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Quality of jobs and services in the Personal care and Household Services sector in Finland

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

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The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-28, EFTA-EEA and EU candidate and pre-candidate countries. For more information see: http://ec.europa.eu/progress.

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CONTENTS

INTRODUCTION

In Finland, household services *(Kotipalvelut)* and home care services *(kotihoito)* were developed in the 1950 and were mostly organized by municipal social welfare authorities and targeting mostly elderly [1]. In 1997, a tax reduction system, granted for domestic work *(kotitalousvähennys)* was implemented and became final in 2011. This scheme covers a range of domestic services such as domestic tasks, repair works, childcare as well as IT services since 2009. Other measures exist in parallel of this first scheme in order to provide personal care for elderly and disabled people. Personal and household services (PHS) in Finland traditionally refer to "*the strictly regulated public social and health care system under the auspices of municipalities*"[2].

The PHS sector was seen as a great potential for jobs creation quite early, mainly due to some specific characteristics of the Finnish society such as the female employment rate as well as the ageing of the population. In 1994, the employment rate (% of working-age population) for women in Finland was 55.4%, nearly the same of the employment rate for men (57.6%)[3]. Furthermore, in the 1990s, the Finnish population was ageing faster than in the other 12 EU member states. Since 1990, the proportion of elderly people rose quite rapidly. It is still a current trend, which is projected to last in the next decades[4].

In 2012, 42600 people were working in the household personal care services sector, depending on social action towards dependent people and children (NACE code 88). The household services sector, under direct employment procedure represented 8100 jobs (NACE code 97). This represents respectively 4.8% and 0.3% of the workforce in Finland, which is rather low compared with other European countries[5].

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[1] Kröger T. and Leinomen, A. (2011), Home care in Finland, living independently at home, reforms in home care in 9 European countries, *SFI-The Danish National Centre for Social Research*: p 118 (27/04/2015). Downloadable here: http://bit.ly/1QeCLLT

[2] Jokinen E. (2015) European Employment Policy Observatory Ad hoc Request: Personal and household services Finland, Publication office of the European Union,, p1 (14/10/2015). Downloadable here: http://bit.ly/1G4Zn0C

[3] European Parliament, an overview of the social policy in Finland, Working documents, social affairs series. http://bit.ly/1QICCkV (29/04/2015)

[4] Frossén K., Laukkanen A. and Ritakallio M. (2002), *Demographic trends in Finland*, *Department of Social Policy*, University of Turku: pp 5-6 (29/04/2015). Downloadable here: http://bit.ly/1HQJski

[5] France stratégie (2014), *gouvernance et organisation des services à la personne en Europe*, working document.

1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy Background

PHS are included in a broad framework law: the Social Welfare Act from 1982 as well as the Social Welfare Decree from 1983. It doesn't provide any detailed regulation on personal and household services but gives a least a definition:

"*Personal and household services mean performance of or assistance with functions and activities related to housing, personal care and attendance, child care and upbringing, and other conventional functions and activities in normal daily life.*"[6]

"*Personal and household services are organized in the following forms:*

1- *Assistance, personal attendance and support provided at home by a trained home helper or house aid for an individual or a family;*
2- *Auxiliary services such as meals on wheels, clothes maintenance, bathing, cleaning, transportation and escort services, and services promoting social interaction."*[7]

At the beginning of the 1990s, PHS services, which were mainly publicly provided, covered 18.6% of the population over 65 years old and 31.4% of the population over 75 years old[8]. These figures were internationally exceptional at that time, even within the Nordic region. However, changes occurred due to the major economic recession faced by the country in 1991, leading to important cuts in central grants for municipal social and health care services.

Furthermore, a radical decentralization occurred in 1993, delegating financial and other responsibilities related to social and health care to the local level. Therefore, municipalities are the public bodies responsible for the health care and social services public sector. The Finnish legislation on this matter is not clearly detailed and, in practice, municipalities have a great degree of autonomy concerning the management of it.

Originally, home-based services were concerning mainly household activities. However, it became more personal care centered in the 1990s, leading to a reduction, even a disappearance of household services (like cleaning) offered by local authorities, trend which is described as "*A shift from taking care of the home to taking care of the body*"[9].

