirement of a fund for wage earners is met if the person has been an insured member of the fund for at least 34 consecutive weeks immediately before applying for the benefit.
[24] Unemployed persons who fulfill the employment requirement but are not members of unemployment funds.



Reference: Finnish Centre for Pensions, <www.etk.fi/en/service/pension_benefits/1424/pension_benefits>.

Sufficiency of social security benefits

The labour market subsidy is an unemployment benefit funded by tax revenue. Its duration is unrestricted. For eligibility for labour market subsidy an unemployed job seeker does not need to fulfil the employment requirement.

The provision of the Unemployment Security Act (*1290/2002*) mentioned in your Committee's conclusions provides that a person who has received a labour market subsidy on account of unemployment for at least 500 days, or for at least 180 days after the end of the maximum period of the basic unemployment allowance, is no longer paid the labour market subsidy for the unemployment period if he or she refuses to accept work, resigns from work without a valid reason or is dismissed from work or labour market training for a reason attributable to himself or herself. The same procedure applies if the person, without a valid reason, refuses to attend a work trial, job coaching or a traineeship agreed about in a plan prepared with him or her, or if the person interrupts a work trial, job coaching or a traineeship without a valid reason or is compelled to interrupt it for a reason attributable to himself or herself.

An unemployed person may again receive a labour market subsidy for an unemployment period after fulfilling the employment requirement, *i.e.*, after participating in work, labour market training, a work trial, job coaching or a traineeship qualifying under the requirement for at least five months. Before that the person is entitled to a labour market subsidy for the duration of the above-mentioned activation measures. During the period when the labour market subsidy is suspended the person is guaranteed minimum subsistence by means of social assistance under the Social Assistance Act (*1412/1997*).

On 25 April 2012 Parliament adopted an amendment of the Unemployment Security Act (*288/2012*) which repeals the above-mentioned provision on the employment requirement of five months concerning long-term unemployed applicants for a labour market subsidy. A study commissioned by the Ministry of Employment and the Economy shows that the threat of suspending the labour market subsidy has not influenced job seekers' active job seeking or participation in services promoting their employment.[25] Thus the provision has not steered the behaviour of job seekers as expected.

[25] Työmarkkinatuen aktivoinnin vaikutukset ("Effects of activating the labour market subsidy"). Publications of the Ministry of Employment and the Economy 7/2009. Available in Finnish at <http://www.tem.fi/files/21928/TEM_7_09_nettiin.pdf>.

In future, the consequences of a job seeker's conduct which is reproachable from the labour market policy standpoint will be determined in the same manner for long-term unemployed applicants for a labour market subsidy and for other job seekers.

After the amendment of the Unemployment Security Act, a job seeker has a valid reason for refusing an employment service referred to in the Act or for interrupting it if the service does not suit the person's state of health or capability for work and activity, if the service is provided outside the person's commuting area or if his or her daily travels to the place of the service exceed an average of three hours. The job seeker also has the right to refuse or interrupt the service if the service provider essentially neglects its responsibility for occupational safety and health or fails to comply with the legislation on the provision of the service or the conditions of the service contract, or if the service essentially differs from the conditions of the contract. Moreover, the job seeker has a valid reason for refusing labour market training or interrupt it if work in the field in question does not suit his or her state of health and capability for work and activity, or if the subsistence of the job seeker and his or her dependants is not reasonably safeguarded during the training. The job seeker also has a valid reason for refusing an employment service referred to in the Act or to interrupt it for other comparable reasons.

Suspension of labour market subsidies because of refusal to accept activation measures for persons who have received the subsidy for 500 days, or for 180 days after the maximum period of the unemployment allowance						
Suspension of labour market subsidy	2006	2007	2008	2009	2010	2011
Number of persons / year	2 026	6 345	5 079	3 441	3 341	3 926

Source: Social Insurance Institution

Employment and Economic Development Offices issue a statement concerning a job seeker's eligibility for an unemployment benefit from the labour market policy standpoint. The statement is binding on the Social Insurance Institution and cannot be appealed. Instead, job seekers are always entitled to appeal against a labour market subsidy decision of the Social Insurance Institution to the Unemployment Appeal Board. Furthermore, a decision of the Unemployment Appeal Board is always appealable to the Insurance Court.

In their legal practice the Unemployment Appeal Board and the Insurance Court have assessed the fulfilment of the statutory requirements for a valid reason in different cases of refusal, resignation and interruption.

Example: Decision 5556/7/T of the Unemployment Appeal Board of 18 December 2007

> Employment authorities had referred X to labour market training. He had applied for the training by means of an electronic application form on the Internet. X had not confirmed his application in person in an employment office before the expiry of the application period as instructed. Therefore, the application had not become pending. Since X had not applied for the labour market training as required, he was considered to have refused training suitable for him without a valid reason. X had received a labour market subsidy for more than 500 days during his unemployment period. Because he had refused training, he had no right to the labour market subsidy during the unemployment period until he had fulfilled the employment requirement of five months under the Unemployment Security Act.

Your Committee's conclusion

By an amendment (*804/2008*) of the Health Insurance Act (*1224/2004*) the minimum amounts of the sickness allowance, the parental allowances (maternity allowance, paternity allowance and parental allowance) and the special care allowance were increased from EUR 15.20 to EUR 22.04 per day. Moreover, the minimum amount of the rehabilitation allowance under the Act on the Rehabilitation Benefits and Rehabilitation Allowance Benefits of the Social Insurance Institution (*566/2005*) was increased. The increased levels of the allowances with a minimum amount apply since the beginning of 2009.

In addition, from 1 March 2011 the allowances with a minimum amount (sickness allowance, parental allowances, special care allowance and rehabilitation allowance) have been linked to the national pensions index, which reflects changes in consumer prices. On that date the allowances with a minimum amount were increased to EUR 22.13 per day. In 2012 the amount of the allowances with a minimum amount is EUR 22.96 per day. These allowances are payable for working days, *i.e.*, all days other than Sundays and holidays. This amounts to six days per week and a calculatory number of 25 days per month. Thus, in 2012 the calculatory amount of allowances with a minimum amount is EUR 574 per month.

General Questions from the Committee

The right to social security is largely based on residence. This means that a self-employed person who is considered to reside permanently in Finland is entitled to many social security benefits on account of the residence. In practice, self-employed persons have the same social security as employees.

The basic objective is to guarantee all gainfully employed people sufficient and reasonable social security. However, self-employed persons have a wider choice of possible compositions and levels of social security benefits. Still, their social security is largely comparable to that of employees. The purpose has been to guarantee farmers and other self-employed persons the same key social benefits as employees receive.

A self-employed person moving to Finland is considered to reside permanently in Finland if the person fulfils the criteria laid down in the Act on the Application of Residence-Based Social Security Legislation (1573/1993). A self-employed person moving to Finland becomes insured under the Health Insurance Act after becoming insured under the Self-Employed Persons' Pension Act (1272/2006).This presupposes continuous self-employment for 4 months.

The benefits of a self-employed person under different sectors of the social security scheme are described below.

Pension security

The employment pension legislation concerning farmers and other self-employed persons was enacted in 1970. A self-employed person must take out a statutory pension insurance if his or her annual self-employment income amounts to at least EUR 7,105.84 (in 2012) and the self-employment activity continues without interruption for more than 4 months. In such cases the pension insurance for a self-employed person is obligatory. For a farmer, the pension insurance is statutory if the farmer's annual income amounts to at least EUR 3,553 (in 2012). Under certain conditions, also the self-employed person's family members are covered by the pension insurance if they work in the enterprise. If the earned income of the self-employed person is lower than the threshold for insurance, he or she may take out a voluntary insurance.

The amount of the pension for the time of self-employment is determined by the earned income.[26]

[26] According to the Self-Employed Persons' Pensions Act the earned income must correspond to a pay that should be paid if the work falling under the scope of the Act were performed by another, equally skilled person instead of the self-employed person, or to a pay that otherwise corresponds to a remuneration which, on average, is commensurate with the insured work in question. The earned income referred to in the Self-Employed Persons' Pensions Act must correspond to the self-employed person's work contribution (the financial value of the work contribution), not to the financial performance of the self-employment activity. In defining the earned income, account is not taken of the book profit or loss of the activities. The earned income referred to in the Self-Employed Persons' Pensions Act is determined on the basis of an overall assessment, taking account of the above-mentioned circumstances and, among other things, the self-employed person's age, education

The amount of the pension and the insurance premiums are calculated on the basis of the earned income corresponding to the work contribution. The pension security of self-employed persons includes the same pension benefits as the pension security of employees. The pension insurances for self-employed persons guarantee them disability pension and old-age pension. If a self-employed person dies, his or her family members are entitled to a survivor's pension.

E.g. The influence of earned income on a self-employed person's pension (the person retires at the age of 65; estimate without index increases)

Time of self-employment	**Earned income 20 000 EUR**	**Earned income 30 000 EUR**	**Earned income 40 000 EUR**
20 years	EUR 667	EUR 1 000	EUR 1 333
25 years	EUR 792	EUR 1 188	EUR 1 583
30 years	EUR 917	EUR 1 375	EUR 1 833

The self-employed person's whole employment history influences the final amount of the pension. If the amount is low, the self-employed person may receive a national pension and possibly also a guarantee pension. All persons who have resided permanently in Finland for more than three years are entitled to a national pension and a guarantee pension if the amount of their other pensions would otherwise remain below a certain limit. The accrual of a self-employed person's pension is the same as for other employees, and a self-employed person may retire at the age of 63–68 years, as the insured under other employment pension legislation, too.

The employment pension index is also used for adjusting existing pensions of self-employed persons. At the beginning of 2012, the pensions of self-employed persons were raised by an index increase of 3.61 %. The guarantee pension guarantees a minimum pension of EUR 713 (in 2012).

Birth

The family of a self-employed person is entitled to a child benefit, a child home care allowance and a private day care allowance, as all other permanent residents in Finland. A self-employed person residing permanently in Finland is covered by the national health insurance and thus entitled to maternity, paternity and parental allowances. The payment of earnings-related allowances is determined on the same grounds as for employees. The minimum allowance amounts to EUR 22.96 / day (in 2012).

Sickness

The social security against short-term sickness consists of the public health care and hospital service system, on one hand, and of the national health insurance, on the other hand. In public health care, no distinction is made between self-employed persons, employees and other people.

All people residing permanently in Finland, including self-employed persons, are covered by the health insurance. The amount of the sickness allowance is determined on the basis of the amount of earned income determined in taxation (as regarding the parental allowance). The minimum amount of the basic daily allowance is EUR 22.96 / day.

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and experience of the field of activity, and the location of the enterprise. In the assessment, account may also be taken of the general income level in the sector and the pursued amount of pension security.

As compensation for a person's loss of income due to short-term sickness, a sickness allowance is paid for the time of the person's incapacity for work. In the case of long-lasting sickness a self-employed person is entitled to rehabilitation and allowances on account of loss of earnings. A self-employed person may also receive a disability allowance or care allowance. All people residing permanently in Finland are entitled to compensation for medical expenses.

Employment accidents and occupational diseases

A self-employed person is not obliged to take out an accident insurance but may affect a statutory accident insurance of employees voluntarily. Farmers insured under the Farmers' Pensions Act have a statutory obligation to take out a farmers' accident insurance.

The full amount of an employment accident pension is 85% of the annual earned income for persons at working age (70% for persons over 65 years of age).

