Annual National Report 2010

Pensions, Health and Long-term Care

Iceland

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Author: Stefán Ólafsson

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1 Executive Summary

Iceland has a pension system which has many characteristics commonly associated with 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. It has three pillars. The universal public social security part (Pillar I) is primarily tax-funded, while the occupational pensions (Pillar II) 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. Despite the strains of the present financial crisis, the pension system remains mainly intact, and some reforms that were initiated in 2008 are still to some extent in effect, albeit with reductions and cost containments. Some reforms are still being planned such as a large-scale simplification of the social security system and some aspects of the vocational rehabilitation and activation system.

While the Icelandic health care sector, which has had a very high quality level by international standards, is obviously also facing a very stringent test due to expenditure cuts, there are clearly some signs of success in preserving the security and quality of services to date. Waiting lists have actually been significantly reduced in 2009, and despite increased pressure on staff at various levels, there are also healthy signs of stamina and effort to do better. Plans for new buildings for the national University Hospital are an important sign of the goal of government and staff to fight to preserve the high standard of the Icelandic health care system, despite the temporary difficulties. The next two years will decide how well that goal will be achieved.

By most measures, the long-term care sector in Iceland has a high level of service provision, including home help and nursing facilities. Still, there have been significant complaints in recent years about inadequate caring facilities, especially for the frail. Another frequent complaint is that too many elderly have to share rooms with strangers in homes for the elderly and in care homes for people in need of more intensive care.

On the whole, one can say that the consequences of the financial crisis for living standards in Iceland have been very serious indeed. The government has aimed to alleviate the worst consequences, particularly directing its limited financial resources towards lower income households. This is reflected in social protection developments since the time of the crash in October 2008, such as the raising of the minimum pension guarantee and increases in general social security pension and benefit payments on 1 January 2009, some increases in the amount of the basic unemployment benefit, increases in child benefits and tax rebates for mortgage interests. This is also reflected in the distribution of the increased tax burden (against which low-income earners have largely been sheltered) and with the general aim of keeping the public welfare system intact. Difficult problems remain and, even though the economy may be bottoming out at the present time, the standard of living consequences are likely to continue to surface into the next year or two. Further tax increases and cuts in public expenditures seem inevitable in the next two years, in order to balance the state budget and to start paying debts. Iceland has indeed tried to shelter the more vulnerable groups with social protection measures.

2 Current Status, Reforms and Discourse 2009-2010

2.1 Pensions

2.1.1 Characteristics and functions of the Icelandic pension system

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 in respect of 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 (SOCSEC) 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 SOCSEC 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. At 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 (thus including the self-employed and farmers). 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' federations.

III. Individual pension accounts (IPA). The framework legislation is from 1997. These are voluntary accounts with a defined contribution. Individuals can pay contributions of up to 4% tax free (when paid in) and have the right to 2%

additional contribution from employers with the first 2%. So altogether a maximum of 6% are exempt from direct taxation when paid in. IPAs are managed by occupational funds, banks or private investment funds and are 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 system 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 lowest 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 since 1 January about 20% of old-age and disability pensioners get some supplement from the minimum guarantee, many, however, only a small sum.[1] This proportion was reduced somewhat with an introduction of a greater degree of income-testing on 1 July 2009. The function of the minimum guarantee is primarily that of improving the standard 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. Therefore, it does 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 SOCSEC. 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). While membership in OP funds is mandatory for all working persons there, is a very small group of self-employed individuals that fail to contribute to the funds. The funds try to survey employment activities of such individuals and have means of putting pressure in cases of negligence.

The individual accounts (IPAs), being voluntary, have an incomplete coverage, with about 60% of wage earners contributing (which is considered 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 the government opened up the pillar for subscribers who were allowed to liquidate up to a prescribed sum (ISK 1 million per person for the year 2009). A

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

couple where both have such accounts could, thus, liquidate ISK 2 million to alleviate their debt burden. This provision will also apply for 2010.

Since the social security pillar uses income-testing to a high degree, also fully now against occupational pension earnings, the amounts paid to pensioners from social security decrease as occupational pensions increase, with growing maturity of individuals' rights in the occupational pension funds (social security institution - Staðtölur almannatrygginga 2007 and 2009). Looking at the three components of the social security pension (basic pension; income supplement; household supplement), we see that in 2009 81.5% of pensioners received full basic pension (the first component) without any cuts (which before 1 July 2009 was only cut due to employment and financial earnings and not due to occupational pension receipt). Before these changes of 2009 this component was received without any cuts by 94-95% of old-age pensioners. So pensioners with higher occupational pension earnings had their total earnings reduced by this measure.

