



Annual National Report 2011

Pensions, Health Care and Long-term Care

Iceland

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1 Executive Summary

Iceland had the most spectacular financial collapse when the main banks all became bankrupt in October 2008. The affair was of unusual proportions, despite the small population size of the country. The crash and consequent recession has now, according to IMF assessments, bottomed out and growth is expected this and the following years. The government budget deficit reached 12% of GDP and is now in the region of 6%, it is expected to even out by end of 2012. The adjustment to the crisis has meant large cuts in expenditures and increased taxes. So the welfare system has had to face cuts. The overall cuts in government expenditures were some 10% each year in 2009 and 2010, but the welfare sector (pensions, benefits, health and education) got some 6% cuts each year.

Iceland went into the crisis with a strong welfare system, in many ways a typical Nordic-type of a welfare state, yet with its own deviations. This has proved to be an important asset in the crisis and the government has succeeded in using the social protection system to shelter the lower and middle-income groups against some of the vagaries of the crisis. Pensioners, the unemployed, families with children and the heavily indebted have all received some softening of the cuts in living standard from the system. Still all have suffered from the crisis, with average reduction of purchasing power of disposable incomes having gone down by some 15%, from 2008 through 2010. Lower income groups however got less reductions of their purchasing power, due to the social protection system.

The three pillar pension system (I. Public social security, tax funded and greatly equalising; II. Mandatory occupational pensions, funded and managed by the labour market partners; III. Individual pension savings accounts, voluntary but subsidised by employers with 2% on top of pay) has been affected by the crisis. Pillars II and III lost significant sums of their assets (20-25%), but the year following the collapse was however good for increasing assets, not least from foreign investments. Many occupational pension funds (OPF) have regained their pre-crisis overall assets level (including in-payments). They however cut their pension payments by between 10-20% in 2009 and 2010, yet maintained their rule of increasing pension amounts in line with price rises. Hence most pension receivers got more from the OPFs during the crisis years. They have also got more from the public Social Security, particularly lower earning pensioners, who were particularly well protected. So the pension system remains shaken but basically intact.

The health care sector has been struggling with cost containment programmes for most of the last decade, so the cuts now came on top of that. This has thus been tough for staff and management but all indications are that the previously high standard of quality has been maintained to the largest degree. Waiting lists for hospital operations actually shortened in 2009, but they got longer again in 2010 and complaints of inadequate service and mistakes increased somewhat. There has been a growing concern about risk of medical brain drain in the last year, but the statistics indicate that this is not yet serious. The position of general practitioners (GP) still remains rather weak.

Long-term care services have continued the underlying trend of reducing institutional occupancy, with a shift from retirement homes to nursing homes being a strong trend. At the same time home help has increased as well as day care services for the frail elderly. The policy goal is to make it possible for most to stay in their homes for as long as possible, with support services. Long-term care has got an unexpected support from the economic policy area, in the idea of increasing construction of nursing homes as a form of economic stimulus, to increase jobs. That is a part of various government initiatives to reduce unemployment, while at the same time trying to protect the welfare system.

On the whole, one can say that the biggest crisis for public finance to hit Iceland since 1944 has not so far resulted in a serious weakening of the social protection system. Expenditures have both been cut and increased, but the overall picture that emerges is one of a rather successful use of the social protection system to shelter lower and middle incomes groups from the crisis.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

Prior to the financial crisis neoliberal policy emphasis had been predominant in Iceland. This involved a very strong confidence in the power of markets, including financial markets, to self-regulate their operations and deliver growth. A part of this ethos was a strong dose of *laissez faire* and the private sector was increasingly seen as having most advantages over the public sector as a provider and caretaker of services and to some extent governance. Tax cuts, privatisation and business competitiveness became priority goals. That orientation increased the power and freedom of finance and needless to say is now associated to the build-up of an extreme bubble economy which collapsed spectacularly in the autumn of 2008, marking the start of the present crisis. These were rather extreme developments for a Nordic welfare state.

This policy environment was rather negative towards public social protection. In the field of pensions the goal was aired that the funded occupational pensions (in care of the labour market partners) should replace the public social security, as were ideas of increased public-private partnerships in the field of welfare. Increasing self-sufficiency was also preached and exemplified in the emphasis on establishing individual pension accounts, which became effective with tax exemption incentives from 1997 (law no. 129/1997). While this was a welcomed broadening of pension savings the atmosphere towards the public role in pensions eroded somewhat, it was for example reflected in the lagging of social security minimum pensions behind pay developments from 1995 to 2003.

The new government that came to power after the financial collapse, i.e. in February 2009, was a social-democratic led government, pledging to change policies and aim more than before towards the Nordic welfare model. This was seen as involving the need for a confident public sector able to regulate and to restrain the tendencies of the private sector (business and finance) towards inequality and disruption. Thus egalitarian and security goals should be strengthened and the lower and middle incomes groups sheltered against the worst consequences of the crisis. That policy goal has been prominent for the last two years and shaped some of the measures undertaken in the field of social protection, taxes, welfare monitoring and services. Seriously strained public finances were though obviously a limit on possibilities for deliveries

The government has though succeeded in implementing significant shelters for the lower and middle incomes groups. This is for example evident in the raising of minimum Social Security pensions while higher pensions were cut, temporary lengthening of the unemployment entitlement period from 3 to 4 years (December 2010) and increases in the local social assistance allowance and other benefits. In Table 1 expenditures on the main social protection categories is shown for the period through 2010. Housing debt relief and increased mortgage interest rebates for homeowners have also been an important feature of social protection during the crisis so far.

Main benefit categories had increased their expenditure share by 2009 in all cases while service expenditures remain more similar as proportions of GDP. Overall transfer

expenditures lowered again in 2010, but still remain higher than in 2008. Pensions and benefits to the lower income groups were generally increased but reduced to higher earning groups. Expenditures in fixed prices have gone down in some cases with the GDP, but clearly not in all categories. In that sense the Figures do not tell a singular story of a significant decline of the social protection system in the field of pensions and benefits.

Table 1: Social Protection expenditures as % of GDP, 2006-2010

% of GDP	2006	2007	2008	2009	2010
Total expenditure on social protection	21.08	21.5	22.06	25.32	
2.1. Cash benefits due to disability	2.13	2.08	2.28	2.79	
2.2 Services for disabled persons	0.69	0.71	0.77	0.75	
3.1 Cash benefits to elderly persons	4.21	4.39	4.42	4.85	
3.2 Services to elderly persons	0.43	0.42	0.45	0.47	
5.1 Cash benefits to families and children	1.31	1.4	1.44	1.58	
3.2 Services to families and children	1.47	1.46	1.51	1.59	
6.1 Cash benefits due to unemployment	0.22	0.2	0.33	1.67	
6.2 Services to unemployed persons	0.04	0.04	0.04	0.04	
Transfers to homes, total	5.70	5.76	6.05	8.16	7.82

Source: Statistics Iceland

The overall policy of the government in relation to its austerity measures was to raise taxes (mainly on higher income earners) for up to 45% of the budget deficit and to cut expenditures by 55%. The overall government deficit (central plus local) in 2008 was in the region of 14% of GDP and is now down to about 8%. It is expected to lower further in 2011 and 2012. The general policy on expenditures cuts was to reduce public expenditures by 10% except for health and welfare where the cuts were in the region of 6% each year. Thus the welfare sector was partly sheltered.

Given the large share of health care expenditures it is not surprising that health services would be affected by cuts in 2009 and 2010. That was in some cases a continuation of efforts to cut and rationalise that had prevailed for the last decade, since Iceland had one of the highest expenditure rates on health care in the early 2000s. The present cuts are thus from great heights and generally high standards.

The picture that emerges from Table 2 is mixed, with the share of GDP increasing on the whole in 2009 and 2010 as against 2008. The private share of expenditures increased significantly in 2009 and 2010 while the public share decreased in some cases. The most marked examples of increased shares of GDP for expenditures are on medical products and pharmaceuticals.

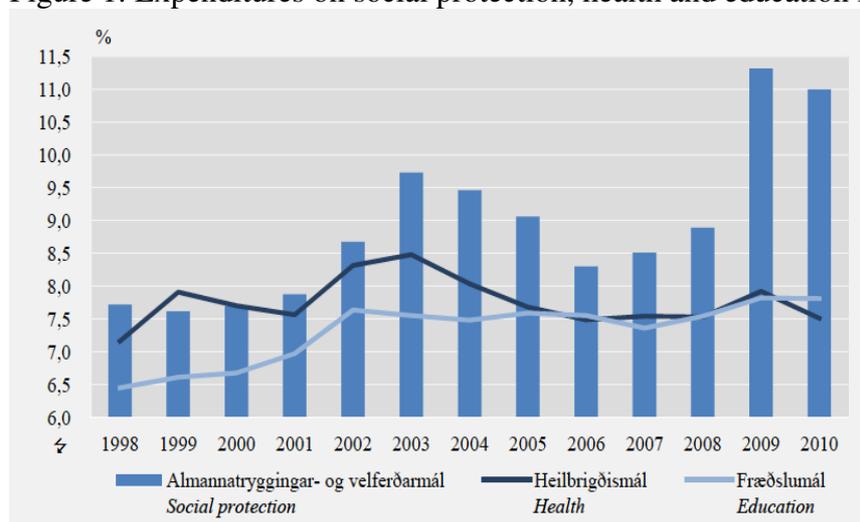
Table 2: Health care expenditures (% of GDP), total and private, 2006-2010

	Total (public and private) expenditures, % of GDP				Private expenditures, % of GDP			
	2007	2008	2009	2010	2007	2008	2009	2010
1 Medical products, appliances and equip.	1.42	1.52	1.72	1.68	0.72	0.73	0.81	0.86
11 Pharmaceutical products	1.01	1.11	1.25	1.2	0.47	0.48	0.54	0.58
12 Other medical products	0.41	0.41	0.46	0.48	0.25	0.25	0.27	0.29
2 Outpatient services	2.23	2.25	2.35	2.29	0.82	0.81	0.88	0.9
21 General and special medical services	1.31	1.34	1.4	1.32	0.26	0.25	0.27	0.27
23 Dental services	0.55	0.54	0.56	0.57	0.45	0.45	0.47	0.49
24 Paramedical services	0.37	0.37	0.39	0.4	0.12	0.12	0.14	0.14
3 Hospital services	5.23	5.15	5.29	5.09	0.04	0.04	0.04	0.04
4 Public health services	0.06	0.05	0.05	0.05				
5 Health n.e.c.	0.2	0.19	0.21	0.21	0.01	0.01	0.01	0.01
Total health expenditure	9.14	9.15	9.62	9.32	1.59	1.59	1.73	1.81

Source: Statistics Iceland

In long-term care there have been cuts in expenditures on operating the present facilities, such as on nursing homes and rehabilitation. There we see both a cut in real expenditures and a lowering of those expenditures from 1.39% of GDP to 1.29% in 2010. At the same time the government has though announced that a part of its measures to create jobs will be extra finance for building new nursing home facilities, in many regions of the country.

Figure 1: Expenditures on social protection, health and education in Iceland 1998-2010



Source: Statistics Iceland

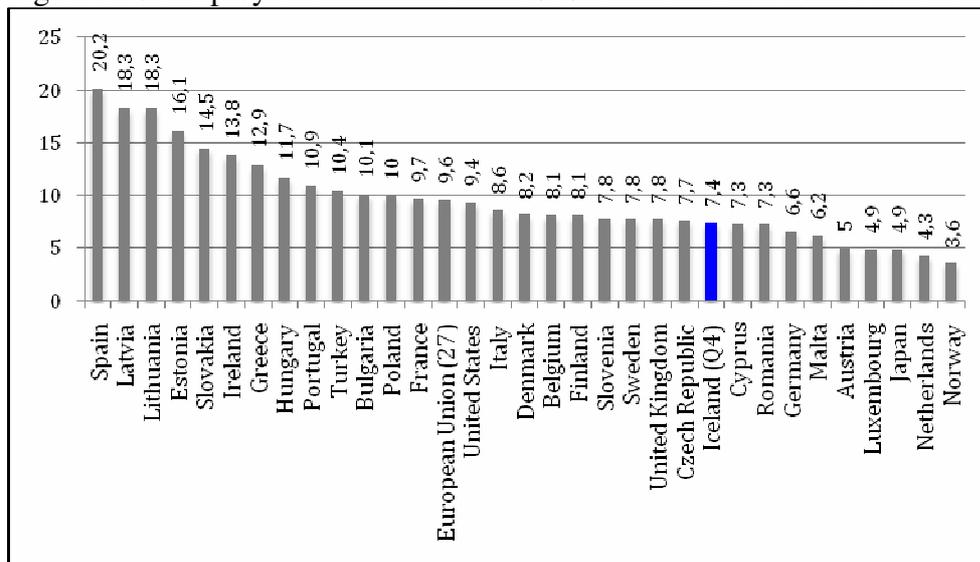
Figure 1 clearly tells the story of an increased share of GDP spent on social protection related pensions and benefits (columns), while health and education have shown a much more modest change in expenditure shares in 2009 and 2010. The largest growth in benefits expenditures is of course on the unemployment benefit. So we are not seeing an end to social protection as we know it, but rather a temporarily increased role (cf. Statistics Iceland).

Iceland's financial crash in October of 2008 was of course particularly spectacular and attracted a lot of international attention. The economic crisis that followed was predicted to be very deep and unprecedented. GDP per capita was expected to go down by some 10%, purchasing power by about 20% and unemployment to reach at least 10% by end of 2009.

Now two and a half years later we can sample the facts. The verdict now from the IMF, EUROSTAT and OECD is that the bottom has been reached and the climb up was already started by the last quarter of 2010. GDP pc actually went down altogether by nearly 10% from 2008 to end of 2010. There are prevailing predictions of 2-3% growth for 2011 and some more for 2012.

The unemployment rate has however not been as high as predicted and it did not really reach 10%, as measured in EU labour market surveys (registered unemployment is however some 1-percentage point higher, due to some part-time workers being counted as unemployed if they receive part-unemployment benefit). As Figure 2 shows Iceland's unemployment rate at the end of 2010 is low by EU standards. Some 23 Western nations have a higher rate than Iceland and some 9 have a lower rate. Devaluation of the Icelandic krona, which has helped the export industries, has been important for alleviating the unemployment problem, as well as some emigration of labour to the neighbouring countries, especially to Norway. Government has also put considerable extra efforts into activation and rehabilitation measures in the labour market in 2009 and 2010, especially for younger unemployed and in 2010 concentrating on older workers (50+).

Figure 2: Unemployment rate at end of 2010. Iceland and Western countries compared.



Source: Eurostat

The debt burden problem, equally for government, households and firms, was of course thought to become almost unmanageable. The debt problems of government have however turned out to be less extensive than predicted and the public deficit has already been reduced from about 12% to some 6% and continues downward this year, set to be evened out by 2012. The IMF and government programme for debt containment has thus been deemed a considerable success. The debt relief measures towards households to date have made it possible for households in greatest difficulties to return to the debt level and debt servicing burden that they had in the earlier part of 2008, i.e. before the collapse.