Unemployment

Both employees and self-employed persons are entitled to a basic daily allowance. Self-employed persons may, in the same manner as employees, insure themselves through the unemployment fund of self-employed persons. The members of the fund are paid an earnings-related daily allowance. The amount of their earned income is determined when they take out the insurance under the Self-Employed Persons' Pension Act. For eligibility for unemployment security the earned income must amount to at least EUR 8,520 per year (in 2012).

In 2010 the employment requirement for self-employed persons was shortened from 24 to 18 months. Thus, for eligibility for an earnings-related unemployment allowance, a self-employed person must be insured in the Finnish Entrepreneurs' Unemployment Fund for at least 18 months and be self-employed at the same time. A self-employed person who is not a member of the fund may receive a basic daily allowance from the Social Insurance Institution of Finland. In 2012 the basic daily allowance is EUR 31.36, *i.e.*, approximately EUR 674 per month.

In addition, all persons residing permanently in Finland without earlier work experience are entitled to a labour market subsidy.

Occupational health care

A self-employed person may arrange occupational health care for himself or herself voluntarily and receive compensation for the costs incurred. The Social Insurance Institution of Finland reimburses 50 or 60 per cent of the costs for preventive occupational health care (e.g. health checks).

Article 12 para. 2: Maintenance of a social security system at a satisfactory level at least equal to that required for ratification of the International Labour Convention No. 102

Question 1

In respect of this Question, the Government refers to its previous periodic reports.

Question 2

Maintenance of a social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security

Finland has neither signed nor ratified the European Code of Social Security. Finland signed the revised European Code of Social Security Code but found later that ratifying it was unfeasible.

Sickness, maternity and family benefits

In respect of the minimum amount parental allowances, special care allowance, sickness allowance and rehabilitation allowance, the Government refers to the information given in connection with Article 12 paragraph 1.

Unemployment

At the beginning of 2012 the amounts of the basic unemployment allowance and the labour market subsidy were increased by EUR 100 per month. In addition, the allowances were increased on the basis of an index clause so that the amount of the basic unemployment allowance and the full amount of the labour market subsidy rose by approx. EUR 121 per month, from EUR 553 to EUR 674 per month.

In 2012 the amount of the basic unemployment allowance and the full labour market subsidy is EUR 31.36 per day. The benefits are payable for five days a week and for a calculatory number of 21.5 days per month.

The increase of the basic unemployment allowance also increased the earnings-related unemployment benefits. The daily earnings-related benefit of an unemployed person consists of a component equal to the basic unemployment allowance and of an earnings-related component. The amount of the increase of the benefit made at the beginning of 2012 depends on the amount of the pay on which the benefit is based.

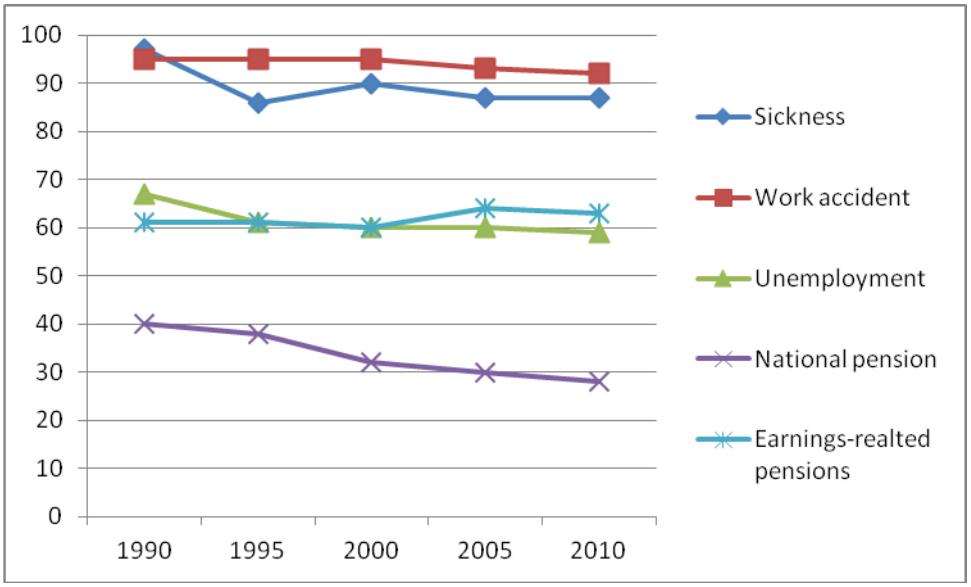
Question 3

The compensation rate of the national pension in relation to net pay has decreased since the 1980s as the pensions have not kept up with pay developments. In 2010, the compensation rate was around 30 per cent of the net pay. By contrast, earnings-related pensions have remained at a stable level in relation to pay (the net compensation rate is around 65 per cent, higher than the OECD average). The majority of all pensioners also receive an earnings-related pension.

Insurance against employment accidents or occupational diseases guarantees a high compensation rate, over 90 per cent of the recipient's net pay. A short-term absence from work because of an employment accident or an occupational disease does not cause any significant loss of earnings for the insured. The level of the benefits is higher than in most countries and has not been affected by cuts in social spending as many other benefits since the 1980s. After the cuts in unemployment benefits during the recession of the early 1990s, the compensation rate of the unemployment insurance has been quite stable, around 60 per cent of the net pay. Daily sickness allowances compensate for almost 90 per cent of the net pay, which is a significantly higher level than the OECD average.

Developments in benefit levels in Finland 2005–2012								
Median disposable income, all (in 2010 price)	*1 875*	*1 869*	*1 913*	*1 936*	*2 001*	*2 047*		
50% of median poverty line	*938*	*935*	*957*	*968*	*1001*	*1024*		
Euros/month (in current price)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Child allowance								
1. child	100	100	100	100	100	100	100	104
2. child	111	111	111	111	111	111	111	115
3. child	131	131	131	131	141	141	142	147
Single-parent raise	37	37	37	47	47	47	47	49
Parental allowance								
Minimum	380	380	380	380	551	551	553	574
Average, men	1 483	1 545	1 620	1 747	1 858	1 936	1 997	1 973
Average, women	995	1 060	1 170	1 241	1 342	1 398	1 427	1 452
Sickness allowance								
Minimum (after 55 days)	380	380	380	380	551	551	553	574
Average, men	1 180	1 200	1 228	1 277	1 368	1 429	1 421	1 445
Average, women	1 033	1 053	1 075	1 110	1 184	1 235	1 249	1 276
Labour market subsidy	500	505	514	527	551	551	553	674
Basic unemployment allowance	500	505	514	527	551	551	553	674
Earnings-related unemployment benefit								
Average, men	1 137	1 164	1 201	1 234	1 326	1 401	1 409	1 498
Average, women	861	899	922	945	1 017	1 071	1 082	1 128
National pension, single person	498	511	525	558	584	584	586	609
Guarantee pension							688	714
Old age pension (excl. survivors' pensions etc.)								
Average, men	1 408	1 453	1 507	1 557	1 659	1 687	1 731	..
Average, women	896	932	971	1 000	1 071	1 097	1 138	..
Disability pension								
Average, men	1 092	1 100	1 117	1 077	1 117	1 119	1 147	..
Average, women	901	914	934	891	927	929	960	..
New old age pensions								
Average, men	1 600	1 755	1 814	1 793	1 922	1 974	1 947	..
Average, women	1 073	1 189	1 250	1 199	1 326	1 365	1 370	..
New disability pensions								
Average, men	987	1 014	1 044	1 018	1 090	1 126	1 174	..
Average, women	786	814	841	809	842	884	907	..
Basic social assistance, single person	378	383	390	399	417	417	419	461

Net compensation rates of various benefits in Finland 1990-2010



Note: Unemployment benefit calculated for members of unemployment funds with average pay.
Source: O. Kangas and M. Niemelä (2012) Riskit, vakuutus ja sosiaalivakuutus ("Risks, Insurance and Social insurance"). P. Havakka, M. Niemelä and H. Uusitalo (eds.) Sosiaalivakuutus ("Social Insurance"). Sastamala: FINVA.

Answers to the Committee's conclusions

Maintaining a satisfactory level of the social security system

In respect of this conclusion, the Government refers to the information given in connection with Article 12, paragraph 2 above.

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

Questions 1, 2 and 3

Minimum pensions

As mentioned in the previous reports, national pensions are adjusted annually according to changes in the national pensions index (National Pensions Index Act; 456/2001). The national pensions index is linked to the cost-of-living index[27], which is compiled by Statistics Finland and tracks the changes in prices of key commodities. In 2010, the national pensions index went down from the previous year. To prevent the reduction of benefits, the index was frozen at the level of 2009. Guarantee pensions, too, are affected by the increase in the index. Moreover, in 2008 the level of national pensions was increased with EUR 20. The increase applied to old-age pensions, disability pensions, survivors' pensions and special assistance for immigrants.

[27] Official Statistics of Finland: Consumer Price Index [web publication]. Helsinki: Advisory Board of Official Statistics of Finland. Available at:<http://www.stat.fi/til/khi//index_en.html>.

Disability

In 2010 the legislation on earnings-related pensions was reformed in order to raise the level of disability pensions, particularly for the young. The accrual of the compensation paid for the future period (*i.e.*, the period between the occurrence of the risk and the age of retirement) was raised to 1.5 per cent for the whole future period. Earlier the percentage of accrual was 1.3 per cent after the age of 50. Studies leading to a diploma and periods of care for children under the age of three are also taken into account in calculating the amount of the compensation for the future period.

In addition, the application of a life expectancy coefficient to disability pensions in the earnings-related pension scheme was revised in 2010. The coefficient was included in the 2005 pension reform and was applied for the first time to pensions starting in 2010. When the disability pension starts, its amount is multiplied by the life expectancy coefficient. The amount of disability pension earned by the time of the pension contingency is multiplied by the life expectancy coefficient issued for the cohort turning 62 during the year of the pension contingency.

The life expectancy coefficient does not apply to the pension component for a projected pensionable service. The coefficient applied to the disability pension is thus permanently more lenient than the coefficient for those who continue working until the old-age retirement age: it is applied only to a part of the pension and is determined according to the expected longevity of the older cohorts. If the longevity evolves as projected, the coefficient for younger cohorts will have a larger cutting effect.

At the beginning of 2010, disability pensions that have continued for five years were increased permanently by a lump sum. The amount of the increase depends on the age of the pension recipient. For those aged 24–31, the increase is 25 per cent. The increase is reduced by one percentage point per year of age. If the pension is granted after the recipient has turned 50, no lump-sum increase is made.

Sickness

Since the beginning of 2010, on the basis of an amendment (*531/2009*) of the Health Insurance Act, an oral hygienist's examinations and treatment based on a private dentist's order are reimbursable from the health insurance. The insured receives a reimbursement in euros without a fixed-rate excess.

By an amendment (*1247/2010*) of the Health Insurance Act an insured person was given the right to get a sickness allowance based on the earlier illness even after the maximum allowance period if he or she returns to gainful employment and relapses when the employment has continued without interruption for at least 30 days. In such cases the sickness allowance is payable after the waiting period under the Health Insurance Act for at most 50 working days. The amendment of the Act entered force on 1 July 2011. It is intended to encourage persons who have been incapable for work to return to working life after their sick leave.