The Finnish LTC system is publicly funded and universal, open to every citizen. As the Finnish

[6] Social Welfare Act 710/1982, Section 9.
[7] Social Welfare Decree 607/1983, Section 9.
[8] Kröger T. and Leinomen A., *op. cit.* p120.
[9] *Ibid.* p123.

government is entitled to implement fundamental and human rights such as equality and social security (sections 6 and 19 of the constitution), the public sector has the obligation to provide a decent level of LTC services for the elderly[10]. LTC services provision in Finland depends on two main laws: the Social Welfare Act, already mentioned above as well as the Primary Health Care Act. Furthermore, the Service and Assistance for the Disabled Act stipulates that severely disabled people have a right to a number of different services (home services included) as well as personal assistance (since September 2009). If the applicant fulfils the criteria defined by the law, municipalities have the obligation to provide these services[11].

The new Social Welfare Act concerning household services came into force the first of January 2015. With this new Act, families with children have access to household services in case of illness, birth giving, burn-out or difficult life situation like death or divorce in the family. Before that, access to household services was only restraint from the children welfare viewpoint[12]. The family which is facing difficulties to deal with everyday life activities doesn't necessarily have to become a client of critical child welfare services to have access to home services. As a consequence, this new piece of legislation extends the application scope of public household services and places this kind of activities at the heart of a social "*proactive operating model*"[13].

1.2. Structural framework, funding and actors involved

1.2.1. Structural framework

Personal and household services in Finland can be divided into three categories:

- Home care services *(kotihoito)* which include domestic and personal care services, with a specific focus on dependent people (elderly, disabled, sick people).
- Auxiliary services, which are personal and health care centred. These services cover child care as well as support services such as meal service, help with dressing and washing, transport, cleaning as well as escort service.
- Home nursing which is more related to the health of the beneficiary such as help with medication[14].

Personal and household services are under the control of municipal authorities, which are also the main service provider of PHS. Either each municipality provides services themselves or they are organised in federation of municipalities formed by one or more neighbouring municipalities for the provisions of such services. Municipalities can externalise by purchasing services from another local authorities or from

[10] Johansson, E. (2010), The Long-Term Care System for the Elderly in Finland, *ENEPRI research Report* , No.76: p 1
[11] *Ibid.* p119
[12] Jokin E., *op. cit.* p2.
[13] *Ibid.* p9.
[14] *Ibid.* p2.

private providers[15]. The Finish Legislation does not strictly regulate provisions on the extent, content or arrangement of services, leading to differences between PHS services provision from one local authority to another. Thus, local authorities are untitled by the law to cover the essential basic services, which are specified by the legislation.

- Home care services *(kotihoito)*

One of the specific features of Finland concerning PHS is the integration process between home help and home nursing. At first, home nursing services *(kotisairaanhoito)*[16], provided by health care authorities, were clearly separated from home help services which were provided by the social welfare. This separateness faced wide-spread criticism, as home-help and home-nursing were too fragmented, forcing users to deal with two systems which were not cooperating. In order to respond to this issue but also to increase cost-effectiveness, many local authorities created one new single provision form of services called 'home care' *(Kotihoito)*, integrating both services in one single system. In many cases, this process has been connected to administrative reforms, merging social and health care administrations in one single entity at the local level[17]. This new model aims at combining home-help services and home health care services, offered by the same care worker (see section 2.2).

- Tax deduction for household services *(kotitalousvähennys)* and the municipal voucher system for home care *(palveluseteli)*

The PHS sector has known considerable development in Finland since the 90s, relating to customer choice and the opening up to competition of the sector.

In 2001, the Domestic Work Temporary Tax Deduction Act implemented the tax deduction scheme (introduced for the first time in 1997) for household services *(kotitalousvähennys).* With this system, Finnish people were able to purchase home-help services from for-profit providers, opening up the PHS sector to competition. This system is the result of an initiative launched by the Social democrat party. It was first tested over a three-year period between 1997 and 2001 in three regions of the country (Southern Finland, Oulu and Lapland)[18]. Direct purchased of household services has been extended to the entire country in 2001 by being a permanent part of the income tax legislation in 2001 (law 24.11.2000/995). The tax credit scheme partly covers paid costs for household activities.

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[15] OECD (2000), Early childhood education and care policy in Finland: pp 4-5 (27/04/2015). Downloadable here: http://bit.ly/1DXkMTj

[16] Kotisairaanhoito refers to home nursing services for people with diagnosed illness.

