Annual National Report 2012

Pensions, Health Care and Long-term Care

Iceland

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On behalf of the
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DG Employment, Social Affairs and Inclusion

Table of Contents

1 Executive Summary

Iceland's financial crash of October 2008 was a major blow to the economy and society, by any standard applicable in advanced Western societies. GDP went down by some 10% and unemployment increased fourfold, the currency lost half of its value, leading to galloping inflation, which then seriously eroded the general living standard of the population. Government finances received a devastating blow, landing the budget with a deficit of 14.5% and rapidly accumulating debt. Household debt levels also increased drastically. It was inevitable that the next few years would be a trying time for the society, not least its politics.

Now at the beginning of 2012 Iceland has come through the worst and seems to be firmly sailing out of the crisis. Economic growth resumed in 2011 (at 3.5-4%), real earnings are rising and various debt relief programmes for households have been implemented, even though more is continually called for. While public expenditures were significantly cut and taxes raised, in order to rebalance the public budget (tax increases contributed about a half against expenditure cuts), the social protection system was strategically used to soften the consequences of the crisis, particularly on low and middle income households. The cuts in living standards were thus less extensive amongst the lower income groups, including pensioners. The minimum pension guarantee was significantly raised while higher income earning pensioners got cuts.

The Occupational Pension Funds (OPFs) lost about 25% of their assets and reduced pension payments by some 10-15%. As their pensions declined and financial earnings, particularly amongst old-age pensioners, the social security pensions were raised (due to the income-testing mechanism used in social security). The net effective income tax burden was lowered on about a half of the households (those with lower earnings), at the same time that it was raised on the top 40% of households. Redistributive/equalizing effects of the taxation system were thus greatly increased. Thus many lower income earners amongst pensioners, as well as the unemployed, got reduced tax burden. The government also tripled the public subsidy of interest cost of mortgages which in effect means that the government pays up to a third of the interest costs of lower income households (lower for higher incomes). Child benefits were also made more targeted at lower income households. The strategy of sheltering lower and middle income households against the consequences of the crisis was quite successful.

The health care system had to cut expenditures significantly, even though the government strategy was to cut welfare expenditures less than other public expenditures. With reduced resources and manning levels the fear was that the services might be negatively affected, eroding the high quality of the health care and the long-term care systems. Most measures and indicators suggest however that the overall productivity has increased, delivering high volumes and high quality service, despite the setback. Thus waiting lists for most hospital operations have either been reduced or maintained during the crisis rather than lengthened. The medical staff seems to have put in a greater effort and management succeeded in improving the efficient use of resources.

Unemployment remained below the EU average all through the crisis and is now in the region of 7%. The enviable high rate of employment participation amongst the elderly (and high retirement age) has been maintained. Activation and educational measures for the unemployed have been stepped up and delivered good results. Unemployment seems set to come further down this year.

In long-term care the government policy of building new nursing homes has served the dual function of creating jobs for the unemployed and improving the life qualities of the elderly and handicapped. The welfare strategy has thus played a very large role in crisis containment.

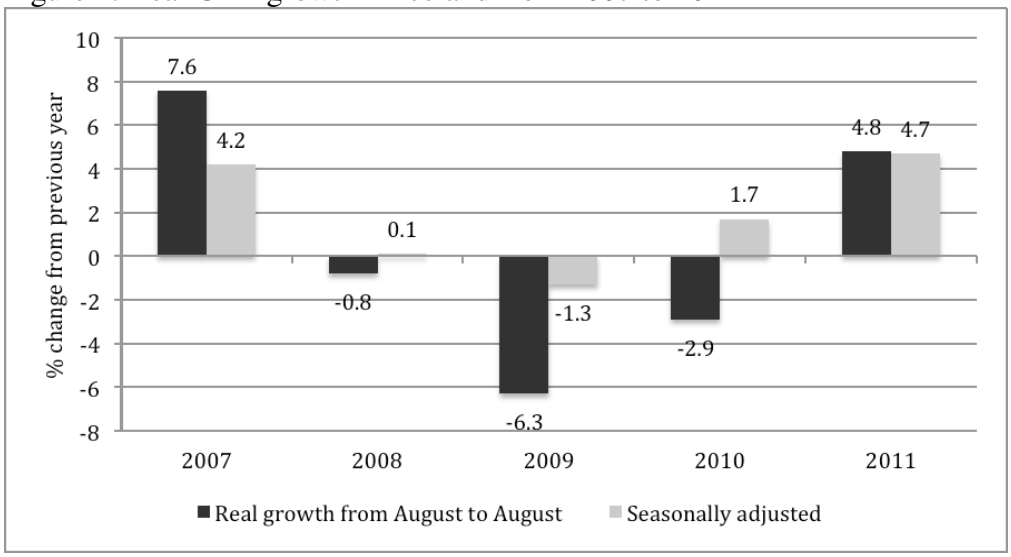
2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Iceland's financial collapse in October 2008 was one of the most spectacular ever seen. The financial system had grown over the size of the national economy by a factor of ten. The collapse involved the bankruptcy of the three main banks (accounting for the best part of the financial system), a collapse of the national currency (the Icelandic Krona - ISK) and a collapse of the government in February 2009 (Ólafsson 2011a). It was a major blow in many ways, leading to a wide-ranging loss of trust amongst the public in politics and public and private institutions. Public finances were wrecked with the public budget run at a 14.5% deficit by end of 2008.

What followed was a major economic recession with a great reduction in the real purchasing power of the public, through price rises and galloping debt burden (since debts and interests are tied to the price index). Altogether the gross national product came down by about 10%. Figure 1 shows how that recession came in primarily in 2009 and 2010.

Figure 1: Real GDP growth in Iceland from 2007 to 2011

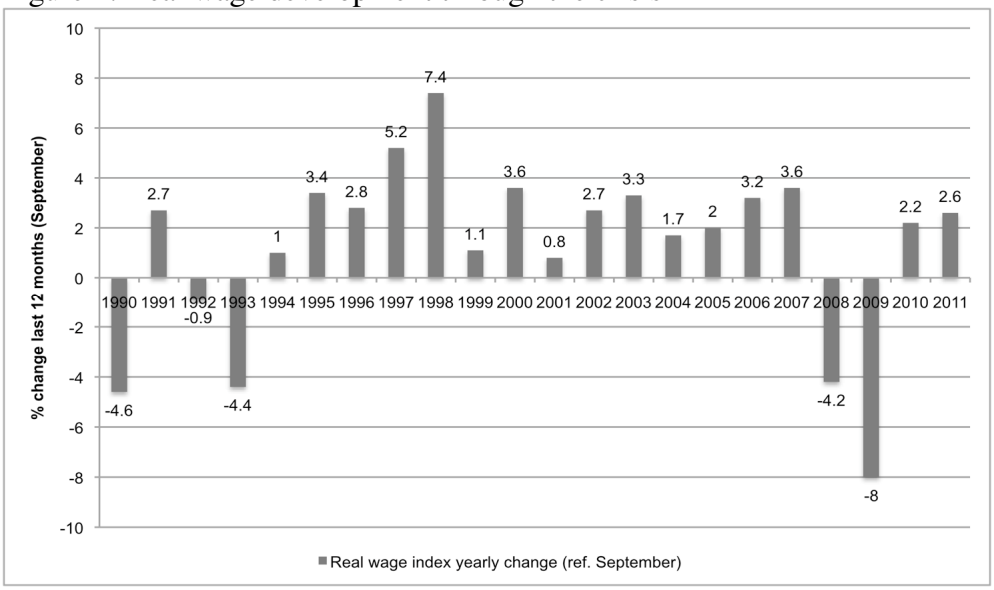


Source: Statistics Iceland.

The Figure also shows the more pleasant fact that the recession has been halted and healthy growth resumed by 2011, i.e. in the region of 4-5% (measured from August 2010 to August 2011). The estimate for the whole of 2011 is closer to 3.5%. So Iceland has started to climb up the economic ladder again.

Figure 2 shows the real wage development through the crisis. Altogether real wages came down a little more than the GDP, or by just over 12% in 2008 and 2009. Wages started to increase again in the latter part of 2010 and more firmly so in 2011. During the depth of the crisis (2009-2010) it was primarily the lowest wages that were raised while higher salaries in the public sector were directly cut in many cases by close to 10% in addition to the cut in real purchasing power emanating from the price rises that the fall of the national currency caused.

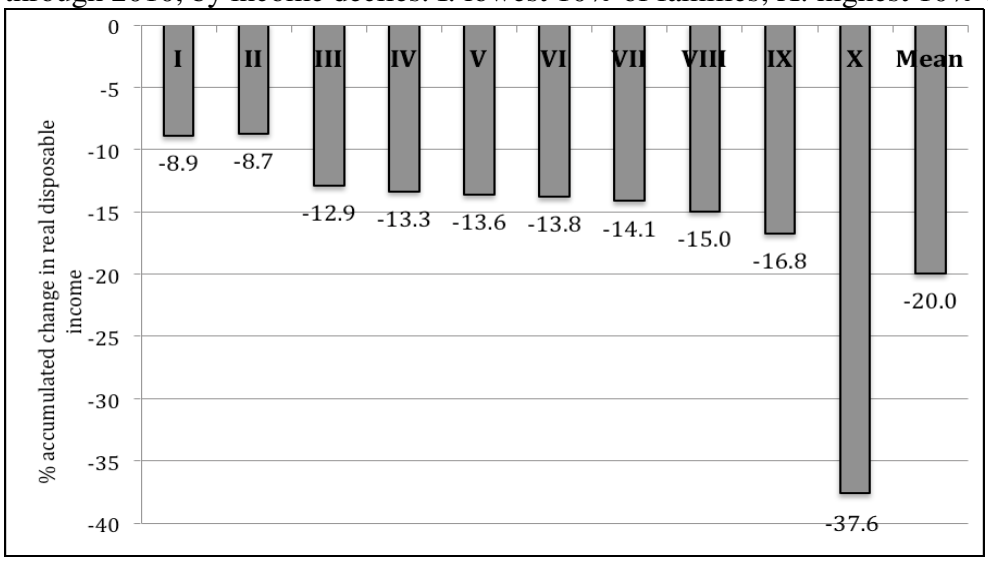
Figure 2: Real wage development through the crisis



Source: Statistics Iceland.

Cuts in living standards were in fact greater that the indicator of real wages shows, since many lost occupational benefits and also had to reduce volumes of work, such as overtime, which in some industries has been an important source of extra earnings (Ólafsson 2011b). Given the increased debt burden of the majority of households the average cuts in living standards are likely to have been in the region of 20% or more. That was however unevenly distributed amongst income groups as we show in Figure 3 below.

Figure 3: Accumulated change (%) in real purchasing power of disposable earnings, from 2008 through 2010, by income deciles. I: lowest 10% of families; X: highest 10% of families



Source: Tax Authorities; analysis by Social Research Centre, University of Iceland.

It is evident from the Figure that the lower income groups have to some extent been sheltered during the crisis and that the higher income groups have shouldered larger burdens, both due to lower financial earnings and higher direct taxes. As we showed in last year's asisp report the lower income groups were sheltered by targeted rises of income components that primarily go to lower income groups, such as the minimum pension guarantee, minimum wage in the labour market, social assistance allowance and the unemployment benefit. Tax rebates on interest costs of mortgages were also increased greatly, or tripled during the crisis period (Ólafsson 2011b). So

the crisis was extensive with large consequences for the general living standard of the population as well as for government finances. Lower income groups were however sheltered against the consequences of the crisis, both by targeted use of the social protection system and the income taxation system.

As regards employment developments, the increased unemployment is the most decisive feature. Unemployment levels reached unprecedented levels in the whole of the post-war period, with registered unemployment being measured at about 9% when it topped and survey-based levels approaching 8% (these were slightly higher during individual quarters, but the figures in Table 1 are yearly averages from the labour force surveys).

Table 1: Employment developments 2007 through 2010 (Q4)

	Activity rate	Activity rate by age			Unemployment	Unemployment by age		
	Total	16-24	25-54	55-74	Total	16-24	25-54	55-74
2007	81.7	75.6	89.2	66.8	1.9	6.2	1.2	0.8
2008	81.5	72.4	89.8	67.2	4	10.8	2.9	2.3
2009	80.3	67.2	89.4	68.1	6.7	16.1	5.6	3.2
2010	79.9	68.1	89.4	66.2	7.4	15.4	6.6	3.8
2011	78.4	66.4	87.8	66.1	6	13.9	4.9	3.7

Source: Statistics Iceland (Labour Force Survey averages).

As Table 1 shows the activity rate went from 81.7% down to 78.4% in the 4th quarter of 2011. Unemployment topped on the other hand in 2010. It is enlightening to examine the employment and unemployment rates by age groups. While the 55-74 age groups and the 25-54 only got a minor change in their activity rates the youngest cohort tells a different story, with much larger contraction in the rate. Unemployment increased though significantly in all groups, close to a factor of three, but the unemployment rate amongst the older cohorts remained by far the lowest (Andersen et. al. 2011).

This shows that the elderly in the labour market were better sheltered during the crisis than the youngest cohorts. School leavers to a significant extent came to a closed door in the labour market during the depth of the crisis.

On the whole the unemployment level remained modest by international standards despite the enormity of the financial collapse and the ensuing crisis. That is a notable achievement and can be partly credited with the effect of the devaluation of the Icelandic Krona, which helped export industries and tourism extensively, at the cost of drastically reduced purchasing power level of the household sector. Accordingly tourism has boomed during the crisis, with the number of foreign visitors reaching record levels in the last two years.

Table 2: Social protection expenditures in real 2010 prices (000s ISK)

Fixed 2010 prices	2000	2005	2006	2007	2008	2009	2010
10 Social protection	102623	136393	130885	140972	150590	175759	172065
1011 Sickness	1242	1143	970	890	1028	906	832
1012 Disability	24811	32858	33620	36055	40054	42503	42034
1020 Old age	32189	40007	34786	36878	37810	34617	32469
1030 Survivors	404	378	316	324	328	325	316
1040 Family and children	23455	36858	39364	42420	42706	43299	42017
1050 Unemployment	3346	5386	3999	3924	6206	26672	25300
1060 Housing	9861	11313	10107	10030	11466	15185	16255
1070 Social exclusion n.e.c.	2756	2935	2630	4588	5262	6106	6714
1090 Social protection n.e.c.	4559	5515	5092	5864	5731	6144	6127

Source: Statistics Iceland.