So on the whole, one can say that the biggest crisis for public finance to hit Iceland since 1944 has not so far resulted in a serious weakening of the social protection system. Expenditures

have both been cut and increased, but the overall picture that emerges is one of a rather successful use of the social protection system to shelter lower and middle incomes groups from the crisis.

2.2 Pensions

2.2.1 The system's characteristics and reforms

Iceland has a pension system which has many characteristics commonly associated to the Scandinavian pension systems while also retaining some of its own characteristics. The pension system is universal in coverage, with rights based on period of residence in the country. The universal public social security part is primarily tax funded, while the occupational pensions are contribution-based. The system is redistributive on the whole and succeeds well in alleviating poverty amongst the elderly and other pensioners, in comparison to other European societies (OECD 2008a, 2009; Kangas and Palme 2005; Ólafsson 1999).

The main deviation from the Scandinavian model is that the occupational pension pillar is in the private sector, unlike what prevails in Sweden and Norway. The Icelandic system is most similar in structure to the Danish one, and partly to the Finnish one. In the Icelandic Social Security System the use of flat rate benefits with a high degree of income-testing to other earnings is a deviation, more in the direction of the Anglo-Saxon models, while the services part of the Icelandic welfare state is more in line with the Scandinavian systems.

Iceland has a three-pillar pension system, with the following characteristics and workings:

- I. A public tax funded pay-as-you-go universal Social Security System (Social Security) with a defined benefit. The legal basis dates from 1946, originally modelled on Beveridge's plan, but also incorporating significant use of income-testing, in line with New Zealand's legislation from 1938. It has a universal coverage unlike the other two pillars. The Social Security pension has three components: Basic pension; Pension supplement and Household supplement. The benefits had a tradition of being rather low in early decades. Hence the growing need for "additional pension", which eventually led to the second pillar in 1969.
- II. A funded Occupational Pension System (OPS) with defined contributions, introduced as a result of collective bargaining between unions and employers' federations. From the beginning employees contributed 4% of pay and employers another 6%. Nowadays the overall contribution is 12% of total earnings (4% from employees and 8% from employers). The occupational pension became mandatory for employees in 1974 and for all employed persons from 1980. Even though the system is a DC-system, it promises 56% of average career earnings (stipulated in framework legislation from 1997) as a minimum. Contributions are exempt from taxation when paid in, but fully taxed when taken out as earnings. The OPS funds are managed by the labour market partners, the unions and employers' organisations.
- III. Individual Pension Accounts (IPA). The framework legislation is from 1997. These are voluntary accounts with a defined contribution. Individuals can pay contributions up to 4% tax free (when paid in) and have the right to 2% additional contribution from employers with the first 2%. So altogether 6% are exempt from direct taxation when paid in. These are managed by occupational funds, banks or private investment funds and subject to public scrutiny by the Financial Supervisory Authority, as are the OPS funds.

The different pillars have different roles in society and differing effects on the distribution of living standards. The Social Security equalised the income distribution with its minimum guarantee and universal income-tested benefits. It is thus of great importance for alleviating

poverty and quite successful in that respect, since Iceland has along with the Scandinavian countries one of the lower poverty rates in Europe (Eurostat: EU-SILC data and OECD 2008). It is also of great importance for elderly women, especially widows who have little accumulation of rights in the Occupational Pension Funds or other means of earnings. The great majority of old age pensioners receive some pension from Social Security and only a small minority have to rely solely on the minimum guarantee (less than 5%). For many of those who have little earnings from the pension funds the minimum guarantee provides a supplement and at present about 16-17% of old age and disability pensioners get some supplement from the minimum guarantee, many however only a small sum.¹ This proportion was previously higher (from September 2008 through 1st July 2009) but it was reduced somewhat with an introduction of a greater degree of income-testing on the 1st of July 2009, as a part of austerity measures. The function of the minimum guarantee is primarily that of improving the level of living of those pensioners that have low other earnings, whether from the OP funds or other means (employment or financial earnings).

The second pillar aims to replace the income distribution in the labour market proportionally, without any roof. It does thus not significantly equalise the income distribution, but it has been gradually more important for raising the living standard of pensioners by adding to the modest earnings provided by Social Security. The yearly accrual rate for rights in the OPS is 1.4% of pay and the system works on notional accounts. Rights are proportional to pay and indexed during periods of accumulation by a fixed rule. After pensioners start receiving their pension the amount they get is indexed to the cost of living index from then on (Ísleifsson 2007).

The individual pension accounts, being voluntary, have an incomplete coverage, with about 60% of wage earners contributing (which is though high by international standards). The 40% who do not contribute come disproportionately from low earners and single parents (mainly women). This pillar thus makes the income distribution amongst pensioners more unequal on the whole.

The first two pillars are the main building blocks of the Icelandic pension system. The second pillar pays out to pensioners a slightly higher proportion of GDP than the public Social Security System at present. The importance of the third pillar has declined in the last year due to losses of assets in the financial crash, but also due to the fact that government opened up the pillar for subscribers under age 60, who were allowed to liquidate up to a prescribed sum (1 million IKr. per person for the year of 2009). A couple where both have such accounts could thus liquidate 2 million IKr. to alleviate their debt burden. This provision still applies and the sum for couples was raised up to 2.5 million IKr. for each (max 5 millions for a couple).

Since the Social Security pillar uses income testing to a high degree, also fully now against occupational pension earnings, the amounts paid to pensioners from Social Security decrease as occupational pensions increase, with growing maturity of individuals' rights in the Occupational Pension Funds (cf. Social Security Institution - Staðtölur almannatrygginga 2007 and 2009). Looking at the three components of the Social Security pension (Basic Pension; Income Supplement; Household Supplement) we see that in 2009 81.5% of pensioners received full Basic Pension (the first component) without any cuts (which previously was only cut due to employment and financial earnings and not due to occupational pension receipt until from 1st July 2009). Before these changes of 2009 this component was received without any cuts by 94-95% of old-age pensioners. So pensioners with higher occupational pension earnings got their total earnings reduced by this measure.

¹ Cf. a personal communication from the Social Security Institute.

As regards the second component of Social Security (Pension Supplement, which is income-tested against all other income) 19.9% of pensioners got that without any cuts (thus 80% of pensioners get this component partly reduced or not at all), and the third component (Household Supplement, also income-tested against all other income, but payable only to single pensioners) is received only by 7% of pensioners without any cuts.

Due to income testing, and increased pension receipts from the Occupational Pension Funds the overall expenditure on Social Security pensions has remained stagnant or lowered as a % of GDP in recent years. It went from 2.5% of GDP in 2002 to 3.1% in 2003; then it lowered to 2.8% in 2006 and increased again to 2.9% in 2007 and 2008. All of these years were years of growth in GDP, the lowest however being the growth of 1% in 2008, the year of the financial collapse (in October). This proportion is likely to have increased in 2009, with the GDP declining by 6.5% during the year at the same time that expenditures of Social Security were increased on the whole, not least with 9.6% general rise of the pension amounts and a 20% rise of the minimum pension guarantee on the 1st of January 2009. The OP funds are paying a somewhat higher proportion of GDP to pensioners in addition to these payments from Social Security (SSI – Staðtölur almannatrygginga 2007).

Review of main Social Security reforms in 2010-11:

- Recommendations for a new housing policy (19.04.11)
- Work on new social security legislation started, based on recommendations of task force from 2009 (18.04.11)
- Minimum subsistence budget estimates for Iceland introduced for the first time (07.02.11)
- New agreement on interaction between Social Security and Occupational Pensions Funds regarding income testing for disability pensioners (reduction of cross income-testing) (05.01.11)
- Recommendation from Ministry of Welfare to local communities to raise Social Assistance Allowance (04.01.11)
- New Ministry of Welfare starts its operations (merged from Ministry of Health and Ministry of Social Affairs) (01.01.11)
- Right to unemployment benefit increased from 3 to 4 years (18.12.10)
- Closing conference of Iceland's participation in EU's Year Against Poverty and Exclusion (17.12.10)
- Transfer of caretaking of services for the disabled from the state to local communities (23.11.10)
- Thor – Activity plan against long-term unemployment (03.08.10)
- New Office of the Ombudsman for Debtors starts operating (01.08.10)
- Pension supplements for medication and related cost no longer taken into account in income-testing of benefits – reduces the degree of income-testing of public benefits (16.06.10)
- Earnings from private voluntary pensions savings accounts do no longer reduce unemployment benefits (16.06.10)
- Plans for merging of Directorate of Labour and Directorate of Occupational Health announced – to take effect in 2011 (22.03.10). This has however not been carried out yet.

2.2.2 Debates and political discourse

The main pension-related issues in public debates, in politics, policy, academia and amongst interest groups have in the recent years been six. Two of them are by far the largest and most consequential. These are:

- Cuts in public expenditures, raising issues of adequacy of social security and benefits
- Debt problems of households, especially young families' households
- Equalisation of pension rights amongst employees of the private sector and of public employees
- Need for lengthening the period for unemployment rights, from 3 years to 4
- Negative effects of spiralling income-testing for low earning disability pensioners
- Need for greatly increasing activation measures and job creation

The first two are the issues of greatest concern and relate both of course to the consequences of the financial collapse and the following recession. As explained in the first section of this report the cuts in expenditures were necessary due to the collapse of public finances. While general expenditures of government have been cut by 10% for two years consecutively welfare issues were however sheltered and cuts there limited to 6% each year. These are however big cuts and have touched many. The main concern is that pensions and benefits of the public social security system have not been raised with the galloping prices, hence effecting cuts in purchasing power. For pension receivers on low earnings this can be more difficult to adjust to than for people on higher earnings, even though the lower income groups have been relatively sheltered with less cuts. They simply have less leverage to adjust their level of living with adequacy.

Similarly the debt levels were greatly raised following the collapse (due to inflation indexing of loan principals and due to the fall of the currency which raised the principals and payment burden of foreign denominated loans, mainly on cars but some mortgages were in foreign currencies as well). These escalated debt burden problems have most significantly affected those families (mainly younger couples) who bought homes in the last 5 years or so before the crisis, at elevated prices and hence taking on larger debts that previously had been the norm. These debts were then elevated and the burden of servicing them as well. Hence there have been frequent and continuous calls for debt relief from the early days of the crisis.

The government promised from the beginning to “shelter the households” against the crisis and the debt burden. Given the very difficult financial position of the new government that started its career in February 2009 with about 12% budget deficit, the room to move was tight indeed. The government approached this by rejecting from early on all calls for a flat rate cut of all debts (20% cuts were most frequently mentioned) and went for targeted debt relief aiming at helping the hardest hit amongst lower and average income households. Measures were gradually introduced without fully satisfying the public, until last December a new packet based on extensive surveying of the problems and costs of various ways of adjusting (Snævarr et. al. 2010; see also Central Bank of Iceland 2010). That measure was also presented as the final package. From then on concerns about debt problems have receded somewhat and calmed down. We have in previous reports outlined the main measures and they have generally been modified and made more effective in operations and the main new part of the last package was an extra emphasis on raising the tax rebates on interest costs of mortgages to take effect from this year onwards, still with a limited time frame into the future. Now the government rebate covers about a third of the interest cost of households due to

mortgages. For the lowest income groups the rebate can approach 80% of interest costs (Sigfússon 2011).

Most of the heavily indebted households have now an option of lowering their debt burden ratios to the levels that prevailed in early 2008, i.e. before the crisis and there are options for those who's debt ratios are significantly higher than the value of their houses to get the principal of their debts lowered to 110% of the present value of the property (this refers to values of an average valued home at maximum, so extravagant investments are not supported to the same degree, if at all). So I will not deal much further with the debt burden problem in this year's report.

One of the issues related to occupational pensions that came up as a great concern shortly after the onset of the crisis is the different position of public employees and employees in the private sector. It has of course been well known for decades that public employees have enjoyed better occupational pension rights (with defined benefits and higher accrual rates, i.e. 2% yearly accrual of rights instead of the 1.4% in the private OPFs) than members of the private sector Occupational Pension Funds. The government has guaranteed the public employees' pension fund (LSR) and this extra pension right has been rationalised for decades as a compensation for 15-18% lower pay levels in the public sector in comparison to comparable jobs in the private sector. While this has at times been criticised through the years the issue gained a new importance during the crisis since the OPFs lost about 25% of their assets in the financial collapse and had to cut their benefits in 2009 and 2010, some by 10-20%. Public employees were however not subject to the same cuts, due to the government guarantee. Then the issue rose that public employees had privileges and that members of the private sector would also pay for these privileges with their taxes in the future, in addition to taking on the cuts in their own funds. Now it increasingly seems that the public OPF will become unsustainable without either increased premiums paid into it or a reduced accrual right for the defined benefit (ASÍ, VINNAN, 2011).

So a new side to this old issue surfaced and caused concern. The labour market partners (Federation of Labour – ASÍ, and Employers' Federation – SA) are now making demands in relation the collective bargaining process under way, that pension rights be equalised between the public and private sectors. This is however framed in such a way as to equalise without reducing the rights already accumulated in the public system, and for some the issue is to equalise by raising the rights of the private sector employees upwards. Alternatively this could involve a closing of the present divisions of the public OPF for new public employees. It is presently unclear how the issue will progress and be resolved, if at all.

With the unusually high unemployment rate prevailing in Iceland at present (even though it is not particularly high by international standards) it became of growing concern in 2010 that the long-term unemployed might run into the situation of fully utilising their right to unemployment benefits (max right on full benefit has been three years). Hence growing demands for lengthening the period up to 4 years emerged. As listed in the section above on reforms implemented in 2010-11 this was done already in December 2010 by the government. There was general agreement amongst all political parties (who otherwise do not agree on much these days!) that this should be done smoothly. (Hence there was no need to bargain or horse-trade as for example happened in the USA where the Republicans rejected to lengthen the rather short unemployment benefits period there, unless tax cuts for the wealthy were extended).

The fourth issue of debate and concerns in 2010 and recent years has been the issue of spiralling income-testing amongst disability pensioners, receiving benefits both from the Social Security and the OPFs. The OPFs started to income-test their disability benefits three

years ago. This was one of the consequences of growing numbers of disability pensioners from the early 1990s that caused a considerable concern in Iceland (Herbertsson 2005; Ólafsson 2005). In practice this meant that a spiral was formed since all Social Security benefits are income-tested. As the OPFs started to cut their benefits the Social Security increased its payment to the respective individual, who then got a further cut from his OPF the following year and onwards this spiralling cutting process could go on for some 8 years until it stopped, by what time the part of the cost of benefit payments in these cases had been transferred onto the Social Security system from the OPFs and the pensioner also got reduced payment, which actually mainly hit lower earning disability pensioners. The interest organisation of disability pensioners (ÖBÍ) has struggled against this, both in courts and in the policy arena. A new agreement between government and the OPFs was signed at the beginning of this year, aiming to reduce these spiralling effects, without however fully stopping them.