As regards the second component of social security (pension supplement, which is income-tested against all other income), 19.9% of pensioners received pension supplement without any cuts (thus, over 80% of pensioners had this component partly reduced or not at all), and the third component (household supplement, also income-tested against all other income, but payable only to single pensioners) is received only by 7% of pensioners without any cuts.

Due to income-testing, and increased pension receipts from the occupational pension funds the overall expenditure on social security pensions has remained constant or even lowered as a percentage 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 being the growth of 1% in 2008, the year of the financial collapse (in October). The proportion, however, is likely to have increased in 2009, with the GDP declining by 6.5% during the year, at the same time that expenditures of social security were increased on the whole, not least by a 9.6% general rise of the pension amounts and a 20% rise of the minimum pension on the 1 January 2009. The OP funds are paying a somewhat higher proportion of GDP to pensioners, in addition to these payments from social security (SSI – Staðtölur almannatrygginga[2] 2007 and 2009).

[2] A yearly statistical report for the social security system.

Table 1: Minimum pension guarantee (for disability and old-age pensioners), unemployment benefit, minimum pay and other benefits in December 2009 compared. Figures are in ISK.

	Disability pension; old-age pension	Minimum bargained pay	Unemployment benefit - basic	Social Assistance	Student loans
Single persons without children:					
Minimum income entitlement before tax	180,000	157,000	152,000	116,000	121,000
Minimum income entitlement after tax	155,000	136,000	133,000	115,000	121,000
Single parents, with 2 children under 6 years of age:					
Minimum income entitlement after tax	152,000	139,000	145,000	115,000	230,000
Total income entitlement after tax, including child benefits	280,000	235,000	240,000	211,000	326,000

Source: Welfare Surveillance Report December 2009 (http://www.felagsmalaraduneyti.is/).

Overall expenditures on pensions and benefits are rather low in Iceland, due to the young average age of the population, extensive income-testing in the social security part of the system, and due to late retirement of the elderly population (OECD 2009).

In the ASISP report for 2009 we showed how the new minimum pension guarantee was introduced in September 2008 and became higher than ever before in January 2009, in relation to pay in the labour market. This has been an important measure to alleviate poverty amongst pensioners in general. In Table 1 we show a comparison of the minimum pension (column 1) to other benefits and social protection payments, such as unemployment benefit, minimum bargained pay, social assistance and to student loans.

As the table shows the minimum pension guarantee (in this case for a single disability pensioner or a single old-age pensioners) is significantly higher than the minimum bargained pay in the labour market, it is about 18% higher than the unemployment benefit and 55% higher than social assistance allowance. Student loans are somewhat higher than the social assistance allowance, which in many cases functions as a supplement to other payments which low income earners receive, often due to special family conditions. The table also shows the effects of direct taxes on the sums, still leaving the pensioners in an advantaged position.

Those who have children to support receive significantly higher sums when child benefits are included, and in some cases (such as for disability pensioners and students) they are tax-free. On the whole one can say that the unemployed are likely to be the most vulnerable group in the present crisis situation (see also Eydal 2009).

