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Assessing the costs of violence against women in Finland

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1. Background

Finland has been ranked as one of the most egalitarian and women-friendly countries in the world by several measures, including the Gender Equality Index report by EIGE (2020). Finland boasts a long history of women's voting rights, high-quality health care and education, as well as paid maternal leaves and other welfare benefits provided by the state. On the other hand, Finland has scored much weaker on measures evaluating gender segregation in the fields of education, financial income and political power (EIGE, 2020). Furthermore, violence against women remains to be a significant problem in Finland, as highlighted in this discussion paper. Previous and on-going research concerning the costs of violence in Finland are also presented and their meaning and applicability to other countries discussed.

1.1 Prevalence of violence against women in Finland

Like in most EU-countries, violent crime and especially homicides have declined significantly in Finland since the 1990's (Lehti, 2020). However, the number of murdered women has decreased less than male victims and Finnish women currently score 8th in the EU on the risk of being killed. Finnish homicide statistics from 2013-2018 show that 60% of female victims are killed by their current or previous intimate partners, compared to 8% of the male victims. This reflects the fact that domestic and sexual violence are mostly experienced by women, whereas Finnish men are mostly subjected to other interpersonal violence (Heiskanen & Ruuskanen, 2010). Significant associates of violence among Finnish women are young age, being divorced or cohabiting with a partner and living in an urban area (Piispa et al., 2006).

Two national population-based victim surveys have been conducted in Finland in 1997 and 2005 to evaluate the prevalence of violence experienced by women. Contrary to the homicide statistics, their results indicate a slight increase in the prevalence of violence, with 40% of Finnish women reporting lifetime physical or sexual violence in 1997 and 44% in 2005 (Piispa et al., 2006). Further increase was reported by the EU-wide survey conducted in 2012, with 47% of Finnish women

reported having experienced physical or sexual violence (FRA, 2014). On the other hand, reported rates of recent violence have stayed the same, with the prevalence rates being approximately 11% in 1997 and 2005 (Piispa et al., 2006) and 10% in 2012 (FRA, 2014).

A recent population-based survey reported that 8% of Finnish women have experienced any forms of violence in their close relationships in the past year (Hisasue et al., 2020), whereas the FRA survey (2014) reported that 5% of Finnish women had experienced recent physical or sexual violence by their (ex-partners). Additionally, 52% of Finnish women report having experienced psychological partner violence, 24% have been stalked and 42% sexually harassed (FRA, 2014). The prevalence of all measured forms of violence in the FRA survey were higher in Finland than the EU-average. However, the authors of the report conclude that this is more likely to reflect higher disclosure rates than actual differences in the prevalence of violence. In general, Finnish people have high trust for official institutions, which is likely to be reflected on willingness to disclose violence when inquired about them.

1.2 Help-seeking and victim services in Finland

Women exposed to violence suffer from injuries and various somatic and mental health problems (FRA, 2014; Heiskanen & Ruuskanen, 2010; Hisasue et al., 2020; Siltala et al., 2020). However, only a minority of victims report having sought help from official services, such as health care, social services or police (Piispa et al., 2006). Disclosing violence to a close friend is more common, with 53% of Finnish women exposed to domestic violence and 60% of women exposed to other violence reporting to have done so (Piispa et al., 2006).

Police, health services, legal services and therapy are the most common sources of help for Finnish women experiencing violence (Piispa et al., 2006). Almost all victims seeking therapy stated that they were satisfied with their treatment. On the other hand, 20-33% of women reaching out to health services or police announced that they were dissatisfied. The most dissatisfied group (45%) were victims of domestic violence seeking help from social services. Research has demonstrated that Finnish social and health care professionals are reluctant to intervene with violence (Husso et al., 2012) and as a result, only 1-4% of victims visiting health care are identified and properly recorded (Siltala et al., 2020; Kivelä, 2020).