The last big issue of debate and concerns is the issue of a growing need for activation and rehabilitation needed in the present situation of higher unemployment levels. Iceland has for decades been outstandingly successful in getting people at working age into paid employment and so the need for ALMP and even for vocational rehabilitation was not an issue of much concern. This changed in recent years, firstly (as we showed in the last two yearly reports) with the growing number of disability pensioners and now with the higher unemployment rates from the autumn of 2008. There was agreement across the board about this and the government has made available greatly increased resources for ALMP and the labour market partners have also in cooperation with government put a significantly more effort into vocational rehabilitation (Andersen et al. 2011 forthcoming).

We examine and assess further the most important aspects of these issues in the impact and evaluation sections below.

2.2.3 Impact of EU social policies on the national level

On the whole there are not many cases of EU social policies having an impact on the national level in Iceland. The reason for this is of course that Iceland has not (yet) joined the EU and so formal avenues for such influences are not established. EU policy initiatives are generally not well known in Iceland and hence do not enter much public discussions. Still Iceland as a member of the European Economic Area zone introduces automatically up to 70% of EU legislation in the relevant fields covered by the EEA framework. Thus influence comes in that way but that is mainly a silent way. The public and media are not generally aware of issues involved and there is hardly any public discussion of issues emanating from that source. Looking specifically at the EU 2020 targets in the welfare field Iceland has already achieved some of them and they are therefore not potent as incentives for public debates.

Occasionally there are however examples of direct influences. One is the EU Year against Poverty and Social exclusion 2010. Iceland took an active part in that and a number of interesting activities were organised and presented at the closing conference last December.

Another example of direct influences is from the EU-SILC data collection that Iceland has participated in from 2004. Data from that source has gradually entered the administrative and academic communities and seems set to indirectly have some growing influences in the near future. But direct impacts on policy debates or initiatives are on the whole rare, except perhaps in the area of allowed working time. The EU directive on maximum length of weekly working hours has frequently been used by union spokesmen in their arguments for shorter working hours, but there has been considerable resistance in the labour market to following that yet.

2.2.4 Impact assessment

Looking first more closely at the impact of the financial crisis on pensions and benefits we see in Table 3 how the cuts in social expenditures were working out in separate areas in 2009 in comparison to earlier years. In the first section of the report we showed expenditure numbers as % of GDP. Since welfare expenditures were in some respects cut by less than the GDP itself (which went down altogether by some 10%) we saw growing expenditure shares in many cases. Here we look more directly at the real expenditures that give a more realistic impression of the effects of the cuts and where they have hit the hardest. Social protection expenditure was clearly increased to soften the impact of the crisis.

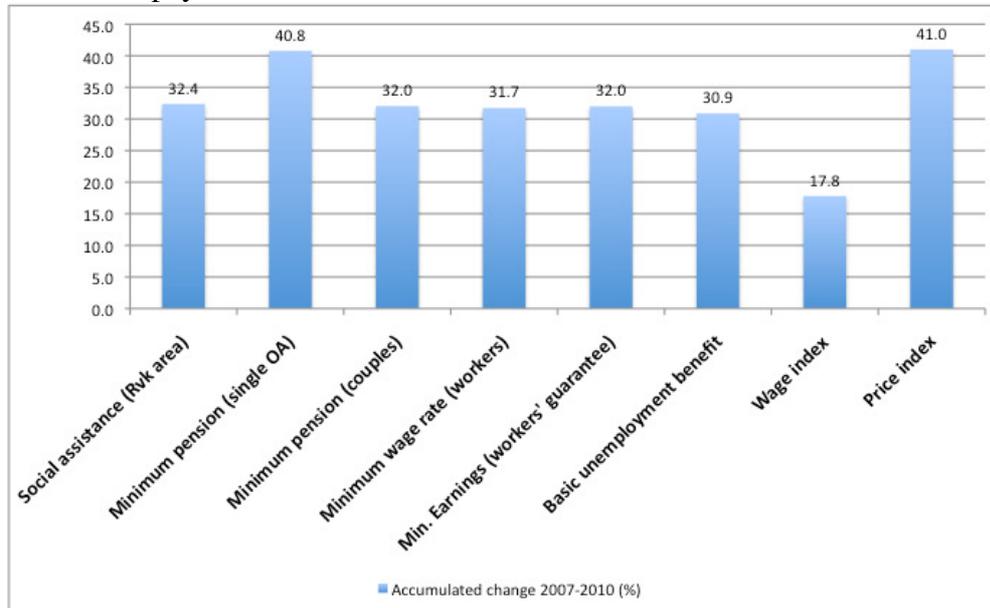
Table 3: Real expenditures on main social protection benefits and transfers - Per capita in thousands ISK, at 2008 price

	2006	2007	2008	2009
Expenditure on social protection	955.3	995.5	1019.8	1190.4
Social benefits, cash	457.3	483.7	499.7	625.3
Services	498	511.7	520.1	565.1
1.1 Cash benefits due to sickness	72.2	74.2	72.5	67.9
2.1 Cash benefits due to disability	96.7	96.1	105.2	131
2.1 Cash benefits to elderly persons	190.9	203.1	204.5	228
2.1 Cash benefits to families and children	59.3	65	66.4	74.1
2.1 Cash benefits to unemployed persons	9.8	9.3	15.1	78.7
6.2 Services to unemployed persons	1.7	1.8	1.9	1.8
7. Housing	29	28.2	31.4	45.8
8. Social exclusion n.e.c.	23.2	27.1	26.1	33.8
8.1 Cash benefits due to social exclusion	10	11.8	12.6	17
9. Other social protection n.e.c.	9.9	11.5	10.5	11.8

Source: Statistics Iceland

As the Table shows it was only in the area of sickness benefits that real expenditures decreased in 2009, other types of benefits got more money than in previous years and of course the expenditures on unemployment benefits increased eightfold from 2007. Expenditures on services increased less than benefits.

Figure 3: How low-income pensioners were protected during the crisis (2008-2010) - Comparison of nominal increases of minimum pensions, average and minimum pay and social assistance benefits



Source: Social Security Administration; Reykjavik City Welfare Services and Federation of Labour (ASÍ).

Another important feature of the adjustments to the crisis in Iceland is reflected in Figure 3. There we see that the goal that government set itself of sheltering the lower income groups against consequences of the crisis has been at least partly achieved. The columns stand for accumulated percentage changes of the nominal value of the benefits, pay, social assistance and prices. The message is that the minimum pension guarantee for a single pensioner, which was raised by 20% on the 1st of January 2009 has increased about as much as the price index in the period, so it had maintained its purchasing power at the time of great reductions of purchasing power for most in the society (Statistics Iceland 2010; Andersen et al. forthcoming). Pensioners with average and higher pension earnings lost however significant purchasing power. Social Assistance, the basic unemployment benefit and minimum pay in the labour market increased a little less (32% as against 41%), but that is still significantly higher than the increase of the general wage index with 17.8% increase (which measures average wage changes in the labour market as a whole). So this data clearly indicates that low-income earning pensioners, the unemployed and the working poor have been sheltered to some extent in the crisis. Analysis of tax data also shows that total real earnings, before and after taxes and benefits, reduced less amongst the lowest 10% of households between 2008 and 2009, while the reduced earnings were the largest amongst the highest income groups (Kristjánsson and Ólafsson 2010).

Table 4 shows a decisive change in one feature that touches on a number of issues, namely the increase in the number of new disability pensioners. As mentioned above there were great and growing concerns about the increasing number of disability pensioners from early 1990s. Studies by Thorlacius et al. (2008 and 2010; also Hannesdóttir et al. 2010) showed that there was a statistically significant relationship between unemployment levels and the incidence rate of disability pensioners. When unemployment increased significantly the incidence rate would go up, often with a one-year time lag. This applied to the period running up to 2007. Thus one might have expected that the great increase in the unemployment level in 2009 and 2010 would have resulted in a great increase in the number of new disability pensioners. As

the Table shows this has not happened, at least not to date. In 2010 the growth was at an all time low for the years after 1990.

Table 4: Changing number of disability pension receivers, 1990-2010

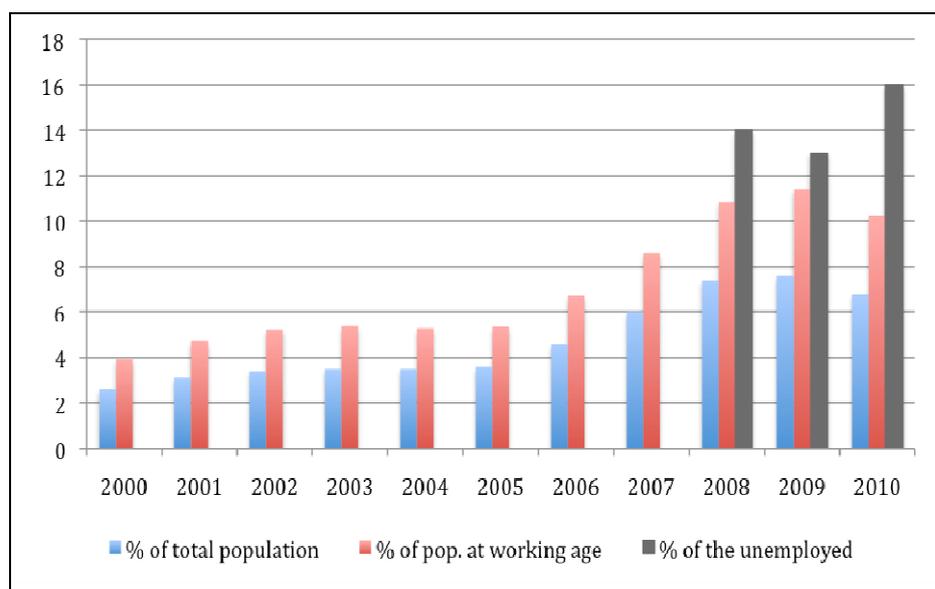
	Invalidity and rehabilitation pensioners, plus invalidity allowance recipients (% of pop. 16-66)	% change from previous year
1990	3.9%	4.8
1991	4.1%	5.8
1992	4.2%	4.2
1993	4.5%	8.4
1994	4.8%	7.1
1995	5.1%	7.7
1996	5.4%	5.6
1997	5.5%	2.8
1998	5.5%	2.5
1999	5.6%	2.7
2000	5.8%	4.9
2001	6.0%	5.1
2002	6.2%	4.3
2003	6.6%	7.5
2004	7.0%	7.9
2005	7.2%	6.3
2006	7.2%	3.4
2007	7.1%	2.5
2008	7.4%	4.4
2009	7.7%	3.6
2010	7.7%	0.3

Source: Social Security Administration (www.tr.is and direct contact).

The main reasons for this are probably related to the great awareness within the public administration about the risks involved. This spurred greatly increased emphasis on activation measures and rehabilitation, as mentioned above, and within the Social Security Administration procedures for disability/capability assessments were changed so as to channel applicants to a greater extent into rehabilitation and activation (Pálsdóttir et al. 2009). All of these measures seem to have been quite successful.

Risks of social exclusion: The unemployment rate increased most markedly amongst younger labourers so elder labourers are not in a greatly changed situation in the labour market (Halldórsdóttir et al. 2009; Andersen et al. 2011 forthcoming). As shown in previous asisp reports there are effective incentives for late retirement in Iceland and I do not see that as changing greatly as a consequence of the crisis (Nielsen and Nielsen 2009). Foreign labourers, whose numbers increased in Iceland greatly in the years leading up to the crisis, are however decisive candidates for risks of social exclusion, as Figure 4 indicates.

Figure 4: Immigrants as a proportion of the registered unemployed 2008-2010



Sources: Directorate of Labour and Statistics Iceland

There we see that the unemployment rate amongst immigrants has been significantly higher in 2008-2010, despite the fact that many immigrants have emigrated again, or about a fifth of those who came in the last 5 years before the crisis (Andersen et al. 2011 forthcoming).

The OPFs are despite the loss of assets sustainable for the future. They have their actuarial tests regularly done to assess their sustainability and adjust their benefits payments if needed. The biggest fall in assets came with the financial collapse of the banks in autumn of 2008 but already in 2009 the rate of return on their foreign assets was favourable. So one should not expect any decisive changes in the foundation of the funded parts of the pension system (cf. <http://www.ll.is/>).

The system is also very effective in averting poverty amongst old-age pensioners, as evidenced by figures from EU-SILC surveys, which continually show Iceland with one of the lowest poverty rates amongst the elderly (Statistics Iceland 2009 and 2010).

2.2.5 Critical assessment of reforms, discussions and research carried out

On the whole we can say that the adjustment of Icelandic society to the crisis has been greatly facilitated by the effective application of the social protection system, as we have shown in previous sections. In fact the success is all the more spectacular given the extremely poor state of public finances. This is in effect born out by the data in Table 5 showing subjective measures of financial hardships, derived from EU_SILC surveys for 2004 through 2010.

Here we see a good summary of the consequences of the crisis on the financial hardships of Icelandic households in the context of the years before the collapse. While hardships were generally going down in the years at the height of the bubble economy (2005-7), and while they were obviously increasing with the onset of the crisis, the outstanding feature is though that the level of hardships in 2009 was not much higher than in 2004.

Table 5: Financial hardships in Iceland 2004 through 2010 - % of households reporting different types of hardships (EU-SILC surveys)

	2004	2005	2006	2007	2008	2009	2010
Arrears on mortgage or rent payments	9.4	8	5.7	5.8	5.5	7.1	10.1
Housing cost is a heavy burden	12.4	11.6	9.9	9.6	11.8	15	16.5
Arrears on other loans	10.7	7.9	5.8	8.4	5.5	10.3	13.3
Payments of other loans is a heavy burden	9.7	9.7	7.6	11.5	10.3	15.5	19.2
Unable to meet unexpected expenses	36.1	38	31.9	29.8	26.9	29.8	35.9
Difficult to make ends meet	46.2	36.8	34.8	28.4	30.1	39	49.3
Very difficult to make ends meet	9.7	6.9	5.8	5.6	5.9	8.2	13.6

Source: Statistics Iceland 2010

Hardships increased again in 2010, in some cases only just above the level of 2004. This shows that the strategy of sheltering the lower income sections of the society has been successful, whereas in 2004 the lower income groups had lagged behind all others, both due to pension and other benefits lagging behind but also due to increased tax burden of lower income groups in the years from 1995 to 2004.

So on the whole the strategy of sheltering lower and middle groups has been important and it may also have played an important role in maintaining consumer demand in the recession environment, thus softening the macro-economic consequences of the crisis.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Prevailing legislation on health care in Iceland, from 2007, states the following aim for the population: "...all citizens should have available to them, the greatest quality health care services that is possible to provide them with at any given time, to protect their psychological, physical and social health" (Althingi, law 2007 no. 40, 27 March). This goal is to be attained irrespective of people's financial situation or residence.