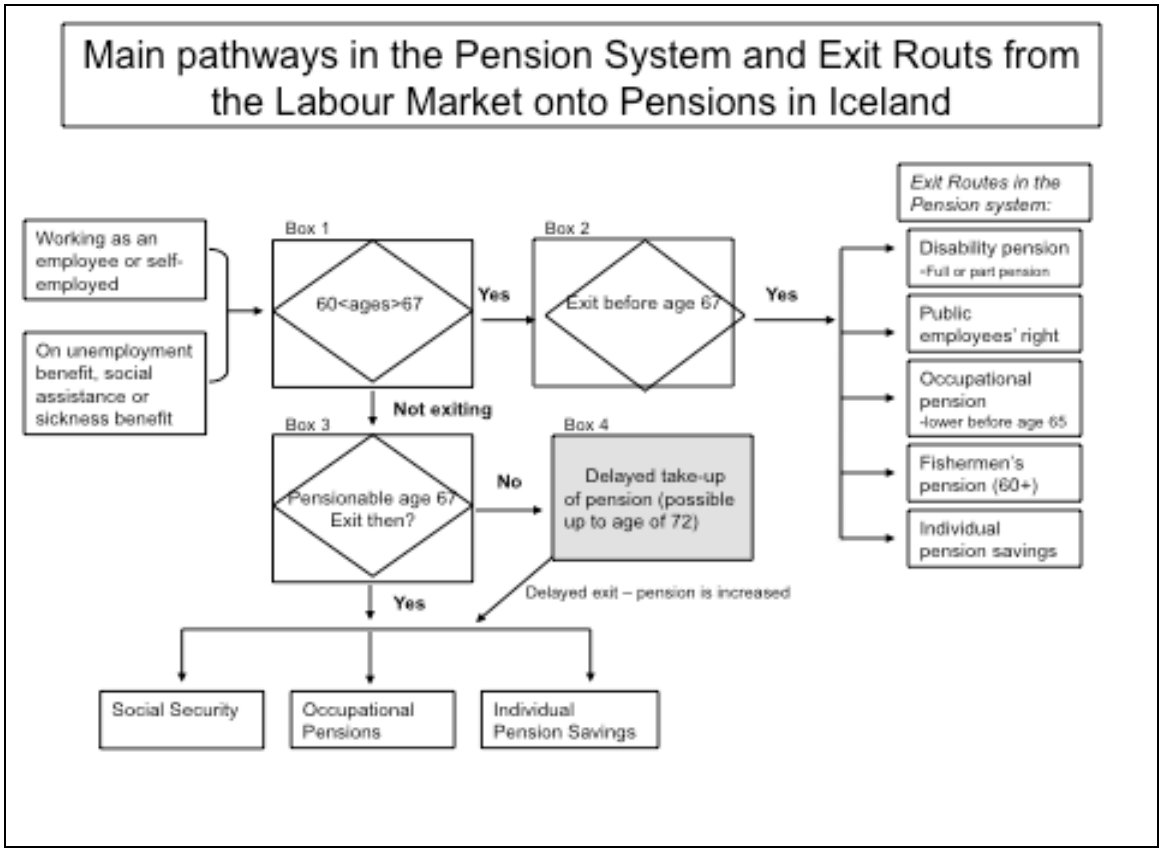
2.1.2 Exits from the labour market into the pension system

One of the main problem areas for European pension systems concerns early exits from the labour markets into the pension system, reflected for example in reduced effective employment participation and riskier financial foundation for pension systems. Iceland, which has for a long time had a very high employment rate for people at working age (16-67), may be considered a very successful country as regards avoiding the problems of too extensive early retirement. The workings of the Icelandic pension system are, thus, of some interest in this respect.

In Figure 1 we show an overview of the main pathways in the Icelandic pension system, with the exit routs from labour market to the welfare state for those who have not reached the official retirement age (67). The figure shows the main patterns and options for early retirement, regular retirement or delayed retirement (Nielsen and Nielsen 2009).

Those who are not provided for by active work are typically found in homework (provided for by another earner in the family), in education, on unemployment benefit, sickness benefit or social assistance. The options for those who are on the labour market or are counted as unemployed or inactive (yet not in the pension system proper) but are below retirement age (boxes on far left) are to either continue working or to retire early (choices in Box 1). Those who aim for early retirement go by Box 2 to the early retirement options available in the system (boxes on far right). There is no formal early (old-age) retirement pension option as such in Iceland. The main pathway for people coming from the labour market is, thus, to go on to disability pension, which requires the passing of a disability test (personal capability test), undertaken by physicians and social workers at the state social security institution or within the occupational pension funds (OPFs). In social security two degrees of disability are accepted: 75% or more, which is full disability (with full pension), and 50-75%, which is partial disability and gives right to partial pension, which is a very low sum. This is the main route into early retirement and it has a rather high entry port (the disability test). The absence of an early old-age retirement scheme, which is common in EU countries, is also a hindrance (or disincentive) to early exits from the labour market.

Figure 1: Pathways in the Icelandic Pension System: Rights and Entry Ports



Source: Nielsen and Nielsen 2009.

Other options do, however, exist but only for special groups, outlined in the boxes on the far right. Public employees have a right to early retirement by the so called 95 year rule. That means that if combined life age and number of contributory years working for public institutions equals or exceeds 95 they can retire with a full pension at that time. Members of other occupational pension funds can retire at age 65 and take out a pension in accordance with their accumulated contribution. Earlier or later retirement is possible in the OPFs, but on the basis of no overall gain or loss. Delayed take-up of the pension, thus, raises the monthly amount by what is saved by the delay (and earlier take-up similarly reduces the monthly amount). Fishermen who have been working in that industry for at least 25 years have a general right to retirement at age 60 and receive full pension (income-tested though) from social security, in addition to their occupational pension. And lastly, people who have accumulated sufficient individual pension savings (IPA) can, of course, retire from age 60 or later, but few have at this time accumulated sufficient amounts to cover their subsistence costs.