Family

At the beginning of 2010, an amendment (*962/2009*) of the Health Insurance Act extended fathers' right to a paternity allowance for a continuous period immediately after a parental allowance period used by them. The right was extended from 12 working days to 24 working days. During the so-called daddy-month fathers are entitled to 24 extra days with paternity allowance if they, instead of the mother, use at least the 12 last days of the parental allowance period.

The child benefit, the parental allowance and the child home care allowance were linked to changes in the cost-of-living-index in March 2011. The indexation is made annually. It now applies to the daily sickness allowance as well.

Unemployment

Since the beginning of April 2009 an amendment of the Unemployment Security Act (*1290/2002*) facilitates the advance payment of an adjusted unemployment benefit on the basis of the employee's own payroll declaration. In addition, the grounds on which an unemployment benefit may be paid to a job seeker in advance were expanded at the beginning of July 2009. The purpose is to safeguard the subsistence of an unemployed person in a situation where an unemployment benefit decision cannot be issued within a reasonable time.

A number of legislative amendments improving unemployment security took effect at the beginning of 2010. The employment requirement on a person receiving an unemployment benefit for the first time was reduced from 43 to 34 weeks. The employment requirement on an entrepreneur was reduced from 24 to 18 months. As a new benefit, an increment in the basic unemployment allowance or an increased earnings-related component of the earnings-related allowance was introduced for the first 20 days of unemployment for those who had been employed in three years before their unemployment. Those participating in activating employment measures now receive an increment in the basic daily allowance and the labour market subsidy or an increased earnings-related component of the earnings-related unemployment benefit for the maximum of 200 days of the time of their participation. Moreover, since the beginning of 2010 all unemployed job seekers attending training are entitled to an equal amount of a benefit irrespective of whether the training is arranged by an Employment and Economic Development Office or sought by themselves. The Act on the Public Employment Service (*1295/2002*) contains provisions on support through unemployment benefits for job seekers' independent studies that improve their opportunities for employment.

An Act (*144/2011*) that took effect on 1 March 2011 supplemented the Unemployment Security Act with a provision on a time limit within which applications for unemployment benefits must be processed. A decision on an unemployment benefit must be issued within 30 days of the receipt of the application. If the application is so deficient that the decision cannot be made within 30 days, the unemployment fund or the Social Insurance Institution must, within a prescribed time limit, take measures to process the matter. The decision must be issued within two weeks from the date when the fund or the Institution received the information necessary for deciding on the matter.

Since the beginning of 2012, employees working a shortened week because of a layoff receive a full unemployment benefit instead of an adjusted benefit for the layoff days. This change applies to those employees whose weekly working hours are reduced by at least one day. The procedure was earlier applied temporarily in 2010–2011. The payment of a full unemployment benefit for the layoff days speeds up the processing of applications for unemployment benefits, because the benefits are no longer adjusted. Moreover, the definition of part-time work has been broadened. Work is regarded as part-time work if the working hours correspond to at most 80 per cent of the maximum hours of a full-time employee. The earlier limit was 75 per cent. As a result of the amendment, an increasing number of part-time employees are entitled to an adjusted unemployment benefit in addition to their pay.

In other respects of the paragraph, the Government refers to information given in connection with Article 12, paragraph 1.

Answers to the Committee's conclusions

Health insurance

Health insurance comprises earnings security insurance and medical care insurance. The earnings security insurance includes sickness allowances, parental allowances, rehabilitation allowances and reimbursements payable to employers for costs of occupational health care. The medical care insurance covers costs of medical care and rehabilitation services. The amount of the current assets of the National Health Insurance Fund are subject to a statutory minimum level of 8 per cent of the costs and a margin of 4 percentage units within which the amount of the current assets may vary without influencing the scales of premiums of the next year.

The financial reform of the health insurance system has improved the realisation of the insurance principle. The premiums have been raised only moderately for both the earnings security insurance and the medical care insurance. Moreover, the 2011 premiums were lower than those of the previous year.

Health insurance premiums in 2008–2012					
Health insurance premiums	2008	2009	2010	2011	2012
Employers (% of payroll)	1.97	2.00	2.23	2.12	2.12
Pensioners Health insurance (for medical care) (% of taxable income)	1.41	1.45	1.64	1.36	1.39
Employees Health insurance total For medical care (% of taxable income) For earnings security (% of payroll)	 1.91 1.24 0.67	 1.98 1.28 0.70	 2.40 1.47 0.93	 2.01 1.19 0.82	 2.04 1.22 0.82
Self-employed persons Health insurance total For medical care (% of taxable income) For earnings security (% of earnings)	 2.05 1.24 0.81	 2.07 1.28 0.79	 2.52 1.47 1.05	 2.11 1.19 0.92	 2.19 1.22 0.97

After the financial reform of the health insurance system, the statutory allowances with a minimum amount included in the earnings security insurance have been raised.

The primary responsibility for arranging health care services lies with the public health care system, which, as a rule, is not financed by health insurance. The medical care insurance included in health insurance is intended to supplement the public health care system, taking account of the available funds. Through the health insurance system, society contributes to the financing of health care services at a relatively low cost. This facilitates the statutory task of the public sector to arrange health care services.

In respect of the revised health insurance benefits, the Government refers to information given in connection with Article 12, paragraph 3.

Sickness allowance

The provisions of the Health Insurance Act concerning the part-time sickness allowance were amended by an act (532/2009) that took effect at the beginning of 2010. By these amendments the insured person on sick leave was given the right to work part time and, at the same time, to receive a part-time sickness allowance from the beginning of his or her disability for work, after a waiting period stipulated in the Health Insurance Act. The payment of a part-time sickness allowance is no longer conditional upon an immediately preceding continuous period of 60 days with a sickness allowance. In addition, a part-time sickness allowance may be granted immediately after a period with a sickness allowance or rehabilitation allowance, and a rehabilitation allowance may be granted immediately after a period with a part-time sickness allowance. The reform promotes the recovery of persons incapable of work and helps them stay in working life and return to full-time work.

The amount of the part-time sickness allowance is always half of the amount of the immediately preceding sickness allowance, or half of the amount of the sickness allowance to which the insured would have been entitled when the right to the part-time sickness allowance began. The amount of the part-time sickness allowance is always at least half of the amount of the minimum sickness allowance, if the recipient's incapacity for work due to illness has lasted continuously for 55 days. In 2012 the minimum amount of the part-time allowance is EUR 11.48 per day.

Part-time sickness allowance	**2008**	**2009**	**2010**	**2011**
Recipients, total	1 984	2 180	4 737	6 907
Men	581	598	1 284	1 811
Women	1 403	1 582	3 453	5 096
Average number of days with allowance per recipient	50	52	47	47
Average amount of allowance per day	29.06 €	30.78 €	32.36 €	32.72 €

Source: Social Insurance Institution

Rehabilitation benefits

On the basis of the Act on the Rehabilitation Benefits and Rehabilitation Allowance Benefits of the Social Insurance Institution (566/2005) the Social Insurance Institution arranges and reimburses for vocational rehabilitation of persons with disabilities if their capacity for work and opportunities for gainful employment are considered as essentially impaired because of an appropriately diagnosed illness, handicap or injury or if the illness, handicap or injury is likely to lead to the threat of their incapacity for work. The purpose of the vocational rehabilitation is to improve the person's capacity for work. Vocational rehabilitation consists of such measures as rehabilitation courses, training, job coaching and work and training trials.

On the basis of the Act, the Institution arranges medical rehabilitation for persons with severe disabilities and reimburses for their rehabilitation costs. A person is considered to have a severe disability if he or she suffers from a general medical and functional impairment because of an illness, handicap or injury and this impairment causes a need for rehabilitation that lasts at least one year, and if the impairment is so severe that it causes the person considerable difficulties or strain in coping with everyday activities at home, school or work and in other situations outside public institutional care.

The purpose of medical rehabilitation is to ensure or improve the rehabilitee's capacity for work or activity. Medical rehabilitation consists of treatment periods in rehabilitation institutions and open therapy. The public health care system is responsible for the medical rehabilitation of persons with severe disabilities if it is immediately connected with medical treatment.

An amendment (*874/2010*) of the Act obliges the Social Insurance Institution to arrange rehabilitative psychotherapy, which the Institution paid earlier as discretionary rehabilitation. Rehabilitative psychotherapy is paid for those rehabilitees in the target group whose capacity for work or studies is threatened by a mental disorder and whose treatment relationship has lasted at least three months. The purpose of paying the costs for rehabilitative psychotherapy is to restore or improve the rehabilitee's capacity for work or studies and thus to help the person to stay in or return to working life or to make progress in studies. The amendment of the Act entered force at the beginning of 2011.

The discretionary rehabilitation by the Social Insurance Institution, which is based on the Act, supplements both vocational rehabilitation and medical rehabilitation for persons with severe disabilities. The most important objective of discretionary rehabilitation is to support the rehabilitees' capacity for work or studies and activities. The Social Insurance Institution arranges discretionary rehabilitation in such forms as vocationally oriented medical rehabilitation (ASLAK), rehabilitation courses, adaptation training courses and neuropsychological rehabilitation. Part of the funds reserved for discretionary rehabilitation is allocated for developing the rehabilitation activities.

A plan for discretionary rehabilitation is made annually for the next three calendar years. This three year plan determines the allocation of the reserved funds and the priorities of the development activities. On the basis of the plan, Parliament decides the amount of the funds to be used for rehabilitation annually.

Recipients of rehabilitation services of the Social Insurance Institution	**2008**	**2009**	**2010**	**2011**
Vocational rehabilitation	14 260	12 905	12 950	13 390
Medical rehabilitation of persons with severe disabilities	20 758	20 654	20 750	21 496
Rehabilitative psychotherapy	–	–	–	12 609
Discretionary rehabilitation	53 297	52 084	51 843	48 054

Source: Social Insurance Institution

If the rehabilitee is prevented from working during the rehabilitation, his or her subsistence is safeguarded by means of a rehabilitation allowance. An insured aged 16–67 years is entitled to a rehabilitation allowance if he or she has received an acceptable rehabilitation decision and the purpose of the rehabilitation is to prepare the person for working life or keep or return the person there. The other benefits payable during rehabilitation are the maintenance allowance and the discretionary rehabilitation assistance. In addition, the Social Insurance Institution may pay a rehabilitation allowance for a young person to those insured aged 16–19 years who need intensified rehabilitation. No rehabilitation decision is required for eligibility for a rehabilitation allowance for a young person.

Unemployment benefits

Labour market subsidy for young people (18-24 years)

During the first three months of their unemployment, skilled persons may, without forfeiting their right to an unemployment benefit, refuse to accept employment that can be considered unsuitable for them considering their skills. A skilled person refers to a jobseeker who either has received vocational or professional education and related work experience of at least one year, or has obtained vocational or professional qualification by working in at least two years in the field in question. The exemption for skilled persons also applies to young people aged 18-24 years, but because of the definition of a skilled person, young jobseekers aged 18-24 often do not enjoy the exemption for skilled persons.

In 2008, a total of 4 590 young people aged 18-24 forfeited their right to labour market subsidy because they refused to accept employment, resigned from work, refused to use the services of an Employment and Economic Development Office or interrupted their use of such services. The corresponding figure was 5 233 in 2009, 5 634 in 2010 and 5 868 in 2011.

