

## Chapter 6

# Finnish Experiences<sup>1</sup>

Juha Mikkonen

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### Introduction

Historically, the Finnish welfare state model has been based on the universal provision of equal social rights for all. These rights are clearly defined in the Constitution of Finland (see Box 6.1). Finland belongs to the group of Nordic countries (Finland, Sweden, Norway, Denmark, and Iceland) that all share the same commitment to provide basic security, free education, and social and health services for everyone regardless of income and wealth. These welfare services are equally available to all citizens and funded through relatively high levels of progressive taxation. In Esping-Andersen's (1990) welfare typology, Finland is identified as a social democratic welfare regime, which generally emphasizes full employment and the role of the state in ensuring adequate income and service provision for citizens (Saint-Arnaud & Bernard, 2003). In international comparison, the Nordic social and economic model has been successful in preventing deep poverty and profound economic inequalities among citizens.

Finnish society has strived to combine social equality with economic competitiveness. According to the Organisation for Economic Co-operation and Development (OECD), Finland is the seventh most equal of 30 most developed OECD countries in terms of income disparities. Poverty rates in Finland are relatively low, but have increased since the recession of the 1990s (OECD, 2008). In terms of economic competitiveness, the World Economic Forum ranks Finland as the sixth most competitive economy in the world (Schwab, 2009).

In Finnish policy-making, health problems have been often seen as socio-political problems rather than as problems that could be solved solely by educating people on healthy lifestyles or by improving health care services. Moreover, Finland has been a strong advocate of the Health in All Policies approach, which emphasizes cross-sectoral actions and broader social and economic factors as the key determinants of health (Puska & Ståhl, 2010; Ståhl, Wismar, Ollila, Lahtinen & Leppo, 2006).

Finnish governments have produced numerous policy papers and strategies that emphasize tackling inequalities in health during the past decades. These health policy strategies have a

clear objective of reducing health inequalities (Ministry of Social Affairs and Health, 1987, 1993, 2001, 2008, 2009, 2011). Currently, reducing poverty, inequality, and social exclusion is one of three priority areas of the Finnish government (Prime Minister's Office, 2011a). Although the overall health of Finnish population has improved, relative health inequalities between socio-economic groups have increased despite the policy goals set in public health programs (Rotko, Aho, Mustonen & Linnanmäki, 2011). This may indicate a divergence between strategic policy objectives and the actual implementation of those policies.

## National Description and Political Organization and Structure

Finland is the fifth largest country in the European Union with a relatively small population of 5.37 million inhabitants (Statistics Finland, 2011a). A large part of the population (1.5 million) is concentrated in the region of Uusimaa in southern Finland. The most populous city is Helsinki (600,000 inhabitants), which is the capital of Finland. The country is bordered by Russia to the east, Norway to the north, and Sweden to the west. Estonia is situated to the south across the Gulf of Finland.

Nordic countries share the same commitment of providing their citizens with an adequate income and equitable welfare services regardless of socio-economic position. These universal principles see society as providing citizens with a decent standard of living regardless of their social background. For example, Nordic universalism sees many benefits targeted not only to the poor and needy but to the whole population. The main element of income redistribution is a relatively high level of progressive taxation combined with efforts at attaining full employment.

### Box 6.1

#### Social Rights in the Constitution of Finland

Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care.

Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider.

The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the wellbeing and personal development of the children.

The public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.

Source: Government of Finland, The right to social security: Section 19 of the Constitution of Finland (Helsinki: Government of Finland, 1999).

Finland joined the European Union in 1995 and since 2002, its currency has been the Euro. Finland is a highly industrialized nation with an annual gross domestic product of €180 billion (US\$240 billion) (Statistics Finland, 2011a). Finnish trade is largely dependent on foreign exports, which account for over one-third of GDP (Statistics Finland, 2011a). Its main industries are electronics, engineering, forest products, chemicals, and shipbuilding (32 percent of GDP). The service sector has a share of 65 percent of Finnish GDP.

### **Population Demographics**

The population of Finland is rather homogeneous in terms of ethnic origin. Only 4.2 percent of its population (224,388) are foreign-born and only 3.1 percent of those (167,954) living in Finland are foreign citizens (Statistics Finland, 2011a). The largest groups of foreigners are people from Estonia, Russia, and Sweden. Finland has two official languages: Finnish and Swedish. Finland has a rather large bilingual Swedish-speaking minority (5.4 percent of all citizens).

Two notable future challenges for Finnish society will be changing demographics in terms of a growing immigrant population and the aging of its citizens. The beginning of the 2010s is a turning point, with a rapid increase in old age pensioners and a declining tax-paying workforce. Projections indicate that the proportion of Finnish citizens over 65 will increase from 17 percent to 27 percent by 2030 (Blomgren, Mikkola, Hiilamo & Järvisalo, 2011). The challenges of aging populations affect all the European countries, but these changes will be greater in Finland than in other EU countries.

Due to the changing ratio between working and retired citizens, there are pressures to keep aging citizens in the workforce. At the political level, there are numerous debates about how to improve the quality of working life and reduce health inequalities among wage earners. In addition, there have been proposals that the age for old age pension should be raised from 63 to 65 years. However, there are various types of early retirement plans and the expected effective retirement age was 60.4 in 2010 (Finnish Centre for Pensions, 2011; [www.etk.fi](http://www.etk.fi)).

### **Form of Government and Political Parties**

Finland is a democratic republic with a unicameral Parliament of 200 members who are elected for a four-year term on the basis of proportional representation. The president of Finland, who is the head of state, is elected for a six-year term. A decade ago, amendments were passed that reduced the president's governing power by increasing the powers of the prime minister and the Finnish Parliament. The prime minister is the head of the government and appoints other ministers of Cabinet. Finnish politics has a multi-party system and a long tradition of coalition governments. There has not been a one-party majority government during the entire time of Finland's independence. One notable democratic milestone was experienced in 1906, when Finnish women were the first ones in the world to have an unrestricted right to vote and to stand for parliamentary elections. The first female president of Finland was elected in 2000.

During the past 100 years, the Finnish Social Democratic Party and the Agrarian Party (now the Centre Party) have had a significant presence in national governments. Most recently in the 2011 parliamentary elections, six parties formed a coalition government.<sup>2</sup> This kind of wide coalition is unexceptional in Finland and represents a general shift in European politics in which traditional political parties have lost support to nationalist and populist movements.

## **Municipalities and Regions in Finland**

Finland has 336 municipalities that have a high degree of self-governance (Tukia, Lehtinen, Saaristo & Vuori, 2011). Along with maintaining local infrastructure, which includes schools and libraries, municipalities are obliged to provide basic services such as health care and social services. Municipalities are given a right to collect an income tax with marginal rates of between 16 to 21 percent (Finnish Tax Administration, 2011). Currently there are substantial pressures to merge and reform municipalities into larger units to sustain their capability to provide high-quality social and health services in the future. To date, many municipalities work together and have formed social and health care districts to provide legally obligated services such as hospital care for their citizens.

At the regional level, Finland has 19 regions that are governed by regional councils that coordinate co-operation between the municipalities. In 2010, a new regional administration system was established and six regional state agencies were formed to carry out the administrative functions of different ministries at a regional level. These agencies have responsibility for legislative implementation and monitoring regional activity. The state steers municipalities' activities by three means: (1) regulations defined by the law (norm guidance); (2) subsidies (resource guidance); and (3) information to local governments (information guidance) (Ministry of Finance, 2011). Laws and resource provision have been seen as the most effective means of steering municipal activity. In contrast, information guidance has been seen as less effective because it does not provide incentives or sanctions for local governments' activities.

## **Historical Context**

The history of Finland is distinct from that of other Nordic countries because of long periods of Swedish (600 years) and Russian (100 years) rule in the country. From 1809 to 1917, Finland was an autonomous Grand Duchy of the Russian Empire. The Parliament of Finland adopted the Finnish declaration of independence in 1917, with Finland becoming an independent and sovereign nation rather than a part of the Russian Empire.

During the turmoil caused by World War I, Finland experienced a civil war in 1918 that was fought between working-class socialists (commonly called "the Reds") and the ruling conservatives (commonly called "the Whites"). The Russia-leaning Reds lost the battle against the ruling Finnish government, which was better trained and equipped.

Finland fought two wars against the Soviet Union during World War II (1939–1944). These wars united the nation and reduced the social and political divides caused by the Finnish civil war three decades earlier. In 1944, Finland lost its war against the Soviet Union, but the country was able to maintain its independence. After the war, the future of the country was uncertain and social infrastructure was in many ways underdeveloped. The foundations of the Finnish welfare state aimed at social equality were built during the decades following World War II.

## **Welfare State System Reforms in Finland**

The principle of universalism has played an important role in shaping social policies of the Nordic countries. The history of the Nordic welfare state can be divided in two phases. The first phase was accepting the notion of universal social rights and the second phase, starting

from the 1960s, was the gradual formation of the institutional base of the welfare state and the introduction of new benefits and services (Kildal & Stein, 2005; Kuusi, 1964).

Postwar social security reforms were seen as a means of supporting Finland's national unity and promoting the sense of shared responsibility among citizens (Niemelä & Salminen, 2006). The improvement of living conditions occurred in tandem with the introduction of many social reforms in the decades following the war. The co-operation of the Social Democrats and the Agrarian Party resulted in the significant socio-political reform of the National Pensions Act (1937), which shifted the trend from employee-based insurance toward national insurance (Kangas & Saari, 2009).

Other major socio-political reforms included the family allowance scheme (1948) and maternity grants (1949), both of which were paid directly to mothers. Another significant socio-political reform of the 1950s was the national pension reform, which increased the overall public pension expenditure 2.5 times between 1956 and 1957 (Niemelä & Salminen, 2006). In 1956, the Social Assistance Act replaced the former Poor Relief Act (1922). The new Act obligated the state to provide necessary maintenance and care for citizens by providing income even when they did not suffer from absolute poverty (Niemelä & Salminen, 2006, 12).

### **The Era of Health Care Reforms**

In the 1940s, the most significant public health innovation was the introduction of publicly run maternity and child health clinics to monitor and promote the health of pregnant women, mothers of young babies, and schoolchildren. A law in 1944 on maternity and child health clinics obligated every municipality to run these clinics free of charge. By 1946 there were 1,500 clinics across the country and the system played a strong role in improving children's health. After the 1940s, child mortality rates began to fall rapidly, and since that time the life expectancy of Finns has increased by 20 years (Teperi & Vuorenkoski, 2006).