Several free violence-specific services exist in Finland for victims seeking help. These include shelters for victims of domestic violence, local crisis centres and 24/7 national support phone line *Nollalinja.* Additionally, victims of rape and sexual assault can receive legal, therapeutic and medical help from the three rape crisis centres provided by the NGO *Tukinainen* or from the *SERI* rape crisis centres located in ten hospitals around Finland. The shelters, phone line *Nollalinja* and the *SERI*-centres are funded by the state, whereas other victim services are NGO-based. There are also some organizations, which provide interventions for help-seeking perpetrators of violence. Most of these violence-specific services, including the shelters, are gender-neutral and cater for both women and men seeking help for violence. In

2019, the 28 Finnish shelters had 5 350 clients, out of whom 46% were children (THL, 2020). 90% of the adult clients were women and the clients stayed in the shelter on average for 17 days.

1.3 Recent developments and future issues

In Finland, various NGOs and researchers have sought to increase awareness of violence against women since the 1990s. Legal progress has been made since then, including penalization of marital rape in 1994, making prosecutors responsible for pressing charges also in less severe cases of domestic violence instead of the victim in 2011 and penalization of physical sexual harassment in 2014. Finland ratified the Istanbul convention in 2015 and in the same year Finnish state became responsible for the funding of shelters catering for victims of domestic violence. As a result, the total number of clients has increased by 75% from 2015 to 2019 as more shelter places have become available in Finland (THL, 2020). The number of state-funded rape crisis centres has also increased. The current Finnish government has stated that violence against women is a crucial justice and safety issue and announced their own programme for reducing violence in October 2020 (Ruuskanen, 2020).These policy changes go together with the public discourse and attitudes concerning violence against women, which have recently been build up by the #MeToo-movement.

However, much remains to be done to combat violence against women in Finland. For example, many of the policy recommendations issued by the UN Human Rights Council (UN General Assembly, 2017) remain unratified by the Finnish state. The NGO-status of the major service providers significantly restricts the long-term funding and development of the violence-specific services. Although shelters are nowadays state-funded, their number is still insufficient: According to the Istanbul convention, Finnish shelters should be able to cater to 500 clients, but the current capacity is 202. The implementation of the Istanbul convention in Finland has further been criticized, for example due to inequalities in the level and access to victim services (Laaksonen et al., 2018). These issues affect women living in Eastern and Northern Finland, which are scarcely populated areas and where the closest police department can be over 100 km and the closest shelter several hundred km away. Furthermore, there are insufficient services for various vulnerable populations, such as women with disabilities or women with migrant background (Laaksonen et al., 2018).

The current Finnish legislation defines rape based on physical violence instead of lack of consent and non-physical sexual harassment is still not penalized. In 2019, over 40% of sexual crimes reported to police remained unsolved (StatFin, 2020). During the past decades, the rise of internet and social media has created new forms of violence against women, including online harassment, hate speech and revenge pornography. Female Finnish politicians are one group of women, against whom cyber abuse is targeted in a systemic manner (Van Sant et al., 2021). The slow development and remaining issues in legislation demonstrate that violence against women has long been regarded in Finland as private and individual events instead of systematic criminal or human rights issues requiring public attention.

2. Methodologies for assessing the direct costs of violence against women

2.1 Previous studies conducted in Finland

The first Finnish study evaluating the direct costs of violence against women utilized a top-down approach and resulted in estimated costs of 68 million euros in 1998 (in 2020 currency) (Piispa & Heiskanen, 2001). Justice system accounted for 53% of the costs, 30% were allocated to social services (including shelters and other victim services) and 7% to health care. The second study utilized bottom-up data collected from the city of Hämeenlinna in November 2001 and the annual direct costs of violence were evaluated to be 115 million euros (in 2020 currency) (Heiskanen & Piispa, 2002), which equals to approximately 21 euros per resident each year. Over half of the costs were allocated to social services, 27% to justice system and 20% to health care. Most of the costs were attributed to violence perpetrated by current or previous intimate partners, which constituted 50-75% of the recorded cases within each studied service sector.

These two studies provide a starting point for evaluating the costs of violence against women in Finland. The bottom-up approach based on empirical costs recorded by various service providers seems to more accurately evaluate the true costs of violence, resulting in almost doubled costs compared to the top-down approach. Hämeenlinna is a middle-sized Finnish city with its 46 000 inhabitants and its demographic and socio-economic structure closely resembles Finnish averages. However, the data collected by Heiskanen and Piispa (2002) constituted only those cases of violence identified by professionals working in health care, social service and justice system. Thus, even those estimates are likely to underestimate the true costs of violence against women in Finland. The cross-sectional nature of data collection in Hämeenlinna also affects the reliability of the estimates for annual costs.