The Icelandic health care system is primarily publicly funded, administered and supervised. Hospitals are mainly state operated and most health care personnel are employed by the state. The Ministry of Health, now the Ministry of Welfare (see Appendix I) has the administrative responsibility for the overall system and the Directorate of Health has the main supervisory role, according to a new law from the 1st of September 2007. The latter now has overall responsibility for supervision of health institutions, health care personnel, prescription of pharmaceutical products, measures for combating substance abuse and quality promotion of all public health services. There is also a special supervisory authority for medicines control and a supervisory commission dealing with prices of medicines. (Ministry of Health homepage- www.heilbrigdisraduneyti.is; also NOMOSKO, 2009).

Despite the large public role in the health care sector in Iceland there is a significant private sector operated alongside the public sector, but this sector is also to a great extent publicly financed. The main aspects of the private practice are specialist services, some health care centres, physiotherapists, occupational therapists, psychologists, all dentists and some nursing homes and old peoples' homes (most often run by not-for-profit voluntary or social organisations). User fees are generally applicable in the private parts of the service provisions. Thus nursing homes and old peoples' homes are partly financed by user charges and partly by the public authorities.

The Icelandic health care system can thus be classified as following the Scandinavian health care systems, with a large role for government and mainly financed by taxation. The Icelandic system does however have its own characteristics (Magnussen, Vrangbaek and Saltman 2009). The main ones are more centralisation in its governance structure, management, regulation, implementation and financing (Ásgeirsdóttir 2009). The roles of local authorities are very small indeed. In that sense one can say that Iceland as a whole is to some extent comparable to a single local health area in the other Nordic nations, that have large roles in governing and delivering health care services. Due to its relatively small population Iceland thus lacks the intermediate local administrative structure in the health care system (Ólafsson et al. 2010).

Health care centres are responsible for primary health services, preventive services (including child health care, maternity care, school health care, immunisation and family planning). The private physicians and specialists generally work according to a contract, previously to the state Social Security Institute (SSI), but since 2009 with a new institution, Sickness Insurance of Iceland (SÍ), which subsidises the cost. Hospitals also provide out-patient services. In general no referral is needed for use of specialists' services so GPs are not effective as gate-keepers in the operation of the services. Still the prevailing law assumes that the primary health care service should be the first stop in the system for patients. There are though no general penalties or significantly higher fees for directly seeking services of a self-employed specialist. Health care centres also provide home nursing services but home help services (for the elderly and long-term sick) are provided by local municipalities' social services. There are measures now being undertaken to join together administration of home nursing and home help at the level of municipalities (Sigurðardóttir 2008).

There is now one major high-tech university hospital in Iceland serving the country (Landsspítali – Háskólasjúkrahús), a teaching hospital in Akureyri (the biggest municipality in the Northern part of the country) and lastly a few smaller local hospitals, some operated partly as nursing homes for the elderly. In some cases these local hospitals have facilities for some minor operations and facilities for birth and maternity care.

Pharmacies are privately run and freer from public control than seems to be the case in Denmark, Norway and Sweden (NOMOSKO 2009, Ólafsson 2008a).

The Icelandic health care system has for a number of years ranked with the more costly ones in Europe, as a proportion of GDP. In 2006 it consumed about 9.6% of GDP when the OECD average was 9.0%. In 2007 the expenditures were 9.3% as against 8.9% average for OECD countries (OECD 2009), putting Iceland in 12th place on the OECD list of relative health expenditures. In recent years it has typically come second to the Norwegian one as regards costs in the Nordic community. This is somewhat surprising given that the Icelandic population is relatively young compared to the other Nordic and European societies. With a smaller proportion of elderly people health expenditures should be smaller in Iceland, all else being equal.

OECD has voiced the opinion that while the Icelandic health care system delivers very high quality service levels by international standards it in some cases does so at too high cost, thus lacking in efficiency and incentives for using less costly available means (OECD 2008b; Suppanz 2008).

The main reasons for the relatively high cost of the Icelandic health care system are a high level of services, high prices of medicines and extensive use of specialist physicians (due to lack of gate-keeping for the use of their services). Maintaining a high level of health care services in the more sparsely populated areas of the country is also relatively expensive. Icelandic physicians are also said to be prone to subscribe new and more expensive medications to a greater extent than what is typical in the neighbouring countries (OECD 2009, NOMOSKO, 2009; Ólafsson, 2008a).

The main health care reforms undertaken in 2010-11:

- Provision for free dentist services for children of low income parents (26.04.11) (previously there was only a subsidy)
- Public cost of medication lowered by 11% in 2010 (07.04.11)
- Recommendations for new organisation of provision of specialist medical services (18.03.11)
- Merging of St. Joseph's hospital in Hafnafjordur (private) to the National University Hospital (31.01.11)
- New Ministry of Welfare starts its operations (merged from Ministry of Health and Ministry of Social Affairs) (01.01.11)
- Merging of Directorate of Health and Public Health Institute decided (12.11.10) – takes effect in the spring of 2011.
- Design plan for construction of New National Hospital in Reykjavik announced (08.07.10)

Other reforms are more piecemeal in character. Given the financial constraints associated to the financial crisis there has not been much scope for costly reforms. The operations of the health care systems have primarily been directed at sailing through the regular tasks as well as possible without sacrificing any of the good standard that has prevailed for a long time. This situation has also shaped the debates and political discourse to a great extent (Jónsson 2011; Vilhjálmsón 2007).

2.3.2 Debates and political discourse

The main issues for debates and political discourse during the last year or so have been the following:

- The cuts in expenditures in the health sector, both in the Reykjavík area and in provincial areas
- Merging of institutions
- Weak position of general practitioners (ageing, staffing problems, weak position within the system)
- Fear of medical brain drain
- Poor dental health of children
- High cost of medication and increased user fees

Again, the cuts are the key issue in health just as in the realm of pensions and benefits. The cuts now in the crisis are affected by the fact that cost cutting has been a persistent goal within

the health care system for many years prior to the crisis (Gunnlaugsdóttir et al. 2009). This surfaced because in the early 2000s the overall cost of the Icelandic health care system was amongst the highest in OECD and EU countries, measured as a % of GDP. Merging of hospitals was implemented along with various rationalisation measures, year after year leading up to the crisis. Thus when the crisis hit the requirement for cutting expenditures on health came on top of an already long-term effort to that end. Iceland had by 2008 already achieved some success in reducing health care costs (OECD 2009), which put the country closer to the OECD average. Thus the cuts made life quite difficult in the health care sector indeed.

In the summer and latter part of 2010, when the budget for 2011 had been introduced, a very strong opposition arose against health care expenditure cuts in the provincial areas. This should be considered in the context of the small-scale communities prevailing in many provincial areas. In such societal settings the health care centres and local hospitals have a very important role, not just as providers of health care but also as employers of educated personnel. Such jobs are often in short supply in the small communities and reduction in their numbers has an importance for the community beyond the health care sector and can to some extent stimulate emigration and erode the foundation of the fragile communities. Such communities also have rather strong voices representing them in the political system (like in parliament) and this opposition to the planned health care cuts became very noisy and in the end effective. It even dawned on some that perhaps it might be easier to raise taxes than to cut some highly valued public services. This situation led to reconsideration of the budget on behalf of government, reducing the proposed cuts, especially in the provincial areas. Still there were cuts deemed inevitable, not least because of the very large share of public expenditures that health care constitutes.

Another issue of considerable concerns has related to merging of institutions, especially in the hospital sector (Heimisdóttir et al. 2009; Sigurgeirsdóttir 2005). More has though been said about that than done. Still some mergers have been effected, like the merging of St. Joseps Hospital with the National University Hospital (Landsspítali). There has also been some merging of health care authorities in the provincial areas as well as reorganisations in the Reykjavik area. The former Minister of Health started work on redefining the administrative institutions of the public health care sector, with plans to merge institutions and rationalise (Ólafsson et al. 2010). This ended with the plan to merge the Directorate of Health with the Public Health Institute that is taking effect these days (May the first 2011). The idea there was to create synergies and utilise resources better. This is relevant since the Icelandic administrative environment is often thought to have rather many institutions, considering the small size of the population. Hence many of them are small and hence at times weak.

A continuing concern has been the situation of General Practitioners within the Icelandic health care system. Icelandic health care law prescribes that the local health care centres shall be the first stop for users within the system. Still there is no gate-keeping function for them nor effective incentives for not using specialist services, without stopping over at the GPs. This is responsible for the rather large and costly role that specialist physicians have in the Icelandic system. Another consequence of this is now becoming ever clearer. The situation has weakened the GPs' status to the extent that there has for some time been insufficient recruitment into those positions. The average age of practitioners has gone up and the GP's occupational class seems to be heading for a crisis (Directorate of Health 2010). Low status and lower earnings are thus eating at the foundations of this important group, and that affects the access for the general population to general family health care.

During the crisis there has been considerable talk about a risk of medical brain drain, mainly affecting doctors and nurses. The interest organisations of these medical groups have been

very outspoken about this and warned against the consequences of such a presumed loss. It is also frequently mentioned that new Icelandic doctors who finish their studies abroad are returning to Iceland to a lesser extent than before. This debate has caused some concern both within the health care sector and in the community in general (Jónsson 2011).

Poor dental health of children, in comparison to the neighbouring societies in the Nordic countries and the UK has been a concern, as we pointed out in last year's report. This concern has grown in the crisis and particularly as regards the situation of low-income families. This is important since public subsidies of dental cost are significantly less generous in Iceland and that has meant that those facing financial hardships delay regular maintenance and repair. This has prompted the present government to implement a new provision, taking effect these days, for a free dental servicing for children of low-income families. This is thought to be particularly important for unemployed immigrant labourers' families, as well as for other low-income families.

Lastly with reduced purchasing power of most people in the crisis situation there has been a growing concern about rising costs of medication and for provision of some health care services, where out-of pocket expenditures are involved. This has at times been directed at the unemployed but other low-income families and pensioners are also a cause for concern regarding this issue. In the media this is at times related to fear of increasing tendencies for such groups to not seek the medication or services they actually need.

In the following sections we analyse further the situation regarding these issues and other related factors.

2.3.3 Impact of EU social policies on the national level

It is difficult to point out significant impacts of EU social policies on the Icelandic health care system, for the same reasons that were outlined regarding the pensions.

2.3.4 Impact assessment

The biggest issue has of course been the expenditures cuts and their effects. Let us analyse their features closer and assess their effects and consequences. Table 6 has the basic figures on overall expenditures, disaggregated by government expenditures and household direct expenditures, expenditures as proportions of GDP and in real figures, including per capita expenditures at constant prices.

Table 6: Public and private expenditures on health care 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Government expenditure on health care, % of Gross Domestic Product	7.7	7.56	8.31	8.48	8.04	7.68	7.48	7.5	7.53	7.92	7.51
Household expenditure on health care, % of Gross Domestic Product	1.8	1.78	1.84	1.9	1.86	1.76	1.65	1.59	1.59	1.74	1.81
Total expenditure on health care, % of Gross Domestic Product	9.5	9.34	10.15	10.38	9.89	9.43	9.13	9.09	9.12	9.66	9.32
Government expenditure on health care as % of total government expenditure	20	19.25	20.32	20.12	19.81	19.83	19.47	19.17	18.19	16.52	16.54
Household expenditure on health care as % of total expenditure on health care	18.95	19.04	18.11	18.33	18.79	18.64	18.05	17.49	17.4	18.01	19.46
Government expenditure on health care at constant prices	102687	104962	112812	114098	114717	115596	118034	124237	127510	122946	115596
Household expenditure on health care at constant prices	22226	23033	23410	23657	24021	24273	24946	26054	27600	27238	27939
Total expenditure on health care at constant prices	124913	127995	136222	137754	138738	139869	142980	150291	155109	150184	143535
Total expenditure on health care per capita at constant prices	444.3	449	473.7	476.2	474.2	472.7	469.8	482.6	485.7	470.4	451.4

Source: Statistics Iceland

As the data in the Table reveal the health care expenditures took the largest part of GDP in 2002-2004, topping at 8.48% in 2003. Since then the share came down to 7.5% in 2006-7. In 2009 the share was slightly raised, due to the contraction of GDP, but came down to 7.5 again in 2010. So the overall share has maintained its pre-crisis level, but remembers that the GDP has come down by some 10% in 2009 and 2010 together. The cuts in real money are significant, yet not devastating. The household share, as % of GDP, was highest in 2003 at 1.9 (the highest in the Nordic countries at that time (cf. Ólafsson 2008a), but came down as GDP expanded to 1.59 in 2007-8 and then increased to 1.74 in 2009 and 1.81 in 2010, a significant increase. The pattern of overall expenditure shares is similar, the top was in 2003 at 10.38 (one of the highest in Europe) and the share lowered to 9.09 in 2007, went up in 2009 but came down to 9.32 in 2010. The 2010 level is still higher that it was in the years before 2006. So the share of the GDP has not collapsed at all, but given the large contraction of GDP real expenditures have been decisive and caused increased burdens.

The overall real expenditures figures, at constant prices, are in the lower part of the Table. If we focus on the situation in 2010 we can say that the level of government real expenditures is then similar to what it was in 2005, but decisively lower than in 2007. The household real expenditures are now similar to the 2008 figures, but paid out of household budgets that have had their purchasing power of earnings reduced by some 15% altogether in 2009 and 2010. So the expenditures are a significantly larger share of household earnings. Total expenditures per capita in real prices were highest in 2007, at the height at the bubble economy, but in 2010 they have come down to a level just above what it was in 2001. This larger relative setback in the per capita figures is also explained by increased emigration in 2009 and 2010, when some 2% of the overall population was lost to the neighbouring countries, mainly Norway. Just under a half of those emigrating were foreign labourers (Andersen, Hougaard and Ólafsson 2011, forthcoming). So the burden of financing the expenditures is also falling on fewer shoulders than before the crisis.

Table 7: Expenditures on health care services: per capita in fixed 2008 prices

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
1 Medical products, applicances and equip.	72.8	72.7	74.3	76.9	78	74	73.9	75.1	82.5	84.1	81.2
11 Pharmaceutical products	56.3	55.1	56.1	57	58.3	53.1	52.1	52.5	60.2	61.4	58
12 Other medical products	16.4	17.5	18.2	19.9	19.6	20.9	21.8	22.7	22.3	22.8	23.2
2 Outpatient services	106.2	108.1	109.4	113.8	116.4	115.4	116.1	117.3	118.7	115	111
21 General and special medical services	60.3	62.4	63.9	66.6	66.9	66.4	67.2	68.7	70.6	68.3	64
23 Dental services	29.7	29.2	28.7	29.1	29.2	29.1	28.5	28.2	27.9	27.4	27.6
24 Paramedical services	16.2	16.5	16.9	18.1	20.3	19.9	20.4	20.4	20.2	19.3	19.4
3 Hospital services	253.1	256.8	275.1	271.1	267	269.4	267.9	276.5	271.8	258.1	246.3
4 Public health services	2.4	2.4	2.4	2.4	2.6	3	2.5	3.1	2.6	2.5	2.4
5 Health n.e.c.	9.8	9.1	12.4	12	10.2	10,9	9.4	10.6	10.1	10.4	10.2
Total health expenditure	444.3	449	473.7	476.2	474.2	472.7	469.8	482.6	485.7	470.1	451.1

Source: Statistics Iceland

Looking more closely at where in the health care sector the real cuts have fallen the hardest, in Table 7, we see that per capita real expenditures on hospital services have come down decisively (by about 11%) from 2007 and those are also by far the largest sums. So this has been the most important health factor in reducing the overall public deficit. It is at the same time interesting that the real expenditures on medical products (pharmaceuticals and other products) have increased decisively, and that is both in real values and as proportions of GDP (see Table 2 above). These are mainly imported and given the collapse of the Icelandic Krona the values of these imports have increased, even though there has been a great move from more expensive to less expensive medications and investments in medical equipments have been greatly reduced in quantity. So many effects are at work in producing the overall outcome.