The modern and publicly funded hospital system in Finland was built during the 1950s (Kokko, 2000). A nationwide hospital system was a major improvement. At that time, there was an imbalance between hospital and outpatient care, where the latter suffered a shortage of medical doctors (Teperi & Vuorenkoski, 2006). This was especially the case in more rural areas, where citizens did not necessarily receive outpatient care. The next developmental step was to focus on preventive care and outpatient care. In 1963, a national sickness insurance system was introduced that made all permanent residents of Finland eligible for services in outpatient health care. The national sickness insurance compensated for financial losses in case of illness and gave more equal opportunities for different socio-economic groups to access the health care system.

Probably the single most important health care reform in Finland was the Public Health Act (1972), which shifted the health care system to emphasize disease prevention and outpatient care. The reform obliged every municipality to organize a wide range of services accessible in one location. These services included general medical practices, maternity clinics, dental care, and long-term in-patient care. Central and local governments shared the new costs for primary health care services with a state subsidies system.

Workers' trade unions and employers' organizations (labour market organizations) signed an agreement in 1971 that was a starting point for the Occupational Health Care Act (1978).

The Act mandated that employers provide occupation health care services for workers to help prevent health hazards and maintain the population's working capacity (Räsänen, 2006). Currently around 90 percent of wage earners are covered by these occupational health services, and only small-scale employers can have an exemption from providing occupational health care for their employees. Originally, occupational health services had a strong preventive orientation, but later the focus has turned more on general practitioner-level medical services and clinical laboratory testing.

### **Health in Finland Today**

In international comparisons, Finland ranks fairly high on measurements of various health indicators. Due to improved living conditions and healthy behaviours, the life expectancy in Finland has continued to increase, and that for Finnish women is among the highest in Europe. The life expectancy in Finland has doubled during the past 100 years. Currently, the life expectancy for Finnish males is 76.7 years and for females, 83.2 years (Statistics Finland, 2011a). Finland's infant mortality rate in 2010 was 2.3 per 1,000 children, which is very low when placed in international perspective (Statistics Finland, 2011c).

Among Finnish men, cardiovascular disease mortality began to decline from the late 1970s. However, the high prevalence of cardiovascular diseases (CVD) among Finnish men partly explains their elevated CVD mortality rate, which is higher than the OECD average (Blomgren, et al., 2011; OECD, 2011a). In 2009, cardiovascular diseases caused 40 percent of all deaths, neoplasms 22 percent, and dementia 12 percent. The overall cancer mortality is lower in Finland than in many other developed Western countries. Among Finnish males aged 15–64 years, the three most common causes of deaths are alcohol-related deaths, ischemic heart disease, and accidents. The three most common causes of deaths among working-age females are breast cancer, alcohol-related deaths, and accidents. The previously high suicide rate in Finland has recently reached its lowest level since 1967, and the rate of suicides per 100,000 people was 17.78 in 2010 (for men 27.28/100,000 and for women 8.63/100,000) (Statistics Finland, 2011c).

### **Finnish Policy Documents and Statements on Health Inequalities**

Most of the Finnish health policy programs and strategies are published in English for international readers. In addition, there are numerous brief reviews available on the developments of the Finnish health policy (Canada Senate, Subcommittee on Population Health, 2008; Kokko, 2000; Palosuo et al., 2008; WHO, 2002)

The modern foundations of Finnish health policy were laid in a report prepared by the Economic Council (1972). The report defined the equal distribution of health as the general objective of health policy and highlighted how broader social and economic policies have a significant impact on the population health (Palosuo, Koskinen & Sihto, 2008).

Over the past decades, Finnish public policy has been built on governmental programs carried out by governments in power. The single most significant Finnish policy paper is the *Government Programme*, which sets the priorities for the government's four-year term. There are also numerous sectoral programs and strategies that focus on more specific policy goals. In

general, many programs recognize the health inequalities among socio-economic groups, but often have a limited set of concrete proposals and actions that would reduce these inequalities. The following section outlines a set of significant Finnish policy programs and their key objectives over the course of the past decades.

### **Health for All Program (1986/1993)**

The Finnish Health for All (HFA) program (Ministry of Social Affairs and Health, 1987) was modelled upon the objectives of the World Health Organization's (WHO) Health for All by the Year 2000 strategy (WHO, 1981). The Finnish HFA program was adopted in 1986 and focused on providing equal access to health care, reducing health-damaging behaviours, and paid less attention to broader socio-economic factors as health determinants. However, the HFA program set the level target to attain the best possible health. Importantly, it emphasized a distribution of health targets focused on reducing health inequalities:

The aim is to achieve the best possible level of health for the population and the reduction and elimination of differences in health between population groups. Instead of being disease oriented or focusing on the service system, the expression Health for All emphasizes the best possible level of health and functional capacities (the level target). On the other hand the expression emphasizes the goal of social equity and the reduction of inequality; the most even distribution of health possible (the distribution target). (Ministry of Social Affairs and Health, 1987, 46)

Finland revised the HFA program in 1993. The revised version put more attention upon health differences and cross-sectoral co-operation and contained 12 action lines. It called for governmental actors to take responsibility for program implementation (Kokko, 2000; Ministry of Social Affairs and Health, 1993).

On one hand, the revised HFA 1993 program paid more attention to health inequalities, but on the other, it focused less on universal principles and uniform services for the whole population, core foundations of the Nordic welfare states. The revised HFA program outlined an approach that “concentrates heavily on the people worst-off in terms of health and health related lifestyle” (Sihto & Keskimäki, 2000, 280).

### **Health 2015 Public Health Program (2001)**

The Health 2015 public health program set targets for Finland's health policy for 2001–2015 (Ministry of Social Affairs and Health, 2001). The program focuses less on the health service system and more on health promotion. Co-operation between different administrative sectors and actors outside of the government is highlighted as the basis of implementation. The program acknowledges that population health is extensively determined by factors outside of the health care sector.

The Health 2015 program has five objectives that address the health of different age groups and three general objectives that target the whole population (see Table 6.1). Significantly, the program also sets a quantitative target to reduce mortality differences between different vocational and education groups by a fifth by 2015. However, it seems that the target will not be reached by 2015.

**Table 6.1**  
**Main Health Policy Targets in Finland up to 2015**

**Targets for Different Age Groups**

1. Child wellbeing and health will increase, and symptoms and diseases caused by insecurity will decrease appreciably.
2. Smoking by young people will decrease to less than 15% of those aged 16–18; health problems associated with alcohol and drug use among the young will be dealt with appropriately and will not exceed the level of the early '90s.
3. Accidental and violent death among young adult men will be cut by a third on the level during the late 1990s.
4. Working and functional capacity among people of working age and workplace conditions will improve, helping people to cope longer in working life; retirement will be about three years later than in 2000.
5. Average functional capacity among people over 75 will continue to improve as it has during the last 20 years.

**Targets for Everyone**

6. Finns can expect to remain healthy for an average of two years longer than in 2000.
7. Finnish satisfaction with health service availability and functioning, and subjective healthiness and experiences of environment impacts on personal health will remain at least at the present level.
8. In implementing these targets, another aim will be to reduce inequality and increase the welfare and relative status of those population groups in the weakest position. The objective will then be to reduce mortality differences between the genders, groups with different educational backgrounds, and different vocational groupings by a fifth.

Source: Ministry of Social Affairs and Health, *Government resolution on the health 2015 public health programme* (Helsinki: Ministry of Social Affairs and Health, 2001), 6.

An evaluation report published in 2008 (Muurinen, Perttilä & Ståhl, 2008) concluded that Health 2015 was well known in the social and health field, but less familiar to actors from other sectors. Experts and municipal officers who were interviewed indicated that the main obstacles for the program implementation were a lack of financial resources and untrained staff at the local municipal level. A new interim evaluation of the Health 2015 program will be published in the near future by the National Institute for Health and Welfare.

**National Action Plan to Reduce Health Inequalities, 2008–2011**

The *National Action Plan to Reduce Health Inequalities* (Ministry of Social Affairs and Health, 2008) was prepared by the multi-sectoral National Advisory Board for Public Health in 2008. The Ministry of Social Affairs and Health has the main responsibility for implementing and



monitoring of the *Action Plan*. Numerous stakeholders from various governmental research institutes, universities, and civil society organizations were consulted during the document's preparation. The *Action Plan* describes general strategies and specific measures to reduce socio-economic-related health inequalities in Finland.

The main objectives of the plan are to reduce social inequalities in “work ability and functional capacity, self-rated health, morbidity and mortality by levelling up” (Ministry of Social Affairs and Health, 2008, 3). The program aims to ensure the good quality of public services and to increase the employment rate. The *National Action Plan* has three priority areas (Ministry of Social Affairs and Health, 2008, 4):

1. Social policy measures: improving income security and education, and decreasing unemployment and poor housing.
2. Strengthening the prerequisites for healthy lifestyles: measures to promote healthy behaviour of the whole population with special attention to disadvantaged groups where unhealthy behaviour is common.
3. Improving the availability and good quality of social and health care services for everyone.

The *Action Plan* highlights the importance of further developing a reliable knowledge base on health inequalities in Finland. The plan identifies a need for improved monitoring of health inequalities and increased knowledge transfer from researchers to decision-makers on how to reduce health inequalities. The *National Action Plan to Reduce Health Inequalities* contains a list of actions and their responsible actors, but does not include any quantitative targets to measure progress (Ministry of Social Affairs and Health, 2008).

### **Program for Health Promotion, 2007–2011**

The main aims of the Program for Health Promotion are to improve population health and tackle health inequalities by supporting intersectoral co-operation within governmental structures (Finnish Government, 2007). Objectives are to strengthen health promotion structures, support lifestyle changes, improve working and living conditions, strengthen the basic services of social welfare and health care, and reinforce the activities of civil society organizations that provide support for health promotion. In particular, the program highlights the role of municipalities to promote health at a local level.

The policy program was steered and monitored by a ministerial group, with one full-time program director responsible for coordinating its practical implementation. The results of the program were reported in 2011 (Prime Minister's Office, 2011a). The final report of the program emphasizes the positive developments (e.g., increased life expectancy) and cross-sectoral actions that took place during the parliamentary term. In contrast, the National Audit Office's performance report (National Audit Office, 2010) suggested that the Program for Health Promotion lacked clear focus, and that the preparatory resources needed for effective implementation were rather small. Despite the shortcomings and budget constraints, the program was seen as successful in producing new co-operation between different governmental and civil society actors.