Significantly higher cost estimates for violence against women were reported by EIGE (2014), based on which the true costs in Finland might be even 22 times higher than estimated by Heiskanen and Piispa (2002). The EIGE evaluations were based on a case study conducted in the UK, which provided 13% higher cost estimates for health care and 95% higher estimates for legal services than the data collected by Heiskanen and Piispa (2002). Up to 32% higher health care costs for women experiencing domestic violence were also reported by a recent longitudinal data collected in Finland by Siltala et al. (in review). These costs were estimated using a bottom-up method based on longitudinal data collected from victims of violence identified in emergency care. The health care use of the identified victims was analysed for two years before and two years after their identification using their medical records and exact costs were calculated for each visit.

2.2 On-going research on the cost estimation in Finnish health services

One new study regarding the costs of violence against women is currently being conducted in Finland by Tomomi Hisasue. This study will include various measures for health services use, reflecting both the immediate and long-term health effects of violence. However, the study will not include costs for justice system or social services due to the availability of well-established administrative data at the national level. The included measures for health service use are:

- Medical treatment for physical injuries related to violence
- Hospital stays
- Primary health care service use
- Mental health service use
- Mental health medication

2.2.1 Identification of violence and data sets to be used

The true extent of violence is unlikely to be identified via any single data source. Therefore, this on-going study will identify victims from several data sets. The study includes women aged 19-54 who have reported experiences of violence to the police, used shelter services or contacted health services due to violence in 2015-2020. Victims of violence will be identified from corresponding administrative register-based data sets: *The Finnish care register for health care, Shelter data of domestic violence*, and *Statistics on offences and coercive measures.* These three registers are nation-wide and the study will thus include all Finnish women experiencing violence who have appeared at least once in administrative data. A reference population will be formed from people who have not contacted any of these public services due to an incident of violence between 2015 and 2020.

2.2.1.1 The Finnish care register for health care

The Finnish care register for health care established in 1969 (formerly the Hospital Discharge Register), includes inpatient care, specialized outpatient care and day surgery in the public sector. In the Finnish care register for health, every contact to the healthcare service has been recorded using the International Classification of Diseases, 10th version (ICD-10) diagnosis since 1994 (Sund, 2012). For the purpose of this study, victims of violence will be identified through ICD-10 codes (X85-Y09).

2.2.1.2 Shelter data for domestic violence

There are currently 29 shelters for victims of domestic violence in Finland, which offer temporary accommodation, psychosocial support, advice and counselling to persons who have been exposed to domestic violence. All shelters use a client data software, where information about each client is recorded. The data collected from each shelter are sent to the National Institute for Health and Welfare. The data includes a personal

identification number for each client, and thus it is possible to link the shelter data to other registry data sources.

2.2.1.3 Statistic on offenses and coercive measures

The police records of reported crimes in Finland include data on domestic and intimate partner violence, which will be utilized in the study. The original police records do not include information on the specific relationship between the perpetrator and the victim, but Statistics Finland can create links to other register data using personal identification numbers. Then, it is possible to identify the relationship between victims and perpetrators. All types of domestic and intimate partner violence will be included in the study.

2.2.2 Methods of cost estimation

After identifying the victims of violence their data will be linked with health administrative data (including information on primary and secondary health care services) and medication data. The health care costs will be estimated over a period of up to 5 years for incidents of violence first occurring within 2015-2020. The study will include cost data for all years and probably all victims at the national level. The data will thus have a much broader coverage of women being exposed to violence in Finland than the previously used data sets. The costs will be estimated using the Finnish version of the Nordic Diagnosis Related system (NordDRG).

3. Challenges for assessing the direct costs of violence against women

3.1 Identification of violence

Violence is a sensitive topic and it is often under-reported. Thus, availability of data poses a major challenge for identifying victims of violence. For example, only 10% of physical or sexual assaults experienced by Finnish women come to the attention of police and only 48% of the reported cases lead to an offense report and are thus recorded to the police statistics (Heiskanen & Ruuskanen, 2010). For intimate partner violence experienced by women, as many as 80% of the disclosed cases go unrecorded. This means that the official police recordings in Finland seriously underestimate the prevalence of violence against women.