It is thus clear that a very heavy burden has fallen on the hospital services and that came on top of persistent attempts in the last decade to restrain expenditures (with some significant successes). In the light of that it is interesting to ask how services have been affected? In last years report we showed that waiting lists for many hospital operations had in fact shortened in

2009. That was quite an achievement and a tribute to administrators and staff. New figures from the Directorate of Health on waiting lists in 2010 show however a lengthening in some cases, most for hip and knee replacements (<http://www.landlaeknir.is/pages/915>), as well as for some other types of operations. Emergency operations do however not have waiting lists and emergency room services seem to be coping. In some cases there is an increased number of operations (such as *cataract surgeries* and *heart-related operations*) and in others there are fewer operations (for example *prosthetic replacement of hip joint*). So there seems to be more selectivity in operations. Formal complaints to the Directorate for Health regarding insufficient services or mistakes in the health care services were 252 in 2010 as against 237 in 2009 (<http://www.landlaeknir.is/>). So these indicators give no decisive signs of significant deterioration of the quality of services so far.

On the whole we can say that the Icelandic health care system is universal in terms of rights and that has not changed during the crisis. There has not been undertaken any significant survey of inequalities in access to the services in 2010. Planned cuts in the provincial areas were thought to involve increased inequalities in access to services, since there were plans for increasing transportation of patients between regions as levels of local services would be reduced. These plans were scaled back as mentioned above, but some such effects may be felt, but in most cases involving lower risk areas.

Fear of brain drain in the main medical occupations has been frequently voiced, not least by the respective interest organisations. While Iceland has had a rather high ratio of medical personnel per capita (cf. asisp report from last 2 years) there would seem to have been some room for reducing numbers without threatening volume and quality of services. Incentives for doctors to take up part-time jobs in the neighbouring Scandinavian countries (where many of them are educated in the first place, especially specialists), not least due to the collapse of the Icelandic Krona. That means that the purchasing power of earnings from abroad has greatly increased since 2008. This feature has no doubt increased (for example specialists work a part of each month in some of the neighbouring countries) and some recently graduated from foreign medical schools may have delayed their return to Iceland. Anyway recent figures from the Directorate of Health indicate a minor reduction in the numbers of employed staff. There are some reductions in the numbers of GPs and nurses but physicians are at a similar level as in 2008, which was at a high level compared to previous years (<http://www.landlaeknir.is/pages/961>). So talk of possible brain drain seems to date to be somewhat overstated.

The weak position of GPs is still an unsolved issue. The Ministry of Welfare commissioned a task force last year to provide recommendations to improve issues of division of labour within the health care services. This task force delivered its report by mid March this year, with various suggestions for improvements. The issue of strengthening the position of GPs is however it seems mostly unsolved and no direct recommendation is given for an increased screening role for them as operators of the first stop for patients in the service system, with increased emphasis on screening and references for use of specialist services. There are however suggestions for using more electronic registration systems facilitating cooperation between various sectors of the system, including between GPs and specialists. There are most likely some issues of entrenched interests and power also involved in this issue.

Lastly in this section we mention some aspects of the increased user fees in the Icelandic health care system. It is interesting that while the overall level of user fees has gone up (for medical products, pharmaceuticals, and for services) the user fees for hospital services has not significantly gone up (cf. Table 2 above). Private expenditures on outpatient services have however gone up in 2009 and 2010. In some cases patients have reduced their use of services as prices have gone up, such as in dentistry. But as mentioned above the government in early

2011 specifically addressed the fear of worsening dental health status of children from low-income families. Those groups are most likely to be seriously affected in the present situation.

The general form of user fees payments in the Icelandic health care sector is such: "...the maximum user charge payable for out-patient treatment at hospitals in the primary health-care sector and at specialists' is ISK 21 000 per year for people in the age group 18-66 years and ISK 7 000 for children under 18 years. For pensioners between 67 and 69 years receiving full basic pension, and for pensioners 70 years old or more, (for those) who draw disability pension, and for people, who have been unemployed for more than six months, the maximum user charge payable is ISK 5 200. When a patient has been paid the maximum amount, s/he only has to pay one-third of the rates. There are also special rules governing payment for physiotherapy, occupational therapy and other therapeutic treatment" (Nososko 2010, pp. 126-7). Unlike in some of the other Nordic countries there is only a discount in Iceland rather than a free access once the roof is reached (Ólafsson 2008a).

2.3.5 Critical assessment of reforms, discussions and research carried out

On the whole it appears that while the health care sector has been heavily affected by cuts in expenditures in 2009 and 2010 the system as a whole has stood up to the test in most respects. Deliveries and qualities of services seem to have been mostly maintained and that is in the context of a service standard which prior to the crisis was at a very high level. The universality of rights to services has been maintained and equitable standards maintained, but user fees have clearly gone up and these are born by households that have generally faced severe reductions in their purchasing power, in the region of 15% net to date (real wages have gone down by some 10% but higher taxes and lower perks and overtime have added to the effects of lower real wages (cf. Andersen, Hougaard and Ólafsson 2011).

Some merging of institutions has been effected and improved division of labour, but more could have been done on that front. The political environment has however been very difficult, with the load on government and specific ministries unusually high. The merging of the Ministry of Health to the Ministry of Social Affairs into a new Ministry of Welfare has no doubt delayed further activities in implementing rationalisations in the institutional structure of the welfare sector. But a part of the rationale for creating the new ministry was to make such rationalisations and merging of institutions easier as well as to utilise resources better across the board. We might therefore expect more rationalisation initiatives and mergers in the next few years.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

In Iceland the care services for the frail elderly and disabled or long-term sick are collectively the responsibility of government, local authorities and third sector voluntary organisations (mainly not-for-profit). Governments primarily finance the services (both at central and local level), but also for the third sector organisations, which frequently receive contracts with government payments of operational costs, such as charges on a per bed/person per day basis). Voluntary organisations of individuals from particular disease groups and the organisations of the disabled are particularly active in such activities that provide services to their members (see for example www.obi.is; www.saa.is; www.sjalfsbjorg.is). Many service homes for the elderly are also of this type, reflecting a very healthy relationship between government, local authorities and the civil society voluntary sector in the provision of welfare services (www.hrafnista.is; www.eir.is; www.grund.is; <http://www.island.is/efri-arin/busetumal/hjukrunarheimili-umsokn>). This form has the added benefit of often producing

employment opportunities for people with handicaps. In addition to these formal services significant informal services are also provided by relatives and neighbour, which make a difference in a tightly knit small-scale society, such as the Icelandic one is (Egilsdóttir and Sigurðardóttir 2009; Sigurðardóttir 2010).

The legislation that shaped the structure of present long-term-care system in Iceland dates from 1983 but with the transfer of responsibility for the issues relating to the elderly and disabled from the Ministry of Health to the Ministry of Social Affairs, effective from January 1st 2008, a new basis for reorganisation was laid, as well as a policy shift from medical consideration to more social emphasis in shaping policies for these groups (Sigurðardóttir 2008 and Guðmundsson and Sigurðardóttir 2009). From then on all services to the elderly should be defined and operated as local services under the supervision of local authorities. A main goal would be to make it possible for the elderly to reside in their own accommodation for as long as possible. The new form should be fully implemented no later than 2012 (Sigurðardóttir 2008). The state would continue to define policies and supervise that the operations are in accordance with law and stated aims. This responsibility has now been transferred to the new Ministry of Welfare from 1st January 2011 (see Appendix I for an account of the new ministry).

Table 8: Elderly living in institutions, service housing or receiving home help in 2008-9

	Denmark	Finland	Iceland	Norway	Sweden
Age:	People 65 or older living in institutions or service housing				
65-74	1.2	1.5	1.5	2.2	1.2
75-79	3.5	4.1	5.6	6.1	4.2
80+ years	13.9	14.1	22.6	23.9	16.6
Total 65/67+	4.9	5.4	8.2	9.7	6.4
	People 65 or older receiving home help				
Total 65+ years	17.6	6.3	20.1	10.8	9.2

Source: *Social tryghed de nordiske lande 2010, 160-161*

Denmark: Includes residents in nursing homes, sheltered housing, housing where care is provided as well as long-term stays in housing units. 2. Norway: Age groups 67-74, 75-79 and 80+ years. 3. Sweden: Update as per 1 October 2006. The age group 65+ years furthermore includes people staying on a short-term basis as well as residents in service housing.

Figures for Denmark and Iceland 2009, others 2008.

Iceland has for some years had the reputation in the Nordic community of having relatively large number of long-term-care beds in institutions, as well as providing home help to a great extent in comparative terms (see Table 8).

This is somewhat surprising given that the demographic composition of the Icelandic nation is such that it has a lower proportion of people at ages above 65, and the numbers of disabled people under 65 are not significantly larger in Iceland either. In some cases this ample supply of places in institutions can be related to the operations of local hospitals in the provincial areas. These and residential and service homes for the elderly were possibly built beyond a well defined need in earlier decades, partly for regional policy reasons, particularly at the time when central government carried larger share of the costs.

However it is particularly interesting that Iceland has by far the highest proportion of elderly people receiving home help, equally amongst the Nordic and EU countries (Fujisawa and Colombo 2009). That has been the major policy goal in recent years, to reduce the number of people living in institutions and increasing the possibilities for people to stay as long as possible in private homes (the ratio of home ownership amongst elderly Icelanders is very

high (Ólafsson and Jóhannesson 2007). Norway has a similar rate of elderly individuals living in institutions or service housing but a lower rate for home help, whereas Denmark comes second to Iceland in that category.

In Table 9 we see the development of the main forms of care taking from 2000 to 2010. By far the largest numbers of beds are in nursing homes and they have been increasing in numbers through the last decade (by 34% from 2000 to 2010). On the other hand beds in retirement homes are declining in numbers, almost by a half in the decade. So that is the transition that is taking place, since these are the two largest categories. Nursing beds in hospitals have come down by almost a half but beds in geriatric wards have remained at a similar level through the decade.

Table 9: Numbers of beds and places in retirement homes, nursing homes and wards, 1993-2010

	Beds and places, total	In retirement homes	In nursing homes	Nursing beds in hospitals	Beds in geriatric wards
2000	3265	1038	1653	432	142
2001	3226	1031	1666	381	148
2002	3232	927	1790	403	112
2003	3342	926	1894	394	128
2004	3402	890	2007	357	148
2005	3397	852	2046	332	167
2006	3458	816	2138	343	161
2007	3383	748	2179	299	157
2008	3461	658	2316	320	167
2009	3369	612	2315	278	164
2010	3125	542	2217	227	139

Source: Statistics Iceland

So while the long-term care sector of the Icelandic welfare system is significantly smaller than the pensions and health care sectors it is a fast growing sector with the ageing of society and rising levels of ambition for welfare services. Iceland seems to be at quite a high level in terms of volumes of services and facilities, as well as quality, of this sector (cf. OECD Health Data 2010; also Fujisawa and Colombo 2009).

2.4.2 Debates and political discourse

Main issues of debate in 2010 regarding long-term care are the following:

- Waiting lists for beds in nursing homes and lack of privacy (too much sharing of rooms)
- New construction of nursing homes as an example of economic stimulus activity in recession and more varied residential options for the elderly
- Changed form of payment for residence in nursing institutions
- Promotion of RAI evaluation system and EDEN ideology
- Promotion of user-directed personal assistance instead of institutionalisation (VIVE)

While nursing homes for the elderly or disabled have not been a major issue in public debate or political discussions they have had their place. Iceland is, as has emerged in previous reports, at a high level as regards provision of facilities in institutions for both the elderly and the disabled (under 65). The major concern, especially as regards the elderly, is still waiting

lists and access to such rooms and for some the greatest concern has though been lack of privacy in such homes, sine unrelated individuals frequently have to share rooms with strangers. This issue has had a persistent life in debates and pressure from interest groups.

The increased provision of beds/rooms in nursing homes has gained considerable goodwill in the crisis, not least because that goal has been aligned with the government's goal of stimulating economic activity. Thus in 2010 the government has already announced the initiation of new constructions of nursing homes and long-term care centers, both in the capital area and in many provincial areas. Hence the goal of improving the state of affairs in that field seems to be on a rather good tract at the moment, not least considering the poor state of government finances, but public-private cooperations and some financing from pension funds has facilitates these initiatives.

A continuing issue for complaints is the form of payment for stay in nursing homes. The prevailing form has been to let the individual's pension earnings cover the cost of the stay and care-taking but instead the social security system pays the individual a monthly allowance for extra expenditures. This has been criticised with growing force in recent years, not least with the claim that this form denies the individual financial independence. While the individuals in question in some cases are not able to conduct or manage their financial or other affairs, due to their illness, this is still a real issue for many concerned and there is a wide-ranging agreement that this form should be outdated and replaced with a new form of financing of the operations of these institutions which also allows the pensioners to have more control of his pension earnings. Both government (cf. policy initiative from 27th June 2008-Ministry of Welfare) and interest organisations of the elderly (www.leb.is) emphasise this goal.

While government has done considerable work in implementing increased quality assessments, such as the RAI evaluation system in care institutions in recent years, improving the quality of services is still a great concern amongst interest organisations, both for the elderly (www.leb.is) and the disabled (www.obi.is). The Directorate of Health has coordinated much work in implementing the RAI system, since a part of their role is to monitor the quality of services and standards in the health care and long-term care sectors (see www.landlaeknir.is; Aradóttir and Thorsteinsson 2009). They also coordinate the residential requirement assessment that provides entry for needy individuals into nursing homes (Guðmundsson and Sigurðardóttir 2009). The Federation of the elderly citizens (FEB) emphasises the EDEN ideology in its strategic plan for 2010-2011, which stresses that design and operations of care institutions places humanitarian and personal goals at the forefront.²

The promotion of user-directed personal assistance instead of institutionalisation has been gaining increased interest in Iceland in recent years, partly influenced by developments and experiences in the disability field in Denmark (www.vive.is). This form of services aims primarily to give individuals with severe forms of disability the opportunity to have personal assistance that makes it possible for them to take an active part in society instead of being institutionalised. This is presently a rather labour intensive form of services and costly as such, but it also saves large expenditures in operating of expensive specialised institutions and of course is much more valuable for the individuals that can benefit from such services. Some significant initiatives have been started in Iceland and there is growing talk of extending this provision to the elderly, since it corresponds to the prevailing goals there of facilitating the elderly to stay in their own homes for as long as possible with increased personal home help and related services from the local communities (Jóhannsdóttir and Haraldsdóttir 2010). This

² Cf. http://www.leb.is/index.php?option=com_content&view=article&id=137&Itemid=100011. See also the university site of disability studies at http://www.fotlunarfraedi.hi.is/notendastyrd_thjonusta_og_sjalfstaett_lif.

policy goal is an entrenched aspect of the common emphasis of both the federations for the elderly and the disabled that there should be “One society for all”.