### **National Development Program for Social Welfare and Health Care, 2008–2011 (Kaste Program)**

The Kaste Program (Ministry of Social Affairs and Health, 2009) is coordinated by the Ministry of Social Affairs and Health and institutions under the ministry's auspices. The program follows the Finnish government's long-term strategic objectives to improve the population's health and well-being. The focus is on preventive measures and improving the delivery and quality of health care and social services at the local municipal level. The general aims of the program are to: (1) increase municipal inhabitants' social inclusion and reduce levels of social exclusion; (2) increase municipal inhabitants' well-being and health and diminish inequalities in well-being and health; and (3) improve the quality, effectiveness, and availability of services for the municipal inhabitants and reduce regional inequalities (Ministry of Social Affairs and Health, 2009).

The National Advisory Committee on Social Welfare and Health has the main responsibility for monitoring the program's implementation. The monitoring work is divided among consolidation, regional, and civic subcommittees, which have specific responsibilities for supporting local municipalities (consolidation committee), transmitting program proposals from a regional to a municipal level (regional committee), and collecting the views of service clients and individual citizens (civic committee) to support the program implementation.

The Kaste Program, which is funded from the annual state budget, supported development projects in municipal health care and social services with a total amount of €80 million between 2008 and 2011. The program will continue after 2011 and focus particularly on two main actions: (1) reducing inequalities in health and welfare; and (2) restructuring social and health services to increase their efficacy and accessibility.

### **Finnish Government Programme, 2011–2015**

The Finnish *Government Programme* is an action plan that the ruling political parties follow for their parliamentary term. The *Programme* defines the main strategic objectives and sets the priorities for the work of ministers and government bodies. In the past years, the *Government Programme* has been one of the most important government documents. Therefore, many political lobbyists and interest groups have carried out efforts to have their priorities mentioned in the paper.

The current Prime Minister Jyrki Katainen's government (2011) has three priority areas: (1) the reduction of poverty, inequality, and social exclusion; (2) the consolidation of public finances; and (3) the strengthening of sustainable economic growth, employment, and competitiveness (Prime Minister's Office, 2011a). The document presents rising inequality as a threat to Finnish society and highlights the importance of strengthening the basic structures that support citizens' health and welfare. In particular, the *Programme* emphasizes cross-sectoral actions and co-operation to tackle poverty and inequality:

The promotion of wellbeing and health as well as the reduction of inequality will be taken into account in all societal decision-making, and incorporated into the activities of all administrative sectors and ministries. Poverty and social exclusion cause human suffering, health disparities, and inequality, among other things. (Prime Minister's Office, 2011a, 95, <http://www.vn.fi/hallitus/hallitusohjelma/en.jsp>)

The Prime Minister's Office and other ministries have a responsibility to monitor and promote the *Programme*. The government holds annual policy review sessions to evaluate whether changes in the economic situation create a need to review the objectives of the *Government Programme*.

### **Finnish Government Programme, 2007–2011**

The *Government Programme* of Prime Minister Matti Vanhanen's second Cabinet (Prime Minister's Office, 2007) emphasized a strong economy and a high employment rate to further health and social welfare. From a welfare perspective, the *Programme* focuses on the sustainable financing of municipal services and reducing the regional differences in access to these services:

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. Additionally, steps must be taken to ensure an adequate level of income security and maintain the work ability of the people and to guarantee the availability of well-functioning primary services to all citizens irrespective of place of residence and wealth. (Prime Minister's Office, 2007, 45–46)

The Vanhanen government set three sub-programs for the parliamentary term 2007–2011 (Prime Minister's Office, 2011b): (1) the Policy Programme for Health Promotion; (2) the Policy Programme for Employment, Entrepreneurship, and Worklife; and (3) the Policy Programme for the Wellbeing of Children, Youth, and Families. In addition, the government initiated a SATA Committee to restructure and develop the social protection system. Due to conflicting political interests, the committee was not able to produce a comprehensive social security reform that was anticipated, but it succeeded in increasing minimum pensions and proposed approximately 50 smaller reforms to enhance the Finnish social security system.

### **Socially Sustainable Finland, 2020**

The most recent strategy of the Finnish Ministry of Social Affairs and Health states that Finland needs to have a strong foundation for welfare and health in 2020 (Ministry of Social Affairs and Health, 2011). The purpose of the strategy “is to achieve a socially sustainable society in which people are treated equally, everyone has the opportunity to participate, and everyone's health and functional capacity is supported” (Ministry of Social Affairs and Health, 2011, 3).

The strategy aims at a socially sustainable Finland by reducing differentials in health; providing adequate social protection; attaining longer working careers through well-being at work; and achieving a balanced economy and social development, among others (see Box 6.2). The implementation of the strategy requires co-operation of all administrative sectors and knowledge-based decision-making that draws on research and innovations for promoting health and welfare.

## **Research on Health Inequalities in Finland**

For the past three decades, Finnish health policy documents have highlighted the importance of reducing health inequalities as a goal of public policy (see above). Various indicators show that the overall health of the Finnish population has improved from 1980 to 2005, but health

**Box 6.2****Strategic Choices for Socially Sustainable Finland in 2020**

1. A strong foundation for welfare
  - Health and welfare in all policies
  - Longer working careers through wellbeing at work
  - Balancing the various areas of life
  - Sustainable social protection financing
  
2. Access to welfare for all
  - Reduce differentials in welfare and health
  - Customer-oriented services
  - New service structures and operating practices
  - Strong sense of social inclusion
  
3. A healthy and safe living environment
  - Strengthen the viability of the environment
  - Ensure that society can continue to function under exceptional circumstances

Source: Ministry of Social Affairs and Health, *Socially sustainable Finland 2020: Strategy for social and health policy* (Helsinki: Ministry of Social Affairs and Health, 2011), 4.

inequalities between socio-economic groups have remained stable and may even have widened (Palosuo et al., 2009). International comparative studies have shown that the level of *relative* mortality differences between socio-economic groups, especially among men, are greater in Finland than in many other western European countries (Mackenbach et al., 2008).

Most of the current Finnish research on public health, health inequalities, and well-being is carried out in governmental research institutions such as the National Institute for Health and Welfare, Statistics Finland, Social Insurance Institution, and the Finnish Institute of Occupational Health. In addition, several universities have programs of research in public health and health sociology. For instance, researchers at the Population Research Unit at the University of Helsinki have produced a large number of studies on socio-economic-related mortality differences in Finland. Civil society activity includes a variety of non-governmental organizations producing research reports and surveys on health and welfare in Finland.

Finnish researchers can access individual-level information from different registers and link the data together to carry out population research (Palosuo et al., 2008). However, Finland does not have a continuing structure for carrying out research on health inequalities, and most of the existing studies have been prepared in the context of short-term projects. An extensive Finnish research bibliography (Forssas et al., 1999) on health inequalities identified 351 studies on health inequalities published between 1966 and 1998. Over 70 percent of these

studies were carried out in the 1990s. During the 2000s, the number of publications on health inequalities in Finland has most likely further increased.

### **Agencies and Organizations Carrying out Research on Health Inequalities**

The largest institute that carries out research on health inequalities in Finland is the National Institute for Health and Welfare (THL, [www.thl.fi](http://www.thl.fi)). THL is a research and development institute under the Finnish Ministry of Social Affairs and Health with over 1,000 employees working in seven different cities. THL promotes health and welfare in Finland and works as a statutory statistical authority. The institute was established in 2009 by the merger of the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute (KTL). THL and its predecessors have produced numerous studies and reports on health inequalities.

The WHO Collaborating Centre on Social Determinants of Health was established at THL in 2011. Ongoing work at the centre includes activities such as evaluating the Finnish Action Plan to reduce health inequalities, operationalization of the WHO's policy recommendations, analyzing policy programs from a social determinants of health perspective, and developing equity focus in public health programs (THL, 2011c). However, the centre does not have resources of its own and its purpose is to collect THL's existing research activities under one umbrella.

A joint project (TEROKA) was started in 2004 to increase knowledge and develop tools to reduce health inequalities in Finland (see Box 6.3). The Ministry of Social Affairs and Health commissioned research institutes to find practical measures to reach the key targets of the national Health 2015 public health program. The TEROKA project group and its steering group consisted of experts from the ministry, research institutes, universities, and non-governmental organizations. The TEROKA group was actively involved in promoting and preparing the *National Action Plan to Reduce Health Inequalities 2008–2011* (Ministry of Social Affairs and Health, 2008) and the report *Health Inequalities in Finland: Trends in Socioeconomic Health Differences 1980–2005* (Palosuo et al., 2009).

The TEROKA project has now ended, but it has generated many new activities such as the website Kaventaja—Reducing Inequalities in Health and Wellbeing, which disseminates accurate and up-to-date information on health inequalities and on ways of reducing them. The website “supports decision-making and planning on the level of municipalities, regions and central government. Key target groups include leading officials and elected officials, together with the specialist staff of the various administrative sectors” ([www.kaventaja.thl.fi](http://www.kaventaja.thl.fi)).

Statistics Finland ([www.stat.fi](http://www.stat.fi)), an agency operating under the Ministry of Finance, is specifically focused on producing statistics and information services. It independently collects and reports the vast majority of official Finnish statistics. The agency has around 1,000 employees with operations in five different cities. The regular production cycle includes over 200 sets of statistics with a wide range of coverage, including statistics on population health and living conditions. Statistics Finland has a good national and international reputation for its high-quality data production and expertise.

The Social Insurance Institution (KELA, [www.kela.fi](http://www.kela.fi)) operates under the Finnish Parliament and has a statutory responsibility to look after the basic security of all residents in Finland. KELA provides public information on social benefits and services, carries out research on

**Box 6.3****The TEROKA Project to Reduce Health Inequalities in Finland**

TEROKA's main aims:

- Strengthen the knowledge base and follow-up on health inequalities and disseminate information
- Chart and promote co-operation needed for reducing health inequalities
- Encourage policies on tackling health inequalities as well as practical measures
- Advance the use of health impact assessment as a means for health and social policy attempting to reduce health inequalities

TEROKA's action to realize these aims:

- Compile and publish reports on trends in health inequalities
- Maintain and develop Internet services, produce educational material, and provide presentations and lectures
- In co-operation with partners, develop and assess national, regional, and local operation models aiming to reduce health inequalities
- Explore possibilities to reduce health inequalities by means of health impact assessment
- Gather material for the basis of a strategy and action plan for reducing health inequalities
- Build practical models for regional health inequality follow-ups

Source: Retrieved from: [www.teroka.fi](http://www.teroka.fi).

social security, and collects statistical information on the use of benefits and services. KELA's mission is "to secure the income and promote the health of the entire nation, and to support the capacity of individual citizens to care for themselves" ([www.kela.fi](http://www.kela.fi)).