[17] Kröger T. and Leinomen A., *op.cit.* p 123.

[18] EMCC observatory (2009), Tax credit for domestic help, Finland. (26/04/2015) http://bit.ly/1zsQDO6

Types of services	Tasks and/or conditions
Household work	Cleaning, cooking, sewing, ironing and washing clothes, maintenance of the garden outside the house.
Caregiving and day care work	Taking care of children, helping the ill or the elderly person at his/her home.
Repair and maintenance work	• Can be done at the permanent home or the leisure home of the user • If the taxpayer live in a rented home, he/she is eligible for the credit on the condition that the person paid for the repair. • The person have to live in the home during the year • It is not applicable for household appliance and for building and construction work.
IT services (since 2009)	Installation, maintenance, and user support of IT and telecommunication technology in the home, including hardware, software, data security and network connection.

In addition to the taxpayer's home (and leisure home), services provided at the home of parents, grandparents as well as relatives are also supported by the tax credit. However, tax deduction is not possible if the client already receives service vouchers, support for informal care or private day care allowance[19]. Finnish residents with taxable income can deduct 15% of wage in 2015 (against 30% in 2012) as well as work compensation (45% in 2015 against 60% in 2012) when purchasing domestic services[20]. Between 2009 and 2011, the maximum amount of deduction was 3000 euros. In 2011, it diminished to 2000 euros. In 2015, the maximum amount of deduction is 2400 euros[21]. If services are provided by an independent employee, wages received by the worker will yield the maximum tax credit at 5,962 euros of gross wages, assuming that the average social-cost contribution represent 22% of it. However, the exact amount can vary according to the exact social costs associated with the wage of the individual employee. This system covers around 10,000 working hours per year. The last study of the tax deduction system was done in 2007 by the Ministry of Finance, leading to the conclusion that the system "*does not necessarily add to the employment of low-wage sector as much as intended*[22]".

This system is mostly used for repair works and maintenance and the share of personal care services provided under this system represents only 20% of the total scheme. Even if adult children can deduct expenses related to PHS services purchased for their parents, this system is not commonly used for this specific purpose.

The law on Health and Social care Voucher was introduced in 2009 in order to regulate more efficiently the diversity of local practices concerning home care services[23]. With this system, personal care services production and provision are managed through a more market-based mechanism. The introduction of this voucher system started in 2004 with the Act on Social and Health Care Voucher. Several municipalities started to give vouchers to home care users (more specifically dependent people) to pay for personal care

[19] Jokin E. *op.cit.* p9.
[20] *Ibid.*
[21] *Ibid.*
[22] *Ibid.* p10.
[23] Orseu, Structural framework – Overview of the personal and household services in the EU-FINLAND, working document.

services or to pay their informal carers. Through this system, the user can select different service providers from a list approved and subsidized by the municipality. Municipalities have the choice to decide to use this system or not. This choice is rather made by big municipalities. In the private sector, the use of voucher system may have prevented the use of outsourcing services. The share of household services expenses of the total social and health care in 2012 is about 3.5% and the share of outsourcing is about 23%[24].

1.2.2. Funding

Home care services (LTC, home care for dependent people, childcare) provided by municipalities are funded with local taxes and state subsidies. Usually, state subsidies are not dedicated toward specific purposes within municipalities. Therefore, they have the power to decide the total budget distribution between various types of expenditure and the amount of money they wish to spend on personal care and household services for instance[25]. The proportion of the social and health care expenditure allocated to local authorities by the State is determined according to the age distribution, morbidity rate, population density, surface area and the financial situation of each municipality.

Local taxes for municipal home care services are income-related, meaning that people with higher income pay higher fees. This system led to the privatisation of the sector as private alternatives for home care can be less expensive than public care services for people with a good or modest pension[26]. This shift from public provision to market provision underlines the pressures for an increasing erosion of the principle of the 'Nordic universalism', stipulating that any person, regardless of income levels, should have access to one and single service system (Kroger, Leinonen, 2011).