Finnish administrative health data is regarded to be high quality and it has been widely used in the fields of epidemiology and economic analysis of health care costs (Sund, 2012). The ICD-10 coding utilized in Finnish health care includes specific codes for violence, which should be recorded in all cases of violence. However, studies have demonstrated that intimate partner violence is poorly identified and documented in Finnish health care (Kivelä, 2020; Siltala et al., 2020). As a result, the typical approach of looking only at the health care register data will not capture all consequences of violence and the associated costs are underestimated. Social service data is even more skewed and difficult to access in Finland, because the services are provided by individual municipalities and third-sector service

providers, incidents of violence are not systemically documented and access to the client records is heavily restricted to protect confidentiality.

Another major issue in Finland is that there are not enough comprehensive statistics regarding different minority groups, such as women with disabilities, women with migrant background, or other ethnic minorities. This is a major disadvantage since a Finnish study has stressed the health inequality and lower health service utilization by people with migrant backgrounds or people with lower socio-economic status (Çilenti et al., 2021). There are also no reliable statistics on the prevalence of honour-related violence or forced marriage in Finland. Thus, particular attention should be paid in the future to the appropriate identification of women experiencing violence in Finland.

3.2 Identification of violence-related costs

Some immediate costs of violence are relatively easy to identify, such as dispatching of a police patrol or an ambulance, a visit to an ED, days spent in a shelter, contacts with child protection services or a court trial. However, many of the effects of violence are generated during longer time and are thus much more difficult to calculate. Such less-tangible effects include decreased physical and mental health, decreased quality of life, absence from work, costs resulting from divorce and custody disputes, financial scarcity and use of various welfare benefits. Finnish women experiencing violence have been noted to use many different services, including (but not restricted to) social services, health care, police and legal services, therapeutic services, church, shelters and other victim-support services (Piispa et al., 2006). However, both professionals and the victims themselves might not associate their service use with violence. Costs resulting from emotional or sexual violence might be especially challenging to identify.

It is also important to note that violence does not only affect the women experiencing it but also other people, including children, friends and families (Piispa et al., 2006). Violence or its effects also do not exist in a vacuum and thus various psychological, social and demographic confounders are likely to either increase or decrease the costs of violence in each individual case. Several effects of violence also make the victims more vulnerable to further abuse (Piispa et al., 2006; Siltala et al., 2020) and thus it is often difficult to distinguish the causal relationships between violence and other social problems, such as poverty and substance abuse.

3.3 Research methodology

No ‘gold standard’ exists for estimating the costs of violence and thus studies on the subject have applied a variety of methods, including bottom-up, top-down and econometric approaches for cost estimation (Chan & Cho, 2010). These methods can provide complementary information, depending on the purpose of cost estimation and the availability of data. The two main means of gathering data on costs of violence against women are administrative data and self-report surveys, both of which have their own pros and cons.

Administrative data makes it possible to follow up same individuals and assess the long-term physical and mental health impacts of violence at the national level. However, violence is not a disease and thus it often remains unidentified and unrecorded, which affects the reliability of administrative data. Therefore, self-report surveys are an important method for establishing the extent of violence exposure in the general population. However, the structure of questions related to violence and health service utilisation may influence the quality of such data. Cost analysis based on self-report are likely affected by memory and identification bias and thus resulting in underestimation of service use. For example, some women choose to report only the most severe violent incident, or only report service use related to physical injuries. Hence, reliable assessments regarding the long-term health impacts and patterns of services use cannot be made based on self-report surveys alone.

When research on the costs of violence against women is planned and conducted, methodological choices concerning the included variables must inevitably be made. However, there is a real risk that these choices are more affected by the ease of access to information rather than the true costs and effects of violence. Another problem with estimating the costs is that they are not stable through time. The health effects of violence experienced by women can endure for years, but they also decrease with time after the incident (Siltala et al., in review). This sets further challenges for research, as cross-sectional studies are not sufficient to capture the lasting and fluctuating effects of violence against women. Methodological choices are also inevitably affected by the goals of research, i.e. what is the purpose of estimating the costs of violence against women.