The Finnish Institute of Occupational Health (FIOH/TTL, [www.ttl.fi](http://www.ttl.fi)) has six regional offices around the country and functions under the Ministry of Social Affairs and Health. Its mission is "to promote occupational health and safety as part of good living." The agency has three main areas of activity: (1) to create solutions for well-being at work; (2) to provide client services to serve workplaces and other clients to promote health in working life; and (3) to influence through knowledge, to share information, and to aid decision-making on work and well-being ([www.ttl.fi](http://www.ttl.fi)).

## Health Inequalities in Finland

The significance of health inequalities to Finnish society is illustrated by estimates of avoidable public health problems. Table 6.2 presents an assessment on which proportion of health problems could be avoided if the prevalence of problems in the lowest socio-economic group were the same as that in the highest socio-economic group (Koskinen & Martelin, 2007).

**Table 6.2**  
**Proportion (%) of Avoidable Key Public Health Problems If Their Prevalence in Population Was Similar to the Highly Educated**

Health Problem	Proportion (%) of Cases Avoided
Edentulousness (toothlessness)	80
Respiratory deaths	50–75
Alcohol deaths	50–60
Need for daily help due to restrictions in functional capacity	50
Coronary heart disease deaths	30–50
Accidental/violent deaths	20–45
Diabetes	30
Back disorders	30
Osteoarthritis of knee/hip	30
Stroke deaths	20–40
Cancer deaths	20–30
Impaired vision/hearing	20

Source: S. Koskinen & T. Martelin, *Nykyiset kansanterveysongelmat ja mahdollisuudet niiden torjumiseen* [Current public health problems and opportunities for prevention]. In M. Pekurinen & P. Puska (Eds.), *Terveysthuollon menojen hillintä* [Reducing health care costs] (pp. 78–92) (Helsinki: Prime Minister's Office, April 2007).

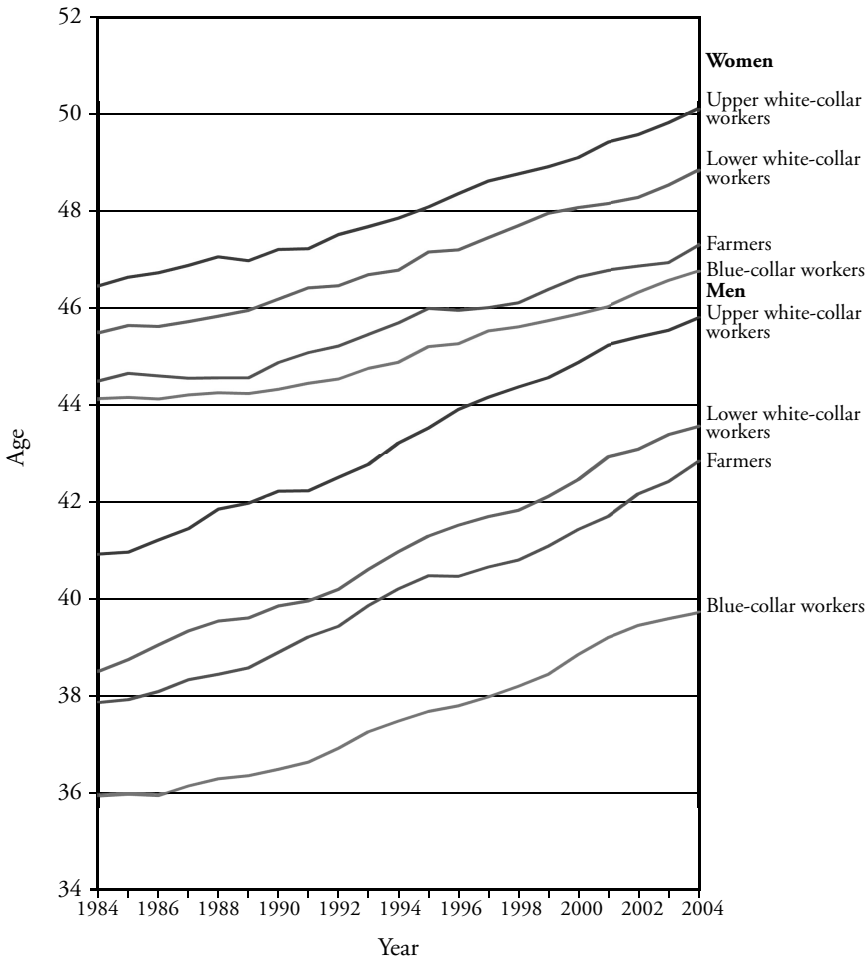
### Health Inequalities as Manifested in Mortality

Health inequalities can be observed by analyzing differences in mortality between different groups of occupation, education, and income. Figure 6.1 presents the life expectancies for Finnish females and males aged 35 by occupational group in 1983–2005 (Valkonen, Ahonen, Martikainen & Remes, 2009). The figure illustrates the existence and continuity of mortality differences between occupational groups in Finland. To analyze the results, the researchers used three-year moving averages to reduce random variation that might occur in annual data.

Figure 6.1 shows that the difference in life expectancy between male upper white-collar and blue-collar workers increased by 1.1 years over the course of 20 years. The increase was from 5.0 to 6.1 years between two periods of measurement (1983–1985 and 2003–2005). A similar pattern is seen also among Finnish women whose socio-economic differences in life expectancy increased from 2.3 years in 1983–1985 to 3.3 years in 2003–2005.

Inequalities in mortality between socio-economic groups in the highest and the lowest income quintiles have increased rapidly in Finland. A recent study found that difference in mortality rates of Finnish men was as high as 12.5 years between the highest and the lowest income groups in 2007 (Tarkiainen, Martikainen, Laaksonen & Valkonen, 2011). The increase has been rapid; when measured in 1988, the difference between these groups was only 7.4 years. However, a

**Figure 6.1**  
**Life Expectancy of Men and Women Aged 35 by Social Group in 1983–2005 (Three-Year Moving Averages)**



lack of comparable statistical data does not allow these results to be put in an international perspective. The researchers have interpreted these findings to reflect the increased life expectancy among the men in the highest income quintile as well as increased social exclusion and alcohol use among the men in the lowest income quintiles (Tarkiainen et al., 2011).

### Health Inequalities as Manifested in Morbidity

Relative socio-economic health differences can be observed in many chronic illnesses, including the prevalence of coronary heart disease, type 2 diabetes, and musculoskeletal disorders (Palosuo et al., 2009). The general pattern is that the overall morbidity is higher in lower socio-economic



groups. For instance, the lowest socio-economic groups are 50 percent more likely than the highest socio-economic groups to experience long-term illnesses (Palosuo et al., 2009).

In Finland, these socio-economic differences in chronic diseases have stayed rather constant from the 1980s to the beginning of the 2000s (Koskinen et al., 2009). Mental health problems seem to be more common among people who experience financial difficulties (Laaksonen et al., 2007). However, the connection between mental health and socio-economic position is complicated and includes selection processes because mental health problems can weaken a person's earning capacity in the job market (Lahelma & Rahkonen, 2011).

Self-rated health is a commonly used indicator that is shown to correlate with mortality rates. Socio-economic differences in self-rated health among Finnish citizens aged 25–64 have stayed stable between 1979 and 2004 (Rahkonen et al., 2009). These findings show that both Finnish men and women in the lower education groups reported poorer self-rated health than in the higher education groups. A similar pattern was also present when health differences were observed by labour market status, and the unemployed consistently reported their health as lower than the employed population. The percentage of people who felt that their health is below the average was 40–50 percent in the lowest education group as compared to 20–30 percent in the highest education group (Rahkonen et al., 2009).

Health inequalities between socio-economic groups are also seen in a range of other issues such as infant mortality and stillbirth, although the number of these incidents is relatively low in Nordic countries (Rom et al., 2010). For instance, a risk for preterm birth was 14 percent higher and low birth weight was 25 percent higher among blue-collar workers when compared to upper white-collar workers in 2003–2006 (Gissler et al., 2009). Socio-economic differences in perinatal health in Finland decreased during the 1990s, but the positive development came to an end in the 2000s (Gissler et al., 2009).

### **Socio-economic Differences in Alcohol Use and Smoking**

From a health equity perspective, alcohol-related problems are significant public health issues affecting disadvantaged populations globally (Babor et al., 2010). Alcohol mortality has increased in Finland during the past decades, especially among men in lower socio-economic groups (Blomgren et al., 2011). The most common cause of death was alcohol related among Finnish men aged 15–64 in 2009 (Statistics Finland, 2011c).

It is likely that the changes in Finnish alcohol policy have played a role in the increase in mortality rates (Herttua, Mäkelä & Martikainen, 2009). In 2004, Finnish import restrictions for alcohol from foreign countries were lessened and the national alcohol tax was decreased. These changes increased the alcohol consumption and alcohol mortality in Finland. However, the alcohol tax was raised again in 2008–2009, which resulted in a decrease in alcohol use and alcohol mortality in Finland. Currently, the total consumption of alcohol is 12.2 L per capita among Finnish citizens aged 15 and over (THL, 2010).

Socio-economic differences in Finland are also significant in terms of smoking prevalence. The number of daily smokers in Finland has sharply decreased in the higher socio-economic groups in the past decades. At the same time, the change has been less rapid in the lowest socio-economic group. In 2009, the proportion of daily smokers in the population over the age of 15 was 22 percent for men and 16 percent for women (Blomgren et al., 2011). Smoking habits

are adopted in the early teens and there are significant socio-economic differences in the same age cohorts. For example, the percentage of daily smokers among vocational school students is around 40 percent and only 11 percent in a secondary school, which prepares students for higher education (THL, 2011b).

Recently the Finnish government adopted the Tobacco Act (2010), which aims “to end the use of tobacco products in Finland” (Ministry of Social Affairs and Health, 2010). The new law tightens the restrictions on tobacco marketing and prohibits smoking in most public facilities.