Total LTC expenditure (health and social components) in 2011(or nearest year) represented 2.1% of the Finish GDP. The average annual growth rate in public expenditure on long-term care (health and social) in real terms between 2005 and 2011 (or nearest year) was 3.8%. Between 2005 and 2011, the annual growth rate in public expenditure on LTC at home was 6.5%, against -4% in institution LTC[27]. The social Insurance Institution of Finland contributes very little if anything to LTC in Finland. Instead, funding is taken directly from taxes and user fees. Legislation determines the amount of the fees that municipalities are allowed to charge for LTC services. Concerning home care, the ability to pay is the guiding principles for user fees, depending on income, the type of care provided and the size of the household. Maximum user fees are always a percentage of income that exceeds a certain threshold[28].

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[24] Jokin E. *Op. cit.* p9.

[25] Johansson E. *Op.cit. p5.*

[26] Kröger. T. and Leinomen A. *Op.Cit.* p124.

[27] OECD (2013), "Long-term care expenditure", in Health at a Glance 2013: OECD Indicators, OECD Publishing: p187 (26/04/2015). Downloadable here: http://bit.ly/1Kqf7YN

[28] Johansson E. *op.cit.* p 5

1.2.3. Actors involved

The Ministry of Social Affairs and Health leads and steers the national development and operating policies of social security and social and health care services. Together with the Government and Parliament, it lays down the national guidelines for social and health policy, prepares social and health care legislation and major reforms and steers their implementation and maintains contacts with the political decision-making level. There is a public expert centre, the National Research and Development Centre for Welfare and Health (STAKES), operating under the auspices of the Ministry of Social Affairs and Health. STAKES acts as a unit conducting researches and development and acting as a statistical authority.

Personal care and household services for elderly and disadvantaged people are mainly publicly provided; targeting families with children, elderly households, handicapped households and to a lesser extend other households[29]. In 2012, municipalities provided services to a total of 133,007 Finnish households and 10,009 (7.6%) of them through service vouchers. The share of elderly people accessing these services has been rapidly growing during the 2005-2012 period, unlike the share of families with children which register a decline of 83% compared to 1990[30].

The private market sector, represented by for-profit companies as well as NGO's offer non care household services (cleaning, gardening, meal services…). There were 3,305 private household work service companies ("kotityöpalveluyrityksiä") employing a total of 29,606 people in 2013 against a total of 3,353 companies employing a total of 27,000 people in 2011[31].

The third sector, funded by a minor state subsidy and by volunteer membership fees and donations, is the third major actor for the provision of PHS for people in needs[32]. The sector employs a little more than the private sector, representing 27,700 jobs in 2011 and with a total turnover of EUR 1.5 million, almost equivalent at the one of the private sector. However, the share dedicated to household services in terms of both turnover and personnel with the third sector is rather small, not exceeding 1-2%.

Concerning personal care services, two third of care services are provided by local authorities. However, municipalities can outsource a part of their care services towards private organisation when it concern personal care services for dependent people[33]. Furthermore, the development of the voucher system for home care mentioned previously also modifies the offer structuration of PHS as these vouchers can only be used to buy care services (medical services included) from private structures[34]. A number of

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[29] Jokin E. *op.cit*. p3.

[30] *Ibid.*

[31] *Ibid*.

[32] *Ibid.*

[33] France stratégie, *op.cit*. p79.

[34] *Ibid.*

municipalities are now outsourcing at least a part of their own service provision. Thus, publicly funded home-help services are in practice provided by non-profit or for-profit providers. However, the variety of both no-profit and for-profit home care providers is more developed in larger municipalities, whereas PHS are still only provided by municipalities in small ones (Kröger, 2009).

- Informal care

Since the early 1990s, public discussions focused on the difficulties faced by family carers and a specific support system was firmly established. In 1993, the Informal Care Act was implemented in order to institutionalize informal care and integrate it within care policies concerning elderly. This specific law was reformed in 2005 and is now named the *Act on Support for Informal Care*[35].

According to surveys, family members represent an important source of help (if not the only one) among people 60+. However, only a small part of these carers receive formal support as the system lies on local policies as well as on the economic condition of the municipality. It also should be mentioned that numerous family members don't wish to apply for support and become formally labeled and paid for these activities.

2. WORK AND EMPLOYMENT QUALITY

2.1. Career and employment security

2.1.1. Employment status

Employment status in the PHS sector can take many different forms in Finland. As municipalities are the first providers of PHS, the largest group of employment in the field is in the various municipalities' social work departments (about 80% in total). Workers hired by municipalities cover an extensive range of tasks from medical operations to personal care or household services, some workers being entitled to perform medical task and household services[36].