An Employment and Economic Development Office issues the relevant unemployment fund or the Social Insurance Institution of Finland with a binding employment policy statement on the question how a jobseeker's refusal to accept employment, resignation from work or refusal or interruption of a measure influences his or her right to an unemployment benefit. On the basis of the statement the unemployment fund or the Social Insurance Institution of Finland issues the jobseeker with an appealable decision. The decision may be appealed against to the Unemployment Appeal Board, whose decision is appealable further to the Insurance Court.

Activation reform of the labour market subsidy scheme

A jobseeker who has received labour market subsidy on account of his or her unemployment for at least 500 days or has received labour market subsidy on account of unemployment for at least 180 days after the maximum period for the basic unemployment allowance, forfeits his or her right to labour market subsidy if he or she, without a valid reason, refuses to accept offered employment or services of an Employment and Economic Development Office, resigns from work or interrupts employment services.

In 2008, a total of 7 868 persons forfeited their right to labour market subsidy for the above-mentioned reasons. In 2009, the corresponding figure was 5 661, in 2010 it was 4 935 and in 2011 it was 5 490.

An Employment and Economic Development Office issues to an unemployment fund or the Social Insurance Institution of Finland a binding employment policy statement on the question how a jobseeker's refusal to accept employment, resignation from work or refusal or interruption of a measure will influence his or her right to an unemployment benefit. On the basis of the statement the unemployment fund or the Social Insurance Institution of Finland issues the jobseeker with an appealable decision. The decision may be appealed against to the Unemployment Appeal Board, whose decision is appealable further to the Insurance Court.

In respect of this conclusion the Government further refers to information given in connection with Article 12, paragraph 1.

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

Questions 1 and 2

Bilateral and multilateral treaties

- The Agreement on Social Security between Finland and Chile entered into force on 1 January 2008.
- The Agreement on Social Security between Finland and Australia entered into force on 1 July 2009.
- The Agreement on Social Security between Finland and India was signed in June 2012 and will enter into force in 2013.
- In 2012, Finland has initiated negotiations on social security agreements with China and Japan.

Question 3

New insurance decisions - Moving to Finland	
2011	
Country of origin	**Decisions**
--Chile	21
--Israel	22
--Canada	54
--USA	233

Answers to the Committee's conclusions

Equal treatment

The Government notes that according to EU regulations, third country nationals are treated equally when moving within the EU. Therefore, third country nationals coming to Finland from other Nordic countries (or EU/EEA countries) benefit from this equal treatment.

Right to retain accrued benefits

No plans have been made to conclude bilateral agreements with the aforementioned countries. However, the association agreements between the EU and these countries apply to Finland as well. Children from these countries are entitled to family benefits when residing legally in Finland. These benefits are not paid to children living in the (non-EU/EEA) country of origin of the family breadwinner working in Finland.

Right to maintenance of accruing rights (Article 12§4b)

Work-related benefits accrue according to the same principles as for Finnish nationals.

Earnings-related pensions: 1.5 per cent of the pay for those aged 18–52, 1.9 per cent for those aged 53–62 and finally 4.5 per cent for those older than 63 years. The pension insurance is compulsory for all those earning more than EUR 52.49 per month, or more than EUR 7,000 per year for the self-employed.

Employment accident insurance

Employers are obliged to insure their employees against employment accidents. The accident pension represents 85 per cent of the annual earnings for those below 65 years and 70 per cent for those older than 65. In the case of temporary incapacity for work, the lost earnings are covered fully. 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.

Conclusion

Work-related benefits are paid also outside of the EU/EEA states (*i.e.*, they are exportable). Thus, the retention of accrued benefits is guaranteed for persons moving to a State Party of the Charter not covered by Community regulations. The accumulation of insurance or employment periods is irrelevant in this context.

ARTICLE 13: THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

Article 13 para. 1: Adequate assistance for every person in need

Question 1

During the reporting period the legislation on social assistance was amended as follows.

Amendments (*583/2007*) of the Social Assistance Act (*1412/1997*) which took effect on 1 January 2008 abolished the classification of municipalities (local authorities) into different cost-of-living categories. After the amendment, the basic amount of social assistance is the same in all municipalities. In the same context, a so-called processing guarantee was introduced by a new Section 14a (*1202/2007*) of the Act. The processing guarantee means that an applicant for social assistance must be given a decision on the application no later than on the seventh working day from the receipt of the application. In urgent cases the decision must be made on the same working day or on the next working day at the latest. The decision must be enforced without delay. Moreover, an applicant for social assistance must be given an opportunity to discuss in person with a social worker or a social advisor no later than on the seventh working day after the applicant's request for such discussion.

In 2009 the Act on Regional State Administrative Agencies (896/2009) transferred the guidance and supervision of municipalities in implementing the Social Assistance Act and the processing guarantee to the Regional State Administrative Agencies. The Act entered force at the beginning of January 2010.

An amendment (*1172/2010*) of the Social Assistance Act that took effect at the beginning of January 2011 made it possible to reduce, by at most 20 per cent, the basic amount of social assistance for young persons aged 18–24 without vocational or professional education if their need for social assistance is based on ineligibility for unemployment benefits because of their refusal or interruption of education or training. The person in question must, without a valid reason, have refused work or an employment policy measure offered to him or her verifiably on an individual basis. A failure of the person may also have prevented the authorities from offering him or her work or an employment policy measure. This provision of the Social Assistance Act also applies in cases where a major person under 25 years of age and without vocational or professional education has interrupted or refused education or training so that he or she is not entitled to an unemployment benefit.

Sections 9 and 9a of the Social Assistance Act have been amended by increasing the basic amount of social assistance by six per cent. The basic amount of social assistance for single parents has been increased by ten per cent (*1184/2011*). The amendments took effect at the beginning of 2012.

As to the parental allowances, special care allowance, sickness allowance and rehabilitation allowance, which have a minimum amount, the Government refers to the information given in connection with Article 12, paragraph 1.

Regarding the basic unemployment allowance and the labour market subsidy, the Government further refers to the information given in connection with Article 12, paragraph 2.

The new regulation of the guarantee pension is described above.

Question 2

In respect of this Question, the Government refers to its previous periodic reports.

Question 3

Statistics on the development of the benefit levels in 2005-2010 (including the median disposable income and poverty line calculated as 50 per cent of the median) are presented above in connection with Article 12, paragraph 2.

Answers to the Committee's conclusions

Forms of support and criteria for granting support

In the Government Bill concerning the Social Assistance Act (*HE 217/1997* vp), the detailed reasoning for Section 10 of the Act emphasises that everyone's right to indispensable subsistence is linked with the person's ability to acquire himself or herself the security required for a life of human dignity. The proposal further states regarding the application of Section 10, subsection 3 that it must be possible to propose for the person a concrete means of livelihood that is suited for his or her capacities and circumstances, and that Section 10, subsections 1 and 3 involve consideration of reasonableness. Moreover, in its statement on the Government Bill (*PeVL 31/1997*) the Constitutional Law Committee of Parliament has paid particular attention to the need to interpret the unreasonableness criterion in a manner positive towards basic rights.

Appeals against social security decisions, and legal aid

As to appeals against social assistance decisions, the applicants may get cost-free counselling of the municipal officer for social affairs in preparing a request for rectification to the municipal social welfare board. The decisions of the board are appealable to an administrative court. The procedure is free of charge for the applicant. Besides from the municipal officer for social affairs, the applicant may also seek advice from the local legal aid office of the state. The amount of the applicants' available funds determines the question whether they receive legal aid free of charge or with their own contribution. Aid and counselling by municipal officers for social affairs and legal aid offices of the state are also available for appeals against decisions of administrative courts to the Supreme Administrative Court.

Decisions on earnings-related pensions, unemployment security, statutory accident insurance and benefits paid by the Social Insurance Institution are appealable to appeal boards for social insurance matters: the Social Security Appeal Board, the Employee Pensions Appeal Board, the Unemployment Appeal Board, the Occupational Accidents Appeal Board and the Student Financial Aid Review Board. The decisions of the Appeal Boards can be appealed to the Insurance Court.

The Appeal Boards and the Insurance Court do not charge any processing fees. However, a person who fulfils certain conditions concerning mainly his or her financial standing may also be granted legal aid for an appeal before the Insurance Court. Moreover, legal aid may be granted in the form of other legal counselling e.g. for appeals against decisions of pension institutions to the relevant Appeal Board.

Scope of application

According to the Social Assistance Act (*1412/1997)* everyone is entitled to social assistance paid by the local authority if certain conditions laid down in the Act are fulfilled. The payment of social assistance to a person residing permanently in Finland or staying in the municipality in question is not conditional upon Finnish citizenship. Section 14 of the Social Assistance Act stipulates which municipality is responsible for granting social assistance in each case.

If an alien is staying in Finland on the basis of a valid residence permit, he or she may be considered to reside permanently in the country at least if the residence permit is continuous or permanent. If the residence permit is temporary, social assistance is usually granted only in urgent cases and for indispensable costs of living.

Regarding the scope of social assistance the Government refers to its previous reports.

Article 13 para. 2: Non-discrimination in the exercise of social and political rights

Questions 1, 2 and 3

The political and social basic rights and liberties are safeguarded under the Constitution of Finland (731/1999) and guaranteed in principle for every person within the jurisdiction of Finland. This also applies to such rights and liberties as the rights to freedom of expression, freedom of assembly and freedom of association and the right to social security. The rights to vote and participate in state elections are vested only in major Finnish citizens. The corresponding rights related to local elections and municipal referendums belong not only to Finnish citizens but also to aliens residing permanently in Finland.

Section 14, subsection 3 of the Constitution provides that the public authorities must promote the opportunities for the individual to participate in societal activity and to influence the decisions that concern him or her.

According to Section 6, subsection 2 of the Constitution no one shall, without an acceptable reason, be treated differently from other persons on the ground of sex, age, origin, language, religion, conviction, opinion, health, disability or other reason that concerns his or her person.

According to Section 22 of the Constitution the public authorities shall guarantee the observance of basic rights and liberties and human rights.

The Convention for the Protection of Human Rights and Fundamental Freedoms (subsequently European Convention on Human Rights, 1950; Finnish Treaty Series 63/1990) has been implemented in Finland by an Act of Parliament.

The restriction imposed in Article 13 of the Charter is not permissible under Finnish constitutional law.

In other respects of these Questions the Government refers to its previous periodic reports.

Answers to the Committee's conclusions

Non-discrimination in exercise of social and political rights

The Administrative Procedure Act (*434/2003*) is the general Act regulating the procedures in authorities' activities. The purpose of the Act on the Status and Rights of Social Welfare Clients (*812/2000*) is to promote a client-oriented approach, confidential client relationships and the clients' right to receive high-quality social welfare services and good treatment from the service provider without discrimination. According to Section 4 of the Act the client must be treated without violating his or her human dignity and by respecting the client's conviction and privacy. In realising social welfare, account must be taken of the client's wishes, opinions, interests, individual needs, mother tongue and cultural background. The Act applies to all social welfare services, whether arranged by authorities or private service providers. When a municipality or a joint municipal board acquires services from a private service provider, either under a purchase contract or by a service voucher, the municipality or joint municipal board must ensure that the services meet the standard required from corresponding municipal actors. A unit producing private social services must have a person responsible for compliance with the requirements made on the services.

The Act on the Status and Rights of Social Welfare Clients contains provisions on e.g. municipal officers for social affairs (Section 24) and on a client's right to file a complaint about received treatment with the responsible person in the unit providing social welfare services (Section 23).