## **Public Policy and Health Inequalities in Finland**

In order for public policies to promote health and welfare, the focus should be not only on at-risk groups and socially excluded people. It is important to prevent social exclusion and other risk conditions before they impact individuals. Numerous macro-level factors such as social safety nets, provision of social and health services, employment policies, taxation and income transfers, and the quality of education system all have an influence on the health of a population. These broader factors that influence daily living conditions and the health of a population are generally known as “social determinants of health” (Mikkonen & Raphael, 2010; WHO, 2008).

In Finland, people in the higher socio-economic groups have benefited the most from the improved living conditions and increased life expectancy produced by the Finnish welfare state (Palosuo et al., 2009). Relative health inequalities in the Finnish population can be partly explained through the good living conditions of the healthiest and most well-off citizens. However, less is known about how the experience of material and social deprivation influences the health of lower socio-economic groups. Public policies have a significant impact on the level of material and social resources that are available to the citizens. The following section briefly summarizes some of the recent public policy developments that might increase, maintain, or reduce health inequalities in Finland.

### **Income Inequality and Poverty in Finland**

One of the central debates during the past few years has been the relation of income inequality to health and well-being (Wilkinson & Pickett, 2006, 2009). Finland has been a very equal country in terms of income distribution, but, as in many Western developed nations, income inequality has risen in Finland. Finnish society began to experience deepening socio-economic differences and income inequality after the recession of the 1990s. During the past few decades, the disposable income of Finnish wage earners has increased, but, at the same time, the level of many minimum social benefits has stagnated (Moisio et al., 2011).

Between 1995 and 2000, Finland experienced the fastest-growing income inequalities among the OECD countries (OECD, 2008). Meanwhile, the incomes of the top income earners more than doubled between 1992 and 2000 (Riihelä, 2009). From 1995 to 2000, the Gini coefficient, which measures income inequality, increased in Finland from 21.7 to 26.7 (Statistics Finland, 2009).<sup>3</sup> During the next decade, the income inequalities among the Finnish population continued to grow, and the Gini coefficient of disposable income was 28.0 in 2007. However, the global financial crisis lowered incomes in the highest income group and the Gini coefficient in Finland fell to 25.9 in 2009 (Statistics Finland, 2011d).

Regardless of these recent changes, income inequality in Finland is still below the average OECD Gini coefficient of .31 in the mid-2000s (OECD, 2008, 51). The growth of Finnish income inequality is caused largely by the fact that minimum social and unemployment benefits in Finland have not been raised since the mid-1990s, and benefits have fallen behind the general wage trend (Moisio, 2006; Moisio et al., 2011). Table 6.3 shows average household disposable income by four specific income deciles between 1995 and 2010. The highest-earning decile has experienced a 66 percent increase in income from €54,751 to €91,115, whereas the lowest-earning decile's increase has been only 12 percent from €9,759 to €10,943 (Statistics Finland, 2011b).

Along with income inequality, the level of relative poverty has risen rapidly in Finland. According to Statistics Finland (2009), in 1996 only 8.5 percent of the Finnish population lived below the at-risk-of-poverty line, which is set at 60 percent of median equivalized income (Eurostat,

**Table 6.3**  
**Finnish Household-Dwelling Units' Average Disposable Income in Euros by Income Decile, 1995–2010**

Year	1st Income Decile (lowest income)	4th Income Decile	7th Income Decile	10th Income Decile (highest income)
1995	9759	22 007	30 363	54 751
1996	9780	21 937	30 765	55 175
1997	9769	22 481	31 968	60 717
1998	9764	22 667	32 526	64 988
1999	9815	22 991	33 121	72 669
2000	9706	23 132	33 544	78 123
2001	9897	23 600	34 215	73 213
2002	10 072	24 056	34 851	74 312
2003	10 142	24 462	35 653	77 082
2004	10 267	25 301	37 069	83 709
2005	10 310	25 626	37 629	83 962
2006	10 371	26 116	38 539	87 514
2007	10 494	26 921	39 722	94 087
2008	10 663	27 118	40 022	89 564
2009	10 798	27 691	40 480	86 815
2010	10 943	27 822	41 011	91 115

Source: Statistics Finland (2011b), Income distribution statistics, PX-Web databases, retrieved from: [http://tilastokeskus.fi/tup/tilastotietokannat/index\\_en.html](http://tilastokeskus.fi/tup/tilastotietokannat/index_en.html).

2009). The percentage of people living at risk of poverty reached 13.3 percent (696,120 citizens) in 2008. The percentage of children aged 0–17 living under the at-risk-of-poverty threshold increased from 6 percent to 13 percent during the period 1996–2008. Finland had 144,782 children living in families under the poverty cut-off line in 2008 (Statistics Finland, 2010).<sup>4</sup>

### **Labour Policy**

The Collective Agreements Act (1946) defines collective bargaining in Finland. The types of collective agreements vary and they can be central, industry-wide, and local agreements, among others. Around 75 percent of Finnish wage earners belong to a trade union (Ministry of Labour, 2006). Unions have had a role in safeguarding workers' rights and benefits, such as wage development, employment security, and the quality of working life. Finland has had a long history of Comprehensive Income Policy Agreements from 1969 to 2007. These agreements were negotiated between trade unions,<sup>5</sup> employers' unions, and the Finnish government (MOL, 2006). These agreements have provided predictability to the Finnish economy and made strikes and other disputes less likely.

However, in 2008, the Confederation of Finnish Industries (EK), an employers' association representing businesses (around 70 percent of the Finnish GDP), announced its unwillingness to make any new national income policy agreements. Comprehensive agreements were argued to be inflexible and unsuitable to new global economy. However, in 2011, trade unions and employers' organizations re-entered into a comprehensive agreement by negotiating the broad-based "framework contract," which included over 90 percent of the members of the Confederation of Finnish Industries and 100 percent of public sectors (HS, 2011; Jokivuori, 2011). The agreement will offer a lump payment of €150 and a 4.3 percent pay increase by the end of the 25-month agreement period. In addition, the Finnish government will support the agreement with tax reliefs worth €400. The future challenges in terms of collective bargaining are related to the potential decrease in union density and to the willingness of unions, employers' organizations, and the government to continue mutual collective agreements in the age of a global economy.

### **Social Assistance and Unemployment Policy**

Studies have indicated that unemployment is strongly associated with health problems and risk of premature death. The recent financial crisis has not increased the unemployment rate in Finland to the extent seen in many southern European countries. In 2011, the seasonally adjusted unemployment rate was 7.3 percent and the labour force participation rate was 69.2 percent among people aged 15–64 years (Statistics Finland, 2011e). However, unemployment is much more common in lower socio-economic groups, though this ratio has remained stable in recent years (Koskinen, 2011). In 2010, the number of people covered by active labour market measures was 118,000, which constituted 4.4 percent of the total labour force (Statistics Finland, 2011e).

Unemployed citizens are eligible for the basic unemployment allowance for a maximum of 500 days if they have been previously employed. If they have not been employed or if they exceed the 500-day limit, they are eligible for the labour market subsidy. This is a means-tested benefit, but it can be paid for an indefinite period. For one adult, the labour market subsidy was on average €553 per month in 2010 ([www.kela.fi](http://www.kela.fi)). In addition, unemployed citizens may be eligible for the general housing allowance for rental costs.

The most important last resort for social security in Finland is social assistance, which is applied through municipal social service centres. Social assistance was a rather marginal benefit until the late 1980s. However, in the past decades the number of recipients has increased. Social assistance is paid to a person who cannot attain an adequate minimum income for living expenses by other means. In 2010, 7 percent of Finnish citizens received social assistance at least once (THL, 2011a). As a recent development, the Finnish government decided to increase the minimum levels of social assistance and unemployment benefits starting in 2012.

In Finland, social expenditure as a share of the GDP was 30.6 percent in 2009, which was 4.3 percent higher than in 2008 (Statistics Finland, 2011c). A large part of social spending in Finland is on old age, health, and disability. In contrast, the average public social expenditure as a share of GDP in OECD countries has been around 20 percent during the past decade (OECD, 2011b).

### Health Care System

Finland's health expenditure is 9.2 percent of GDP, which is a bit below the OECD average of 9.6 percent (OECD, 2011a). Finnish municipalities are responsible for organizing health services, but they can decide whether they obtain services from public or private providers. Publicly funded providers produce around 80 percent of health services, private enterprises 17 percent, and non-governmental organizations 3 percent (Kangas & Saari, 2009). According to OECD statistics (OECD, 2011a), public funding covers 75 percent of Finland's health expenditure, which is above the OECD average (72 percent), but less than those of the other Nordic countries (81–84 percent).

Although municipalities are the major funders of Finnish health care provision, Finland also has a mandatory National Health Insurance with universal coverage. Three separate health care systems receive public funding: municipal health care, occupational health care, and private health care. These systems differ significantly in the scope of services provided, in user fees, and in waiting times (Vuorenkoski, Mladovsky & Mossialos, 2008). Currently, Finland has a system of dual public financing for health care. Funding takes place through municipalities, which fund health centres, and through the National Health Insurance, which funds some parts of private health care, occupational health care, outpatient drugs, sickness allowance, and maternity leave allowance (Vuorenkoski et al., 2008).<sup>6</sup> A reform in 1993 placed a responsibility for health care provision more firmly on municipalities and the state control was weakened in terms of reduced requirements for advance and centralized planning (Teperi & Vuorenkoski, 2006).

One challenge in the Finnish health care system is geographical inequities because there are significant differences in the quality and scope of municipal health services. In addition, Finland has relatively large socio-economic differences in the use of health services (Manderbacka et al., 2009). From an equity perspective, another major challenge is municipal health care provided in local health centres, which have increasingly suffered a lack of medical doctors. Municipal health services are used mostly by citizens who are outside the labour market. They are not eligible for occupational health care and often cannot afford private health services. In municipal health care, waiting times are longer than in occupational health care, and the centres are allowed to collect out-of-pocket payments from patients.<sup>7</sup> On average, these patient payments cover around 7 percent of municipal health care expenditure (Teperi, Porter, Vuorenkoski & Baron, 2009, 40).