The remaining 20% represents the share of private entrepreneurs (5%) and employees working for the private sector (15%). In most of cases, they are providing non-care services[37]. Their employment status can be arranged by municipalities via outsourcing agreements, rental work or part-time entrepreneurships or via an employment relationship with a private company or a NGO. Entrepreneurs work mostly directly for the household, under the tax deduction system. Domestic workers, which tasks are usually limited to cleaning activities are most of the time employed by service companies operating in the cleaning sector.

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[35] Kröger T. and Leinomen A., *op.cit.* p124.

[36] Jokin E. *op. cit.* p6.

[37] *Ibid.*

- Existence of collective agreements

Most employees of the PHS sector are either depending on General agreement in the municipal sector (KVTES), Private social service sector collective agreement or Real estate service sector collective agreement, which are all generally binding[38].

- Migrants work

According to statistics from 2009, the proportion of foreign citizen working in the social and health care sector is relatively small (3.4%), which is representative of the number of foreign people in Finland. The type of jobs with the highest percentage of foreign people are cleaning (13%), kitchen helpers (4.9%) and hospital/nurses' aides (4%). Foreign people are over represented in the lower echelons of jobs within the social and health care services sector[39].

Percentage of foreigners in Social and Care sector in Finland in 2009:

	Foreigners
Home aids and care assistants	1.3%
Personal assistants	2.2%
Child carer and nursery aids	2.1%
Cleaner	13%
Kitchen helpers	4.9%

Source: Statistics Finland, Employment statistics, 2009.

For the city of Helsinki, statistics show that the number of foreign people employed in the social and care sector has almost tripled between 2001 and 2009. In 2001, foreign people represented 2.7% of the total of employees in the sector. In 2009, they represented 6.1% of it. In addition, the number of foreign nationals employed in the elderly care sector has more than triple, representing in 2009 10.5% of the employees providing elderly care services. This fraction is higher than the fraction of foreigners in total working in Helsinki, across all sectors. This figure confirms the emergence of a migrant division of care labour in the capital[40].

[38] Jokin E. *op. cit.* p6.

[39] Näre L. (2013), Ideal workers and suspects: Employers' politics of recognition and the migrant division of care labour in Finland, *Nordic journal of immigration research*, Versita: p74 (26/04/2015). Downloadable here: http://bit.ly/1ItjK7h

[40] Näre L. *Op.Cit.* p75.

Percentage of foreigners in social and health sector (SHS), in elderly care and in the employment in the City of Helsinki, 2001-2009

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Foreigners in SHS	2.7	3.0	3.0	3.5	3.8	4.3	4.8	5.6	6.1
Foreigners in elderly care	2.5	3.0	3.4	4.0	4.8	5.9	7.2	9.0	10.5
Foreigners of all employed	3.8	4.0	4.1	4.4	4.8	5.3	6.0	6.7	6.9

Source: Statistics Finland.

- Regulation of undeclared work

According to the last evaluation done in 2006 (Niilola and Valtakari, 2006), the tax deduction for household services allowed to reduce the proportion of undeclared work from 60% to 25% between 2001 and 2004. This shift mostly occurred in the renovation sector[41].

This chart shows an estimation of the increase in regular employment according to the entrepreneurs' own estimate.

	Estimation of jobs created (work-year)	Jobs which would have existed anyway*	Undeclared jobs (former estimation-2004)**	Undeclared jobs (new estimation-2006)	Undeclared work into regular
Renovation	9077	6082	3467	1399	2068
Cleaning	880	289	179	75	104
Total	9957	6371	3646	1474	2172

* around 32% of purchasers of cleaning services would have bought them anyway (62% for renovation services)

** 62% for cleaning services according to entrepreneurs' survey (57% for renovation)

*** 26% for cleaning services according to entrepreneurs' survey (23% for renovation)

Source: (Niilola and Valtakari, 2006), p. 84

2.1.2. Income and wages

There is no minimum wage in Finland. However, the collective agreement in most of the employment branches determines the minimum wage and other minimum employment terms. According to the Statistic Finland and Association of Local and Regional authorities, the average pay level in the PHS public sector is 2,534 euros per month (should be link with the Finnish high cost of living), with 200

[41] ORSEU, *op.cit.*

working days per year, 2.5 visits per day and 7.25 working hours per day[42].