Furthermore, the purpose of the Non-Discrimination Act (*21/2004*) is to foster and safeguard equality and enhance the protection provided by law to those who have been discriminated against in cases of discrimination that fall under the scope of the Act.

The Act also applies to discrimination based on ethnic origin in the context of social welfare and health care services, and social security benefits or other forms of support, rebate or advantage granted on social grounds.

Social assistance is part of municipal social welfare and supervised by the relevant Regional State Administrative Agency. The National Supervisory Authority for Welfare and Health, operating under the Ministry of Social Affairs and Health, guides the Regional State Administrative Agencies in order to ensure uniform supervision all over the country (Act on the National Supervisory Authority for Welfare and Health; 669/2008).

Clients have filed complaints about social welfare services mainly with Regional State Administrative Agencies. A complaint concerning the legality of social assistance may also be filed with the Parliamentary Ombudsman or the Chancellor of Justice.

The Ministry of Social Affairs and Health has published a handbook on the status and rights of social welfare clients for municipalities.[28] The handbook describes in plain language the rights of a social welfare client defined in the Act on the Status and Rights of Social Welfare Clients.

Article 13 para. 3: Prevention, abolition or alleviation of need

Questions 1, 2 and 3

In respect of these Questions the Government refers to its previous periodic reports.

Answers to the Committee's conclusions

Prevention, removal and alleviation of want

According to Section 1 of the Social Assistance Act social assistance is last-resort financial assistance under social welfare, the purpose of which is to ensure a person’s or family’s subsistence and to help them cope independently. The purpose of preventive social assistance is to further a person’s or family’s social security and independent living as well as to prevent social exclusion and long-term dependence on social assistance. Thus the purpose of social assistance is also to enable participation in societal activities.

[28] Sosiaalihuollon asiakkaan asema ja oikeudet ("Status and Rights of Social Welfare Clients"). Handbooks of the Ministry of Social Affairs and Health 2001:11. Available in Finnish at:
< http://pre20031103.stm.fi/suomi/pao/julkaisut/soshuoselko.pdf>.

On the basis of Section 13 (*923/2000*) of the Act, municipalities grant preventive social assistance on the grounds decided by them to achieve the above-mentioned objectives. Preventive social assistance may be granted for instance for measures to support the activation of the recipient, to secure housing, to alleviate difficulties as a result of over-indebtedness or a sudden deterioration of the financial situation and for other purposes to promote the recipient's independent living. An amendment (*1202/2007*) of the Social Assistance Act that took effect in 2008 requires the authorities to process a social assistance matter without endangering the client's right to indispensable subsistence and care. According to Section 14a of the Social Assistance Act, a decision on social assistance in urgent cases must be made on the basis of the available information during the same working day or at the latest on the next working day after the receipt of the application. In non-urgent cases the decision must be made without delay, but no later than on the seventh working day after the receipt of the application. The decision to grant social assistance must be enforced without delay.

Moreover, an applicant for social assistance must be given an opportunity to discuss in person with a social worker or a social advisor no later than on the seventh working day after the applicant's request for such discussion.

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

Questions 1, 2 and 3

In respect of these Questions the Government refers to its previous periodic reports.

Answers to the Committee's conclusions

Emergency social assistance provided to stateless persons

If an alien is staying in Finland without a required residence permit, his or her stay in the country cannot in principle be considered as permanent within the meaning of the Social Assistance Act. Even in such cases it can as a rule be required – as regarding tourists – that the alien returns to his or her country of residence as soon as possible, so that the social assistance possibly granted to the alien is limited to the necessary travel costs and other costs. Social assistance may be granted to an alien only if he or she cannot use e.g. those means of help which tourists are primarily expected to use.

An alien staying in Finland without a residence permit may exceptionally be considered to stay permanently in the country. Such a situation may exist e.g. when the alien's application for a residence permit is pending and it is probable that he or she will be issued with a residence permit. A corresponding situation exists when the authorities have decided to remove or deport the alien from the country but the decision is not yet enforceable.

However, social welfare authorities cannot take a stand on the question whether or not the alien should be issued with a residence permit.

An alien may have arrived in Finland with a visa although the nature of his or her stay in the country would necessitate a residence permit. Such a situation may arise e.g. when the alien is married to a person residing in Finland and intends to stay in the country to live together with the spouse. If such an alien applies for social assistance, he or she is advised to apply for a residence permit because it would make the person eligible for benefits that are primary to social assistance.

ARTICLE 14: THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

Article 14 para. 1: Provision or promotion of social welfare services

Question 1

In 2009 the Ministry of Social Affairs and Health started a comprehensive overhaul of social welfare legislation as part of the municipal reform.

In June 2010 the Ministry published basic guidelines for the overhaul in a report[29] and is currently preparing a Government Bill for a new Social Welfare Act. In the same context, the Ministry will propose a reform of the special social welfare legislation and make proposals to the cooperation partners for revising the common areas of work. The guiding principles for developing the legislation have included improved client orientation, improved access to services, improved service quality and improved cooperation between the social welfare administration and other branches of administration.

Substitute care during informal carer's leave or other absence

Amendments (*318/2011*) of the Act on Support for Informal Care (*937/2005*) entered into force on 1 August 2011.

After the amendments, a municipality may organise the necessary substitute care during an informal carer's leave or other temporary absence by concluding a commission agreement with a person fulfilling the requirements laid down in the Act. By this agreement the person agrees to provide substitute care, which may be organised as described above if the informal carer consents to it. Further preconditions are that the arrangement is made with due account to the opinion of the person cared for and that the arrangement is considered to be in his or her best interests.

The commission agreement concluded with the substitute carer covers:

(1) the amount of the remuneration paid to the substitute carer and the manner of payment;
(2) if necessary, compensation for the expenses incurred by the substitute carer;
(3) the period of validity of the commission agreement; and
(4) if necessary, other circumstances related to the substitute care.

The municipality in question is responsible for organising the substitute carer´s pension security and accident insurance.

The revised Act on Services and Assistance for the Disabled

According to the new provisions, services for persons with disabilities must be planned carefully and within a reasonable period of time. To guarantee this, there are provisions in the legislation on examining the person's need for services, drawing up a service plan and handling the case without delay. The examination of the service need must start on the seventh weekday from the person's contact at the latest. The decisions concerning services and supportive measures must be made within three months from the date when the application for them was submitted.

[29] Reform of social welfare legislation. Progress report by the Working Group preparing a reform of social welfare. Reports of the Ministry of Social Affairs and Health 2010:19. Available in Finnish at: <http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE-11731.pdf>. A summary in English is available on page 4 of the publication.

According to the amendments of the legislation, persons with severe disabilities who are in need of indispensable and repeated assistance in everyday life activities at home or outside the home are entitled to personal assistance. Personal assistance is a social service provided free of charge to persons with severe disabilities by municipal authorities. A municipality cannot refuse to provide the service by invoking lack of funds if the applicant fulfils the criteria under the law for access to the service. Personal assistance is thus a new subjective right to persons with severe disabilities.

Personal assistance can be provided for everyday activities, work and studies to the extent that the persons with severe disabilities indispensably need it. From the beginning of 2011, support for other purposes must be given during at least 30 hours per month.

Municipalities may organise the services in several alternative ways. The first alternative is to compensate a person with a severe disability for the costs of employing an assistant. In this system the assistant has a contractual employment relationship with the assisted person. In the second alternative the municipality gives the person with a severe disability a service voucher for purchasing the assistance service. The third alternative is that the municipality organises the service by purchasing it, through its own service production or in contractual cooperation with one or several municipalities. In this way, the amended legislation has enabled persons with disabilities to obtain personal assistance in the form of a service – without employer obligations.

Interpretation services for persons with disabilities

A new Act on Interpretation Services for the Deaf-Blind, Hard of Hearing People and Persons with a Speech Disorder (133/2010) took effect on 1 September 2010. The responsibility for organising and financing these services was transferred from the municipalities to the Social Insurance Institution of Finland. It means that the state now bears full responsibility for financing the interpretation services.

The Act does not change the rights to interpretation services, but only the administration of the services and the responsibility for financing them. Since January 2007, deaf-blind persons have the right to obtain a minimum of 360 hours of interpretation services a year, and persons with hearing and speech impairments a minimum of 180 hours a year. The amount of interpretation services may vary according to the person's individual needs, e.g. when the person is studying. The new Act also clarified people´s right to get interpretation services when staying abroad. Municipalities are still in charge of arranging other social and health services and support that persons with disabilities might need.

Question 2

Kaste Programme

Pursuant to the Act on Planning and Government Grants for Social Welfare and Health Care (*733/1992*), the Government has launched a National Development Plan for Social Welfare and Health Care (the so-called *Kaste Programme*)[30]. The new Programme will be in force from 2012 to 2015. It is a strategic steering tool used for managing and reforming social and health policies at local level. Government subsidies will be issued to finance projects organized for implementing the Programme. The aim of the Programme is to renew central social and health care services and to improve their availability. The targets of the Kaste Programme are to reduce inequalities in well-being and health so as to improve the risk groups' opportunities for inclusion, well-being and health, to make preventive work and early support more effective, and to reduce interpersonal and domestic violence.

[30] The National Development Programme for Social Welfare and Health Care, THE KASTE PROGRAMME 2012–2015). Publications of the Ministry of Social Affairs and Health 2012:1. Available in Finnish at: <http://urn.fi/URN:ISBN:978-952-00-3328-6> with a summary in English on page 8. Information in English available at <http://www.stm.fi/en/publications/publication/-/_julkaisu/1582307#en>.

Moreover, social welfare and health care structures and services will be organised in a client-oriented way so that clients will be able to rely on the quality and effectiveness of the services, that well-functioning services and skilled and satisfied personnel will be secured through management and that the service structures will be economically sustainable and function well.

A housing programme for persons with intellectual disabilities

In January 2010, the Finnish Government issued a resolution on a programme to organise housing and related services for persons with intellectual disabilities in 2010–2015.[31] The goal is to provide persons with intellectual disabilities individual housing solutions in regular housing environments and to reinforce their inclusion and equal treatment in the community and society.

The programme aims at giving people with intellectual disabilities who are moving out of institutions or their childhood homes the opportunity of individual housing in an accessible and functioning home in a regular housing environment. At the same time, the number of institutional care places for persons with intellectual disabilities is reduced systematically and in a controlled manner.

The programme aims at producing about 1 500 homes for persons with intellectual disabilities moving from institutions, and about 2 000 homes for grown-up persons moving from their childhood homes. Once implemented, the programme will reduce the number of places in institutions from 2 000 long-term places in 2010 to about 500 places by the end of 2015. The costs will be borne by the Ministry of the Environment, the Housing Finance and Development Centre of Finland (ARA), the Slot Machine Association and municipalities. ARA will provide 470 new dwellings per year in 2010-2015 and allocate EUR 30 million for this. In addition, ARA will support the rebuilding of houses and apartments. The Slot Machine Association will support investments in new buildings with EUR 4.9 million a year. This equals 130 new apartments.

In November 2010 the Ministry of Social Affairs and Health appointed a guiding group to outline a national plan on how the services and support for persons with intellectual disabilities should be provided in the community in the future.

The eHandbook on Disability Services

The eHandbook on Disability Services is intended for people working in the field, as support for client work and decision-making. Service users, too, may find the handbook useful. The eHandbook is available in Finnish, and some Sections have been translated into Swedish.