In Table 2 we examine the fate of social protection expenditures during the crisis. The figures in the Table are social protection expenditures in fixed 2010 prices, by major categories. This gives

a good overview of developments in the field of welfare during the crisis. The government pledged to cut less in welfare than in other fields. On the whole there were both cuts and increases in social protection expenditures, leading to a net increase from 2008 to 2009. The total level came down a little again in 2010.

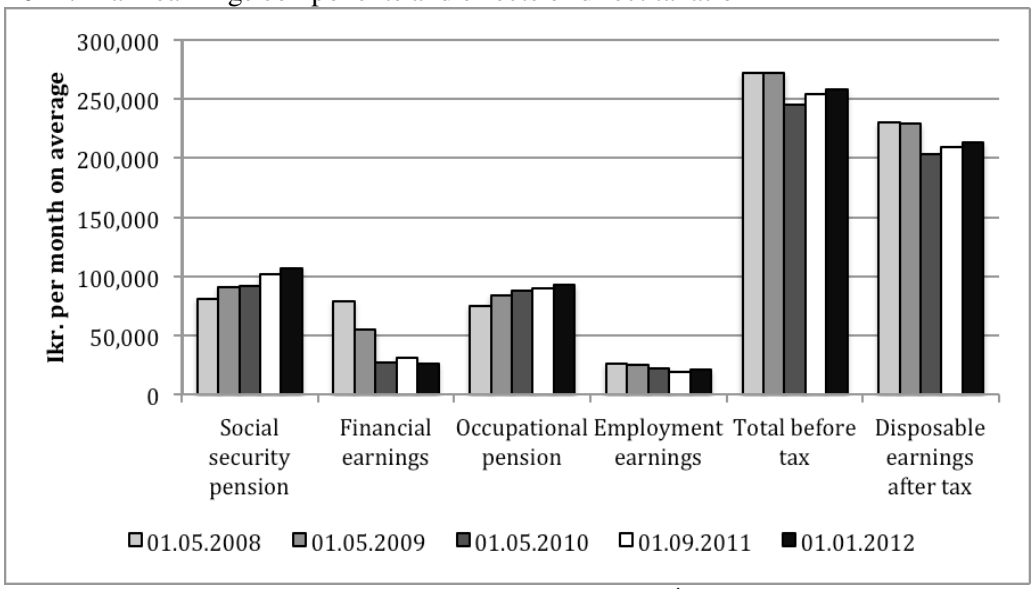
The biggest category of increased expenditures is on unemployment, which increased more than sixfold from 2007, topping in 2009 before coming slowly down in 2010 (and also in 2011, as judged by the unemployment rate, cf. Table 1 above). Sickness benefits came down significantly in 2009 and 2010 and are now lower than they have been since 2000.

Disability benefits expenditures are on the other hand at their highest level in 2009 and 2010, after a significant raising of minimum pension guarantee which many disability pensioners get. Expenditures on the elderly are however significantly down during the crisis, mainly due to cuts in benefits for those who have higher pension earnings. Family benefits expenditures also remain at a rather high level compared to the early 2000s, even though they have come down a little in 2010.

The unemployment expenditures are of course the growth sector, with an increase by a factor of six since 2007. Housing expenditures were also increased during the crisis (especially interest rebates or subsidies) and reached their zenit in 2010. Interestingly social exclusion expenditures were also increased during the crisis.

In Figure 4 we show an interesting new data on earnings developments of pensioners from the spring of 2008 (before the crisis) and up to the 1st of January 2012. We show separately social security benefits, financial earnings, occupational pensions, employment earnings and then the total earnings before tax, and lastly disposable earnings after tax. This allows us to understand better how the crisis affected the earnings levels of pensioners (disability and old-age pensioners together).

Figure 4: Earnings developments for all pensioners in Iceland from spring of 2008 to January 2012. Main earnings components and effects of direct taxation



Source: Social Security Administration, special analysis for SÓ.

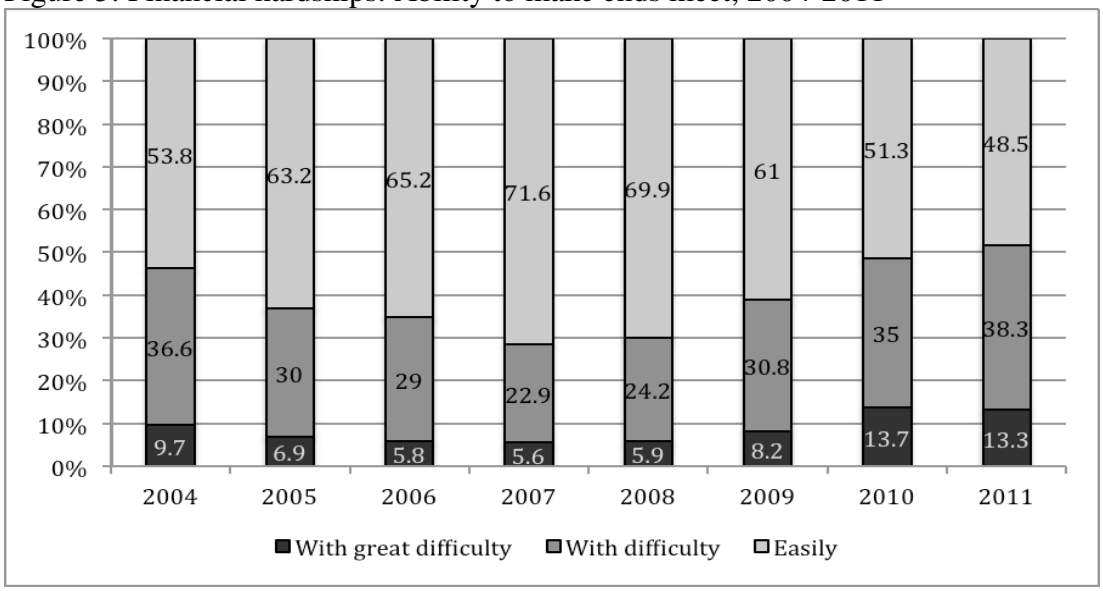
Social security pensions increased on average every year after 2008, especially for lower and middle income pensioners. So did occupational pensions, which are tied to the price index (which went significantly up during the crisis). The increase in the levels of the occupational pensions came about even though many pension funds cut their rates by 10-15%. The inflation

was simply higher than the cuts, giving a net rise every year. On the other hand the pensioners lost significantly on financial earnings, particularly the old-age pensioners. Financial earnings of this group came down in 2010 to about a third of what they had been in 2008. Employment earnings came also significantly down (more important for disability pensioners than old-age pensioners.

All these income components together then give us the total earnings before tax. These came significantly down in 2010, but increased somewhat in 2011 (a rise of 8.1%) and at the beginning of 2012 (3% rise of the pension level). The development from year to year is similar for disposable earnings after tax, but at a lower level. On the whole pensioners with lower incomes got some cut in their tax burden.

Lastly we show indicators of financial hardships from 2004 through 2011, with data from EU-SILC surveys, carried out by Statistics Iceland, in Figure 5.

Figure 5: Financial hardships: Ability to make ends meet, 2004-2011



Source: Statistics Iceland.

These indicators show declining financial hardship from 2004 to 2007/8 and a significant increase in 2009 and 2010. The proportion of households making ends meet "with great difficulty" went from 5.9% in 2008 to 13.7% in 2010 and then came down a little in 2011 (13.3%). The proportion saying they make ends meet "with difficulty" increased in 2011. Accordingly the proportion saying they make ends meet "easily" was at its lowest in 2011. So the bottom seems to have been reached as regards the numbers of households suffering very great difficulties but significant difficulties still remain, mainly associated to housing debt burden. There have been great concerns that the measures for debt relief that were implemented have taken a long time to be fully carried out, but we should expect that the situation has improved in the latter part of 2011 and in 2012. Real earnings have been growing again and the effects of debt relief measures are increasingly coming through.

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 (Soc. Sec.) 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% have been exempt from direct taxation when paid in, but this was reduced to 4% from beginning of 2012 (i.e. for the initial 2% employee contribution and the employer share of another 2%). These accounts 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 accounts (IAs), 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 disproportionally 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 ISK per person for the year of 2009). A couple where both have such accounts could thus liquidate 2 million ISK to alleviate their debt burden. This provision still applies and the sum for couples was raised up to 2.5 million ISK for each (max 5 millions for a couple).

Since the Social Security pillar uses income testing to a high degree, also nearly 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 2010 80% 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 changes in the income-testing rules of 1st July 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.

As regards the second component of Social Security (Pension Supplement, which is income-tested against all other incomes) 3% of old-age pensioners and 39.6% of disability pensioners got that without any cuts (thus the majority 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 1% of old-age pensioners and 14.5% of disability pensioners without any cuts in 2010.

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

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 increased however in 2009-2011, 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. Further increases of social security pensions came in 2011 and at the beginning of 2012. 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 2011-12:

- Parliamentary recommendation for a plan to improve services to disabled individuals. This involves definition of priorities, goals, definitions of evaluations criteria and stages of implementation. The plan emanates from the UN stipulations on rights of disabled people regarding accessibility, services, employment and evaluations of service qualities (13.01.2012 and specified ministerial guidelines 24.01.2012)
- Income reference for rights to rental rebates from local authorities were increased by 12.5% (29.12.2011)
- Change of legislation on parental leave, following recommendation done by the EFTA surveillance authority, involving rules for synchronizing rights from work in more than one member country (19.9.2011)
- A programme negotiated between government, local authorities and industry to provide jobs for 0.7% of those unemployed in 2012 (16.12.2011)
- Measures implemented by Directorate for Labour to increase access of young unemployed and others seeking work to education (06.09.2011)
- Reduction of cross income-testing for low income disability pensioners becomes effective (agreed 05.01.11 and effective from 05.09.2011)
- General debt relief programme (110% program) deadline for application (30.06.2011)
- Increased level of social security benefits and pensions by 8.1% plus a 303 Euros single supplementary payment to all pensioners (15.06.2011)
- Recommendations for a new housing policy (19.04.11) - carried out during the summer months of 2011
- Work on new social security legislation started, based on recommendations of task force from 2010 (VEA) (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)

2.2.2 Debates and political discourse

The main pension-related issues in public debates, politics, policy circles, academia and amongst interest groups have been the following:

- Cuts in public expenditures affecting pensioners (mainly middle and higher earning pensioners)
- Debt burden of households, especially young families' households – continuous calls for more debt relief
- Need for increased activation and job creation for the unemployed
- Privileges of (formerly) public employees in pension provisions during the crisis
- Report into the losses of assets of the Occupational Pension Funds (OPFs) during the crisis, raised various issues in early 2012
    - Governance of the OPFs – role of fund members as against representatives of unions and employers' federations
    - Low pension receipts by many from OPFs as against the minimum pension guarantee of social security
    - Connections of OPFs to business and speculation interests during the bubble economy before the crash
    - Allegations of corruptions in operations of the OPFs, regarding networking with business and investors

Despite the stated policy of the government to shelter the lower income groups and the welfare state in general there have bee cuts in welfare expenditures. In the area of pensions and social protection these came primarily on individuals and families with average and higher incomes. The lower income groups were effectively sheltered, even though they got reductions in their real purchasing power and increased debt burden. In 2010 pension levels and benefits remained stationary and due to inflation this involved some cut in real living standards. These developments have of course caused concern and complaints from interest groups and politicians.

Concerns about debt burdens and calls for further debt reliefs for households have continually been voiced during the crisis – and quite loudly at times. The government has implemented various measures for debt relief. The biggest novelty in 2011 was an additional interest cost subsidy which the great majority of indebted households received, in differing degrees depending on income and debt situation. On average the government subsidies of household interest costs due to mortgages is now about a third of the interest burden for lower and middle income households, less for higher income earners. While this form of support involves a tripling of the government subsidies it has not stopped the calls for more debt relief. Calls for a flat cut of all household debts by some 20% continue to be voiced and as there is now only just over a year until the next scheduled parliamentary elections it seems that high flying promises of debt cuts and reliefs are set to become high on the agenda, for example amongst new political parties, of which two were established recently. More may emerge in the next few months.

The needs for increased activation are generally accepted and much has been done (Andersen et al. 2011). The labour market partners, unions and employers, have continually complained that the government has fallen short of promises for investments and job creation made in relation to last years collective agreement. The government claims that most promises have been fulfilled or

are in the process of being fulfilled. It is certainly true that investment in industry has been at an all time low during these crisis years (2009-2011), not least due to firms generally being over-indebted after the bubble and the crash and government finances have been in such a state that there has not much room to increase expenditures on industrial investments. Still the record on unemployment is not at all so bad compared to other European nations – and considering the enormity of the financial collapse in Iceland. Still growth has resumed as we showed at the beginning of this report.

An issue of considerable debate has been the alleged privileged position of pensioners receiving pensions from the public occupational pension funds (which have higher rates of accrual of rights than the general OPFs and enjoy a governmental guarantee of their "defined benefits"). While the OPFs had to cut their pension levels in 2009-2011 by some 10-15%, due to loss of assets in the collapse, the public funds did not have to cut their payments due to the guarantee. This "privilege" was bargained for a long time ago on the condition that public employees would enjoy better pension rights in return for accepting about 15-18% lower pay for their jobs than paid in the private sector for comparable jobs. So the public employees paid for their better pension rights but these are now increasingly contested by the labour market partners in the private sector and by some politicians, particularly on the right.

An added concern in this debate has been the fact that governments have not paid into the public funds fully what is needed for sustainability and hence the present position of these funds is unsustainable, their financial assets do not fully measure up to the pension promises (Ísleifsson 2011).