Concerning informal care allowance, the average amount reached in 416.32 euros per month in 2006. In 2011, the national minimum amount was defined at 353.62 euros. This allowance is considered as a taxable income. Furthermore, since 1993, the family carer has the legislated right to have days off (three per month since 2007).

2.1.3. Social protection

The finish social protection is based on the Nordic welfare model which relies on:

- The principle of universality
- Earning-related benefits for employed persons
- Equal treatment.

Therefore, any employee in Finland is entitled to social protection.

2.1.4. Workers' rights

➢ Rights to collective bargaining

Finland has a well-developed social dialogue system. In the personal care sector, workers are represented by the Union of Health & Social Care Services (Tehyry) and the Finnish Union of Practical Nurses (Superry).

Domestic workers are organized by the Service Union United, PAM. In 2010, the cleaning branch of PAM represented approximately 10,000 workers (out of a total membership of 221,000 members)[43]. In most cases, private client would buy cleaning services from companies which will send a worker to their house. This employment relationship has been covered by collective agreements since a long time. The current agreement, which will be valid until January 2017, has been negotiated by PAM and the Association of real estate employers[44]. According to the trade union PAM, it is unusual for a private household to hire directly a domestic worker. Therefore, this kind of employment relationship is not covered by any collective bargaining agreement[45].

➢ Non-discrimination

Finland's Gender Equality Act lays down an obligation for employers to draw up a gender equality plan

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[42] Jokin E., *op.cit.* p6.
[43] EFFAT (2015), promote industrial relations in the domestic work sector in Europe, p24. (19/10/2015) Downloadable here :http://bit.ly/1Mf85un
[44] *Ibid.* p 37.
[45] *Ibid.*

which have to include payroll charting and actions to deal with issues related to gender discriminations.[46]

Furthermore, the non-discrimination Act (21/2004) prohibits discrimination based on ethnic or national origin, nationality, language, religion, beliefs, opinion, medical condition, disability, sexual orientation or other reason connected to a person.

2.2. Skills development and professionalization

2.2.1. Qualifications

The Act and Decree on Qualification Requirements for Social Services Professionals (272/2005) regulates qualification. Within the home care services sector, qualification requirements can be considered as quite strict and high level and usually vocational training last 3 years. However, as these restrictions can be considered as an obstacle for the development of the sector. Therefore, current Government negotiations have been suggested that the three mandatory years of Vocational education should be shortened to two years[47].

Concerning the household services sector, several efforts and initiatives have been done to develop the professionalization of the sector. In 200O, a three-year competence-based basic vocational qualification in Household and Consumer services was established as part of Tourism, Catering and Home Economics sector (ISCED 3), meaning that the qualification can be archived through the validation of acquired experience and with skills demonstrations. In 2010, this qualification was integrated with Cleaning Service Qualification (200 people were qualified people in 210-2012). It is also possible to follow a further Qualification in Household Work Services (240 people were qualified in 2012)[48]. These qualifications are strictly differentiated from social and health care qualifications.

Concerning personal care services, changes have occurred in terms of qualification, following the creation of a new service form named 'home care' *(kotihoito)* already mentioned in the section 1.2. In 1993, training programmes for home helpers and assistant nurses were merged, resulting in a new 3 years vocational training programme (or a two year programme for secondary school graduates) and a new occupational title called 'practical nurse' *(lähihoitaja).* Practical nurses have the goal to help, guide and support the users to cope with their daily life. In this integrated home care system, it is now often the same person that performs both the home-help activities and the home nursing tasks. However, this system creates disagreement between Health care professionals and social care professionals. Health care professionals are reproaching to social care professionals a lack of adequate medical expertise and social care professionals regret the focus made on medical treatment[49]. In a large part of the country, 'practical

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[46] Ministry of finance (2006), The Finish public sector as employer: p.14. (26/04/2015). Downloadable here: http://bit.ly/1IvE0oO

[47] Jokin E., *op.cit.* p11.

[48] *Ibid.*

[49] Kröger T and Leinomen A., *op.cit.* p134.

nurses" become the largest occupational group in home-based care services.

Health and Social services represents the third largest field (17%) were people attend vocational training.