2.4.3 Impact of EU social policies on the national level

It is difficult to point to significant direct impacts of EU social policies on the Icelandic health care system, for the same reasons that were outlined regarding the pensions and health. Many of the EU2020 goals for welfare have already been obtained in Iceland.

2.4.4 Impact assessment

We start by assessing how utilisation of long-term care services has been developing through the crisis, up to 2010, in Table 10 and 11. We see in Table 10 that the overall number of occupants has slowly declined (at the same time that there was a great transition from occupancy in retirement homes to occupancy in nursing homes).

In the capital region, where about 60% of the population resides, the % of people 65 and older that were living in such long-term care institutions went from 8.7% in 2004, when it was at its highest, down to 6.9% in the crisis years of 2009 and 2010. The trend is equally effective for males and females, while females have a larger proportion throughout, due to their higher longevity.

Table 10: Occupants of retirement homes and nursing homes and wards by sex and region (ages 65+) - Figures are for end of December each year.

	Capital region			Outside capital region		
	Males and females	Males	Females	Males and females	Males	Females
2000	7.8	6.2	8.9	12	9.5	14.5
2001	7.8	6.2	9	11.6	9.5	13.6
2002	8	6.3	9.2	11.2	9.1	13.1
2003	8	6.2	9.4	11.2	9.4	12.9
2004	8.7	6.9	10.2	11.3	9.5	13
2005	8.4	6.6	9.9	10.9	9.2	12.5
2006	8.1	6.1	9.5	10.8	8.9	12.5
2007	7.5	5.8	8.8	9.6	7.7	11.4
2008	7.5	5.5	9	9.5	7.8	11.2
2009	6.9	5	8.5	9.2	7.8	10.6
2010	6.9	5	8.4	8.5	6.9	10

Source: Statistics Iceland

Table 11: Occupants of retirement homes and nursing homes and wards by age (% of age group) - Figures as of end of December each year.

	Total	65-74 years	75-84 years	85 years and over
2000	8.9	1.8	11.8	39.2
2001	8.7	2.0	10.8	38.2
2002	8.7	1.7	10.7	38.7
2003	8.8	1.8	10.7	38.0
2004	9.2	1.9	10.9	39.5
2005	8.9	2.1	9.8	38.0
2006	8.5	1.4	9.2	38.8
2007	8.3	1.4	9.1	36.4
2008	8.3	1.5	9.0	35.9
2009	7.8	1.4	8.6	34.8
2010	7.5	1.4	8.1	33.2

Source: Statistics Iceland

The rates in the provincial areas are generally somewhat higher but the downward trend is the same, and in fact steeper, so the rates in the different regions have converged to some extent.

In Table 11 we see how the experience of the different age groups has changed in the last decade. The use of these long-term care institutions is very strongly related to age, with only a small proportion of the 65-74 year olds using them (1-2%) and maintaining a relatively stable rate throughout the decade. The 75-84 age group had a user rate in the region of 10-11% in the early 2000s and that came down to 9% before the crisis hit and then it went to 8.6% and ended at 8.1% in 2010.

The group of 85 and older is of course the largest user, having gone up to 39.5% in 2004, when it was highest. The rate for this group has also come down significantly, to about 36% before the crisis and in 2010 it ended at 33.2%. Rationalisation may thus have had an effect in speeding up the decline of occupancy, at the same time that home services were increased, but the effect of the crisis is small in the context of the longer-term trend.

In Table 12 we see the other side of the trend, the increase in the provision of home help.

Table 12: Number of households receiving home help from local municipalities, 2000-2009

	Total	Reykjavík	Capital reg. other	South- west	West	Westfjords	North- west	North- east	East	South
2000	6401	3319	813	339	310	150	149	710	210	402
2001	6771	3412	1010	322	290	140	175	700	259	462
2002	7044	3486	1112	330	275	140	192	770	222	516
2003	7319	3458	1163	369	304	151	187	810	298	578
2004	6846	3637	1211	399	303	144	226	229	237	460
2005	7496	3606	1265	403	296	160	204	839	220	503
2006	7532	3646	1271	406	320	149	179	843	238	481
2007	7626	3710	1290	405	346	131	158	906	237	443
2008	7864	3780	1339	439	335	148	158	951	220	494
2009	8060	3789	1468	431	355	163	170	933	220	531
% increase	25.9	14.2	80.6	27.1	14.5	8.7	14.1	31.4	4.8	32.1

Source: Statistics Iceland

The overall number of households receiving home help has increased in Iceland by 25.9% from 2000 to 2009. It increased less in Reykjavík, where it started on a larger scale earlier. In the other region of the Capital area the increase is however very large, since these have been catching up with Reykjavík. In the provincial areas the increase is slowest in the regions that have suffered from the greatest de-population in recent decades, i.e. the East and Westfjords, and the West and North West regions have had a stagnant population as well. The highest expansion rate outside the Capital area is in North East and South areas, which have the largest urban communities outside the Reykjavik area.

Development of day care facilities for the elderly (Table 13) is a relatively novel feature of the long-term care services and that has been expanding very rapidly in the last decade, sometimes from a very low level however.

There the pattern of expansion is similar to that for home help, except that in the North East region, where the Akureyri urban area is located. They seem to be lagging behind while some of the other provincial areas are getting a good swing in these services.

An interesting survey of the quality of services to the elderly was undertaken in January-February of 2010 by the Federation of elderly citizens (LEB) (available at www.leb.is). They sent questionnaires to all member organisations in Iceland with detailed questions about the various aspects of services to the elderly in their respective communities.

Table 13: Development of day care places for the elderly, by regions, 1993-2010

	Total	Reykjavik	Capital other	South-west	West	Westfjords	North-west	Northeast	East	South
2000	417	203	44	16	23	16	7	66	18	24
2001	424	203	44	16	23	16	7	66	24	24
2002	434	204	44	19	23	16	15	63	26	24
2003	460	203	63	22	24	16	20	59	26	27
2004	428	161	63	22	23	16	22	65	30	27
2005	442	161	83	24	25	16	22	60	24	27
2006	485	165	116	23	22	16	24	63	27	29
2007	503	181	116	26	28	16	21	56	29	30
2008	545	185	112	26	33	29	34	63	31	32
2009	580	215	112	31	33	27	34	63	28	37
2010	584	215	112	31	33	19	23	66	37	48
Change %	40.0	5.9	154.5	93.8	43.5	18.8	228.6	0.0	105.6	100.0

Source: Statistics Iceland

The results are that overall about 75% of respondents (i.e. those running the local interest groups for the elderly) say that the services in their community are “good” or “adequate” and the rest say the services are poor or absent. Nearly all say good or adequate about home services and general social services in the community, similarly a big majority rate the servicing of food to homes as good or adequate, and the same applies to access to leisure activities, physical training and social and cultural activity. That last aspect has improved significantly in the last 5 years, i.e from the time of the last comparable survey by the FEB. There are more complaints over inadequate assistance with shopping, transport services and day care facilities are felt lacking in about a half of the communities. Generally there is satisfaction with access to information and the cooperation with the local communities is generally felt to be good. These results have some commonality with the results from the national sample survey carried out amongst the elderly, which were reported in our asisp report for 2009.

2.4.5 Critical assessment of reforms, discussions and research carried out

In general the services situation for the elderly then seems to be relatively good in Iceland and to some extent comparable to what is found in the other Nordic countries. What is perhaps most lacking are more detailed evaluation studies of the various aspects of the services. While there is notable concern in Iceland that the need for long-term care services is set to increase greatly with demographic changes, there are lacking more formal studies of this and prognoses for planning need to be better founded.

The policy goals are ambitious and realistic, there are ample institutional facilities even though the quality of housing can be improved and that is being called for, both by interest groups and government. The identification of further construction of housing facilities for nursing homes as an economic stimulus in the present crisis situation is an unexpected bonus for the welfare goals in this area. There are continuous initiatives to improve and formal measures are in place to monitor quality of services and outcomes. Some aspects of the services are however relatively recent in they have been developed at differential speeds in the various communities of the country, with the Capital area in general having a good position without at all being the only region with advanced standards.

Table 14: Care workers' work tasks in care institutions in the Nordic countries. New survey.

	Iceland	Denmark	Finland	Norway	Sweden
	%	%	%	%	%
Do the following task at least <i>once a week</i> :					
Clean a client's home	11.5	43.2	31.7	22.1	73.9
Prepare a meal	8.0	43.3	11.4	24.6	29.3
Serve ready meal	79.9	79.6	80.2	89.3	83.6
Shop for groceries	1.8	26.7	6.0	12.4	18.2
Assist with personal hygiene	88.6	98.5	98.2	99.1	99.7
Lift or assist in moving a person	84.1	94.9	94.7	89.9	95.8
Have a cup of coffee or tea with a client	61.8	80.3	26.2	74.7	61.2
Provide support of comfort to a client	88.5	94.3	97.4	98.1	96.5
Accompany a client on a walk	21.8	37.3	39.6	25.0	34.2
Do administrative tasks	15.3	61.4	79.0	49.9	75.6
<i>My work is most often planned in advanced</i>	82.2	85.9	79.0	80.6	78.4
Do the following tasks <i>at least monthly</i>					
Mobility or speech training/rehabilitation work	37.4	49.2	88.5	73.2	68.3
Hand out medicine from a dispenser	65.1	92.4	81.1	88.3	90.9
Give an injection	5.8	19.9	66.2	33.4	38.9
Set a client's hair, give a manicure or pedicure	73.9	69.3	89.0	80.5	77.7
Accompany a client on an errand outside home	13.7	26.5	23.2	29.0	39.5
Participate in recreational activity with client(s)	32.3	27.2	23.3	30.0	35.0
Get in touch with health care system	8.3	63.9	62.2	27.1	45.0
Contacted or was contacted by a client's relative	48.5	80.2	82.8	70.2	74.0

Source: Unpublished report on a survey amongst care workers in Iceland, with comparisons to similar surveys in the other Nordic countries (Center for Child and Family Issues, University of Iceland).

We have got access to data from a recent national survey amongst staff in care services for the elderly and the disabled in Iceland, yet unpublished. This is a survey that was undertaken as a part of an inter-Nordic research programme aiming at reassessing the adequacy of the Nordic Welfare Model (www.reassess.no), with representatives from all the Nordic countries. Standardised questionnaire surveys were carried in all the five countries, asking staff in care services about their background, their tasks, organisations of the services and interactions with the clients. This survey will be a source of important information for next year's asisp report.

Here we show just one table referring to a comparison of the tasks that the respective employees in the five countries undertake in their regular work. That gives an indication of

how the Icelandic system in long-term care institutions is advanced at this stage, in comparison to the other countries.

On the whole we see that the Icelandic care workers do less of most of the respective activities than do the care workers in the other countries. The deviation varies somewhat between tasks. Shopping for groceries for the clients is almost non-existent in Iceland, while 6-26% of care workers in the other countries do that.

The overall pattern then indicates that there may be an important difference between provision of various service features (“it is all there”) and the extent or volume of services and the degree of professionalism. The early indication is that while Iceland may be doing well in having most of the advanced service features it may still be slightly behind in developing the volume and quality of the services. This may be related to a rather later emergence of some of these services in Iceland than in the other countries as well as due to less advanced management and training of the care workers. We will have much more to say about that in future reports.

Appendix I: New Ministry of Welfare

The beginning of 2011 (January 1st) saw the establishment of a new Ministry of Welfare through the merger of two former ministries, the Ministry of Health and the Ministry of Social Affairs. Both were large ministries before merging. Consequently, this super ministry is now responsible for by far the largest part of public expenditures. The merger of the ministries was a part of a comprehensive reorganisation of the public administration aimed at rationalising and utilising resources better. As such, this policy is a part of the general reactions to the financial crisis and particularly difficult public finances. There are also plans for merging public institutions with the same rationalisation goals. An example the merger of the Directorate of Health and the Institute of Public Health into a new Directorate of Health and Welfare, which is currently being finalised. Other institutions are also under consideration for reorganisation.

Figure A1: Organisational chart of the new Ministry of Welfare

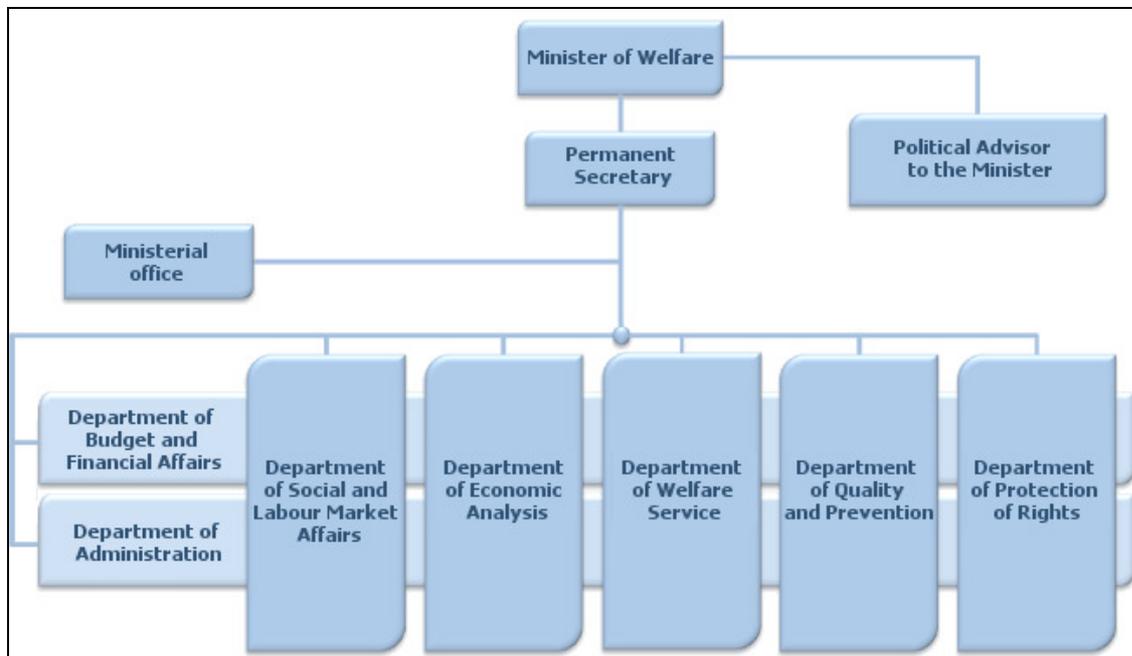


Figure A1 shows the present organisational structure of the Ministry of Welfare. The issues that primarily concern the labour market are unified under the Department of Social and Labour Market Affairs. A part of the ideology behind that structure is presumably the tenets of active social policy aimed at coordinating the social security policies better with activation policies. This is an issue of growing concern at a time of crisis when Icelandic unemployment has reached historical heights, even if it is not particularly high by international standards.