The federations of public employees (BSRB, BHM and KI) organised a conference and introduced a commissioned report with a comparison of the pension rights in the public and private occupational funds, this time taking account of the interaction between social security and occupational pensions and taxes (Jóhannesson 2012). Since those that get less from occupational pension funds do generally get more from social security, the interaction (due to the income-testing mechanism) significantly reduces the advantage that the public employees enjoy, often down to the region of 5-10% instead of 15-18%. This may significantly affect debates about the dual occupational pension system in the near future.

But the biggest provider of intense debate about pension issues was the publication of a public investigation into the losses of the OPF's assets during the crisis following the financial collapse. The funds themselves commissioned the investigation committee, which was however appointed by an independent party (the state arbitration conciliator). The committee consisted of three members and research staff. The report published on February the 3rd 2012 consists of 4 volumes. The main message was that the loss of the funds amounted to about 25% of GDP. The investigative committee found some fault in the operations of the funds in relation to selecting investments and in governance and regulatory frameworks and gave recommendations for improvements in accordance with its findings.

The publication of the report made the general public more aware than before of the extent of losses of the funds and various complaints arose in its wake. These involved criticisms of governance of the funds (for example the primary role of unions' and employers' federations representatives and lack of information about operations and proceedings), inadequacy concerns about pensions, dubious connections of funds' staff with business and financial actors as well as allegations of possible corruption. The debate was quite intense in the first days after the publication of the report and has by now slowed down. There is though some talk in parliament about the possibility of a special further parliamentary investigation or at least some examination

of the regulatory framework to make amendments in line with recommendations of the investigative committee as well as related to other issues.

Lastly, a continuing issue for debate is the interaction between the social security system and the OPFs, mainly through the income-testing mechanism. Work which was started in 2007 and finished in 2010 (VEA 2010), about strategies for simplifying the social security system and improving the income-testing mechanism for the benefits of pensioners, is now being continued by another working group with appointments from political parties and interest groups. This working group has the task of writing a new legislation before the end of 2012. It remains to be seen if that will be successful.

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 in 2010. Iceland took an active part in that and a number of interesting activities were organised and presented at the closing conference in January 2011.

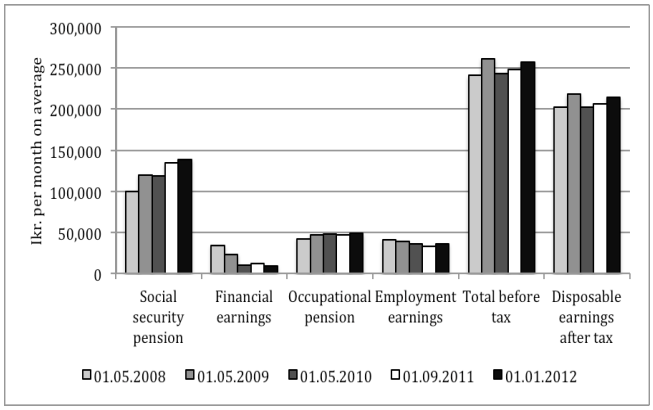
Another example of direct influences is from the EU-SILC data collection that Iceland has participated in from 2004. Data from that source has gradually entered the administrative and academic communities and seems set to indirectly have some growing influences in the near future. But direct impacts 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.

Laws on parental leave in relation to the birth of a child were changed in 2011 following recommendations done by EFTA surveillance authority. These involved rules about assessments of accumulated right to the leave emanating from work in other member countries.

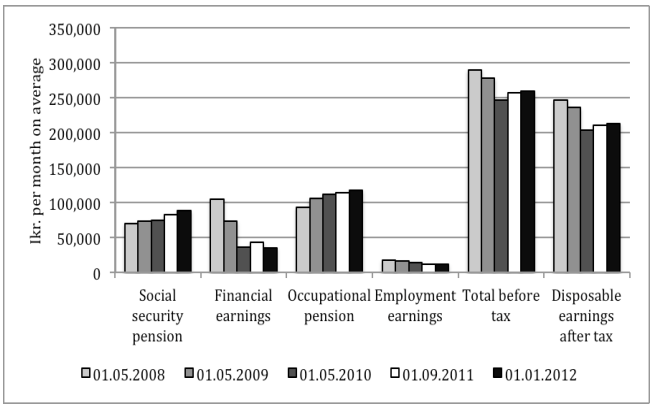
2.2.4 Impact assessment

Given that Iceland has managed to soften the impact of the crisis on lower income households to a significant extent, as shown in the first section, and that unemployment has remained below the EU average all through the crisis clearly indicates that something has been done correctly. In this section I will focus on how the pensioners have fared, mainly as regards financial level of living. We showed already that the elderly were not particularly affected by unemployment, at least not more than other age groups. In fact the young were the main casualties of unemployment and much has been done to alleviate those problems with activation, education and job creation projects.

Figure 6: Development of main income components of disability and old-age pensioners, 2008-2012



Disability pensioners



Old-age pensioners

Source: Social Security Administration, special analysis for SÓ.

In Figure 6 we show the income development for old-age and disability pensioners separately. This is a breakdown of the data from Figure 4 above. It shows clearly how social security is more important as a source of income for disability pensioners than for old-age pensioners. Employment earnings are also more important for disability pensioners. In fact Iceland has the highest employment participation rate amongst disabled individuals within the OECD (Hannesdóttir et. al. 2009).

On the other hand old-age pensioners rely more on incomes from the occupational pension funds (OPFs) and on their own financial earnings. Figure 6 surveys how each of these income components has developed through the crisis. Social security has increased quite a lot for disability pensioners and persistently but to a lower degree also for old-age pensioners. Occupational pensions have on the other hand increased more for the elderly. Both have lost employment earnings. But the cuts in financial earnings are the biggest cuts and they affect the old-age pensioners much more due to the larger role of financial earnings in that group. In fact the loss of financial earnings is the main reason for the cut in overall earnings for that group. There have been compensating increases in social security but they have not fully counteracted the loss of financial earnings. The fact that the disability pensioners have benefitted more from social security during the crisis than old-age pensioners is because their earnings are generally at a lower level and lower income pensioners were protected better than middle or higher earning pensioners, both by the welfare system and the taxation system

On the whole we see in Table 3 that social security pensions increased on average for all pensioners by 31.2% from 2008 to the beginning of January 2012, while occupational pensions increased by 23.6%.

Table 3: Changing fortune of pensioners during the crisis, 2008-2012. Accumulated change of the main income components and tax influences

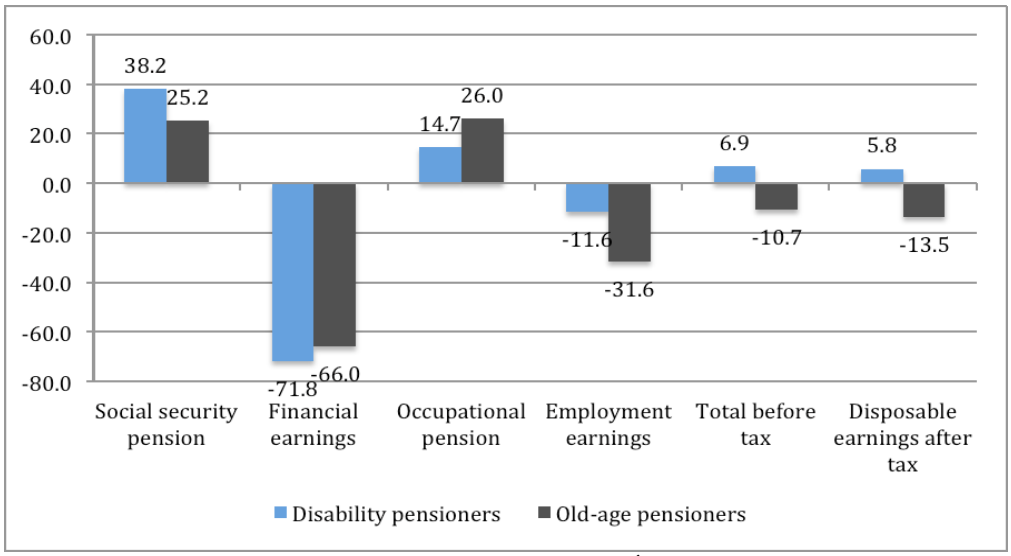
	Social security pension	Financial earnings	Occupational pension	Employment earnings	Total income before tax	Disposable earnings after tax
All pensioners	31.2	-67.0	23.6	-20.0	-5.0	-7.3

Source: Social Security Administration, special runs for SÓ.

Financial earnings declined on the other hand by 67% on average and employment earnings by 20%. These trajectories then produce a 5% cut in pre-tax total nominal earnings of pensioners and 7.3% cut in after tax disposable earnings. Price rises then reduced the purchasing power of all, but the level of living declined by far the most for the highest income groups, which had received the biggest gains during the bubble years leading up to the crisis (Kristjánsson and Ólafsson 2010). Here we see clearly how the social security system acts as a softener of crisis effects, while private sector earnings go down in a big way.

In Figure 7 we lastly show how the cuts and gains impacted differently on disability pensioners and old-age pensioners.

Figure 7: Accumulated change in main income components of pensioners, 2008-2012: Disability and Old-Age pensioners compared



Source: Social Security Administration, special runs for SÓ.

Here we see that the increase of social security benefits was more marked for disability pensioners (+38.2%) than for old-age pensioners (+25.2%), while the increase in occupational pensions was 26% for old-age pensioners and 14.7% for the disabled. Actual proportional decline of financial earnings was somewhat bigger for disability pensioners than for old-age pensioners (71.8% as against 66%), but financial earnings were and are a significantly larger share of total earnings for old-age pensioners. Similarly employment earnings declined more for the elderly but then have a smaller role there than for the disability pensioners.

Altogether the old-age pensioners lost significantly more incomes on average than disability pensioners (-13.5% of disposable earnings as against +5.8% for disability pensioners). That was both due to the great fall in financial earnings and the special raises of the minimum pension level which benefitted disability pensioners more than old-age pensioners. We can thus say that old-age pensioners have on the whole felt the crisis induced cuts in living standard significantly more than disability pensioners. Old-age pensioners are now on average at a similar level with total earnings as disability pensioners but were before the crisis with significantly higher earnings. They have thus lagged behind and that is primarily felt by middle and higher income earnings pensioners.

Pensioners have thus been protected from falling under the poverty line to a significant extent, most importantly by rises of the minimum pension guarantee and lower tax burden on the very lowest incomes. Employment levels of the elderly have also not been drastically affected,

allowing many pensioners to supplement their living standards with some, but declining, employment earnings.

Regarding gender differences amongst pensioners we can say that males were more inflicted with unemployment to begin with but that has evened out during the later part of the crisis period.

2.2.5 Critical assessment of reforms, discussions and research carried out

On the whole we can say that the strategy of using the social protection system, and the taxation system, to soften the negative impact of the financial crisis on the level of living standard of the more vulnerable part of the population has succeeded very well. Everyone has however felt the cuts in living standard inflicted with the 50% collapse of the currency (ISK) in 2008. That produced inflation which reduced real purchasing power as incomes remained stationary or declined nominally. The devaluation of the Icelandic Krona helped export industries and probably helped to contain the unemployment problem, but at a great cost for the real level of living of households. One can of course debate which is better, more cuts in living standards and less unemployment (the Icelandic way) or better protected living standards and more unemployment (the Euro way). It would of course be best to avoid financial bubbles and concomitant financial crises.

But what stands out, which ever way is chosen or prescribed, is that the social protection system can be a major asset in softening the crisis impact on the population. It can shelter the most vulnerable groups in society and alleviate the worst miseries of the unemployed.

Iceland has also been able to learn from well tried activation measures in the Scandinavian labour markets during the crisis. As a part of the learning process some policy makers sought information on the consequences of the financial crises in Finland and Sweden in the early 1990s and aimed to avoid pitfalls that emerged at that time and also to translate well working solutions into the Icelandic context now. On the whole I would argue that many policy initiatives have been successful in Iceland so far. It still remains to deal further with the debt burden problems. The government has employed a piecemeal approach, gradually introducing new measures as the crisis has progressed, often in the wake of evaluation studies of already implemented measures. There clearly is still a lot of anger and dissatisfaction in the society with the debt burden and the associated injustices which are deeply felt in many households. And even though perhaps up to a half of the households presently in greatest difficulties were already in difficulties before the crisis, it seems likely that the government will add more to the debt relief measures as public finances are strengthened with the balancing of the budget in sight and economic resumed growth.

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 from beginning of 2011, has the

administrative responsibility for the overall system and the Directorate of Health has the main supervisory role, according to a 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/www.velferdarraduneyti.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 centralization 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 outpatient 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 have been 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).

In Table 4 we survey the development of public expenditures through the crisis up to end of 2010 (more recent figures are not yet available, but we would expect some further cuts to emerge in 2011 figures).

Table 4: Public health expenditures during the crisis, in fixed 2010 prices (000s ISK)

	2000	2005	2006	2007	2008	2009	2010
07 Health	106833	121659	124891	130703	133936	129665	121020
0711 Pharmaceutical products	9217	8917	9049	8929	10603	11153	9594
0713 Other medical products	1599	2265	2345	2595	2677	2983	3008
0721 General medical services	10292	12672	13511	14221	14591	13520	13377
0722 Specialized medical services	4700	5062	4978	5225	5920	6269	5904
0723 Dental services	1898	1780	1686	1612	1576	1422	1298
0724 Paramedical services	2779	4255	4495	4560	4660	4275	3897
0731 General hospital services	55372	60457	62049	65000	65746	62841	57360
0732 Specialized hospital services	1284	1266	1188	1280	1615	1982	1686
0734 Nursing and convalescent home serv	16165	20890	21842	22975	22424	21079	20647
0740 Public health services	618	826	812	902	793	763	746
0750 R&D Health	68	77	76	74	68	70	66
0760 Health n.e.c.	2840	3190	2860	3330	3262	3307	3438

Source: Statistics Iceland

Overall health expenditures have come down from 2008 and are in 2010 about 90% of the 2008 level. This has impacted differentially on the various sectors of the health care services. Pharmaceutical products increased significantly in price after the collapse of the currency in 2008, leading to increased costs in 2008 and 2009, but in 2010 significant cuts were achieved (the 2010 level is about 86% of the 2009 level). General medical services have come down gradually from 2008 and specialised medical services increased up to 2009 but then came down in 2010.