In contrast to municipal services, the occupational health care in Finland does not have user fees and waiting times are shorter. The situation is problematic because studies have shown that those outside the labour market have more health problems than those who are employed, who are eligible for occupational health care. In addition, the wealthiest citizens can access private health care and still be reimbursed for the fees through the National Health Insurance. In recent years, the structural problems of the Finnish health care systems have received increasing attention, and there have been calls for a comprehensive health care reform (Pekurinen et al., 2010). For example, state subsidy to private health care providers has been under constant debate, but no decisions have been made on radically new reforms that would change the situation. In spite of equity challenges, it can be concluded that the Finnish health care system is still able to provide high-quality services at reasonably low cost (Vuorenkoski et al., 2008).

### **Child Care and the Education System**

In Finland, early childhood education and care (ECEC) is a universal social right, and all children under school age are legally guaranteed a place in municipal daycare. Although municipal daycare is heavily subsidized by the state, it is not completely free of charge. For instance, the maximum monthly fee for a full-time daycare was €254 (2010) in the city of Helsinki ([www.hel.fi](http://www.hel.fi)). The fees are earnings-related and adjusted yearly by a local municipality. In addition to municipal services, parents are eligible for governmental and municipal allowances for paying the fees for private daycare or child home care that they have sought themselves (Heinämäki, 2008).

Finland has a nine-year comprehensive school system from the age of seven. However, over 90 percent of children go to a preparatory preschool at the age of six. One noteworthy detail is that during a school day, all the pupils get a free hot meal, which is aimed at providing a base for a healthy and balanced diet. After nine years of basic education, students can choose to continue their education for three years in a vocational school or in a theoretically oriented high school that prepares them for polytechnic or science universities. The basic education and all its materials are free of charge. There are essentially no private schools in the country (Sahlberg, 2011).

Higher education in universities is also free of tuition charges for Finnish citizens and foreign students from the European Economic Area. Financial subsidies are available to students in higher education (i.e., a study allowance and a housing allowance). The amount of monthly subsidies for students varies around €200–€500 per month. In addition, students are eligible for a state-guaranteed study loan, but the majority of students do not use this option ([www.kela.fi](http://www.kela.fi)).

Finnish children have been the top performers in the OECD's international student assessments (PISA). The PISA assessment measures science, math, and reading skills among 15-year-olds in different countries (OECD, 2011c, 117–158). Most Finnish students receive good educational outcomes regardless of their socio-economic background or geographic location. In recent years, the success of the Finnish education system has received increasing international attention (OECD, 2011c; Sahlberg, 2011). From a comparative perspective, Finland has been able to provide relatively equal opportunities for all students to gain knowledge and skills for further development and employment.

### **Civil Society and NGOs**

Finland has a wide array of non-governmental organizations that work in advocacy, health promotion, public education, and as non-profit service providers. These organizations have a

significant role in efforts to promote health and social welfare. The stated-owned Finnish Slot Machine Association (RAY) supports approximately 800 Finnish non-governmental organizations by funding them with a share of €291 million in 2012 ([www.ray.fi](http://www.ray.fi)). Moreover, RAY offers support and tools for the management and treatment of gambling problems and, due to the state monopoly, private gambling companies are not permitted to operate in Finland. The strategic aims of the RAY are to: (1) strengthen health and social welfare in Finland; (2) prevent social and health problems; and (3) support citizens in need ([www.ray.fi](http://www.ray.fi)).

Altogether there are around 8,000 social and health organizations in Finland. In addition to advocacy and knowledge translation, these NGOs organize volunteer activities, peer support, various training programs, and service provision. Around 20 percent of municipal social services and 5 percent of health services are provided by Finnish non-governmental organizations (STKL, 2009). Two notable Finnish social and health NGOs were founded at the beginning of 2012 after a merger of smaller non-profit organizations. The Finnish Society for Social and Health (SOSTE), with over 200 member organizations, focuses on social and health policy, and the Finnish Association for Substance Abuse Prevention (EHYT), with approximately 100 member organizations, focuses on substance abuse prevention. Finnish NGOs can have a substantial and fairly independent role in raising themes such as health equity and social determinants of health into the public agenda.

## Conclusion

The institutional base of the Finnish welfare state was built gradually after World War II. This process was supported by a strong political commitment to values such as equality and social justice. Finland has been a success story of how an agrarian society was transformed in the course of half a century into a well-developed welfare state with an educated population and high-tech industries. The health of the Finnish population has improved due to improvements in living conditions, education, social safety nets, health care, and individual lifestyles, among others. Public policies promoting shared responsibility and equal opportunities for all citizens, regardless of their economic or social standing, have played a crucial role in Finnish policy-making.

Future challenges of the Finnish welfare state are similar to those of other European nations, including an aging population, economic instability, increased inequality, globalization, and migration. In Finland, the overall health of the population has improved, but health inequalities between socio-economic groups have remained substantially the same despite the equity goals of the Finnish health policy during the past 30 years. This may indicate a lack of efficiency in policy implementation, as well as political decisions that have not been in line with the goals stated in Finnish policy programs. In other words, the aim to reduce health inequalities may have been less a priority than other policy objectives such as market liberalization, economic growth, and short-term financial savings in the government's budget.

Reducing health inequalities requires a strong commitment and political will. In Finland, more focus should be put on the implementation and monitoring of Finnish policy measures and programs that aim to tackle health inequalities. There is a need for a permanent structure with adequate resources to carry out the monitoring of health inequalities in Finland. One important task would be to improve the health impact assessments of different policy initiatives. In particular there is a need to look at the impacts of these policies on the

lowest socio-economic groups and a readiness to formulate alternative policy recommendation if required.

In addition to broader public policies promoting health equity, the Finnish challenge is to maintain the quality of social and health services and ensure good access to these services at a municipal level. A high-quality early childhood education, as well as access to educational and employment opportunities, are needed to prevent social exclusion of young people in their later life. The number of old age pensioners is increasing rapidly, and ensuring adequate support and care for an aging population requires a healthy working-age population.

In half a century, Finland was able to rise from a war-ravaged country to one of the most developed welfare states in the world. Now the country is much more prepared to deal with new challenges, and therefore sustaining the Finnish welfare state is chiefly a matter of commitment and determination.

## Notes

1. I would like to thank Hannele Palosuo, Marita Sihto, Lauri Vuorenkoski, and Anna-Maria Isola for discussions and providing useful comments on an earlier draft of this chapter.
2. In 2011, the political parties that constitute the Finnish ruling coalition in Parliament are the National Coalition Party (44 seats), the Social Democratic Party (42 seats), the Left Alliance (14 seats), the Green League (10 seats), the Swedish People's Party (10 seats), and the Christian Democrats (six seats). The current opposition parties are the Centre Party (35 seats) and the True Finns (39 seats).
3. The Gini coefficient measures the level of inequality of a distribution. A value of 0 expresses total equality and a value of 1 maximal inequality (values are often multiplied by 100). The Gini coefficient is commonly used as a measure of inequality in income or wealth (see OECD, 2008).
4. Using a poverty line at 50 percent of median, at-risk-of-poverty rates in Finland were 6.7 percent for the total population (352,438 people) and 6.8 percent for children aged 0–17 (74,054 people) in 2008.
5. The most important confederations in Finland are the Central Organisation of Finnish Trade Unions (SAK) (20 affiliated trade unions), the Finnish Confederation of Salaried Employees (STTK) (20 affiliated trade unions), and the Confederation of Unions for Professional and Managerial Staff in Finland (AKAVA) (34 affiliated trade unions).
6. The Social Insurance Institution of Finland reimburses the costs of prescription drugs at three different rates (42 percent, 72 percent, and 100 percent of the price). Full reimbursement is given if out-of-pocket expenses in a calendar year exceed €672.7 ([www.kela.fi](http://www.kela.fi), February 24, 2011).
7. For instance, the city of Helsinki had the health centre fee of €13.7, the outpatient clinic fee of €27.40, and the hospital day fee of €32.50 in 2011. The maximum payment limit for one person was €633 during the calendar year. If the limit was exceeded, then a resident could apply for an exemption of payment ([www.hel.fi](http://www.hel.fi), February 24, 2011).



## Critical Thinking Questions

1. What are the key social factors that contributed to the development of the Finnish welfare state?
2. What have been the distinctive aspects of the Finnish health policy during the past decades?
3. What kind of political and economic barriers might there be for successful implementation of Finnish health policy programs that promote health equity?
4. How would you explain the factors that contribute to health inequalities among social groups in Finnish society?

## Recommended Readings

Ministry of Social Affairs and Health. (2008). *National action plan to reduce health inequalities 2008–2011*. Helsinki: Ministry of Social Affairs and Health. Retrieved from: <http://tinyurl.com/c7wxx2r>.

The *Action Plan* outlines strategies and measures to reduce health inequalities in Finland. The publication portrays how the Finnish government can implement and monitor these actions at local and national levels.

Niemelä, H., & Salminen, K. (2006). *Social security in Finland*. Helsinki: Social Insurance Institution (KELA), Finnish Centre for Pensions (ETK), Finnish Pension Alliance (TELA), and Finnish Ministry of Social Affairs and Health. Retrieved from: <http://tinyurl.com/cjn7775>.

The report gives a comprehensive overview of the Finnish social security system and its historical origins.

Palosuo, H., Koskinen, S., Lahelma, E., Kostiainen, E., Prättälä, R., Martelin, T., et al. (Eds.). (2009). *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005*. Helsinki: Ministry of Social Affairs and Health Publications. Retrieved from: <http://tinyurl.com/d3324nx>.

The report summarizes the research on socio-economic inequalities in health in Finland during the past 25 years. It covers changes in mortality, self-rated health morbidity, functional capacity, mental health, and healthy life expectancy, among others. In addition, the report provides information for health policy planning and monitoring.

Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E., & Leppo, K. (Eds.). (2006). *Health in all policies: Prospects and potentials*. Helsinki: Ministry of Social Affairs and Health. Retrieved from: [http://ec.europa.eu/health/archive/ph\\_information/documents/health\\_in\\_all\\_policies.pdf](http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf).

The book describes the main tenets of the Health in All Policies (HiAP) approach, which aims to integrate health considerations into other areas of policy-making. The HiAP approach was prepared in the context of the Finnish presidency, to be disseminated to other countries within the European Union.

## Recommended Websites

Ministry of Social Affairs and Health (MSAH): [www.stm.fi](http://www.stm.fi)

Finland's Ministry of Social Affairs and Health is responsible for the planning, guidance, and implementation of social and health policy in Finland. Many of the ministry's reports and strategies are translated in English and are available online.