The restructuring is a token of the awareness within the Icelandic public administration that there is a great need for synchronisation and rationalisation in the administration to enable Iceland to tackle prevailing as well as new crisis-related problems. As such, it speaks for Iceland's determination to effectively tackle problems and implement solutions. Since some of the problems are new, the results of the implementation goals will require some years to be fully born out.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions

- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BJARNADÓTTIR, Eva and Eygló Árnadóttir, *Konur í kreppu? (Women in Crisis?)*. This is a study published by the Welfare Surveillance Unit of the Ministry of Welfare (the Welfare Surveillance Unit has the role of surveying welfare conditions and spotting early signs of pressing problems with the aim of implementing preventive measure if possible) in February 2011, available at <http://www.velferdarraduneyti.is/>.

The study deals with the effects of the present crisis on the level of living conditions of males and females, with a particular focus on women. The study places the crisis effects into the context of differing original positions of the sexes. To some extent males have been harder hit, such as with unemployment, which primarily affected construction workers. Women are more numerous in lower skilled service jobs and have also been affected significantly, even if their unemployment rates are lower. The authors survey material from many aspects of level of living, some of it is however not suitable for assessing the direct effects of the crisis, due to lack of up to date data. Structural analysis of the differing positions of the sexes does however allow some assessments of areas in which the crisis may have longer-term effects. The unemployment experience is a major factor, but further cuts in public expenditures may threaten the position of women more in the next few years than to date. The survey outlines the effects of reduced birth allowance rights (lowered replacement ratio while tending a newborn). They also survey the receivers of social assistance and food rationing from aid agencies, as well as experiences of violence and health conditions. The survey does not find clear indicators of increased violence against women during the crisis or decisively poorer health status.

[R4] GUÐMUNDSSON, Halldór et.al., *Áhrif starfsendurhæfingar á fátækt, félagslega einangrun og virkni (Influence of vocational rehabilitation on poverty, inclusion and activation)*, Center for Child and Family Research, University of Iceland (available at www.skemman.is).

The research constitutes an evaluation of the influence of rehabilitation on poverty, social exclusion and the activity level manifested by participants in the rehabilitation programme operated by SN –Rehabilitation Centre. The research applied a mixed method approach. Data was analysed from ASEBA self assessment list, which participants filled out at the beginning of the rehabilitation (N 241), and again by the end of the rehabilitation, six to eighteen months

later (n 100). Men represented 29% and women 71% of the participants. The youngest participant was 16 years old and the oldest was 57 years old and average age was just below 33 years. Approximately 71% of the participants had completed primary school, 13 % had completed brief vocational training at secondary school level, 10% had completed upper secondary school studies or trade related apprenticeships, about 6% had other studies. A total of almost 60% had been unemployed for a period of 6 months or longer prior to commencing their work rehabilitation programme.

[R2] HALLDÓRSSON, Stefán et.al., Lærdómur lífeyrissjóða af hrúninu 2008-2009 (OPFs' lessons from the financial collapse of 2008-9), Report for the Federation of OPFs, March 26th 2010 (available at <http://www.ll.is/>).

The Federation of Occupational Pension Funds commissioned a report from a task force on what lessons the OPFs should draw from the financial collapse. The recommendations included stricter assessments of issuers of securities, traders, trading houses and stock markets and a stronger focus on securing the funds' interests in more diverse ways. Terms of securities and derivatives need to be stricter and registrations of those on the stock market exchange need to be improved and sped up. It is also recommended that individual Occupational Pension Funds cooperate more with other funds, particularly for the purpose of pressurising for reform in the regulatory environment and in industry in general. This needs to be directed equally at parliament, ministries, regulators and traders. It is finally recommended that the Federation of Occupational Pension Funds sets up standing committees to deal with these issues.

The main conclusion from the research is that the work rehabilitation programme reduces poverty and social exclusion and increases participation levels/activity. It provides improvement in the status of most of the programme participants, difficulties diminish, skills and adaptive levels are fortified and participation grows, mainly in work and studies.

The research project was funded by the European Year for Combating Poverty and Social Exclusion under the auspices of the Ministry of Welfare, and VIRK – the Icelandic Rehabilitation Fund.

[R4] HANNESDÓTTIR, Guðrún, Sigurður Thorlacius and Stefan Ólafsson, Örorka og virk velferðarstefna – Könnun meðal örorku- og endurhæfingarlífeyrisgega (Disability and active social policy), study for the Social Research Center, University of Iceland, Federation of Occupational Pension Funds (OPF) and the Ministry of Welfare, March 2010 (available from <http://www.ts.hi.is/>).

This is a report of a recent survey amongst a representative national sample of disability and rehabilitation pension receivers in Iceland, undertaken by the Social Research Center at the University of Iceland. The focus of the report is on activation in employment and society and hindrances against active inclusion of disabled people in society in general. The study finds that employment participation of people with disabilities (a wider group than disability pension receivers) is amongst the very highest found in OECD countries, i.e. 61% in Iceland as against the OECD average of 43%. Focusing more specifically on disability pension receivers the report finds that the majority of pensioners are in part-time jobs and just over a third are employed in full time jobs. About 84% of disability pensioners say they find it very important to have opportunities for working, indicating a positive attitude to work. A similar proportion says it is important to have access to vocational rehabilitation but only 15% of participants in the survey have received it. Asked about hindrances to their employment

participation the main aspects mentioned are limited opportunities and prejudice (29%), disincentives in the income-testing mechanism of the social security system (21%), and 15% say their own health is the greatest obstacle. The rest primarily mention inadequate support, inadequate vocational rehabilitation and also lack of self-confidence.

[R5] HANNESDÓTTIR, Guðrún, Lífskjör og hagir öryrkja (Level of living of disability pensioners), research report of the Social Research Center, University of Iceland and the Federation of Disability Pensioners (ÖBÍ), October 2010 (available at www.ts.hi.is).

This report is based on a nationally representative survey amongst disability pensioners. The report surveys the financial position of disability pensioners, family status, housing conditions, health conditions, rehabilitation experiences, education, leisure activities, work and poverty experiences, as well as subjective assessments of health and life conditions. The position of disability pensioners is compared to the general public and found to be below average level of living conditions. The disabled do however express significantly lower assessments of their qualities of life than the general public. The earnings of disabled individuals vary considerable, mainly due to varying rights accumulated in occupational pension funds. Educational levels are found to be quite low while the disabled express an interest in increasing their education.

[R5] KARLSSON, Bjarni et. al., Áfangaskýrsla starfshóps um fátækt í Reykjavík (Report on Poverty in Reykjavík), Reykjavík City Council, November 2010, Reykjavík (retrived from www.rvk.is).

This is a report of a task force commissioned by Reykjavík City Council to survey the extent and characteristics of poverty in Reykjavík, as well as the available means of poverty relief in the city. The task force aims to deliver later a more detailed recommendations for improving the means of poverty relief in Reykjavík and coordinate the activities of the various organisations and groups that concern themselves with issues of poverty. The report also provides up to date figures from Reykjavík City Council on families and individuals in hardship and the numbers and characteristics of receivers of Social Assistance in Reykjavík.

[R2] SIGURÐSSON, Ólafur et.al., Góðar venjur í eigna- og áhættustýringu lífeyrissjóða (Recommendations for good practices in asset management), Report of a task force for Federation of OPFs, December 8th 2010 (available at <http://www.ll.is/>).

The Federation of Occupational Pension Funds commissioned a report from a task force on asset managements with a special focus on needed changes in the light of the financial collapse. The group gathered information from OECD about common practices in other Western countries and assessed how the Icelandic practices compared. The group reaffirmed that the Icelandic pension system remains intact and strong despite the loss of some 20-25% of assets in the collapse. Increases in values of assets are already favourable in 2009-10 after the big decline at the end of 2008. The group issued guidelines, based on best practices in the neighbouring countries, on general management, asset management and risk analyses. The group also identified needs for changes of legislative environment and recommended that the Federation aim to work with government on such changes. Changes in the framework legislation on occupational pension funds are needed in order to accommodate to frequent changes in the financial markets, for example regarding authorised forms of investments for

pension funds. Still the group think that the main legislative framework for the funds is adequate, i.e. in light of OECD guidelines and EU directives on occupational pension funds.

[R5] STURLUSON, Jón Þór, Guðný Eydal and Andrés Júlíus Ólafsson, Íslensk neysluviðmið (Icelandic family budget estimates), Report for the Ministry of Welfare, February 2011 (available at www.velferdarraduneyti.is).

The Ministry of Welfare (formerly the Ministry of Social Affairs) commissioned a task force to recommend public family budget estimates, for use in the welfare system. General public family budget estimates have not been in use in Iceland, even though some institutions have worked with such estimates, such as the Student Loan Fund and Citizens Financial Advisory Bureau. The issue was opposed by employers' organisations and even by unions. One reason for the move to create such public estimates now is the reason that many households are going through debt relief processing, in banks and in the public Housing Loan Fund, and that process requires formal and public guidelines for budget requirements, for different family types.

The task force delivered three types of family budget estimates, based on family expenditures surveys undertaken by Statistics Iceland: 1. Basic estimate; 2. Short-term estimate; and 3. Typical estimate (all estimates refer to medians). The group designed a calculator which the Ministry of Welfare operates on its website. The short-term goal with the Family Budget Estimates is to encourage discussions and provide references for the debt relief process and in a longer term the idea is to make use of these in determining minimum pensions and minimum pay and social assistance allowances.

[R4] THORLACIUS, Sigurður and Stefán Ólafsson, From unemployment to disability? Relationship between unemployment rate and new disability pensions in Iceland 1992–2007, article in *European Journal of Public Health*, November 2010.

The study was carried out in order to examine the effect of unemployment on the incidence of disability pension in Iceland by examining changes in this relationship from 1992 to 2007. The annual incidence of disability pension for the period 1992–2007 was calculated. Correlations and significance tests for the relationship between unemployment rates and disability pension incidence rates were calculated. The relationship was examined for different disease groups. Results: Two big fluctuations occurred in the unemployment rate during the study period with an upswing in unemployment from 1993 to 1995 and in 2002 and 2003. In both cases, there were corresponding increases in the incidence of disability pension. The incidence of disability pension declined again when the level of unemployment went down, even though not to the same extent.

Conclusions: Health and mental and physical capability determine the overall incidence of disability pension, but marginal fluctuations over time seem to be related to environmental conditions in the labour market, especially the unemployment rate. The observed disability pension incidence pattern in the two unemployment cycles of the study period indicates mainly that people with impaired health are forced out of the labour market in times of increasing unemployment rather than pointing towards a negative effect of unemployment on health. Our findings indicate that there is a need to strengthen the vocational rehabilitation system in Iceland as well as the support system for employment and social participation.

[H] Health

[H5] BALDURSSON, Jón et. al., Heildarskipulag sérfræðiþjónustu lækna – Tillögur og greinargerð (Organisation of Physicians' Services), Report of a task force for Ministry of Welfare into renewed organisation of the health care services of doctors, published by Ministry of Welfare, February 2011 (available at www.velferdarraduneyti.is).

The task force recommended immediate actions and longer-term reforms. The shorter-term actions were to speed up the implementation of coordinated and complete electronic health journals; define more specifically what services are to be covered by public sickness insurance; improve the transitions of patients between GPs and specialists; finance for services should be allocated with a wholistic perspective taking into account equal rights, quality, production and results; regulation on user charges should be reformed, with the aim of improving direct and active steering of service utilisation.

The task force also recommends an implementation of better cost-and-need analysis for specialist services; better assessments of the most efficient and rational treatment services and payment systems; reform of the out-patient services, both nationally and locally; a more detailed guidelines for specialist services, including for GPs; improve quality evaluations; and make plans for manning requirements in the health care services for the coming years.

[H2] BERNDSEN, Harpa Hrund, The Effect of Obesity on the Labor Market, a MA thesis in Health Economics, University of Iceland, February 2011 (available at www.skemman.is).

The data utilised in this study originates from a health and lifestyle survey “Heilsa og líðan Íslendinga” carried out by the Public Health Institute of Iceland in both 2007 and 2009. The sample is a stratified random sample of 9,807 Icelanders, ranging in age from 18 to 79. The net-response rate in 2007 was 60.8%. The participants from 2007 also received the 2009 version and 69.3% of them participated. A total of 42.1% of the original sample took part in the survey both in 2007 and 2009. Probit analysis was used when estimating the relationship between obesity and employment status, and an ordered probit analysis was used when observing the relationship between obesity and income.

Findings: Obese women are more likely than their optimal weight counterparts to have lost their job following the economic crises in Iceland. The point estimates indicate that the relationship is also positive for men although it is not statistically significant. The point estimates of the analysis on the relationship between BMI and income indicate a negatively relationship for women, but a positive one for men. None of the estimates of the analysis on the data from 2009 were statistically significant.

The relationship between obesity and job loss following the economic crisis is consistent with ex ante expectations. The results from the analysis of income are consistent with results from other studies where obesity has been found to effect women's wages negatively.

[H3] BOGADÓTTIR, María Erla, Income-related mental-health inequality: The effects of the 2008 Icelandic economic crisis, a Masters thesis in Health Economics, University of Iceland, May 2011 (available at www.skemman.is).

Positive health-income gradients are generally accepted. But what happens when an economy collapses? One might expect health to worsen, but recent results indicate that physical health improves in recessions, although the same may not hold for psychological health. The effect of business cycles on income and health has usually been analysed separately. The aim of this thesis is to observe the effect of the Icelandic economic collapse on income-related health

inequality.

Data and methods: The data utilised is a panel data that originated from a health and lifestyle survey carried out by The Public Health Institute of Iceland in 2007 and 2009. A stratified random sampling method was used to gather individual-level information about income, self-assessed health and other socio-demographic variables. To evaluate income-related health inequality concentration curves are plotted and concentration indexes computed. The variable used to capture living standard is equivalent household income, before taxes. The variable used to capture health status is self-reported self-perceived morbidity. Results: There seems to be some evidence of income-related health inequality favouring the higher income groups, based on the considered ill-health conditions (difficulty sleeping, serious worries, anxiety or melancholy) measured by whether they disturbed daily life at least once for the past year. However the concentration curve for 2009 is closer to the line of equality indicating less income-related health inequality than in 2007, except for difficulty sleeping. The reason might be higher prevalence of the ill-health conditions for men in higher income groups in 2009 than in 2007 and thus dragging the overall concentration index closer to zero.