Dental services have had a rather dramatic development from the early 2000s, with a persistent reduction of public expenditures. By 2010 the expenditures on dental services are only about 68% of the level of 2000. The role of user charges have clearly increased in dental services. General hospital services take the largest part of the health expenditures and they were significantly lowered after 2008. In 2010 they are about 87% of the 2008 level. Nursing and convalescent home services have had a gradual reduction of public expenditures from 2007.

There have been considerable concerns about emigration of medical personnel from Iceland to Norway and other Nordic countries, due to the crisis. This is no doubt right but there has also been a significant stream of non-medical emigrants from Iceland during the crisis years, so the number of population per medical specialist may not necessarily have changed drastically, even though this might have led to reduced manning levels in health care services. So the threat of cuts in service volumes and standards need not be serious. We should also keep in mind that Iceland had high levels of health care personnel per population compared to the neighbouring countries (OECD 2009 and 2011). Table 5 surveys the ratio of population to medical specialists of various kinds.

There we see that the development is somewhat varying depending on types of medical specialists. For dental hygienists there was an significant increase in the number of population per specialist in 2009 which continued in 2010. The same applies to examination pharmacists. The ratio of nurses to population has however not changed significantly during the crisis and that also applies to practical nurses. For occupational therapists the ratio of population per specialist has come down persistently from 2005 (probably because they have grown in numbers).The same applies to pharmacists and physiotherapists.

Table 5: Number of population per medical specialist, 2005-2010

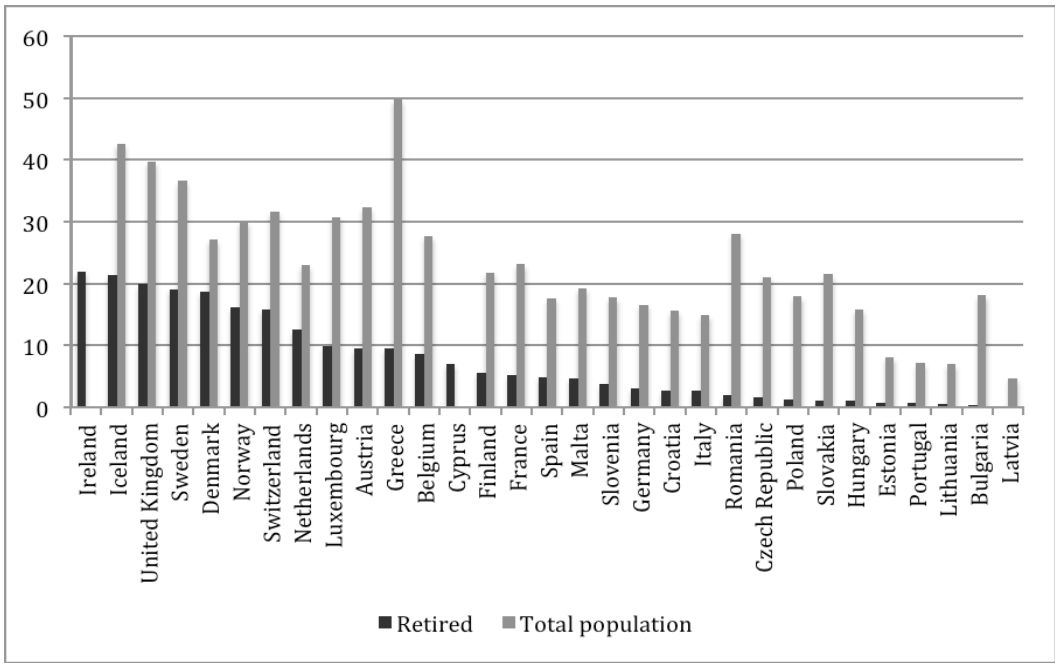
	2005	2007	2008	2009	2010
Dental hygienists	11996	16603	17743	22688	22747
Dentists	1038	1073	1061	1080	1065
Exam. pharmacists	9088	10878	11828	14438	13846
Midwives	1293	1288	1277	1271	1274
Nurses	118	116	117	118	120
Occupational therapists	1922	1867	1736	1663	1642
Pharmacists	1003	965	971	951	931
Pharmacy technicians	..	..	1846	1836	1841
Physicians and surgeons	280	280	276	272	278
Physiotherapists	714	701	672	676	673
Practical nurses	187	193	160	145	161
Proprietary pharmacists	5355	5633	6142	5882	5587
Radiographers	3296	2948	2985	2811	2769
Social workers	..	1052	965	892	808
Biomedical scientists	996	1099	1079	1062	1034
Environmental health officers	5767	6067	5807	5993	5897

Source: Statistics Iceland.

The ratio of population to physicians and surgeons has fluctuated in the region of 278-280 in the period and thus remained at quite similar level. The ratio of population to social workers has come down from 2007, indicating a better capacity to deal with needy clients (who may however grown proportionally during the crisis).

In Figure 8 we show interesting indicators of health standards in Iceland (based on self-reported health qualities), in comparison to the EU member countries.

Figure 8: Self-reported health in 2010: % saying own health is "very good". Retirees and total population compared



Source: Eurostat EU-SILC.

Iceland clearly has one of the higher proportions of general population that claim to have a "very good" health. Greece has the highest rate. Perhaps more realistic is the proportion of retirees that claim to have very good health (also shown in the Figure – the black columns). Iceland and Ireland top the bill on that count, closely followed by UK, Sweden, Denmark, Norway and Switzerland. That is an important measure since retirees are potentially big users of the health care system. Those nations that have a higher proportion of retirees in good health are thus blessed with less load on their health care system, in addition to the advantage enjoyed by the retirees themselves.

The main health care reforms undertaken in 2010-11 were the following:

- Decision to remove all French PIP silicon breast implants by the public health care services, despite the fact that all or most of them were implanted by private practisioners (07.02.2012)
- Legislation proposal in parliament for synchronising and unifying the work of committees for evaluating need and rights of elderly and infirm for nursing home services (26.01.2012)
- Parliamentary recommendation for a plan to improve services to disabled individuals. This involves definition of priorities, goals, definitions of evaluations criteria and stages of implementation. The plan emanates from the UN stipulations on rights of disabled people regarding accessibility, services, employment and evaluations of service qualities (13.01.2012 and specified ministerial guidelines 24.01.2012) (this is also mentioned under Pensions)
- User fees for health care services raised from January 1st 2012 by 5.3% on average. Some changes in the rules about subdsidies were also implemented, for cutting costs (22.12.2011)
- New legislation proposed in the area of scientific health-related research and for handling of bio-samples (15.12.2011)

- New legislation proposed for directing the form of user share in medication costs. This involves an implementation of a limit on individuals' medication expenditures (for prescribed medications), thus lowering the cost for those who have greater needs for medications and unifying subsidies between different categories of medications (23.11.2011)
- Ministry of Welfare receives report of a working group commissioned to recommend changes in fundamental organisation of health care services and use of public funds for health care. The working group received an extensive evaluation study from Boston Consulting Ltd. on characteristics and outcomes of the Icelandic health care system (28.10.2011). The Ministry will work further with the recommendations of the group.
- Ministry of Welfare receives a major study of services for disabled and handicapped individuals, from Social Sciences Research Institute of University of Iceland, to use in evaluating the development of such services after their transfer from the state to local communities (16.09.2011)
- Decided to build new nursing homes in Reykjavík, Isafjord, Reykjanesbæ and Eskifjord. There were a part of job creation and welfare enhancement plan of the government (various dates)
- Evaluation study of the Health Plan Towards 2010 finalised. Most goals found to have been reached or approached, but a few remain without significant success (the most notable failures are the goal of reducing alcohol consumption, reducing dental decay of children at age 12 and the goal of reducing suicides by 25%) (10.06.2011)
- Regulation for temporary subsidised dental services for low income children (26.04.2011)
- Unification of the Directorate for Health and the Public Health Institute accepted in parliament (30.03.2011

2.3.2 Debates and political discourse

The main issues of debate in relation to the health care services in 2001-12 were the following:

- Cuts in public expenditures negatively affecting the health care services, supposedly affecting service levels, qualities and increasing waiting lists for operations
- Cuts in provincial health care services have been particularly sensitive
- Fear of loss of doctors and nurses through emigration, especially to Norway and other Scandinavian countries
- Continued weakening of general physicians in health care centres continues, due to difficult manning conditions and ageing of the specialised labour force.
- The faulty breast implants scandal appears to have been quite extensive in Iceland, with between 60-70% of implants leaking, according to a preliminary survey

Concerns about the consequences of cuts in public expenditures have of course dominated general debates and political discussions, as well as amongst the professional staff involved. At the same time there has been an understanding of the need for cuts and within the system there has been considerable determination to do the cuts strategically so as not to harm the core services. Firstly administrative costs were cut, then benefits and higher earnings and then manning has been trimmed. As the course of the crisis has progressed the pressure on reduced manning has increased. Amongst the staff of the main hospital services the word is now that further cuts will inevitably mean reduced service in important areas.

A part of the strategy has been to redefine roles within the health care service, with increased centralisation of specialised services and reduction of that factor in provincial hospitals and health care centers. Instead transporting patients to main health care centers is to be the goal. This is of course particularly unpopular in the smaller communities concerned, not least since health care staff are an important part of the human capital in these communities. Thus the austerity measures often get an added regional dimension.

A very prominent part of public debates about the health care services has been the issue of emigration of doctors and nurses. Many are assumed to have gone to Norway where there have been ample job opportunities. Spokesmen of physicians and nurses have frequently pointed to that factor as an unfortunate consequences of great cuts in expenditures. It is clearly of financial interest for Icelandic medical specialists to work in Norway and live in Iceland, since they get an extra purchasing power for their foreign earnings due to the low rate of the Icelandic Krona after the collapse. Hence it is quite common for such staff to work part time in Norway or other Scandinavian countries (perhaps a week or two per month). This appears to have increased during the crisis but some have of course emigrated fully.

One important fact should be kept in mind in this respect when predicting serious consequences of emigration for the services. Firstly, the net loss of population during the crisis is in the region of 1.5-2% of population, so many clients of the health care system have emigrated, including foreign labourers that came to Iceland during the boom years of 2003-2007. Secondly, Iceland had a very high rate of specialised medical staff per population before the crisis. So there was room for some cuts in some areas. This may still produce problems when very specialised fields with only a few specialists are affected. We will assess the effects of manning levels on the service in section 2.3.4 below.

A long term characteristic of the health care services in Iceland has been the relatively weak position of general practitioners as against specialist physicians. The community health care centers have also been relatively weak and this had been a trend of decline up to the present. The association of general practitioners has repeatedly warned about this and pointed to declining recruitment into the services and a disproportional ageing of presently working general practitioners. This is an issue of great concern to administrators and the Ministry of Welfare, which has been engaged in considerable work to change the organisation and roles of general practitioners in order to strengthen the health care centers as the first point of entry for patients and by increasing the role of GPs as gatekeeper to the use of specialist services. Iceland has been one of the few countries in OECD where such gatekeeping has been at a very low level (Ásgeirsdóttir 2009; OECD 2009 and 2011). More will be said on that in the impact assessment section.

Towards the end of 2011 the issue of the faulty silicon breast implants (French PIP cushions) emerged as a major health care scandal. The implants were found to be leaking in many cases and causing an increased risk of cancer. After the issue came up it emerged that information about the number of women who had receives such implants was not at all clear and there were inadequate records kept in the private clinics that mostly did this work. An issue of inadequate surveillance and regulation for private medical practise emerged (this is most potent in areas where the government does not subsidise cost of operations, hence inadequate registrations), as well as some issues of tax evasions amongst private practitioners. These issues are presently being examined and of some concern. The Ministry of Welfare has now, on the basis of a recommendation from the Directorate of Health, decided to have all faulty PIP implants removed by the public health care services. Hence the cost of that falls on the public purse even though most of the implants were carried out by private practitioners.

2.3.3 Impact of EU social policies on the national level

In general it is difficult to point to significant impacts of EU social policies on the Icelandic health care system, for the same reasons that were outlined regarding the pensions, i.e. Iceland not (yet) being a member of the EU. There were however a few changes in legislations that can be applied to rulings by the ESA or the EFTA surveillance authorities, mainly concerning technicalities related to transfers of rights between countries. No major changes of policy during the year can be directly connected to impact of EU social policies.

2.3.4 Impact assessment

The financial and economic crisis has clearly strained the health care system. As we showed in Table 5 above there has however not been a serious erosion of population to medical specialist ratios. There have clearly been cuts in manning levels, both in support staff and to some extent of specialists. The number of clients has also gone down, as we mentioned above. So the Icelandic health care service was falling from a very high position as regards quality of services and success rates (see further data in Appendix and in OECD 2011). Even though the system has been forced to rationalise costs continually from the early 2000s it was in 2003 significantly more expensive to run than it is now, and in fact it was along with the Norwegian system the most costly of the Nordic health care systems. It is thus of interest to consider some important indicators of the extent and quality of services, which we do in Tables 6 and 7 below.

Table 6: Contacts with specialists 2005-2010

	2005	2007	2008	2009	2010
Total	489882	493678	535451	617544	620036
Opthalmology	60916	65376	68750	67572	68722
Paediatrics	42916	41629	43774	46565	49152
Orthopaedics	25730	29810	28029	26336	32962
Psychiatry	35152	36766	38273	39243	38635
Child/adol. pshychiatry	3489	2489	2754	2861	2902
Oto rhino laryngology	32806	36423	37805	39785	40601
Dermatology	32657	37404	41237	45112	44907
Gynecology and obstetrics	31578	31114	32891	31087	30845
Internal medicine	65168	43382	64165	79822	78646
General surgery	14731	14509	13653	14750	14167
Anesthesiology	12623	11752	10075	13881	14254
Oncology	2542	1864	1913	2854	2674
Neurology	6077	7843	8409	8361	7816
Urology	10311	10701	11835	12305	12643
Geriatrics	229	384	562	966	1258
Plastic surgery	7131	6944	9887	11647	9670
aser/glaucoma	28	37	27	45	34
Laser therapy	1942	3805	4357	4228	2257
Cataract	.	.		3212	3254
IVF	.	.	685	806	854
Laboratory doctors	58658	63250	65694	68897	66398
Radiotherapy/Radiology	45198	47810	49876	50050	49769
Laboratory research overall LSH	.	.	.	40 68	39990

Source: Statistics Iceland.