The purpose of the eHandbook is to improve nationwide equality in services for people with disabilities, to improve service quality and to promote a new approach to disability policy, giving people with disabilities more right to self-determination and better opportunities for participation.

Answers to the Committee's conclusions

Reform of legislation on private social welfare services

The new Act on Private Social Welfare Services (*922/2011*) entered into force on 1 October 2011. The legislative reform emphasised, among other things, proactive supervision, and it increased service providers' own responsibility for the quality of services. To ensure appropriate activities the service providers must prepare a self-supervision plan, keep it publicly available and monitor its implementation.

[31] Government decision-in-principle on a programme for arranging housing for persons with intellectual disabilities and related services. Available in Finnish at: <http://www.stm.fi/vammaispalvelut/kehitysvammaisten_erityispalvelut>.

The reform strengthened the cooperation between supervisory authorities and underlined the role of municipalities as supervisory authorities. Other supervisory authorities include the Regional State Administrative Agencies and the National Supervisory Authority for Welfare and Health (Valvira). Valvira's permission is required for producing 24-hour social welfare services in the territory of more than one Regional State Administrative Agency. Regarding other services the service providers must file a notification to the municipality in question. With some exceptions the services are recorded in a register of private service providers maintained jointly by Valvira and the Regional State Administrative Agencies.

The supervisory authorities must implement the supervision primarily by giving the service producers the guidance and counselling needed for the service production and by monitoring the developments of the services jointly with the service producers. On justifiable grounds, the supervisory authorities are entitled to conduct inspections in a unit producing services irrespective of the service producer's will. The supervisory measures that the competent Regional State Administrative Agency and Valvira may direct at all producers of private social welfare services include admonition, drawing attention to deficiencies, order to correct them, suspension of activities and prohibition of use. As a last resort, activities subject to permission may be stopped partly or entirely by withdrawing the permission. The precondition for this is that the activities have been found to essentially conflict with the applicable legislation and that the earlier supervisory measures have not led to correcting the deficiencies or eliminating the defects.

Supervision of publicly produced social welfare services

By an Act (*670/2008*) in force since the beginning of 2010, the Social Welfare Act (*710/1982*) was supplemented with provisions on the supervision of social welfare activities of municipalities and joint municipal boards. Valvira and the competent Regional State Administrative Agency may inspect the activities and the premises used for arranging them if justifiable grounds exist for the inspection.

If the supervisory authority notices that deficiencies in the activities endanger client safety, it may order the service provider to correct the deficiencies. The authority may obligate the municipality to observe the order under the threat of a fine or under the threat of prohibiting or suspending the activities. The supervisory authority may prohibit or suspend the activities with immediate effect if client safety so requires. If the municipality has acted erroneously or failed to fulfil its obligations, the supervisory authority may give it an admonition for the future. In the case of a minor error or failure the authority may draw the attention of the municipality to its obligation to arrange the activities appropriately.

Information on the staffing of social service

The Act (272/2005) and Decree (608/2005) on Qualification Requirements for Social Welfare Professionals, which came into force on 1 August 2005, lays down the qualification requirements for social welfare professionals by occupational title and the minimum requirements on the education for other professional posts within social services. The Act also lays down the qualification requirements for management posts in social services. It does not include provisions on the task structure of social services staff or on staffing.

Qualification requirements on social welfare professionals

Social worker: The qualification requirement for a social worker's post is a Master’s degree in social work which includes or has been supplemented with major studies in social work or corresponding university studies.

Officer for social affairs: The qualification requirements for the post of an officer for social affairs referred to in Section 24 of the Act on the Status and Rights of Social Welfare Clients consist of the qualification of a social worker or a Master's degree suitable for the post, and knowledge of the field (Section 5 of the Act).

Child supervisor: The qualification requirement for a child supervisor referred to in the Paternity Act (700/1975) is the qualification of a social worker or a Master's degree suitable for the post. The same qualification is required from persons responsible for the preparation of agreements under Section 8 of the Child Custody and Right of Access Act (361/1983) or Section 8 of the Child Maintenance Act (704/1975).

Social advisor: The qualification requirement for a social advisor is a Bachelor's degree in health care and social services, with specialisation in social services.

Kindergarten teacher: The minimum qualification requirement for a kindergarten teacher's post is a Bachelor's degree in education including a kindergarten teacher's education, or a Bachelor's degree in health care and social services with specialisation in early childhood education and social pedagogy to the extent stipulated in more detail by a government decree.

Practical nurse: The qualification requirement for a practical nurse's post is suitable vocational qualification in social welfare and health care or other corresponding qualification.

Special social worker: The qualification requirements for a special social worker's post are the basic education required for the work and suitable specialisation education or a suitable postgraduate degree. More detailed provisions on the specialisation education or postgraduate degree required for a special social worker's post may be stipulated by a government decree.

Management posts in social welfare administration: The qualification requirements are the following:

- for mainly administrative management posts in the social welfare or social welfare and health care administration of a municipality or joint municipal board: a Master's degree in social work or another Master's degree suitable for the post, knowledge of the field and sufficient management skills,
- for professional management posts in social work: the qualification of a social worker and sufficient management skills,
- for professional management posts in child day care: the qualification of a kindergarten teacher and sufficient management skills,
- for other management posts including guidance of client work within social work: a suitable university degree, knowledge of the field and sufficient management skills.

Other professional occupations in social welfare: The qualification requirement for other professional occupations in social welfare is a suitable vocational qualification or other suitable education.

Article 14 para. 2: Public participation in the establishment and maintenance of social welfare services

Question 1

In respect of this Question the Government refers to its previous periodic reports.

Question 2

Supervision of services

Since the beginning of 2010, the supervision of social welfare administration, too, has been centralised in Valvira to the extent that the administration has significance at national level and far-reaching effects (see the Act on the National Supervisory Authority for Welfare and Health 669/2008, as amended by Act 1569/2010). The Regional State Administrative Agencies continue to supervise social welfare and health care services in their own territories as described in the previous periodic reports.

Disability Policy Programme (Vampo)

In 2010, the Government adopted a new Disability Policy Programme for the years 2010–2015.[32] The programme is based on human rights, non-discrimination, equality and inclusion. It contains 14 key policy areas and 122 concrete measures. For all measures, the administrative sector (Ministry) responsible for the implementation, timetables, financial needs, obligations and an indicator for following the implementation of the measure have been identified.

The main content of the Disability Policy Programme consists of measures to ensure the following objectives:

- Preparation and implementation of the legislative amendments necessary for ratifying the UN Convention on the Rights of Persons with Disabilities;
- Improving the socio-economic status of persons with disabilities and combating poverty;
- The availability and high quality of special services and support measures will be ensured across the country;
- Accessibility in society will be strengthened and increased; and
- Disability research will be reinforced, the information base improved, and diversified high-quality methods developed in support of disability policy and its monitoring.

According to the mainstreaming principle all Ministries are responsible for implementing the programme within their administrative branches. The Ministry of Social Affairs and Health bears the overall responsibility for the implementation and monitoring process. The National Council for Disability (VANE) co-ordinates the implementation and monitoring and the National Institute for Health and Welfare carries out the technical work. The monitoring process must also been seen in the context of the UN Convention on the Rights of Persons with Disabilities.

[32] A Strong Basis for Inclusion and Equality. Finland's Disability Policy Programme 2010–2015. Publications of the Ministry of Social Affairs and Health 2010:4. Available in Finnish at: <http://urn.fi/URN:ISBN:978-952-00-3024-7>. A summary in English is available on page 9 of the publication.

Question 3

Services for people with disabilities, clients 2007 - 2010				
	2007	**2008**	**2009**	**2010**
Transportation services for people with severe disabilities	86 726	88 539	91 376	94 828
Personal assistance	5 034	5 435	6 598	8 985
Interpreter services	3 961	4 024	4 088	4 591
Housing alterations and housing equipment and facilities	8 599	8 587	9 082	9 580
Sheltered housing for people with severe disabilities	3 375	3 525	4 008	4 310
Sheltered and supported housing for people with disabilities, on 31 Dec.	1 760	1 844	2 113	2 184
Group housing services for people with disabilities, no staff available at night, on 31 Dec.	2 588	2 540	2 441	2 443
Group housing services for people with disabilities, staff available also at night, on 31 Dec.	5 699	5 962	6 298	6 913
Support for informal care, clients under 65 years	11 221	11 541	12 175	12 903
Institutional care for people with intellectual disabilities, on 31 Dec., long-term care	2 089	2 002	1 899	1 790
Institutional care for people with intellectual disabilities, on 31 Dec., all clients	2 220	2 145	2 035	1 934
Family care for people with disabilities, on 31 Dec.	1 262	1 269	1 284	1 333
Measures to support employment for people with disabilities	3 148	2 798	2 289	2 458
Day and sheltered work centres for people with disabilities	13 435	14 415	15 032	15 805

Source: SOTKAnet Statistics and Indicator Bank

Answers to the Committee's conclusions

Participation of citizens

The role of private service providers in the provision of social services has grown strongly. The neutrality of competition required by the internal market legislation has been realised in the services purchased by municipalities. Currently more than 30 per cent of all social services are provided by the private sector.

ARTICLE 23: THE RIGHT OF ELDERLY PERSONS TO SOCIAL PROTECTION

Question 1

The Government Programme[33] includes the objective of preparing an Act on Care Services for the Elderly. The Draft Act on Supporting the Functional Capability of Ageing Population and on Social and Health Services for Older Persons was prepared by a steering group established by the Ministry of Social Affairs and Health.[34] The draft is being circulated for comments. The aim is to present a Government Bill to Parliament in autumn 2012, and the Act is planned to enter into force in 2013.

Reimbursement for medical costs

An amendment (*770/2008*) of the Health Insurance Act (*1224/2004*) extended the reimbursement for medical costs to the costs of dose distribution to insured persons aged 75 years or over. The reimbursement for dose distribution covers those persons aged 75 years or over who use at least six medicines reimbursable under the health insurance and suitable for dose distribution. The amendment took effect at the beginning of 2009. Corresponding regulation was in force in a temporary trial in 2006–2008.

Disability supplement for war veterans

From September 2010 a disability supplement for war veterans has been paid to veterans who receive additional front-veterans supplement or pensioners' care allowance at the highest rate. The supplement is EUR 52.09 per month (in 2012). Approximately 8 000 persons received a disability supplement for war veterans in the end of 2010. Most of them were 85–89 years old.

Housing

The Government continues to support the housing of special groups, such as the elderly, with interest subsidies for loans taken out to finance the construction, renovation and acquisition of rental dwellings, and with grants up to 50% of the investment, depending on the needed support. These subsidies for improving the housing conditions of special groups are essential for providing service housing (24-hour care) for the elderly who suffer from dementia or have poor physical functioning capacity (Act on Interest Subsidy for Rental Housing Loans and Right of Occupancy Housing Loans, 604/2001, and Act on Subsidies for Improving the Housing Conditions of Special Groups, 1281/2004). State renovation grants are awarded for the installation of lifts in older multi-storey residential buildings and, on social grounds, for repairs and renovations of homes of elderly people and people with disabilities (Act 1184/2005).

Question 2

Under the existing Government Programme the Government will prepare a programme for developing the housing of the elderly for 2012–2015. The preparation of the programme started in January 2012. The programme will include new measures to meet the housing needs of ageing population and develop services that support housing. The programme is prepared in cooperation between different national administrative sectors, municipalities, and the housing and construction branch.