National Institute for Health and Welfare (THL): [www.thl.fi](http://www.thl.fi)

The National Institute for Health and Welfare (THL) is a research and development institute under the Finnish Ministry of Social Affairs and Health. Currently, THL is the foremost Finnish institution conducting research on health inequalities and social determinants of health.

Social Insurance Institution of Finland (KELA): [www.kela.fi](http://www.kela.fi)

The institution is responsible for providing basic security to residents of Finland. It also conducts research to develop the Finnish social security system and provides public information on its benefits and services.

Statistics Finland: [www.stat.fi](http://www.stat.fi)

Statistics Finland is the main public authority for statistical data in Finland. It offers many up-to-date statistics and publishes *Finland in Figures*, which contains the key statistical data about Finland.

## References

- Babor, T., Caetano, R., Casswell, S., Edwards, G., Geisbrecht, N., Graham, K., et al. (2010). *Alcohol: No ordinary commodity. Research and public policy* (2nd ed.). Oxford: Oxford University Press.
- Blomgren, J., Mikkola, H., Hiilamo, H., & Järvisalo, J. (2011). *Suomalaisten terveydentila ja terveyteen liittyvät etuudet: Indikaattoriseuranta 1995–2010*. Helsinki: Social Insurance Institution (Kela).
- Canada Senate, Subcommittee on Population Health. (2008). *Population health policy: International perspectives*. Ottawa: Standing Senate Committee on Social Affairs, Science, and Technology.
- Economic Council (1972). Attachment 1. Section that investigates public policy objectives and their measurement. *Report of the Work Group Investigating Health Policy Objectives*. Helsinki: Economic Council.
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton: Princeton University Press.
- Eurostat. (2009). *Europe in figures: Eurostat yearbook 2009*. Luxembourg: Office for Official Publications of the European Communities.
- Finnish Centre for Pensions. (2011). *Pocket statistics*. Helsinki: Finnish Centre for Pensions.
- Finnish Government. (2007). *Policy programme for health promotion 2007–2011*. Helsinki: Prime Minister's Office, Finnish Government.
- Finnish Tax Administration. (2011). *Luettelo kuntien ja seurakuntien tuloveroprosenteista vuonna 2011* [A list of taxes to municipal and parishes in 2011]. Retrieved from: <http://www.vero.fi/>.
- Forssas, E., Keskimäki, I., Koskinen, S., Lahelma, E., Manderbacka, K., Prättälä, R., et al. (1999). *Explaining and reducing socioeconomic health differences—a bibliography of Finnish research publications*. Helsinki: National Research and Development Centre for Welfare and Health (STAKES).
- Gissler, M., Rahkonen, O., Arntzen, A., Cnattingius, S., Andersen, A.-M.N., & Hemminki, E. (2009). Trends in socioeconomic differences in Finnish perinatal health 1991–2006. *Journal of Epidemiology and Community Health*, 63(6), 420–425.
- Government of Finland. (1999). *The right to social security: Section 19 of the Constitution of Finland*. Helsinki: Government of Finland.
- Heinämäki, L. (2008). *Early childhood education in Finland*. Postdam: Liberal Institute & National Research and Development Centre for Welfare and Health (STAKES).
- Herttua, K., Mäkelä, P., & Martikainen, P. (2009). An evaluation of the impact of a large reduction in alcohol prices on alcohol-related and all-cause mortality: Time series analysis of a population-based natural experiment. *International Journal of Epidemiology*, 40(2), 441–454.
- HS. (2011, November 29). Labour market: Framework contract to be implemented. *Helsingin Sanomat (HS)* [Daily newspaper].
- Jokivuori, P. (2011). Social partners agree to national pay settlement. *European Industrial Relations Observatory On-line*. Retrieved from: <http://www.eurofound.europa.eu/eiro/2011/10/articles/fi1110011i.htm>.
- Kangas, O., & Saari, J. (2009). The welfare system of Finland. In K. Schubert, S. Hegelich & U. Bazant (Eds.), *The handbook of European welfare systems* (pp. 189–206). London: Routledge.
- Kildal, N., & Stein, K. (2005). The principle of universalism: Tracing a key idea in the Scandinavian welfare model. In N. Kildal & K. Stein (Eds.), *Normative foundations of the welfare state: The Nordic experience* (pp. 13–33). London: Routledge.

- Kokko, S. (2000). The process of developing health for all policy in Finland 1981–1995. In A. Ritsatakis, R. Barnes, E. Dekker, P. Harrington, S. Kokko & P. Makara (Eds.), *Exploring health policy development in Europe* (pp. 27–40). Copenhagen: World Health Organization Regional Office for Europe.
- Koskinen, S. (2011, November 7). *Why are health inequalities increasing in Finland?* Presented at the Inequality and the Nordic Welfare Model seminar, National Institute for Welfare and Health (THL), Helsinki.
- Koskinen, S., Aromaa, A., Huttunen, J., & Teperi, J. (Eds.). (2006). *Health in Finland*. Vammalan kirjapaino Oy: National Public Health Institute KTL, National Research and Development Centre for Welfare and Health STAKES, Ministry of Social Affairs and Health.
- Koskinen, S., & Martelin, T. (2007). Nykyiset kansanterveysongelmat ja mahdollisuudet niiden torjumiseen [Current public health problems and opportunities for prevention]. In M. Pekurinen & P. Puska (Eds.), *Terveysthuollon menojen hillintä* [Reducing health care costs] (pp. 78–92). Helsinki: Prime Minister's Office.
- Koskinen, S., Martelin, T., Sainio, P., Heliövaara, M., Reunanen, A., & Lahelma, E. (2009). Chronic morbidity. In H. Palosuo, S. Koskinen, E. Lahelma, E. Kostiainen, R. Prättälä, T. Martelin, A. Ostamo, I. Keskimäki, M. Sihto, E. Linnanmäki & K. Talala (Eds.), *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005* (pp. 70–82). Helsinki: Ministry of Social Affairs and Health Publications.
- Kuusi, P. (1964). *Social policy for the sixties: A plan for Finland*. Kuopio: Finnish Social Policy Association.
- Laaksonen, E., Martikainen, P., Lahelma, E., Lallukka, T., Rahkonen, O., Head, J., et al. (2007). Socioeconomic circumstances and common mental disorders among Finnish and British public sector employees: Evidence from the Helsinki Health Study and the Whitehall II Study. *International Journal of Epidemiology*, 36(4), 776–786.
- Lahelma, E., & Rahkonen, O. (2011). Sosioekonominen asema [Socio-economic position]. In M. Laaksonen & K. Silventoinen (Eds.), *Sosiaalieupeemiologia: Väestön terveyserot ja terveyteen vaikuttavat sosiaaliset tekijät* [Social epidemiology: Health inequalities and social determinants of health] (pp. 41–59). Helsinki: Gaudeamus Helsinki University Press.
- Mackenbach, J.P., Stirbu, I., Roskam, A.-J.R., Schaap, M.M., Menvielle, G., Leinsalu, M., et al. (2008). Socioeconomic inequalities in health in 22 European countries. *New England Journal of Medicine*, 358(23), 2468–2481.
- Manderbacka, K., Häkkinen, U., Nguyen, L., Pirkola, S., Ostamo, A., & Keskimäki, I. (2009). Health care services. In H. Palosuo, S. Koskinen, E. Lahelma, E. Kostiainen, R. Prättälä, T. Martelin, A. Ostamo, I. Keskimäki, M. Sihto, E. Linnanmäki & K. Talala (Eds.), *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005* (pp. 178–194). Helsinki: Ministry of Social Affairs and Health Publications.
- Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Toronto: York University School of Health Policy and Management.
- Ministry of Finance. (2011). *Kuntiin kohdistuvan valtionohjauksen periaatteet—normihanketyöryhmän ehdotukset* [Principles on central government steering targeted at local government—project group proposals]. Helsinki: Ministry of Finance.
- Ministry of Justice. (1999, June 11). *The constitution of Finland*. Helsinki: Ministry of Justice.
- Ministry of Labour. (2006). *Industrial relations and labour legislation in Finland*. Helsinki: Ministry of Labour (MOL).
- Ministry of Social Affairs and Health. (1987). *Health for all by the year 2000: The Finnish national strategy*. Helsinki: Ministry of Social Affairs and Health.
- Ministry of Social Affairs and Health. (1993). *Health for all by the year 2000: Revised strategy for co-operation*. Helsinki: Ministry of Social Affairs and Health.
- Ministry of Social Affairs and Health. (2001). *Government resolution on the Health 2015 Public Health Programme*. Helsinki: Ministry of Social Affairs and Health.
- Ministry of Social Affairs and Health. (2008). *National action plan to reduce health inequalities 2008–2011*. Helsinki: Ministry of Social Affairs and Health.