Table 6 shows that overall contacts of patients with specialists have increased by about 25% from 2007 through 2010. This is despite the fact that population growth stopped or slowed greatly down in 2009 and 2010, which were the years of greatest emigration of population. This would indicate that there might have been increased productivity levels within the services during the crisis.

With such great levels of increase in contacts with medical specialists we primarily see increases in individual specialty branches, but there are a few cases of modestly declining frequency of contacts, such as for gynecology and obstetrics, neurology and laser therapy. In some areas there have been little changes in numbers of contacts, such as in psychiatry, general surgery, radiotherapy and for laboratory doctors. A particularly steep increase is in the area of geriatrics.

Another important indicator of extent of services is the development of waiting lists for common operations within the hospital services. This we show in Table 7.

Table 7: Waiting lists for common operations in hospitals. Number of individuals waiting more than 3 months, from October 2008 through October 2011

Procedure	10.2008	2.2009	06.2009	10.2009	02.2010	06.2010	10.2010	02.2011	6.2011	10.2011
Decompression of spinal cord and nerve roots, lumbar area	7	4	5	11	5	2	8	6	6	6
Partial or total thyroid excision	4	1	0	0	1	1	6	0	2	3
Cataract surgery	1543	1224	1227	1222	558	381	532	526	379	591
Repair of septum of nose	40	51	35	39	24	15	25	25	13	31
Tonsillectomy and/or adenoidectomy	117	77	55	59	47	48	67	47	47	54
Heart valve surgery	4	8	6	5	6	5	5	1	0	2
Coronary anastomosis surgery	4	5	0	0	3	8	7	1	0	0
Angiography of heart and/or coronary arteries and PTCA	86	43	4	4	6	2	17	5	3	39
Partial excision of mammary gland		46	48	1	0	0	1	1	0	2
Reduction mammoplasty	141	138	145	91	84	91	104	109	67	67
Repair of inguinal or femoral hernia	7	11	11	29	14	10	22	17	24	29
Repair of gastro-oesophageal reflux	1	0	0	12	15	8	9	10	22	10
Bariatric operations on stomach	15	1	0	23	7	0	5	7	9	10
Cholecystectomy or lithotripsy of biliary tract	4	10	13	13	7	8	27	17	17	32
Removal of calculi from kidney and pelvis of kidney/operations for calculus of ureter	2	1	0	2	2	1	1	0	0	0
Extracorporal shock wave lithotripsy of pelvis of kidney or urether	0	0 *	*		0	0	0	0	0	0
Operations for incontinence or prolapsed uterus	118	131	113	174	109	102	157	144	137	146
Operations on prostate	0	2	2	1	1	1	1	1	1	2
Prostatectomy, transurethral procedures	10	15	7	6	4	7	6	6	8	7
Male sterilization	0	0	2	2	0	0	2	1	2	2
Hysterectomy	23	23	21	52	29	16	37	36	21	12
Female sterilization	2	6	6	12	11	2	7	2	9	12
Prosthetic replacement of hip joint	184	132	124	170	141	128	197	199	140	148
Prosthetic replacement of knee joint	263	171	152	210	247	235	330	306	231	269
Ligature/stripping of varicose veins	73	72	37	27	27	21	25	18	16	26

Source: Directorate of Health (fetched and adapted on 13.02.2012).

On the whole the message from this Table and from further data at the Directorate of Health is that waiting for operations in the hospital services has not changed significantly for the worse. In fact what is more common is to see reduced numbers of individuals waiting for more than 3 months for operations. That is a clear sign of increased productivity in the specialised service. That can be taken as reflecting increased effort of staff and better management.

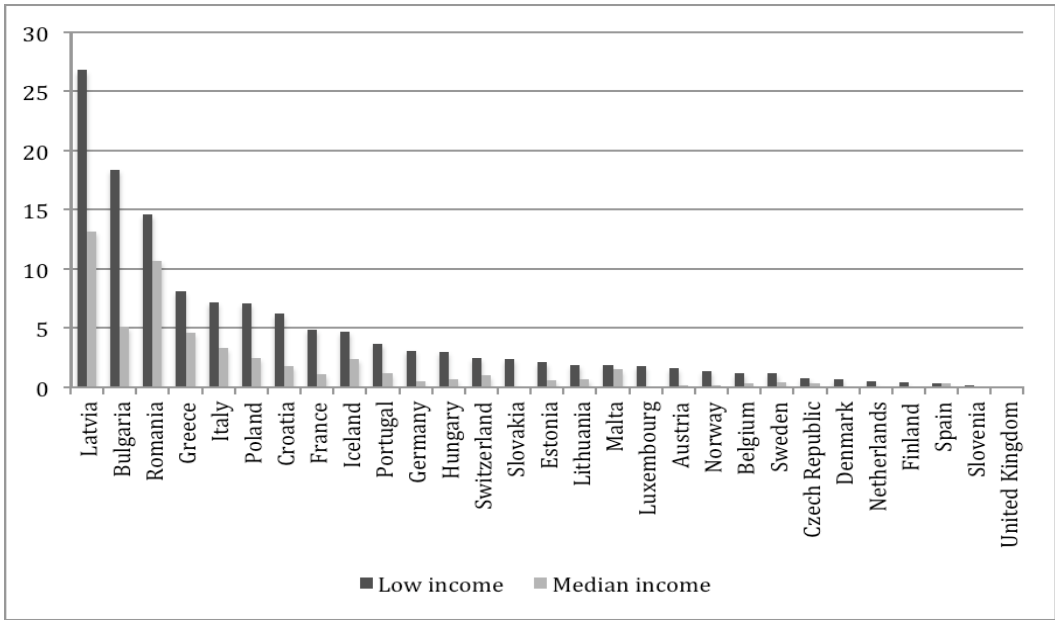
The number of patients waiting more than 3 months for cataract surgery has more than halved from 2009 to 2011, which in a normal year could indeed be taken as a significantly improved service. There have also been shortenings of waiting lists for tonsillectomy and/or adenoidectomy, angiography of heart and/or coronary arteries and PTCA and other heart related operations and partial excision of mammal gland. reduction mammoplasty. Waiting for prosthetic replacement of hip joint increased in 2010 but came down again in 2011. Cases of increased waiting are a few but in most of those the increase in numbers on waiting list is modest.

So on the whole it would seem that adjustments to increasingly strained finances of the health care services have been very successful as regards maintaining service volumes. It remains to be seen if the detailed quality of services has been negatively affected, so as to lower convenience conditions but there are no clear indicators so far of serious cuts in overall success rates (OECD 2011). This means that Iceland has maintained a high quality health care service through the trying crisis. Now that growth has resumed and not much remains as regards need to cut the public budget further after 2012, it is hoped that the health care sector has seen the worst and can hope to obtain some improvements, such as for renewing technical equipment. There have also been launched plans to build some new high-tech hospital buildings on the site of the current main hospital in Reykjavik (Landspítali-Háskólasjúkrahús), which is also seen as an effort in stimulating the labour market in addition to introducing improvement in the hospital services.

2.3.5 Critical assessment of reforms, discussions and research carried out

A part of the consequences of the austerity measures has been an increase in user charges in the health care services. Before the crisis Iceland had slightly higher user charges than the other Nordic nations (NOMESCO 2009; Ólafsson 2008). This has of course involved increased burden on households of patients. One possible consequence is growth of unmet needs for medical examinations and operations. Iceland has had a somewhat higher level of this than the other Nordic nations and in Figure 9 we see an indicator of this and the associated inequality dimension. The Figure includes rates of unmet needs for households with low incomes (the lowest quintile) and those on average incomes. Unmet needs are typically higher in lower income households.

Figure 9: Unmet needs for medical examinations in 2010, by income groups (lowest quintile and medium quintile of equivalised incomes)



Source: Eurostat.

Iceland ranks in 9th place on this scale for unmet needs amongst the low income households, or close to the level of France. It is significantly higher than in the other Nordic countries which have particularly low levels of unmet medical needs amongst low income households. So that is an expected feature of higher user charges and this feature has most likely increased in Iceland during the present crisis, even though the change is not decisive (see also Vilhjálmsson 2011). The Ministry of Welfare has recently changed the system of fees and out-of-pocket payments for medications so as to shelter better those who have greater need for medications and use of health care services. The common public bears higher burdens instead.

Another feature of higher user charges is in the field of dental health care services. Iceland had a very low level of public subsidies to the predominantly private dental care services. This has also declined significantly during the last decade, as shown above. This means that the level of unmet needs for dental care is significantly higher in Iceland than in the Scandinavian countries and UK. The quality of dental health amongst 12 year old children is also significantly lower. It is one of Iceland's goals for the year 2020 to reduce this poor state of dental health amongst youngsters and that calls clearly for a greatly increased effort in the coming 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 organisations 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 active 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/efriarin/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 neighbours, 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 the 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 asisp 2011 report for an account of the new ministry).

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 in Appendix).

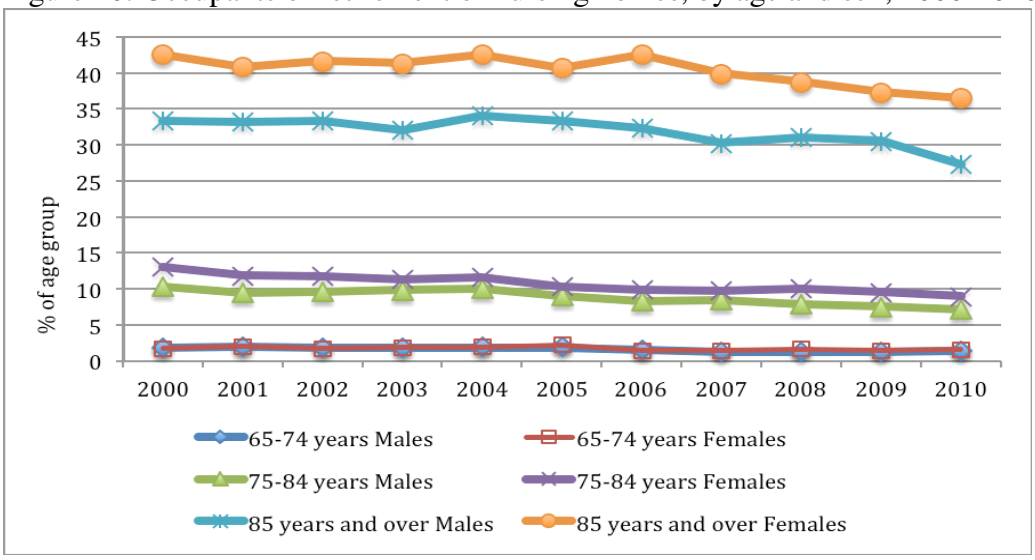
This is somewhat surprising given that the demographic composition of the Icelandic nation is such that it has a lower proportion of people at ages above 65, and the numbers of disabled people under 65 are not significantly larger in Iceland either. In some cases this ample supply of places in institutions 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 a 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; cf. 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 Appendix Table 3 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.

Figure 10: Occupants of retirement or nursing homes, by age and sex, 2000-2010



Source: Statistics Iceland.

Figure 10 shows the development of occupancy in retirement or nursing homes from 2000 through 2010, by sex and age. We see how the older groups are larger users of these services, especially older women. But the common trend is that the proportion of age groups using these homes is going down, especially amongst the older groups. This is associated to the trend of increasing the stay of the elderly in their own homes, and facilitating that by expanding the home help services provided by local authorities. The growth of home help services is shown in Table 8.

Table 8: Receivers of home help, 2005-2010

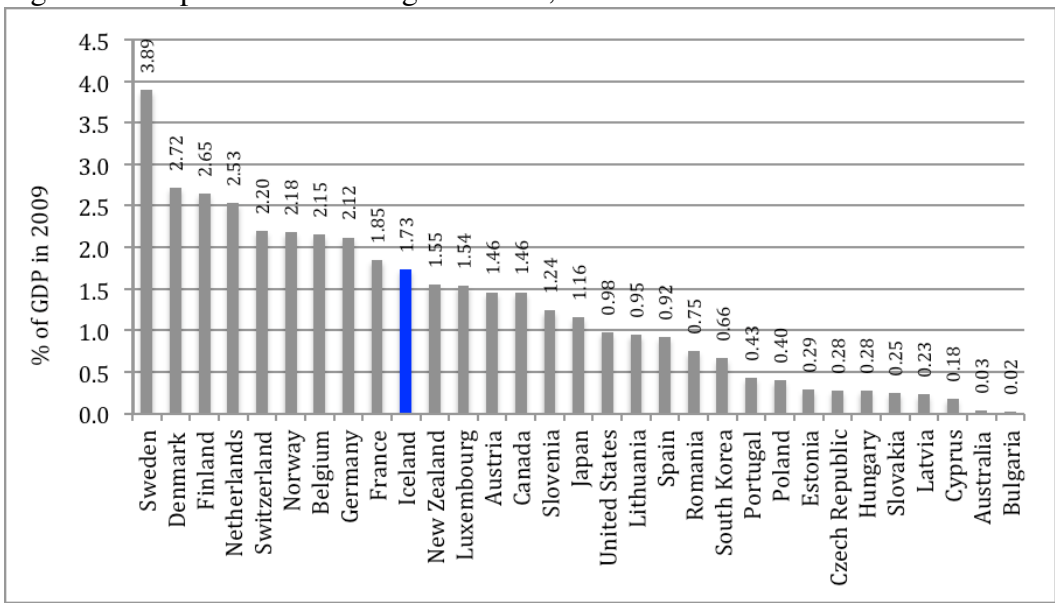
	Total	Homes of the elderly	Handicapped in households	Other households
2005	7496	5687	1119	690
2006	7532	5751	1325	456
2007	7626	5833	1253	540
2008	7864	6019	1413	432
2009	8060	6160	1517	383
2010	8148	6493	1258	397

Source: Statistics Iceland.