[33] The Programme of Prime Minister Jyrki Katainen's Government of 22 June 2011. Available at <http://valtioneuvosto.fi/hallitus/hallitusohjelma/en.jsp>.
[34] Information in English is available at: <http://www.stm.fi/en/pressreleases/pressrelease/-/view/1794724#en>.

Question 3

Monitoring of the quality recommendation for services for the elderly

	2000	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2012**
Regular home care, clients aged 75 and over on 30 Nov, as % of population of same age		11,5		11,3	11,2	11,4	11,9	13,0-14,0
Support for informal care, clients aged 75 and over, as % of population of same age	3,0	3,7	3,7	3,9	4,1	4,1	4,1	5,0-6,0
Altogether		**15,2**		**15,2**	**15,3**	**15,5**	**16,1**	
	2000	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2012**
Service housing with 24 hour assistance for older people, clients aged 75 and over on 30 Nov, as % of population of same age	1,7	3,4	3,9	4,2	4,6	5,1	5,6	5,0-6,0
Care in residential homes or long-term institutional care in health centres, clients aged 75 and over on 30 Nov, as % of population of same age	8,3	6,8	6,5	6,3	5,9	5,4	4,7	3,0
Altogether	**10,0**	**10,2**	**10,4**	**10,5**	**10,5**	**10,5**	**10,3**	

The national targets to be reached by 2012/The National Framework for High-Quality Services for Older People.

Statistics on the realisation of the quality recommendation for services for the elderly are available in English also at address <http://uusi.sotkanet.fi/portal/page/portal/etusivu>.

Social welfare and health care services for dementia patients

At the end of 2009, in all approximately 36,000 clients with memory diseases were covered by institutional social welfare and health care services, service housing and regular home care. This figure accounts for almost one fourth of all clients receiving such services. Health centre hospitals had proportionally the highest number of clients with memory diseases: more than half of their clients had been diagnosed with a memory disease. The percentage of clients with memory diseases was lowest in specialised institutional care.[35]

Since the beginning of the 21st century, the number of clients with memory diseases has increased by more than 10,000 clients. The percentages of these clients have grown during the 21st century especially in homes for the elderly and intensified service housing with 24-hour assistance. However, during the whole 21st century so far, health centre hospitals have had proportionally the highest number of clients with memory diseases.

Type of accommodation	**Clients with memory diseases on 31 Dec.**					**% of all clients**				
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2009
Regular home care	4339	5 234	6 572	7 134	7 998	7,1	8,7	10,4	11,2	12,2
Ordinary service housing	1133	1 439	1 501	1 448	1 184	9,9	11,6	12,6	13,3	12,5
Service housing with 24-hour assistance	2920	4 293	5 931	7 878	10 180	29,7	33,2	36,0	37,9	39,6
Home for the elderly	7406	7 523	8 031	8 546	7 918	35,8	37,6	41,2	44,9	46,3
Institutional long-term care in health centre hospitals	6403	6 181	6 458	6 493	5 655	48,7	50,4	52,6	55,9	56,6
Institutional short-term care in health centre hospitals	1423	1 689	1 866	1 857	2 075	18,2	20,3	22,9	22,9	24,8
Specialised institutional care	638	698	725	681	566	4,8	5,2	5,5	5,9	5,2
Total	24262	27057	31084	34037	35576	17,6	19,4	21,5	23,4	24,2

[35] Muistisairaat asiakkaat sosiaali- ja terveyspalveluissa 2009 ("Social welfare and health care clients with memory diseases"). Statistical report 12/2011, 17 March 2011, National Institute for Health and Welfare. Further information about social welfare and health care clients with memory diseases is available at: <http://www.stakes.fi/FI/tilastot/aiheittain/Ikaantyneet/dementia.htm>.

Private services provided to clients with memory diseases

The Act on Private Social Services (*922/2011*) is described above in connection with Article 14, paragraph 1.

Number of elderly people in public and private institutions

One third of all social security expenditure is spent on services and pensions for the elderly. In 2010, expenditure in the "old age" category amounted to EUR 19.1 billion, whereas cash benefits amounted to a total of EUR 17.0 billion and benefits in kind to EUR 2.1 billion. Benefits in kind for elderly people include institutional care for the elderly, home-help services, support for informal care, day-care for the elderly, services of day and service centres, and service housing. However, health services for elderly people are not included in benefits in kind.

The social expenditure figures given in the previous paragraph are based on the European System of Integrated Social Protection Statistics (*ESSPROS*). In this classification, all health services are comprised in the category "Sickness and health", and no breakdown by age is made in the figures. Long-term care of elderly people in health centres amounted to some EUR 0.5 billion in 2010. The data in the figures of social protection expenditure refer to net expenditure. Thus, clients' contributions are not included.

In 2011 the number of old-age pensioners in Finland was 1,135.000. The number of pension recipients has been on the increase since the first baby-boom cohort reached the age of 63 years in 2008. People may retire on an old-age pension between the ages 63 and 68, according to their own choice.

At the end of 2010, one in eight over-65-years-olds, one in four over-75-years-olds and almost half of all over-85-years-olds were receiving regular services. These services include regular home care (home help services and home nursing), sheltered housing for elderly people, care in residential homes and long-term inpatient care in health centres. At the end of 2010, the clients receiving these services totalled some 120,000. A majority of them (103 000) were 75 years old or older. A total of 23 300 clients aged 65 or over received institutional care (in residential homes and long-term inpatient care in health centres).

Housing situation of elderly persons

Housing situation of over 75 years old population in %			
Over 75 years old population	2009	20010	Existing national target
Living at home	89,4	89,5	91-92
Living in service housing	5,1	5,6	5-6
Living in institutional care	5,4	4,7	3

About 80 % of all persons over 65 years of age own their dwellings. In 2010 about 45.2 % of the elderly lived in single-detached houses and 39.3 % in apartments in blocks of flats. Lack of lifts is a problem in many multi-storey buildings, and the above-mentioned renovation grants are awarded to combat this problem. In 2009–2011 the Government financed the construction of over 11 000 new dwellings for special groups with EUR 330 million. Most of these dwellings are intended for elderly persons for the provision of service housing. Special attention is paid to monitoring the quality of housing.

Answers to the Committee's conclusions

Adequate resources

Your Committee has concluded that the situation in Finland is not in conformity with Article 23 of the Revised Charter because the level of the national pension for low income elderly persons is manifestly inadequate. In this respect the Government refers to information given in connection with Article 12, paragraph 1. The introduction of the guarantee pension has raised the level of the national pension for low income elderly persons, as well.

The right to self-determination of social welfare and health care clients

On 10 July 2010, the Ministry of Social Affairs and Health has set up a working group to consider the right to self-determination of social welfare and health care clients. The working group has prepared preliminary guidelines for the realisation of self-determination. The basic principles in its work are respect for basic and human rights, as well as care and attendance that are voluntary for patients and clients.

The working group has drafted proposals for provisions that strengthen the right to self-determination in various situations and for provisions on the measures necessary for restricting self-determination to prevent risk to health or safety. The regulations support especially practices that help to avoid the use of restrictive measures.

The working group has examined the use of restrictive measures in the voluntary care of persons with memory disorders, brain damage or intellectual disabilities. On this basis the group prepares legislation concerning all client groups. The objective is to create operational practices that help to avoid the use of restrictive measures in social welfare and health care as much as possible.

According to the preliminary proposal, the provisions on the measures restricting self-determination could be applied to social and health services if the cognitive functional capacity of the client or patient is reduced permanently or in the long term so that he or she is unable to understand the consequences of his or her actions. Another precondition would be that the patient's or client's own behaviour seriously endangers his or her health or safety or the health or safety or other interests of others.

It is proposed that the deliverer of the service be obligated to promote the realisation of self-determination. The basic principle would be that care and attendance are voluntary for patients and social welfare clients. Measures that restrict certain basic rights could be used against the patient´s or client´s will in circumstances specified by law only if there are no other means available for securing the necessary care or attendance. A precondition for using restrictive measures would be that the functional capacity of the person in question has been assessed and the person's care and attendance have been planned in accordance with legislation. It is proposed that the provisions apply to inpatient care and housing services and, to a certain extent, to work and day activities, home-help services and home nursing. The working group will complete its work in November 2012.

The work of the working group on the right to self-determination of social welfare and health care clients is part of the Government’s preparations for the measures necessary for ratifying the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol.

Prevention of elder abuse

Development activities have taken place during the reporting period. Recommendations for the prevention of interpersonal and domestic violence have been given (*Recognise, protect and act. How to guide and lead local and regional activities in social and health care services*). English abstract is available at: http://www.stm.fi/c/document_library/get_file?folderId=28707&name=DLFE-3513.pdf.

Research project (incl. information of Finland):
http://www.thl.fi/en_US/web/en/research/projects/avow/outcomes.

Services

Information on this specific matter is gathered regularly (every three years). The latest data gathering took place in 2010. The report (in Finnish) is available at:
http://www.thl.fi/tilastoliite/tilastotiedotteet/2011/tr36_11.pdf .

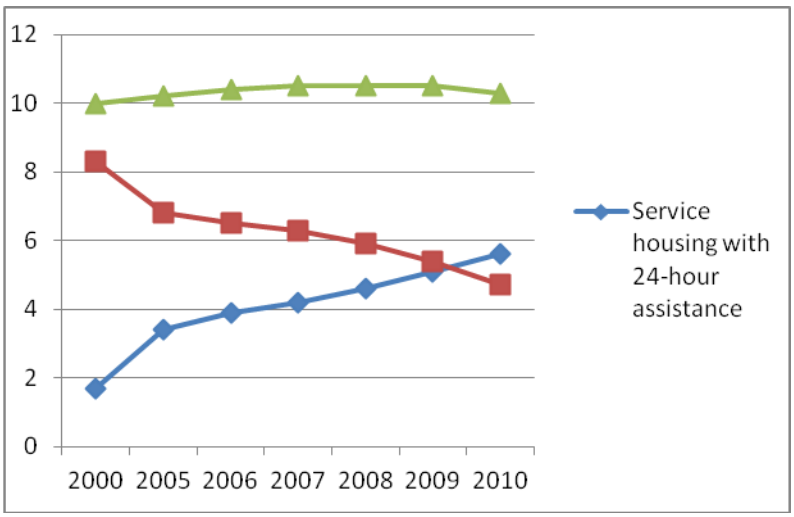
Institutional care

Your Committee's question in this respect is somewhat more complicated than considering the current capacity of institutional care per sé. As a part of implementing the national framework for high-quality services for older persons, the Ministry of Social Affairs and Health set up a working group to draft proposals for developing the structures and contents of 24-hour care.

The working group proposed that the structure of 24-hour care should gradually be changed from the present three-tier 24-hour care system (service housing with 24-hour assistance, residential home care and LTC on health centre hospitals) towards one-tier system of 24-hour care. The change is to be implemented so that institutional care is not replaced by institutional like solutions. There has been an on-going change in the LTC service structure: the traditional institutional care has been replaced by 24-hour care given in service house settings with 24-hour assistance. The change has enabled better physical environments (home-like) for older persons as well as better quality of life (with less institution-like care culture). See the diagrams below.