[H2] EYJÓLFSDÓTTIR, Guðrún Ágústa, Sjúkraskrifaðir einstaklingar með fjárhagsaðstoð hjá Reykjavík: líðan og þjónustupörf (Individuals on sickness benefits in Reykjavík: conditions and service requirements), a study undertaken in cooperation with Reykjavík City Welfare Services, available at www.rvk.is.

This is a survey amongst individuals receiving financial social assistance from Reykjavík city, focusing on health and social position and conditions for rehabilitation. The findings indicate that psychological ailments are a major inhibitor for rehabilitation. About 71% were suffering from mental depression and 68% had severe anxiety distress. An even higher proportion has stress syndromes. The conclusion is that individuals receiving financial assistance while sickness registered are of such nature that they require special treatment, beyond what is implied in usual vocational rehabilitation.

[H2] GUÐMUNDSDÓTTIR, Ingibjörg, Lifestyle and Type 2 Diabetes in Iceland - An Analysis of the Icelandic Health Survey 2007, MA thesis, School. of Health, University of Iceland, February 2011 (available at www.skemman.is).

The data used for this study was collected by The Public Health Institute of Iceland in 2007 in a national survey. The study and comparison groups are composed of 4,155 individuals, age 40-79 years. Those with diabetes are compared with those who have hypertension on one hand and those who have neither diabetes nor hypertension on the other hand. Public health recommendations are used to determine what constitutes a good lifestyle. Fourteen recommended lifestyle variables were examined along with the average practice of lifestyle variables that have no official recommendations.

The study shows that those who have diabetes are older, have a generally worse social-economic status and a higher body mass index than both comparison groups. There was no statistical difference in the number of recommended lifestyle variables between groups. Those who have diabetes take less often cod liver oil, eat less often sweets and potatoes, rice and pasta and exercise less than both comparison groups. They are more likely to have problems with walking and spend more time sitting. There was a positive association between age and the number of recommended lifestyle factors. On its own, age had the highest coefficient of determination (R²) on the number of lifestyle variables followed. In combination with age

and sex, the variable “tries to eat healthy food” had the highest R2 while the lifestyle variable “eats breakfast” had the highest R2. Age, sex and body mass index influence lifestyle along with socio-economic status. It was possible to discern a pattern in lifestyle based on socio-economic status. All the lifestyle variables influence each other but no pattern could be discerned based on them.

As the socio-economic status of those who have diabetes is worse than others but their recommended lifestyle is not worse it can be deduced that they have changed their lifestyle at some point. When educating those with diabetes about lifestyle it is necessary to consider their diminished ability to walk. The body mass index rises sharply until the age of 40 and does not change after that. It is therefore important to aim prevention projects at young people to try to prevent this increase in body mass index. Those who do not work exercise less than others. As the percentage of retired and unemployed people and people with disability rises fast in Iceland it is important to try to increase exercise in these groups, or try to prevent it from decreasing, by specialised prevention programmes that take their diminished ability to walk into account.

[H2] GUTTORMSDÓTTIR, Alma Björk, Experiences of parents of overweight children and what they expect from schools and health care services, MA thesis, School of Health, University of Iceland, August 2010 (available at www.skemman.is).

The objective of this study was to explore the experience of parents raising obese children and find out what kind of service parents of obese children in Iceland would have liked when the children were younger, and then what kind of service they would like to get today from the schools and the health services. Participants in this study were 12 parents of 6 boys and 4 girls (2 couples and 8 mothers), that were classified as obese during regular check-ups in the Reykjavik area. Research methodology was hermeneutical phenomenology in the spirit of Max van Manen (1990). Data was collected by research interviews guided by a interview outline, and the parents also filled out a questionnaire for background data. Because the experience of parents can differ, fathers and mothers were interviewed separately. The Icelandic Human Subjects Committee and the Primary Health Care of the Capital Area approved this study. The Data Protection Authority was notified of the study. This study showed that the parents generally admitted that the weight of their children was a problem. In addition, the parents would have preferred some notification and guidance earlier on from a school nurse when it became apparent that overweight might become a problem, as that might have pushed them to react earlier to the overweight problem. Most of the parents felt that their child started to gain too much weight when it started to go to school, although they also felt their child had enough exercise at the time. Therefore the parents concluded that the source of the problem was at school’s cafeteria, because the children were able to get extra portion more than once in the cafeteria and the food was not healthy enough. The assistance the parents would like the most now was consultation with a nutritionist and that it should be available at the local Primary care center. No difference in themes was observed among mothers and fathers.

In conclusion, the research findings indicated that the parents, in general, admitted that their child’s weight was a problem. Most of the parents were waiting for health care staff at the school or primary health care to contact them to report the situation and offer appropriate help for the family.

[H2] PÁLSDÓTTIR, Ágústa, Development in information gathering and evaluation of information about health and lifestyle, a study published in Netla, December 2010 (available at <http://hdl.handle.net/1946/7787>).

The article discusses the development in information gathering and evaluation of information about health and lifestyle among Icelanders. The results of two studies conducted in 2002 and 2007 will be compared and studied to see if there is a significant difference between them. The studies examined how often four groups of people gathered information from the media, health specialists and on the internet and also how the usefulness and reliability of the information was evaluated. The data were gathered by means of postal surveys. The samples consisted of 1.000 people, aged eighteen to eighty, randomly selected from the National Register of Persons in Iceland. Response rates were 51% in 2002 and 47% in 2007. The findings of the research indicate that the importance of the internet regarding information behaviour related to health and lifestyle is growing and that it is well on its way to establish itself as equivalent to other media.

[H] Long-term care

[L] EYDAL, Guðný Björk and Tine Rostgaard, Umönnunargreiðslur – ógn við jafngrétti eða aukið val? (Care payments – Threat to equality or increased options?), a study undertaken as a part of a Nordic project, in Halldór Guðmundsson (ed. 2010), *Rannsóknir í félagsvísindum XI*, pp. 18-28.

This study compares care payments for children and examines the differential systems and forms of such payments, as well as the policy implications. The study finds that all the other Nordic nations except Iceland have the option of care payments for parents for a certain period after birth, instead of subsidised day care services. The gap between birth leaves and access to day care for children is larger in Iceland due to shorter birth leave periods. The Icelandic legislation is found to deviate somewhat from that of the other countries.

[L] JÓNSDÓTTIR, Marta María, Umhverfi dvalarheimila - hvati til lífsgæða eða hlutlaus umgjörð? (Residential homes for the elderly – incentives for quality of life or impartial shelters?), BA thesis in Public Health, University of Iceland, spring 2011 (available at www.skemman.is).

This thesis examines the environment of a number of residential homes for the elderly, in Reykjavík and in other communities. The aim was to examine if there are differential qualities of these environments and how they can be explained. Physical conditions as well as social conditions were surveyed and related to construction period (age of institution), form of operation (public-private) or region. No regularity was found in the relationship of these background conditions and quality of service environments. Future plans for some of the institutions included expansion of housing and in some cases this involved a reduction of outdoor space/environment for activities and reduced view, as well as less sunshine when high rise buildings were involved.

[L] JÓNSDÓTTIR, Valgerður, Virðing skal borin fyrir öldruðum jafnt í lögum sem lífi : um siðferðileg réttindi aldraðra sem tengjast húbýli og heimili (Respect for the aged – on morality and rights related to residential options), MA thesis, University of Iceland, May 2011 (available at www.skemman.is).

This is a qualitative study of moral issues related to long-term care of the elderly. It uses the Vancouver school of phenomenology method, based on focus groups amongst individuals aged 76-91 in Reykjavík and Akureyri (in the North). The perspectives of relatives of the individuals in questions were also probed. The issue focused specifically on the transition period from own home to a nursing home. Main conclusions indicate that the elderly strongly prefer to stay in own home for as long as possible, with the adequate services provided to make it possible. They also stress the importance of having the right to a place at a nursing institution when needed, without significant waiting period. In nursing homes they stress the possibility of private residence as against sharing rooms, to be able to make their own “home feeling” with their private things. Relatives felt a strong need to be involved in decision-making and on the whole the participants felt strongly about the rights that they considered the elderly and their relatives to behold.

[L] SIGURÐARDOTTIR, Sigurveig, Hver veitir eldra fólki aðstoð? – Eldri borgarar, aðstandendur og opinberir þjónustuaðilar (Who cares for the elderly?), a study in Halldór Guðmundsson (ed. 2010), *Rannsóknir í félagsvísindum XI*, pp. 60-68.

This study reports some conclusions from the project *ICEOLD* (Icelandic older people), which is supported by Icelandic and Nordic foundations. It aims to survey the needs for services of elderly people living in their own accommodation and profiles who deliver the services they presently receive. Amongst the findings are that 43% of the participants receive assistance or care from informal parties like family or friends, whereas about 20% receive care from public providers (home help and/or home nursing). Of those receiving formal care about 10% got home help or nursing four times or more frequently per week while 21% got such assistance from family members. When a spouse is at hand (s)he tends to be the main provider, then comes the family, children, grandchildren etc. living elsewhere. It is more common for males to receive care from their wives (since they live longer on average) and women get especially extensive care from daughters.

4 List of Important Institutions

ASÍ hagdeild – Federation of Labour, research department

Contact person: Ólafur Darri Andrason
Address: Sætún 1, 105 Reykjavík

The federation's research department does interest related assessments and reports and is often influential in shaping policies, for example in relation to collective bargaining in the labour market. The department publishes yearly report on varying topics and regularly issues statistical information.

BSRB – Federation of Public Employees

Address: Grettisgötu 89, 105 Reykjavík.
Webpage: www.bsrb.is

This is a centralised federation of various unions in the public sector. They coordinate bargaining, run various services for members, publish and run courses, in addition to having cooperative relations with governments.

Efnahags- og viðskiptaráðuneytið - Ministry of Economics and Business Affairs

Address: Solvholsgötu 7, 150 Reykjavík, Iceland
Webpage: <http://www.efnahagsraduneyti.is/>

The Ministry of Business Affairs is responsible for all labour- and business-related issues like Competition, Consumer Affairs, Financial Services and Markets, Banking, Merchants and Trade, Capital Movements, Imports and Foreign Investments, Insurance, Company Law.

Félagsvísindastofnun Háskóla Íslands – Social Science Research Institute of the University of Iceland

Contact person: Magnús Árni Magnússon
Address: University site at Sudurgata, 101 Reykjavík
Webpage: www.fel.hi.is/

This is an independent research institute at the University of Iceland. The institute specialises in social scientific research, including welfare research. The institute is funded by competitive research funds and it also does sponsored projects for government or private organisations and interests. The institute is subdivided in centres that specialise on individual topics, such as social policy, child-care and family policy, disability research and political research. The institute publishes reports and occasional books on matters of the social sciences.

Hagfræðistofnun Háskóla Íslands – Economic Institute of the University of Iceland

Contact person: Gunnar Haraldsson
Address: University site at Sudurgata, 101 Reykjavík
Webpage: www.ioes.hi.is/

This is an independent research institute at the University of Iceland specialising in economic research. It is funded through competitive research funds and sponsored projects for government or private organisations and interests. The institute also publishes reports and occasional books on matters of the social sciences.

Landsamband eldri borgara – Federation of the Elderly

Address: Langholtsvegur 111, 104 Reykjavík.

Webpage: www.leb.is

This is a centralised federation of various societies and interest groups concerning themselves with interest (social and health-related) of elderly people. They also run housing facilities in cooperation with builders' firms, leisure services and publish journals and newsletters, in addition to having cooperative relations with governments.

Landssamband lífeyrissjóða – Federation of Occupational Pension Funds

Contact person: Hrafn Magnússon

Address: Sætún 1, 105 Reykjavík

Webpage: www.ll.is/

The Federation is a collaborative body for the individual occupational pension funds in Iceland, run by the labour market partners and two funds run by the state. The federation represents the funds against the public and government and promotes information on rights and policies and also provides a centralised data bank for rights in individual funds as well as some information on the funds' operations. The federation sponsors conferences and research on pension related matters and publishes a yearly report on the funds' activities.

Öryrkjabandalagið – Federation of the Disabled

Address: Hátún 10, 105 Reykjavík.

Webpage: www.obl.is

This is a centralised federation of various societies and interest groups concerning themselves with interest (social and health-related) of disabled people. They also run housing facilities, rehabilitation services and workplaces, in addition to having cooperative relations with governments.

SA hagdeild – Employers' Federation of Iceland, research department

Contact person: Hannes Sigurðsson

Address: Borgartún 35, 105 Reykjavík

Webpage: www.sa.is

The federation's research department does interest related assessments and reports and is often influential in shaping policies, for example in relation to collective bargaining in the labour market. The department publishes yearly report on varying topics and regularly issues opinionated information.

Sjúkratryggingar Íslands – Sickness Insurance Institute

Contact person: Steingrímur Ari Arason

Address: Laugavegur 116, 105 Reykjavík

Webpage: www.tr.is/sjtr

This institute administers the national residence-based state provided sickness insurance and occupational accident insurance, in accordance with the legislation on Sickness insurance from 2008. It also serves the role of negotiating the purchases and prices of health care services provided to the public by private and social organisations. Since the Sickness Insurance Institute was only established in 2008 it is still being shaped. It was in fact split from the Social Security Institute and still operates in close cooperation to that institute.

Talnakönnun – Statistical Research Inc.

Contact person: Benedikt Jóhannesson
Address: Borgartún 23, 105 Reykjavík
Webpage: www.talnakonnun.is

This is a private consultancy company, specialising in pension issues and related matters. The company is particularly influential as an advisor to pension funds, regarding assessments of actuarial issues and funding matters, as well as in disseminating various data and information.

Tryggingastofnun Ríkisins – Social Security Institute

Contact person: Sigríður Lillý Baldursdóttir
Address: Laugavegur 114, 105 Reykjavík
Webpage: www.tr.is

This institute administers the national residence-based pension insurance, and state provided means tested benefits and services, in accordance with the Act on Social Security. Ministry of Social Affairs and Social Security (Félags- og tryggingamálaráðuneytið) is responsible for the supervision of all activities of Tryggingastofnun. The main office of Tryggingastofnun is in Reykjavik with agencies outside Reykjavík for the benefit of residents who live outside the capital area. The SSI publishes a yearly report and also a yearly statistical report on social security developments (such as expenditures and benefit levels, as well as figures on use of services – Staðtölur almannatrygginga).

Velferðarráðuneytið – Ministry of Welfare

Address: Hafnarhusinu við Tryggvagotu - 150 Reykjavik, Iceland
Webpage: www.velferdarraduneyti.is/

The Ministry has the responsibility for administration and policy making of health and health insurance issues in Iceland as prescribed by law, regulations and other directives. Among the issues that the Ministry deals with are Public Health, Patient rights, Operation of Hospitals, Health Centers and other providers of health services, Promotion of Information Technology in the health services in Iceland, Pharmaceutical affairs and Health Insurances.

The tasks of the Ministry also cover inter alia the issues and affairs of the Elderly, Disabled, Immigrants, Employment & Gender Equality, Housing, Family Affairs and Refugees, the Unemployed and ALMPs.

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- (1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
- (2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
- (3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
- (4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
- (5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
- (6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

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