The increase in home help for the elderly has grown persistently through the last decade while the development for households with handicapped individuals is more indeterminate.
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). In Figure 11, we show an international comparison of expenditures on long-term care as a proportion of GDP in 2009.

Figure 11: Expenditures on long-term care, as % of GDP 2009



Source: Eurostat.

Iceland is in 10th place with 1.7% of GDP spent on this area. The Scandinavian countries, the Netherlands and Switzerland spend most. Given Iceland's lower proportion of elderly inhabitants this is as expected, given the rather high level of service capacity prevailing in Iceland.

2.4.2 Debates and political discourse

Main issues of debate in 2011 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)

In fact, the issues of debate are pretty much the same as in 2010, but in some areas, the government has moved forward with progress plans, such as regarding the building of new nursing homes, both as an example of economic stimulus measures for creating jobs, but also to improve the long-term care services at the same time. This accommodates to the most frequent complaint about the long-term care services, that there is too much lack of privacy for interns, due to the prevalence of room sharing with unrelated individuals. Therefore, the goal is clearly to increase single occupancy in such institutions/homes. With new nursing home buildings there usually also is more room to increase use of day care places for individuals in poor health who still stay in their own homes.

While in the political arena there has been considerable talk for some years now to change the form of payment for use of retirement or nursing homes, but little progress towards that has been made to date. The Ministry of Welfare has continued to promote improved quality of services with surveillance and provision of improvement grants, as well as in emphasising the

constructive use of formal evaluation systems (RAI and EDEN). And during 2011, the emphasis on user-directed personal assistance to seriously handicapped individuals gained some ground with the increased emphasis by the Ministry of Welfare on that as a goal.

2.4.3 Impact of EU social policies on the national level

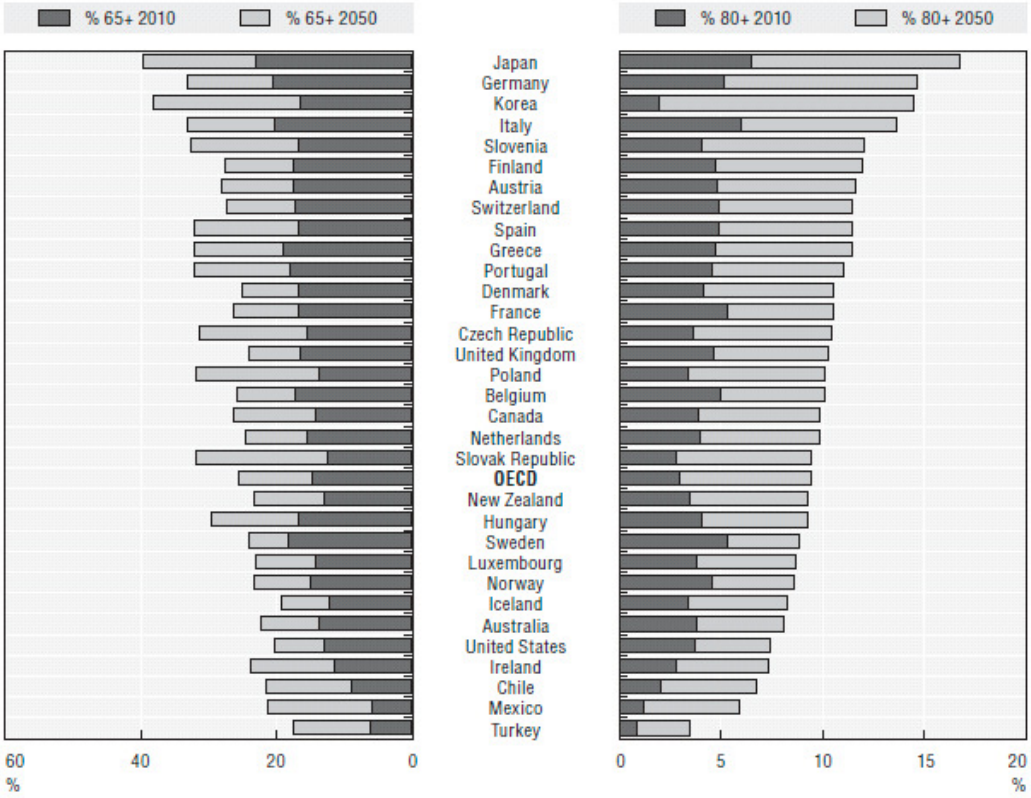
It is difficult to point to significant direct impacts of EU social policies on the Icelandic long-term care system, for the same reasons that were outlined regarding pensions and health. Many of the EU 2020 goals for welfare have already been obtained in Iceland and service levels in the long-term care area are at a higher level than in most EU countries.

2.4.4 Impact assessment

While Iceland already has a quite high level of long-term care provisions, which are however still expanding, the prognosis in the long-term future is also comforting to some extent since the burden of ageing is still low in Iceland and will continue to be low by international standards, as evident from Figure 12.

Iceland will by 2050 still be amongst the countries with the lowest proportion equally of citizens 65 and older as well as the very old (80 years of age and older). This means that the growth of demand in store for the next decades is not at all likely to be a particularly heavy burden. Maintenance and improvement of the already high standard will most likely be a valid and reachable goal, everything else being equal.

Figure 12: Demographic prognosis for elderly share of population, from 2010 to 2050



Source: OECD (2011)

As regards the organisation and quality of the long-term care services we now have access to a new study which was published in late 2011, surveying the staff of the care services in Iceland for the first time in a comprehensive manner (Karlsdóttir 2011). The data comes from a

standardised survey which was conducted in the same way in all the Nordic countries (in 2005 in Scandinavia and 2009 in Iceland), hence allowing for an interesting intra-Nordic comparison.

Table 9: Some characteristics of long-term care staff in elderly care

	Iceland	Denmark	Finland	Norway	Sweden
	%	%	%	%	%
Number of respondents	420	403	440	438	323
Females **	95,2	98,3	98,9	98,4	96,9
Age: ***					
< 25	20,4	2,8	6,2	3,8	7,3
26-30	5,7	5,9	5,0	4,7	7,3
31-40	13,3	17,0	19,9	17,9	19,2
41-50	16,2	34,4	31,1	32,9	28,1
51-60	25,9	36,1	35,0	32,9	27,8
61 +	18,5	3,8	2,7	7,8	10,4
*Length of training for job:****					
0-6 months	56,6	3,8	6,4	7,4	13,8
6 months -2 years	18,5	63,2	46,7	54,8	53,1
2 years or more	24,9	33,1	46,9	37,8	33,1

Source: Karlsdóttir 2011.

Here we see that the Icelandic care workers are generally younger than in the other Nordic countries, but the part of the staff that is above age 60 is also larger in Iceland. About 95-98% are women in all the countries. A decisive difference is that the Icelandic workers have much shorter period of training for the job than in the other countries and further data also show that they have less experience in the job. So the degree of professionalism seems lower and there may be more turnover of staff in the case of Iceland. The proportion of non-native speaking staff is also higher in Iceland.

Table 10: Orientation to the job and working conditions

	Iceland	Denmark	Finland	Norway	Sweden
	%	%	%	%	%
Find the job interesting:					
-always or most of the time	94,5	96,3	97,3	96,3	94,7
Have an opportunity to learn new things:					
-always or most of the time	71,0	83,9	86,2	72,4	70,3
Demands are in proportion to my capability ***					
Agree	78,2	85,4	87,8	87,7	79,8
I often find it rewarding to take care of my clients." ***					
Agree	97,3	87,2	96,1	85,5	88,7
Think that the service receivers appreciate my work: ***					
Rather much	75,1	88,9	90,5	89,7	87,9
Think that relatives of inmates appreciate my work: ***					
Rather much	63,4	78,2	79,5	84,0	81,4
Think that administrators of the municipality appreciate my work ***					
Rather much	17,6	17,6	8,6	14,2	7,1

Notes: *p<0,05, **p<0,01, ***p<0,001
Source: Karlsdóttir 2011.

Altogether about 95-97% find their job interesting always or most of the time in all the countries. Iceland has the highest proportion finding it rewarding to take care of the clients/inmates, but a lower proportion think that service receivers and their relatives appreciate the work and service provided than is found in the other countries, but still it is in the region of 63-75% who think that their work is appreciated by those concerned. Relatively few of the workers think that municipality administrators appreciate the work being done in the LTC services.

So the indication is that the degree of professionalism may be lower in Iceland than in the other Nordic countries' LTC services, but the commitment of the Icelandic care workers seems to be good as well as their working conditions. Iceland does well on the volume of LTC services but can improve on the quality, relative to the other Nordic countries.

2.4.5 Critical assessment of reforms, discussions and research carried out

Overall Iceland seems to rank highly on LTC services in the European context. It is on a similar level as the Scandinavian nations, but has a younger population and is thus less advanced in experience in this field. The pace of build-up of the LTC service facilities is fast, even during the crisis, since the building of new nursing homes has been used as a part of economic stimulus activity to create jobs. Thus, the goals of job creation and welfare enhancement are synchronised, even in these hard times.

Table 11: Assessment of the job and own condition and effort

	Iceland	Denmark	Finland	Norway	Sweden
	%	%	%	%	%
Feel badly because the inmates are not getting the service they should be getting: ***					
-Always or most of the time	66,7	74,5	85,1	86,8	88,9
The work place is undermanned because of illness, summer holidays or lack of staff: ***					
-Every week or more often	39,2	53,7	38,6	44,7	40,2
Need to carry heavy loads or the inmates: ***					
-Often or most of the time	56,8	62,9	89,4	73,1	80,2
Do you have much to do in your job? ***					
-Often or most of the time	38,7	30,2	50,6	38,6	39,9
Are you physically tired after the workday: ***					
-Often or most of the time	67,9	61,9	74,7	69,4	67,2
*Are you mentally exhausted at the end of the workday***					
-Often or most of the time	36,3	30,9	43,3	36,3	41,8
Do you have backpain after the work: *					
-Often or most of the time	42,5	34,7	32,3	35,6	37,8
Do you loose sleep because you are thinking about your work: **					
-Often or most of the time	9,0	15,6	19,6	16,2	16,7

Notes: *p<0,05, **p<0,01, ***p<0,001
Source: Karlsdóttir 2011.

Lastly, we look at further evaluation criteria from the above-mentioned survey. It is interesting that the Icelandic service workers do not as often as workers in the other countries say that they feel badly because the inmates are not getting the service they should be getting (67% as against 75-89%). The Icelandic workers also more rarely complain that there is under-manning of the services or that they are required to lift heavy loads. Just over a third say they have much to do in their job and a lower proportion of the Icelanders find their job either physically or mentally exhausting than is the case in the other countries. More however complain of back pain in relation to the job.

So on the whole the conditions for work in the LTC services seem quite reasonable in Iceland and the possibility of providing good care is thus real. What is also important is that some progress is being made, even in the midst of the financial crisis.

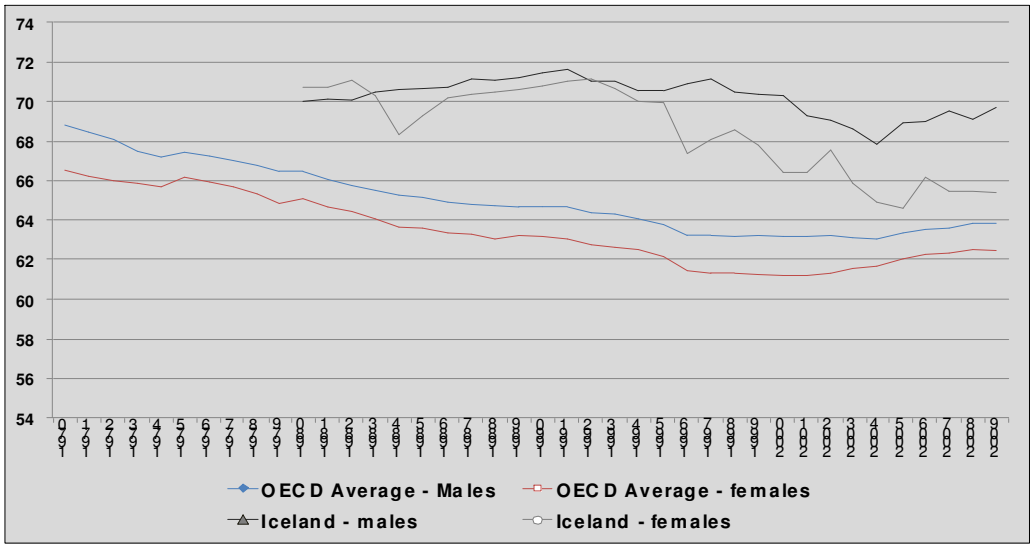
2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Iceland has one of the highest effective retirement ages within the OECD and has done so for a long time. Only some Asian nations, often with sizable agricultural sectors, rank higher than Iceland in this respect. Figure 13 shows the effective retirement ages of Icelandic males and females in comparison to the OECD average.

The effective retirement age for Icelandic males is now 69.7 years of age while women on average retire at just over 65. They have been retiring earlier in the last decade than before, while there has not been much change for the males. Another way to look at this is by examining the employment participation rate, as in Figure 14.