- Ministry of Social Affairs and Health. (2009). *National development programme for social welfare and health care (Kaste) 2008–2011*. Retrieved from: [http://www.stm.fi/en/strategies\\_and\\_programmes/kaste](http://www.stm.fi/en/strategies_and_programmes/kaste).
- Ministry of Social Affairs and Health. (2010). *The aim of the Tobacco Act is to put an end to smoking in Finland*. Press release 224/2010. Retrieved from: <http://www.stm.fi/tiedotteet/tiedote/view/1522179>.
- Ministry of Social Affairs and Health. (2011). *Socially sustainable Finland 2020: Strategy for social and health policy*. Helsinki: Ministry of Social Affairs and Health.
- Moisio, P. (2006). Suhteellinen köyhyys Suomessa [Relative poverty in Finland]. *Yhteiskuntapolitiikka*, 71(6), 639–645.
- Moisio, P., Honkanen, P., Hänninen, T., Kuivalainen, S., Raijas, A., Sauli, H., et al. (2011). *Perusturvan riittävyden arviointiraportti* [Evaluation report on basic security in Finland]. Helsinki: National Institute for Health and Welfare.
- MOL. (2006). *Industrial relations and labour legislation in Finland*. Helsinki: Ministry of Labour (MOL).
- Muurinen, S., Perttilä, K., & Ståhl, T. (2008). *Terveys 2015—kansanterveysohjelman ohjaavuuden, toimeenpanon ja sisällön arviointi 2007* [Evaluation report of the Health 2015 Programme]. Helsinki: National Research and Development Centre for Welfare and Health (STAKES).
- National Audit Office. (2010). *Policy programmes as steering instruments: With the policy programme for health promotion as an example*. Retrieved from: [http://www.vtv.fi/files/2362/2122010\\_Policy\\_programmes\\_as\\_steering\\_instruments.pdf](http://www.vtv.fi/files/2362/2122010_Policy_programmes_as_steering_instruments.pdf).
- Niemelä, H., & Salminen, K. (2006). *Social security in Finland*. Helsinki: Social Insurance Institution (Kela), Finnish Centre for Pensions (ETK), Finnish Pension Alliance (TELA), and Finnish Ministry of Social Affairs and Health.
- OECD. (2008). *Growing unequal? Income distribution and poverty in OECD countries*. Paris: Organisation for Economic Co-operation and Development.
- OECD. (2011a). *Health at a glance 2011: OECD indicators*. Paris: Organisation for Economic Co-operation and Development.
- OECD. (2011b). *OECD Factbook 2011–2012. Economic, environmental, and social statistics*. Paris: Organisation for Economic Co-operation and Development.
- OECD. (2011c). *Strong performers and successful reformers in education: Lessons from PISA for the United States*. Paris: Organisation for Economic Co-operation and Development.
- Ollila, E., Lahtinen, E., Melkas, T., Wismar, M., Ståhl, T., & Leppo, K. (2006). Towards a healthier future. In T. Ståhl, M. Wismar, E. Ollila, E. Lahtinen & K. Leppo (Eds.), *Health in all policies: Prospects and potentials* (pp. 269–279). Helsinki: Ministry of Social Affairs and Health.
- Palosuo, H., Koskinen, S., Lahelma, E., Kostianen, E., Prättälä, R., Martelin, T., et al. (Eds.). (2009). *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005*. Helsinki: Ministry of Social Affairs and Health Publications.
- Palosuo, H., Koskinen, S., & Sihto, M. (2008). Finland. In C. Hogstedt, H. Moberg, B. Lundgren & M. Backhans (Eds.), *Health for all? A critical analysis of public health policies in eight European countries* (pp.125–159). Östersund: Swedish National Institute of Public Health.
- Pekurinen, M., Erhola, M., Häkkinen, U., Jonsson, P.M., Keskimäki, I., Kokko, S., et al. (2010). *Sosiaali—ja terveydenhuollon monikanavaisen rahoituksen edut, baitat ja kehittämistarpeet* [The benefits, problems, and needs for development in dual financed social and health care system]. Helsinki: National Institute for Health and Welfare (THL).
- Prime Minister's Office. (2007). *Government programme of Prime Minister Matti Vanhanen's second Cabinet on 19 April 2007*. Helsinki: Prime Minister's Office, Finnish Government.
- Prime Minister's Office. (2011a). *Government programme of Prime Minister Jyrki Katainen's Cabinet on 22 June 2011*. Helsinki: Prime Minister's Office, Finnish Government.
- Prime Minister's Office. (2011b). *Policy programmes: Parliamentary term 2007–2011*. Helsinki: Prime Minister's Office, Finnish Government.
- Puska, P., & Ståhl, T. (2010). Health in all policies. The Finnish initiative: Background, principles, and current issues. *Annual Review of Public Health*, 31(1), 315–328.

- Puska, P., Vartiainen, E., Laatikainen, T., Jousilahti, P., & Paavola, M. (2009). *The North Karelia project: From North Karelia to national action*. Helsinki: National Institute for Health and Welfare (THL).
- Rahkonen, O., Talala, K., Sulander, T., Laaksonen, M., Lahelma, E., Uutela, A., et al. (2009). Self-rated health. In H. Palosuo, S. Koskinen, E. Lahelma, E. Kostiaainen, R. Prättälä, T. Martelin, A. Ostamo, I. Keskimäki, M. Sihto, E. Linnanmäki & K. Talala (Eds.), *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005* (pp. 61–69). Helsinki: Ministry of Social Affairs and Health Publications.
- Räsänen, K. (2006). Occupational health services. In S. Koskinen, A. Aromaa, J. Huttunen & J. Teperi (Eds.), *Health in Finland* (pp. 138–139). Vammalan kirjapaino Oy: National Public Health Institute (KTL), National Research and Development Centre for Welfare and Health (STAKES), Ministry of Social Affairs and Health.
- Riihelä, M. (2009). *Essays on income inequality, poverty, and the evolution of top income shares*. Publication 52. Helsinki: Government Institute for Economic Research.
- Rom, A.L., Mortensen, L.H., Cnattingius, S., Arntzen, A., Gissler, M., & Nybo Andersen, A.-M. (2010). A comparative study of educational inequality in the risk of stillbirth in Denmark, Finland, Norway, and Sweden 1981–2000. *Journal of Epidemiology and Community Health*. doi: 10.1136/jech.2009.101188.
- Rotko, T., Aho, T., Mustonen, N., & Linnanmäki, E. (2011). *Kapeneeko kuilu? Tilannekatsaus terveyserojen kaaventamiseen Suomessa 2007–2010* [Bridging the gap? Review into actions to reduce health inequalities in Finland 2007–2010]. Helsinki: National Institute for Health and Welfare (THL).
- Sahlberg, P. (2011). *Finnish lessons: What can the world learn from educational change in Finland?* New York: Teachers College.
- Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchical cluster analysis of the welfare regimes in advanced countries. *Current Sociology*, 51(5), 499–527.
- Schwab, K. (2009). *The global competitiveness report 2009–2010*. Geneva: World Economic Forum.
- Sihto, M., & Keskimäki, I. (2000). Does a policy matter? Assessing the Finnish health policy in relation to its equity goals. *Critical Public Health*, 10(2), 273–286.
- Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E., & Leppo, K. (Eds.). (2006). *Health in all policies: Prospects and potentials*. Helsinki: Ministry of Social Affairs and Health.
- Statistics Finland. (2009). *Tulonjakotilasto 2008* [Income distribution statistics 2008]. Helsinki: Statistics Finland.
- Statistics Finland. (2010). *Income distribution statistics*. PX-Web databases. Retrieved from: [http://tilastokeskus.fi/tup/tilastotietokannat/index\\_en.html](http://tilastokeskus.fi/tup/tilastotietokannat/index_en.html).
- Statistics Finland. (2011a). *Finland in figures*. Retrieved from: [http://www.stat.fi/tup/suoluk/index\\_en.html](http://www.stat.fi/tup/suoluk/index_en.html).
- Statistics Finland. (2011b). *Income distribution statistics*. PX-Web databases. Retrieved from: [http://tilastokeskus.fi/tup/tilastotietokannat/index\\_en.html](http://tilastokeskus.fi/tup/tilastotietokannat/index_en.html).
- Statistics Finland. (2011c). *Statistics Finland's PX-Web databases*. Retrieved from: [http://tilastokeskus.fi/tup/tilastotietokannat/index\\_en.html](http://tilastokeskus.fi/tup/tilastotietokannat/index_en.html).
- Statistics Finland. (2011d). *Tulonjakotilasto 2009* [Income distribution statistics 2009]. Helsinki: Statistics Finland.
- Statistics Finland. (2011e). *Työllisyys lisääntyi marraskuussa 2011* [Employment rate increased in November 2011]. Helsinki: Statistics Finland.
- STKL. (2009). *Järjestöpokkari. Sosiaali—ja terveysjärjestöt pähkinänkuoressa* [Pocket book on social and health organizations in Finland]. Helsinki: Finnish Federation for Social Welfare and Health (STKL).
- Tarkiainen, L., Martikainen, P., Laaksonen, M., & Valkonen, T. (2011). Trends in life expectancy by income from 1988 to 2007: Decomposition by age and cause of death. *Journal of Epidemiology and Community Health*. doi: 10.1136/jech.2010.123182.
- Teperi, J., Porter, M.E., Vuorenkoski, L., & Baron, J.F. (2009). *The Finnish health care system: A value-based perspective*. Sitra Reports 82. Helsinki: Sitra.
- Teperi, J., & Vuorenkoski, L. (2006). Health and health care in Finland since the Second World War. In S. Koskinen, A. Aromaa, J. Huttunen & J. Teperi (Eds.), *Health in Finland* (pp. 8–12). Vammalan

- kirjapaino Oy: National Public Health Institute (KTL), National Research and Development Centre for Welfare and Health (STAKES), Ministry of Social Affairs and Health.
- THL. (2010). *Yearbook of alcohol and drug statistics 2010*. Helsinki: National Institute for Health and Welfare (THL).
- THL. (2011a). *Annual statistics on social assistance 2010*. Helsinki: National Institute for Health and Welfare (THL).
- THL. (2011b). *Kouluterveyskysely* [School health promotion study]. Helsinki: National Institute for Health and Welfare (THL).
- THL. (2011c). *WHO collaborating centre on social determinants of health*. Helsinki: National Institute for Health and Welfare (THL).
- Tukia, H., Lehtinen, N., Saaristo, V., & Vuori, M. (2011). *Väestön hyvinvoinnin ja terveyden edistäminen kunnassa—Perusraportti kuntajohdon tiedonkeruusta 2011* [Promotion of wellbeing and health of the population by local authorities—Basic report on a data collection on municipal management 2011]. Report 55/2011. Helsinki: Finnish National Institute for Health and Welfare.
- Valkonen, T., Ahonen, H., Martikainen, P., & Remes, H. (2009). Socio-economic differences in mortality. In H. Palosuo, S. Koskinen, E. Lahelma, E. Kostiainen, R. Prättälä, T. Martelin, A. Ostamo, I. Keskimäki, M. Sihto, E. Linnanmäki & K. Talala (Eds.), *Health inequalities in Finland: Trends in socioeconomic health differences 1980–2005* (pp. 40–60). Helsinki: Ministry of Social Affairs and Health Publications.
- Vuorenkoski, L., Mladovsky, P., & Mossialos, E. (2008). Finland: Health system review. *Health Systems in Transition*, 10(4), 1–168.
- WHO. (1981). *Global strategy for health for all by the year 2000*. Geneva: World Health Organization.
- WHO. (2002). *Review of national Finnish health promotion policies and recommendations for the future*. Copenhagen: World Health Organization, Regional Office for Europe.
- WHO. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.
- Wilkinson, R.G., & Pickett, K.E. (2006). Income inequality and health: A review and explanation of the evidence. *Social Science and Medicine*, 62(7), 1768–1784.
- Wilkinson, R.G., & Pickett, K.E. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.