2.2.2. Recruitment and staff shortage

The ageing of the population in general is leading to a growing need in health and social care in the future as well as a renewal of the workforce. In certain cases, the demand is much higher than the supply. According to the 2014 follow-up study on the implementation of the Elderly Service Act, municipal household services should rely on a total of 16,861 employees. However, only 13,488 vacancies were filled[50].

Concerning practical nurses in 2013, the number of new applicants for the 8,293 new vacancies was only 2,858[51]. One of the key problems is the number of person qualified who makes the choice to work in another sector. For example, there are 20,000 qualified practical nurses working outside the care sector. In the 2014 top20 bottleneck vacancies in Finland, practical nurses and personal care workers had the 3rd place, just after nurses and medical doctors. In order to reply to this staff shortage issues, the number of new places within educational institutions has been increased. The educational system widens the quotas of new students, such as the one applying for practical nurses. Concerning household services, measures have been taken to integrate unemployed workers and immigrants into these professions, with varying success. A non-formal care assistant training (personal assistance in social and health care) has been implemented to target specifically redundant workers, field changer as well as immigrants[52].

In prospective terms, the need of labor will increase by 9% (125,000 employees by 2025) in the health and the social services between 2013 and 2025, putting pressure on both the demand and the offer of personal care and household services[53]. In the meantime, the sector is facing great cuttings of Governments grants, linked with the ongoing restructuration of the Finnish welfare state. The current Government negotiations are targeting a total savings of 2 billion euros during the next four years[54], which will have an impact on PHS as most of these services are provided by public structures.

The multi-agent development program HYVÄ coordinated by the Ministry of Employment and Economy, was implemented to face demographic changes as well as the increasing need of labor in the social and health care sector, targeting the following goals: "*reducing cost effects of public sector by opening up the social and health care sector, diversifying the services and production models, strengthening the customer choice system and finally promoting new business opportunities, growth and*

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[50] Jokin E., *op.cit.* p7.

[51] European Commission (2014), mapping and analyzing bottleneck vacancies on EU labour market: p2 (26/04/2015). Downloadable here: http://bit.ly/1QBefEX

[52] Jokin E., *op.cit.* p18.

[53] *Ibid.* p10.

[54] *Ibid.* p8.

service exports in the sector"[55]. This program ended in 2015. However, no complete evaluation has been done yet.

2.3. Health and well-being

2.3.1. Work organisation

In Finland, all employed people are covered by statutory occupational accident insurance. All employers are required by law to arrange occupational health services for their employees. Self-employed people can arrange access to occupational health care on a voluntary basis. Employers, as well as self-employed people can purchase occupational health services from a local authority health centre or private service supplier[56]. Employers have to provide documentation of the work schedule, listing rest periods and overtime hours to the health and safety authority. This information has to be reachable by workers or their representatives, who can ask for a report based on these records[57].

2.3.2. Risk exposure and health problems

- Harshness of work

According to some studies, working conditions in the PHS sector (related to municipalities) have decreased since 2005, which can be explained by the increasing working load. Since the implementation of the Elderly Service Act which has for main goal to allow elderly to stay at home as long as possible, home care services have naturally become more intense. According to the survey carried out by The Finish Union of Practical Nurse - where 70% of the respondents were working in the public sector and the rest in the private one - well-being at work was at the lowest in the social care sector and more specifically when activities where towards elderly[58].

The problem of staff shortage in the personal care and household services can be partly explained by fairly low salaries in the health care sector, that the work is physically and mentally demanding and that the working conditions are often unfavorable[59].

Care work at home is currently seen as too hectic and an important amount of workers feel that they are not able to respond properly to users' needs and wishes. Consequently, many home care workers do not feel well at their work and are not satisfy with their working conditions. For example, according to the NORDCARE study, a quarter (24.9%) of Finnish home care workers stipulates that they 'usually have

[55] *Ibid.*
[56] Ministry of Social Affairs and Health, characteristic of the social security system in Finland, Brochure 8ng (2013): p17 (26/04/2015) Downloadable here: http://bit.ly/1PdH6BW
[57] EFFAT, *op.cit.*, p19.
[58] *Ibid.*
[59] European Commission, *op.cit.* p2.

too much to do' and almost as many (21.9%) say that they are 'unable to respond to the needs of the users'. In addition, over a fifth has 'considered seriously leaving their work' (Kröger, 2009). When home care workers were asked to report their hopes for change, many wished 'more helping hands' and 'more individualized care', that is, 'work without time pressure' and 'ability to focus not only on basic needs' (Leinonen, 2009)[60].