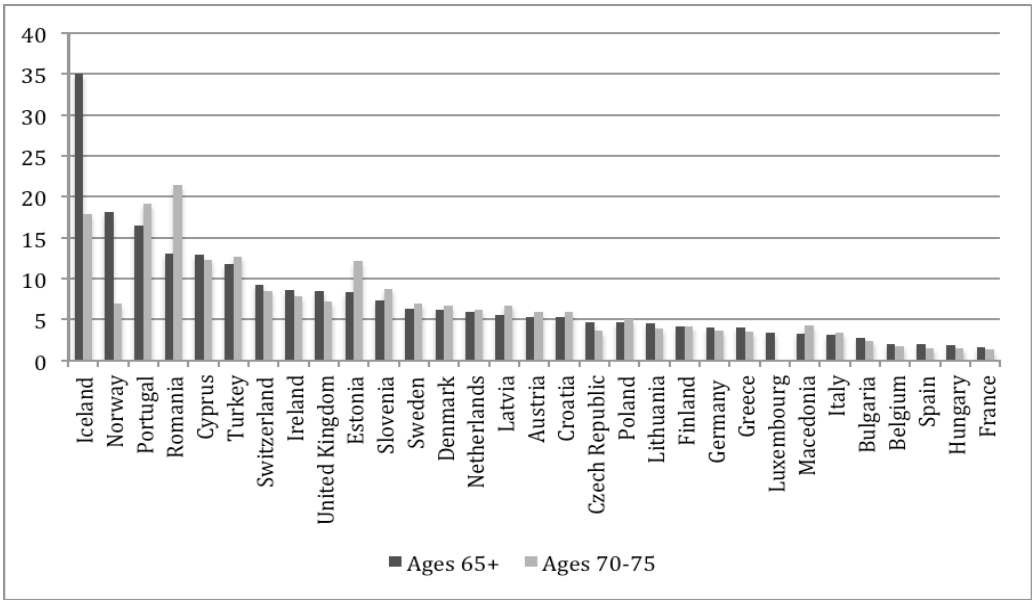
Figure 13: Average effective retirement age, 1980 to 2009: Iceland and OECD compared



Source: OECD.

Figure 14 shows employment rates for the population aged 65 or over and specifically for 70-74 year olds. Iceland tops the rank for 65 and older as a whole but Romania and Portugal have higher rates for the 70-74 age group, which is probably tied to the agricultural sector (which however is very small in Iceland). So even in the midst of the deep crisis, the elderly in Iceland work more that the elderly in other European countries. How does the social protection system support this outcome?

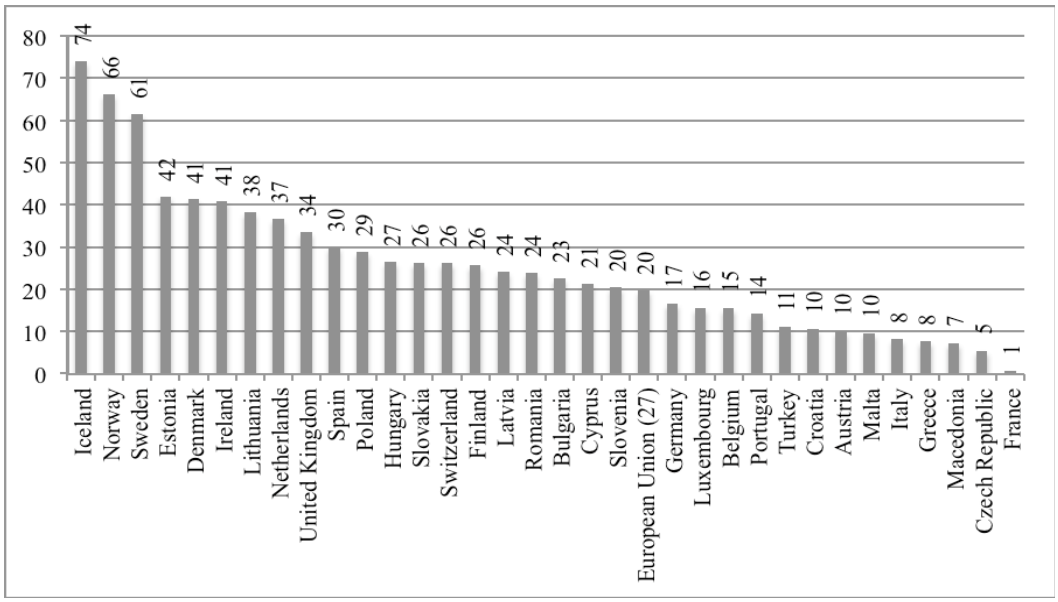
Figure 14: Employment rates for elderly citizens in 2010, 65+ and 70-74 years of age



Source: Eurostat.

Two factors seem of importance for that. Firstly, there is no early retirement scheme in the Icelandic pension system. Those who want to retire early (before 67 in social security or before 65 in occupational pension funds; these are official retirement ages but delays are allowed in both systems) have to qualify in the disability test (i.e. have to have recognised health deficiencies that provide rights to disability pensions). Secondly, there is a provision in the social security system for delaying retirement after 67 and thereby the respective individual raises his/her pension by 6% per year. This delay can be all the way up to the age of 72, thus raising the rate of the social security pension by 30% altogether. So most of those who retire early in Iceland do so for health reasons (see Figure 15).

Figure 15: Reasons for inactivity amongst 50-64 year olds in 2009/10: % saying "Own health or disability"



Source: Eurostat, Active Aging 2012.

2.5.2 Participation in society

Employment participation to higher ages for healthy individuals is of course an important participation in society. There is talk now in Iceland, as well as in the other Nordic nations of aiming to raise the effective retirement age (for example well reflected in the recent Nordic Futures Forum in Stockholm 7-8th of February, where one of the main themes focused on how to raise the retirement age); cf. http://www.sweden.gov.se/nff). In Iceland, there is a greater emphasis on the importance of flexible working hours to facilitate work and participation of the elderly in society (EU-Active ageing 2011).

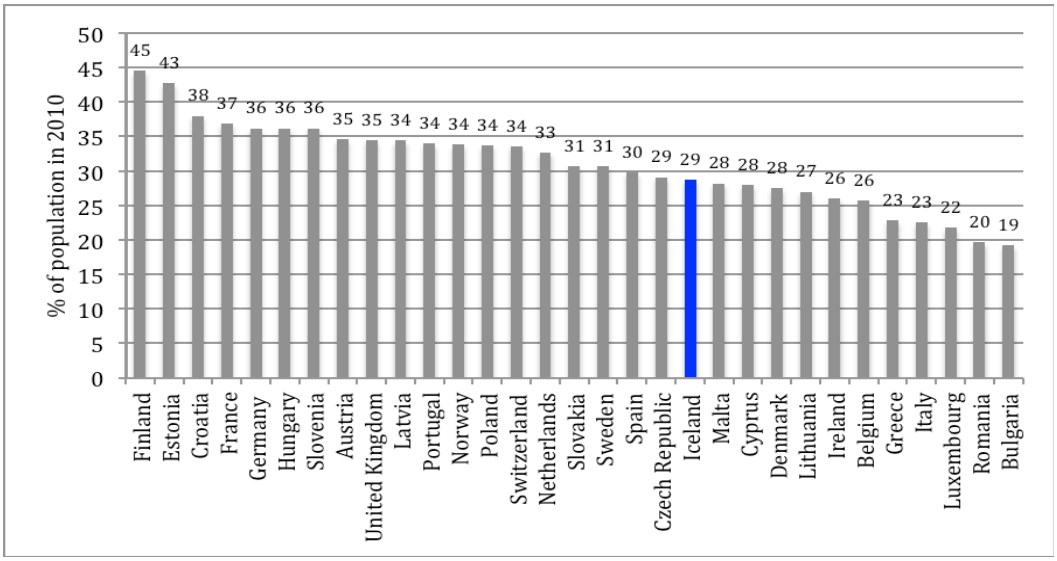
The social protection system does not however have a big role in promoting voluntary unpaid work in the society, but the tight family links in Icelandic society make for much in that area. We also find that the Icelandic elderly take an active part in cultural events (music, theatre, museums and travel).

2.5.3 Healthy and autonomous living

As shown above, both in the pension and LTC sections, the social protection system facilitates and emphasizes longer autonomous living in own homes for the elderly, by providing various types of service facilities in relation to accommodation options, as well as in providing more home help and home nursing, in addition to day care places for the frail elderly. As we showed in former reports to the asisp network Iceland has one of the highest rates of service provisions in this area of LTC, along with Norway (asisp 2010 - Iceland). The rates of occupancy in elderly institutional homes and nursing homes have come down a little in recent years, as the elderly have stayed longer in their own homes, facilitated by the increased home help and home nursing. These are in fact important and growing policy emphases in Iceland, both at the present and in previous years.

Appendix

Figure A1: Proportion of population with long-standing illness or health problem in 2010



Source: Eurostat.

Table A1: Medication consumption: DDD per 1000 inhabitants per day, 2005-2010.

	2005	2007	2008	2009	2010
Alimentary tract and metabolism	111.9	129.2	120.8	135.9	146.7
Blood and bloodforming organs	91.7	91.5	103.4	103.2	106.2
Cardiovascular system	348.3	382.4	400.4	370	360.8
Dermatologicals	2.6	2.5	3.3	77.8	73.8
Genito-urin. system and sex horm.	141.3	134.3	128.4	122.4	127.6
Systemic horm. prep. excl. sex horm.	30.3	32.8	33	31.6	37.5
General antiinfectives, systemic	24.4	24.6	24.2	23.1	23.6
Antineoplastic and immunomodulating agents	10.3	11.2	11.6	11.6	12.4
Musculo-skeletal system	79.3	77	80.7	83.7	88.5
Central nervous system	298	311.3	313.8	319.3	331.7
Antiparasitica	1	1.2	1.2	1.2	1.1
Respiratory system	108.6	113.1	109.7	109.1	115.4
Sensory organs	10.7	10.5	10.7	10.5	10.5

Source: Statistics Iceland.

Table A2: Elderly living in institutions, service housing or receiving home help in 2008-9

	Denmark	Finland	Iceland	Norway	Sweden
	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 aged 65 or older receiving home help				
Total, 65+ years	17.6	6.3	20.1	10.8	9.2

Source: Social tryghed i de nordiske lande 2010, pp. 160-161.

1. 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.

2. Figures for Denmark and Iceland 2009, others 2008.

Table A3: 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

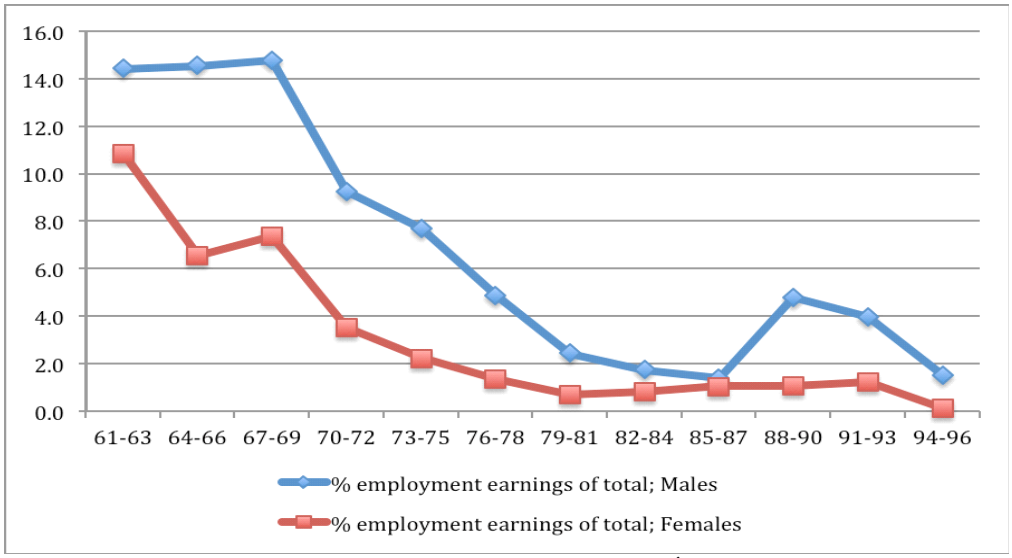
Source: Statistics Iceland.

Table A4: Difficult to make ends meet, by age groups, 2004-2011

	2004	2005	2006	2007	2008	2009	2010	2011
Total	46.2	36.8	34.8	28.4	30.1	39	48.7	51.5
Less than 30 years	55.7	43.5	38	38.6	37	46.5	52.9	56.3
30 to 39 years	47.3	39.3	38.1	27.7	35.7	48.8	59.7	59.4
40 to 49 years	52.4	37.5	35.5	27.2	30.4	41.5	54.4	57.4
50 to 59 years	35.3	30.2	25.3	22.6	28.3	34.9	47.3	50
60 to 69 years	39.7	32.2	33.4	27.8	19.9	27.3	35.6	41.4
70 years and over	38	32.8	35.7	26.8	20.6	21.5	28.2	34.9

Source: Statistics Iceland.

Figure A2: Employment earnings of pensioners, as % of total earnings, by age, in 2011



Source: Social Security Administration, special analysis for SÓ.

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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

[R1; R2] BRAGASON, Hrafn, Héðinn Eyjólfsson and Guðmundur Heiðar Frímannsson, *Úttekt á fjárfestingarstefnu, ákvarðanatöku og lagalegu umhverfi lífeyrissjóðanna í aðdraganda bankahrunsins 2008* (Assessment of investment policy, decision-making and legal environment of the Icelandic Pension funds prior to the banking crisis of 2008), volumes I to IV. Reykjavík: Landssamband lífeyrissjóða (Federation of Occupational Pension Funds), page/retrieved from: http://ll.is/?i=70.

The report was commissioned by the Federation of Occupational Pension Funds but the committee members were appointed by the state labour market arbitration conciliator. The committee assessed the overall loss of the funds related to the collapse of the banks and the following recession. The estimated loss is in the region of 20-25% of GDP. The committee assessed decision-making procedures in individual funds, relations to banks and investors and speculators. The committee also assessed the legal environment and recommends changes, both in governance and legal environment of the funds. The focus was both on the overall funds' environment and the operations of individual funds.