Service form / 75+ population (%)	**2000**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2012***
Regular home care		11,5		11,3	11,2	11,4	11,9	13,0-14,0
Support for informal care	3,0	3,7	3,7	3,9	4,1	4,1	4,2	5,0-6,0
Altogether		**15,2**		**15,2**	**15,3**	**15,5**	**16,1**	
	2000	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2012**
Service housing with 24-hour assistance	1,7	3,4	3,9	4,2	4,6	5,1	5,6	5,0-6,0
Institutional care	8,3	6,8	6,5	6,3	5,9	5,4	4,7	3,0
Altogether	**10,0**	**10,2**	**10,4**	**10,5**	**10,5**	**10,5**	**10,3**	

* Target levels / National Framework


12
10
8
6
4
2
0
2000
2005
2006
2007
2008
2009
2010
Service housing with 24-hour assistance

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

Question 1

The Government supports the housing of special groups, such as the elderly, the homeless, students and persons with disabilities, with interest subsidies for loans taken out to finance the construction, renovation and acquisition of rental dwellings, and with grants up to 50 % of the investment, depending on the needed support (see Act on Interest Subsidy for Rental Housing Loans and Right of Occupancy Housing Loans, 604/2001, and Act on Subsidies for Improving the Housing Conditions of Special Groups, 1281/2004).

Question 2

Prevention of poverty, inequality and social exclusion

The Government has drawn up a strategic plan for the implementation of the Government Programme. The strategic plan has three priority areas: the reduction of poverty, inequality and social exclusion; the consolidation of public finances; and the strengthening of sustainable economic growth, employment and competitiveness. There is a strong inter-relationship between the priorities.

The measures by which the Government aims at preventing poverty, inequality and social exclusion have been collected together as a cross-sectoral action plan. The action plan outlines the main objectives, key projects, division on responsibilities and preliminary timetables and indicators. The ministerial working group on social and health policy is responsible for the implementation of the action plan. The preparation of the implementation is coordinated by a broad-based steering group including the ministries and other stakeholders. The policy measures are specially monitored by the Government. The achieved progress is assessed in annual strategy review sessions.

The action plan to combat social exclusion, poverty and health problems consists of measures aimed to tackle unemployment, poverty, people's lack of prospects and non-participation. The main areas of development are: 1) improving employment and income security and 2) reducing differences in income, well-being and health and promoting equality. The latter area includes such objectives as reducing social exclusion, stopping intergenerational poverty and social exclusion, safeguarding citizens' equality and equal opportunities for participation, strengthening and reforming social welfare and health care services, and strengthening young people's inclusion and early childhood education.

Reducing health disparities

The reduction of health disparities has been one of the main goals of the health policy for a long time. The Government aims at developing co-payments towards a more equal and integrated system, while the restructuring of the municipal service system intends to increase regional equity and cost containment, both of which can be considered as major challenges in the Finnish health care system. The Government has aimed to mainstream health policy objectives by taking health into account in all policies. In the field of health care, maximum waiting times and uniform criteria for non-urgent health care have been introduced in order to eliminate excessively long waiting lists (over six months) in non-urgent surgery and specialist care. The new Health Care Act, too, puts a strong emphasis on the quality of services and patient safety.

National Strategy Report on Social Protection and Social Inclusion

The Europe 2020 Strategy is a new economic and employment strategy initiated in 2010 by the European Council for the pursuit of smart, sustainable and inclusive economic growth throughout the EU.

The Europe 2020 Strategy has five main targets, one of which is the reduction of poverty and social exclusion. Every Member State sets its own corresponding national targets. The implementation of the Strategy's social targets is described in two annual reports. The National Reform Report (NRP) covers all the EU-wide strategy targets. The National Social Report (NSR) 2012 describes activities in the areas of social inclusion, pension policy and health care, as well as long-term care. These reports are based on the Government Programme and the strategic plan for implementing the Programme.

The progress achieved according to the National Social Report of Finland is described briefly below.

Fight against poverty and social exclusion

The Government has taken some important measures to fight against poverty and social exclusion. Firstly, the Government has introduced a social guarantee for young people and made efforts to improve the quality of basic education. The financial aid to students has been linked with an index. Secondly, regarding the most disadvantaged groups, taxation has been eased, the basic daily allowance and the labour market support for the unemployed have been improved, the income limits for housing allowance have been raised, the basic amount of social assistance has been raised by six per cent, the social assistance for single parents has been improved, and the production of social rented housing now receives extra support.

In the field of pensions, some positive progress has been made recently. A guarantee pension introduced in March 2011 has increased the income level of poor elderly people – especially women and immigrants. Moreover, the changes made in the 2005 pension reform have had a positive influence on the length of working careers and raised the effective retirement age. The introduction of a life expectancy index, effective as from 2010, will improve the sustainability of the pension system and provide incentives for prolonged working careers.

The Government has also adopted the social partners' policy outlines on further agreed social security measures. According to the negotiating parties' own assessment, the changes will prolong working careers by slightly over one year on average. The following changes will be implemented in the pension system between 2014 and 2015: the early old-age pension (now available from the age of 62 years onwards) will be abolished, the minimum age of eligibility for the part-time pension will be raised from 60 to 61 years, the minimum age of eligibility for the unemployment path to retirement will be raised from 59 to 60 years. Furthermore, the employee's and the employer's employment pension contributions will be increased by 0.2 percentage points in both 2015 and 2016.

Prolonging working careers

The reform of the Finnish pension system is essential for the aim of prolonging working careers and improving the sustainability of public finances. The Government aims at an effective retirement age of 62.4 years by 2025. In Finland, the employment rate of ageing people has developed favourably in recent years. Ageing people represent the only group in which the employment rate was higher in 2011 than in the 1980s. The employment rates in all other age groups were lower. The framework agreement concluded in autumn 2011 supported the extension of working careers through flexible working hours and by increasing health checks and training. A reform by which working careers will be prolonged by addressing protracted incapacity for work at an early stage came into force in June 2012. An occupational health physician will assess the employee's working capacity together with the employer and the employee when a sickness allowance has been paid for 90 days. Return to work is supported by working capacity counselling, which was launched at the beginning of 2012.

Long-term unemployment

Long-term unemployment will be reduced by means of a local government trial lasting for the parliamentary term. The trial will primarily cover those long-term unemployed who have received an unemployment benefit for at least 500 days.

The target group also includes those job seekers who have been unemployed for at least 12 months and are at risk of being excluded from the labour market. The following changes in the unemployment security will be implemented in 2014 and 2015:

- the right to activation measures before the expiration of the maximum duration of earnings-related unemployment security;
- a daily allowance period will be introduced for unemployed job seekers over 60 years of age;
- earnings-related unemployment security will be graded according to working years;
- an earnings-related daily unemployment allowance will be granted after six months of employment; and
- refusing offered activation measures will shorten the maximum duration of unemployment security by 100 days from 2013 onwards.

Social guarantee for young people

The Government will also implement the social guarantee for young people in full from 2013 onwards. Every young person under 25 years of age and recently graduated people under 30 years will be offered a job, on-the-job training, a period in a workshop, or rehabilitation within three months of becoming unemployed. Moreover, every child who completes basic education will be guaranteed a place of study in upper secondary school education, vocational education, apprenticeship training or a workshop, or in rehabilitation. Problems will be addressed with early-stage study counselling and by offering personal support. In this way, social exclusion among young people and the accumulation of social and health problems can be prevented. Particular attention will be paid to key junctures: ending of basic education, early termination of secondary education, and entering employment for the first time. The Government will allocate an additional EUR 60 million to implementing the social guarantee and to the reform of education, guidance and employment services intended for young people. Implementation of the guarantee will also be supported by extensive cooperation and networking between the authorities.

Housing

In 2010, the Government gave a resolution on providing housing and services for persons with intellectual disabilities in 2010–2015. The aim of the resolution is to reduce the number of places in institutional care for persons with intellectual disabilities and to enable these persons to move from their childhood homes by producing state-subsidized housing that meets their needs and wishes, and by offering individual services and support. Special attention is paid to monitoring the quality of housing, services and support.

A programme to reduce long-term homelessness was implemented in 2008–2011, on the basis of a government resolution. The aim of the programme was to halve the number of long-term homeless persons and to produce 1,250 new dwellings for them. Ten cities with the most pressing homelessness problem were included in the programme. The programme was based on the "housing first" principle, where housing is secured by an individual rental agreement and other support is tailored individually according to the resident's needs. In 2011, the Government continued the programme for the period 2012–2015 with a new government resolution. The aim of the new programme is to eradicate long-term homelessness by the year 2015 by producing state-financed housing and needs-based services for the long-term homeless as well as services helping to prevent homelessness.

Question 3

In years 2009–2011 the Government financed the construction of over 11 000 new dwellings for special groups with EUR 330 million. In 2010, there were approximately 1 900 persons with intellectual disabilities in long-term institutional care and 6 000 adults with intellectual disabilities living with their relatives. According to the Government Resolution on Providing Housing and Associated Services for Persons with Intellectual Disabilities, 3 600 new state-financed dwellings will be produced for these persons in 2010–2015. The quantitative targets set for the programme to reduce long-term homelessness in 2008–2011 were met with approximately 2 000 dwellings provided to the long-term homeless through the programme, and 205 new support workers were employed in services for homeless people. The goal of halving homelessness was realized in seven of the ten programme cities. Approximately EUR 200 million were allocated for the overall funding of the programme.

At the moment there are approximately 7 600 homeless one-person households in Finland. Of these, 3 000 are long-term homeless. The aim of the new programme for 2012–2015 is to produce 1 250 new state-financed dwellings for long-term homeless persons and to intensify measures to prevent homelessness. Moreover, the new programme includes a nationally coordinated, cross-sectoral joint project for the prevention of homelessness of young people.

Answers to the Committee's conclusions

Means to prevent poverty and social exclusion

Information on current measures and trends in poverty has been provided in Finland's National Social Report (NSR) 2012, which has been submitted to the EU's Social Protection Committee. Several reforms on income security benefits and taxation were introduced in 2012. The reforms included:

- the taxation of low incomes was eased;
- the basic daily allowance and the labour market support for the unemployed were improved (this also increased earnings related unemployment benefits);
- the income limits for housing allowance were raised; and
- the basic amount of social assistance was raised by 6 per cent (in addition, the social assistance for single parents was improved).

The aim of these reforms was to reduce poverty and inequality. In autumn 2011 the Government asked the Government Institute for Economic Research to estimate the immediate effects of these reforms on income distribution and relative poverty. A study was carried out using micro simulation models. According to the study, the changes in income security benefits and direct taxation reduced relative poverty by 0.4 percentage points. The reforms also reduced income inequality more generally. The so-called Gini-coefficient was reduced by 0.4 percentage points. The simultaneous increase in consumption taxes had an opposite effect, but it was much smaller (increase in relative poverty by 0.02 percentage points and increase in the Gini-coefficient by 0.07 percentage points).

Monitoring and assessment

The Ministry of Social Affairs and Health has a selected range of well-defined indicators to monitor trends in health and welfare. The indicators are used for monitoring the attainment of strategy goals and performance management, including also the goals of the action plan to combat social exclusion, poverty and health problems. The indicators are being monitored at four levels: social, economic and ecological sustainability; economic and welfare growth; implementation of the Government Programme, policy programmes and action plans; and the effectiveness and efficiency of social protection.

ANNEX

Annex: Unofficial translation of the Health Care Act (1326/2010)