3. SERVICE QUALITY

3.1. Availability and affordability of services

Between 1990 and 2005, the coverage rate of home help for elderly people felt by as much as 45.2%, going against the general trend followed by many countries, which was to expand home-based services provisions. According to a national survey done in 2006, a third of people between 70-74 years old reported that they did not receive enough external help. In addition, 20% of the interviewee who received home care pointed that services were not adequate, especially concerning household tasks[61].

According to the National Audit Office, municipal services increased equality between elderly people, as the system is based on cutting support from people who do not intensive care and the one who have enough resources to purchase services by themselves, allowing a transfer of resources to help people with the weakest position. However, this form of equality leads also to the erosion of the Nordic universalism principle, according to which all people should have access to the same services, without any distinction[62].

To another extent, the tax-deduction system allowed 370 000 Finish households to beneficiate from domestic services in 2010. However, these measures would benefit priority to households with the highest incomes. In the category of average Finnish revenues (between 20 000 euros to 25 000 euros per year), only 7.1% of households have benefited from a tax reduction and less than 5% in the lower category. In contrast, 20% of households with an annual income above 60,000 euros would have benefited of the tax-deduction system. About 48% of beneficiaries are in the 20% wealthiest households and received 56% of the total tax credits[63].

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[60] Kröger T. and Leinomen A., *op.cit.* pp. 134-135.
[61] Kröger T. and Leinome, A., *op.cit*. p133.
[62] *Ibid.*
[63] European Commission, Thematic review on personal and household services, July 2015 (19/20/2015) Downloadable here: http://bit.ly/1Pxf57y

3.2. Comprehensiveness of services

Since 2005, home care in Finland has become more and more selective and directed toward "*the oldest of the old and the frailest of the frail"*. Most of the people under 85 years old are often excluded from the access to publicly provided services, informal care excluded, if the elderly have a family member to lie on[64].

As informal care has been institutionalized in Finland, it has become the prevailing alternative for older people who do not need intensive help. It is creating disparities between users as older people who are not untitled to public care services have to find alternative solutions (either services depending on market-based mechanisms or informal care provided by family members). From the point of view of family carers, the recognition of informal care is perceived as a positive development. However, it is not efficient for the moment as the coverage allowance is still limited, the benefits are low and the days-off system is complicated to put in place in practice.

3.3. Quality of regulation

Municipalities must have a social ombudsman in order to give advices and information to social services users and to evaluate how the rights of users are met within the municipality. Local authorities also conduct surveys toward their residents who used social and care services in order to evaluate the quality of the services provided and the degree of satisfaction of the users[65].

The Act on the Status and Right of Social Welfare Clients (812/2000) formalized the right to good service for users. According to this piece of legislation, the user has the right to complain concerning the way s/he is treated to the responsible managers. S/he has different ways to do it, at different levels. When it concerns a decision taken by a municipal employee, the user have to make a 'demand for rectification', addressed to the social welfare board of the local authorities. If this first request is not taken into account, the person can do an 'administrative appeal' to an administrative court. The user can also directly complain about local authority actions by making a 'municipal appeal' to Regional state Administrative Agency, the Parliamentary Ombudsman or the Chancellor of Justice in Finland.

The national Supervisory authority Valvira provides licensing for social and health care providers which want to be part of the voucher system.

[64] Kröger T. and Leinomen A., *op.cit.* p130.
[65] *Ibid.* p.132

4. CONCLUSION

Since the past decades, the PHS sector in Finland has experienced clear changes. Before the 1990s, public services were covering a large part of the need of elderly and disadvantage people in terms of PHS, providing an important scale of activities. A transformation occurred with the economic recession, leading to public PHS mainly focused on personal care, for people in needs of intensive care (*the oldest old and the frailest frail*). With the introduction of a tax deduction system for household services and the voucher system, the sector also experienced a shift from a publicly mechanism to a more market-based one. However, privatization is not the only goal for the sector and the Finnish landscape of the PHS sector is more complex. Indeed, the new Social Welfare Act (2015) has strengthened the public sector responsibilities concerning PHS. However, the ongoing restructuration of the Finnish welfare state and the current government negotiations on the matter forecast a decrease of the public expenditures on welfare services, which might be problematic for the future of the PHS sector in Finland.

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