[R1; R2] ÍSLEIFSSON, Ólafur, Icelandic Public Pensions – Why Time is running Out, *Stjórnmál og stjórnsýsla,* no. 2, December 2011, vol 7. Reykjavík, http://www.stjornmal-ogstjornsysla.is/?p=762:

The aim of this paper is to analyse the Icelandic public sector pension system enjoying a third party guarantee. Defined benefit funds fundamentally differ from defined contribution pension funds without a third party guarantee, as is the case with the Icelandic general labour market pension funds. We probe the special nature of the public sector pension funds and make a comparison to the defined contribution pension funds of the general labour market. We explore the financial and economic effects of the third party guarantee of the funds, their investment performance and other relevant factors. We seek an answer to the question why time is running out for the country's largest pension fund that currently faces the prospect of becoming empty by the year 2022.

[R5] JÓHANNESSON, Benedikt, Samspil almannatrygginga, lífeyris frá lífeyrissjóðum opinberra starfsmanna, lífeyris frá almennum lífeyrissjóðum og skatta (Interactions of pensions from social security, public and general occupational pension funds and taxes). Reykjavík:

Federations of Public Employees (available at http://www.bhm.is/-media/frettir/Samspil-almannatrygginga-lifeyris-og-skatta-uttekt.pdf).

This report, commissioned by the federations of public employees (BHM, BSRB, KÍ), surveys the interactive effects of social security benefits, occupational pensions and taxes, with a special reference to the differing pension rights of public and private sector employees. The report shows that the difference in accrued rights between these two sectors is less than previously assumed, since income-testing in social security compensates partly for lower pension amounts from private sector occupational pension funds, as do taxes. This is an important information for public debates about these issues and the future development of the dual occupational pension system.

[R4; H7] LÖVE, Laufey E. and rannveig Traustadóttir (2011), the inclusion of marginalized social groups: The link between disability studies and democratic theory, in Þjóðarspegillinn-Rannsóknir í félagsvísindum XII, ed. Ásgeirsdóttir et.al. Reykjavík: Social Sciences Research Institute.

In this paper, the authors discuss whether the social model of disability approach has relevance to democratic theory and its attempts to respond to demands for greater participation in political decision-making. They draw a parallel between the exclusion of disabled people from full participation in industrialised societies to the exclusion of the general public in the political decision-making process instituted by the framers of the American Constitution. The authors draw attention to how, in both instances, the structures were intentionally designed to exclude the respective groups from full participation.

[R5] ÓLAFSSON, Stefán (2011), Social Inclusion Environment in Iceland, Working Paper no. 3:2011, Social Research Centre, University of Iceland (available at www.ts.hi.is).

This paper surveys some characteristics of the social inclusion environment in Icelandic society. While Iceland is geographically and socially, a member of the group of Nordic welfare states, it still has some unique characteristics and deviates from the Nordic model to some extent. The main basis for Iceland's deviations are firstly the smaller size of the population and secondly the different political environment in Iceland, which is not social democratic to the same extent as the Scandinavian nations. Political parties of the right have been more influential in Iceland in the post-war period. The present government is however, a coalition of social democrats and the Left-Green party, the first such solely left government in the history of Iceland's democracy. Iceland however has a very strong labour union movement that has pressed for some of the welfare state measures that are typical of the Scandinavian model.

[R5] WELFARE WATCH, (Administrative committee), Áfangaskýrsla júní 2011 (Progress report, June 2011). Reykjavík: Ministry of Welfare (available at www.velferdarraduneyti.is).

The Welfare Watch is a public committee with a wide representation from the social protection and welfare services sectors, as well as from main interest groups. It was set up in the wake of the financial collapse and given the role of surveying welfare developments during the crisis, with the aim of detecting early problem and risk areas in various vulnerable groups. The committee commissions special studies, gathers information and sounds the grass roots, in order to give government and special institutions information and recommendation about proper reactions to problems that have risen or are foreseeable. More reports from the Welfare Watch are available at the site.

[H] Health

[H1, H6] Althingi's Independent Monitoring Body, "Þróun lyfjakostnaðar 2008-2010" (Development of pharmaceutical costs 2008-2010). Reykjavík: Report by Ríkisendurskoðun (available at www.velferdarraduneyti.is).

The report surveys the impact of changes following the financial crash in pharmaceutical costs. It analyses the characteristics of the pharmaceutical market in Iceland, determinants of prices and cost, legal framework and consequences of small size of the market. Then it surveys the development of prices of the various medications during the period, role of subsidies and the role of the national hospital (Landspítali) in the market.

[H1, H2, H4, H5] BOSTON CONSULTING LTD., Health Care System Reform and Short Term Savings Opportunities – Iceland Health Care Project (October 2011). Reykjavík: Ministry of Welfare (available at www.velferdarraduneyti.is).

The report was a part of the work of a ministerial task force aimed at assessing present organisational characteristics and to improve the use of scarce resources in the health care sector. The report was wide ranging in scope, dealing with care structures, current market rules and gatekeeping, patient flows, direct expenditures and various planning and managerial issues. The task force built its recommendations on this and other work. The ministry will work further on the issue which is of central importance for the future development of the health care services in Iceland.

[H2, H3] DAVÍÐSDÓTTIR, Katrín et. al., "Bætt heilbrigðisþjónusta og heilbrigði ungs fólks á aldrinum 14-23 ára (Report to Ministry of Welfare about improved health care for young people aged 14-23). Reykjavík: Ministry of Welfare (available at www.velferdarraduneyti.is).

The report surveys some challenges to the health of young people in Iceland, focusing on overweight problems, dental health, psychiatric health, suicidal risks, risk behaviours and drug use, accidents, violence, sexual behaviour and young people with long-term illnesses. The commission puts forwards recommendations to the ministry for improvements in these areas.

[H2, H3] GUÐMUNDSSON, Sveinn (2011), Holistic Health: The Doctors View, in Þjóðarspegillinn-Rannsóknir í félagsvísindum XII, ed. Ásgeirsdóttir et.al. Reykjavík: Social Sciences Research Institute.

This article focuses on the main themes of a study among a group of Icelandic doctors and nurses who have a special interest in holistic health. Holistic health is defined in various ways but most definitions centre on looking at the persona as a whole and taking into account physical, emotional, mental and social needs of the individual. (For a discussion on holistic health definitions see Sveinn Guðmundsson, 2010, Strandberg, Ovhed, Borquist, & Wilhelmsson, 2007). Here the focus is on the doctors and their views on holistic health. The article begins with a short overview of the history of dualism to set the stage. Then follows the doctor's discussion on how they became interested in ideas on holistic health, the turn from dualism to holism, what holistic health means to them, how it is influencing medicine and finally their views on complimentary and alternative medicine (CAM).

[H2] GUNNLAUGSSON, Geir, et.al., Skýrsla lýðheilsuhóps, 16. March 2011 (Report of Public Health working group to the Welfare Watch, March 2011). Reykjavík: Ministry of Welfare (available at www.velferdarvaktin.is).

A report from a committee chaired by the director of the Directorate of Health on pressing public health issues, for the Welfare Watch. This report focuses specifically on maternity care, such as anxiety and depression syndromes amongst pregnant women. It is estimated that 10-20% of

prospective-mothers may have problems of this kind and the group put forth recommendations with special reference to impacts of the crisis on low-income mothers and how the service of maternity care could be improved.

[H3, H7] HANNESDÓTTIR, Guðrún and Ása Guðbjörg Ásgeirsdóttir (2011), Why are disability pensioners not as happy as the rest of us?, in Þjóðarspegillinn-Rannsóknir í félagsvísindum XII, ed. Ásgeirsdóttir et.al. Reykjavík: Social Sciences Research Institute.

Icelanders are consistently among the happiest of nations if judged by life satisfaction score. According to The European Values Study performed in 2010 Icelanders have an average of 8.0 on a 10 point life satisfaction scale, with very little fluctuation through recent years. Disability Pensioners in this study were far from being as satisfied with their life as the rest of the population. The authors find that the mean score for disabled participants is 6.2 with variation from 5.7 to 7.2 among subgroups. Why disability pensioners are so much less satisfied with life than the rest of the Icelandic people can probably be explained to a great extent by the factors dealt with in this study. These were health satisfaction and health efficacy, financial satisfaction, perceived prejudices and social exclusion, as well as type of disability and marital status.

[H2, H3] Ministry of Welfare, Árangur heilbrigðisáætlunar 2010 – Lokaskýrsla (Results of Health Plan up to 2010 – Final Evaluation). Reykjavík: Ministry of Welfare.

The report surveys the progress on the various detailed goals of the general health plan implemented in 2001 and targeted on 2010. The report assesses successes and failures on each of the goals and finds that the majority of the goals have been achieved, but a few remain unfulfilled. The ministry is now beginning the work on a new general health plan.

[H7] RICE, James and Rannveig Traustadóttir, Fátækt, fötlun og velferð (Poverty, handicap and welfare), Stjórnmál og stjórnsýsla, vol. 7, no. 2, 2011, , page/retrieved from:

http://www.stjornmalogstjornsysla.is/?p=727.

This study examines the interaction between handicap or disability and poverty in Iceland. It is based on a qualitative survey amongst 80 individuals with handicaps. The focus is on describing the life conditions of this group and how they carry out their life, often on the verge of poverty or shortage. The findings indicate that the disability pensioners have very little room to put some saving aside in their daily struggles and many have to rely on family relations to support in cases of hardship. Many are found to suffer from anxiety and stress which often have negative effects on the individuals' health conditions. The study emphasises the importance of government policy taking account of micro context situations amongst the poor handicapped.

[H2] SIGURVINSDÓTTIR, Anna L. and Ársæll Már Árnason (2011), Þyngd og hreyfing íslenskra skólabarna 2006-2010, in Þjóðarspegillinn-Rannsóknir í félagsvísindum XII, ed. Ásgeirsdóttir etal.. Reykjavík: Social Sciences Research Institute.

This article report on research based on a comparison of weights and activities of Icelandic school children. The data comes from the Health Behavior in School-aged Children – HBSC of 2006 and 2010. The authors analyse the data by relating body weight to demographic variables and amount of activity per week. They find a weak relationship between movement/activity/exercises and body weight. Another important finding is that movement/exercise has declined between 2006 and 2010.

[H3, H4, H7] Social Science Research Institute, University of Iceland, "Flutningur þjónustu við fatlað fólk frá ríki til sveitarfélaga (October 2011) (Report on Transfer of services to handicapped individuals from the state to local authorities, October 2011). Reykjavík: Social Science Research Institute (available at www.velferdarraduneyti.is).

The transfer of services for handicapped individuals from the state to local authorities took place in 2011-2012. The report was commissioned in 2010 in order to survey the conditions of the field and evaluate the present and future division of labour between concerned parties. The research work involved a questionnaire survey amongst handicapped individuals, survey amongst staff in the service sector and a qualitative survey amongst 30 handicapped individuals. The report gives a detailed overview over the situation as it was at the time of the transfer and lays the ground for future assessments and evaluations of how the services will have progressed and worked out.

[H3] Vilhjálmsson, Rúnar, Postponement and cancellation of physician visits among Icelanders: Extent and explanations , Læknablaðið, vol. 97, no. 10, October 2011. Reykjavík: Læknafélag ÍSlands (available at http://www.laeknabladid.is/tolublod/2011/10/nr/4351).

This is a research article. Equal access to health care is a central goal in socialised health systems like the one in Iceland. Previous research in Iceland indicates considerable individual and group differences in access to health care. The study maps the distribution of postponement and cancellation of physician care among Icelandic adults and considers a number of potential explanations. The data come from a national postal health survey of Icelandic adults, age 18-75, who were randomly drawn from the National Register. 1532 individuals responded to the survey yielding a 60% response rate.

Results: 22% of the respondents had postponed or cancelled a physician visit they thought they needed in the past 6 months. The study found considerable variations in postponement rates. Postponement was positively related to younger age, full employment, financial difficulties, high out-of-pocket health care costs, inflexible daily schedules (fixed roles), dissatisfaction with last physician visit, and the number of chronic medical conditions experienced. Postponement or cancellation of medical care is fairly common among Icelandic adults, although considerable individual and group differences in postponement are observed. The results raise concerns, as equal access to care is a central goal of the Icelandic health care system. It is incumbent upon health authorities to pursue effective ways to equalise access to medical care and prevent postponement and cancellation of needed services.

[L] Long-term care

[L] KARLSDÓTTIR, Elísabet, Verkefni, vinnuumhverfi og líðan starfsfólks í umönnum aldraðra á Íslandi (Tasks, working environment and conditions of staff in care work for the elderly in Iceland). Research Center for Child and Family Issues and Social Research Center of University of Iceland, November 2011 (available at http://www.rbf.is/).

This is a report of an intra-Nordic research project into the characteristics and conditions of care work for the elderly in Iceland. The work is based on a synchronised survey done amongst care workers in the 5 Nordic countries. The report describes the elderly care sector in Iceland and goes on to survey the care workers as a social group, their working conditions and organisational features, their orientation and assessments of the job and conditions. The work will be published further in scholarly journals.

4 List of Important Institutions

Vinnumálastofnun – Directorate of Labour

Contact person: Gissur Pétursson
Address: Kringlan 1, 103 Reykjavík
Webpage: www.vinnumalastofnun.is/heim/

This institute is responsible for handling the unemployment benefits system, activation policies, general labour market issues, the public employment services. It also handles the Wage Guarantee Fund, the Childbirth Leave Fund and payments to parents of children with long term illness. In addition it is responsible for facilitating employment participation amongst individuals with disabilities and handicaps.

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 Welfare (previously 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).

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.

Landssamband lífeyrissjóða – Federation of Occupational Pension Funds

Contact person: Hrafn Magnsson
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 pubic 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.

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

Contact person: Magnús Árni Maghnússon
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.

Velferðarráðuneytið – Ministry of Welfare

Address: Hafnarhusinu vid 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.

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.

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.

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.

Efnahags- og viðskiptaráðuneytið - Ministry of Economics and Business Affairs
Address: Solvholsgotu 7, 150 Reykjavik, 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.

Öryrkjabandalagið – Federation of the Disabled
Address: Hátún 10, 105 Reykjavík.
Webpage: www.obi.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.

Landsamband eldri borgara – Federation of the Elderly
Address: Langholtsvegi 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.

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.

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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.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en