4. Main questions and issues for debate at the meeting

4.1 Can the described methods be replicated in other countries?

The EU countries significantly differ on the availability and extent of administrative data relevant to violence. Finland has relatively high-quality data available for research purposes and thus these have been utilized also for estimating the costs of violence. Studies conducted in countries possessing administrative data with good structures and high validity might end up with higher and more accurate cost estimates for violence against women. Establishing high-quality systems of administrative data where they don't already exist will incur costs on its own, but such development can be seen as necessary to access both the immediate costs of violence and the long-term impacts on health and service use.

Similar methods and multinational datasets can be used in countries with comparable data. For example, all five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) have nationwide registries with similar data structures (Maret-Ouda et al., 2017). It is also possible to link between registries through personal ID numbers

within each country. These resources enable setting up registry-based collaborative research with long follow-up within the Nordic countries. However, the main obstacles for such research include the time-consuming and complex processes to obtain all relevant research permits from all necessary institutions. Data management is another considerable issue, due to the need to have sufficient knowledge of the variables of the data in each country.

On the other hand, the structure of self-survey questions has been well developed in the EU and the FRA survey used objective questions for assessing violence (EIGE, 2014). Cultural or other differences in interpretation of survey questions across the EU countries may affect estimates of the true impact of the violence. This FRA effort thus helps to minimise different interpretations across the EU countries. Conversely, the multi-country surveys also have to account for differences in social acceptance to disclose experiences of violence when evaluating their results across the EU countries.

4.2 How to improve responses for violence against women?

The Istanbul convention recognizes that professionals working in relevant fields, such as health care, social services and police, require proper training to be able to encounter violence against women more effectively. To meet this need, several development projects have been conducted both in Finland and elsewhere. However, the long-term implementation of such projects has proven to be challenging and the developed practices are at risk of fading out once the project and associated funding ends (Husso et al., 2020). Successful long-term implementation of future projects should thus be paid special attention.

Encouraging first results have been reported by the *EPRAS* project, conducted in Finland during 2017-2019 (Nikander et al., 2019). A free and publicly accessible online training programme developed during the project has been popular and received positive feedback from the participating professionals working in social and health care sectors and police. *EPRAS* also included a civic campaign raising awareness of domestic violence and shelter services. *IMPRODOVA* is another promising, on-going collaborative project aimed to improve the institutional responses for domestic violence among police and other front-line responders in several European countries. More information on the project is available at *www.improdova.eu*.

Intervening with violence requires strong institutional support for the first-line responders (Husso et al., 2020). Clear service models for intervening with violence need to be implemented and information regarding these practices should be issued widely within institutions. The multi-sectorial nature of violence suggests that collaboration is also needed between institutions (Husso et al., 2020). For example, data sharing between police and health care has been demonstrated to significantly increase the identification of violence (Gray et al., 2017), although such practices are often restricted by stipulations regarding privacy and confidentiality. Active discussion and sharing of experiences are needed on various platforms to plan

and implement effective ways of increasing the identification of women experiencing violence.

4.3 What can be achieved by cost analysis research?

Research regarding the costs of violence can potentially facilitate an understanding of the effects of violence for society and the impact on service utilisation of the victims. Important areas for future focus include the long-term effects of violence and evaluation of the developed policies aimed at reducing violence against women. Longitudinal research concerning the costs of violence could effectively demonstrate how financial investments in violence prevention policies can result in positive outcomes and cost-savings for public services. Economic approaches, e.g., cost-effectiveness analysis or cost-benefit analysis, could also be used to plan and implement more effective victim services. However, violence is a complex phenomenon and thus economic approaches are not always easy to apply in a reliable way.

On the other hand, knowledge concerning the prevalence and effects of violence against women has already been cumulating for decades. Hence, it should be critically discussed whether cost-related research really is a breakthrough way towards better policies or are resources instead wasted on the costly and time-consuming calculations required by such research. In any way, it is clear that the existing and emerging research findings regarding the costs of violence against women need to be effectively communicated among researchers, general public, administrators and political decision makers to implement the much-needed changes in social and institutional levels.

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