People who work until the regular retirement age (67) have a choice (in Box 3) to go directly to old-age pension, and enjoy pension earnings composed of payments from social security (income-tested), occupational pension and individual pension savings (boxes at the bottom of the figure). Alternatively, they can delay their start of retirement (Box 4) and increase their monthly pension amount by 6% a year in social security (and also in the OP funds). Those who delay for the maximum allowed, i.e. up to age 72, will raise their social security pension by 30%. Since the average effective retirement age of Icelanders is very high by international standards, these incentives for delay seem to be working, along with other contributory factors, such as ample job opportunities (in the past) and a strong work ethic. Thus, there are more limited options for early exits from the Icelandic labour market into the pension system than found in many other countries, such as the other Nordic countries (Nielsen and Nielsen 2009, Ólafsson 1999).

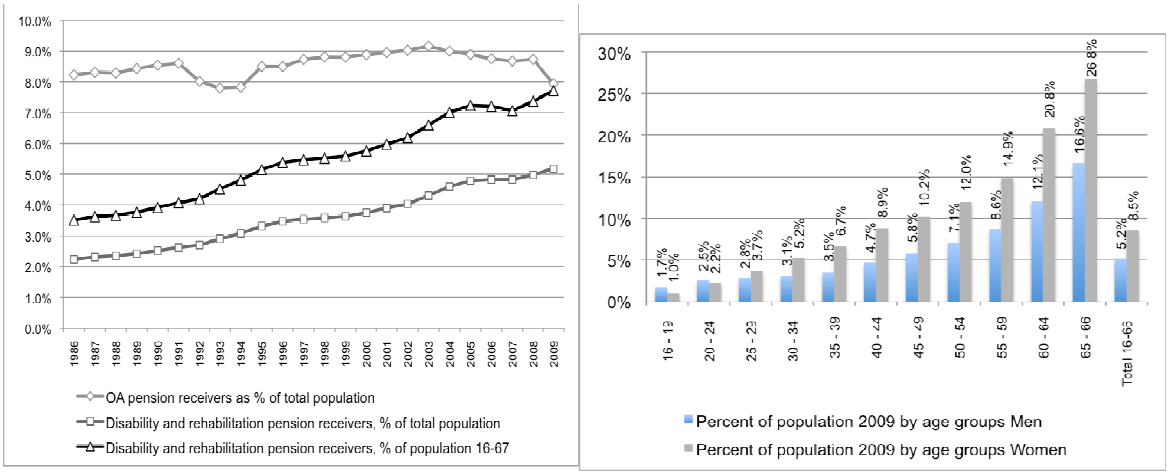
Iceland has had one of the highest rates of active employment for people at working ages (16-64) for a long time (Ólafsson and Stefánsson 2005). That should mean that in Iceland there should be a relatively low proportion of the population of working age on disability pension, on unemployment benefit, on sickness benefit or on social assistance (the other possible categories of provisions in the Icelandic welfare state, for people at working age). As we will show here, the indication is that Iceland has for a long time had rather many people on disability pension, but unusually few on unemployment benefit, sickness benefit or on social assistance (which is the lowest rung of the security net ladder). This is connected to one of the major current concerns about the pension system and an area for reform plans, as we discuss below.

In last year's asisp report we showed the average effective retirement age of Icelanders, which is one of the highest amongst OECD countries. Here, we show a more detailed account of exits from the labour market, as well as figures on growth of disability pensioners from 1990 to 2009.

Firstly, we show the development of the groups of old-age pensioners and disability and rehabilitation pensioners in recent years (Figure 2). The data are only for those receiving pensions from the social security system. Those who receive disability- and rehabilitation pension from social security are very close to the total population of those pensioners (a sizable part also get pensions from the OP funds). But due to the workings of the income-testing mechanism in social security, there are some old-age pensioners who only receive pension from the occupational pension funds (OPFs) and

in 2009, this is close to a quarter of the total old-age pensioner population, mainly those who have higher pensions from the OP funds.

Figure 2: Growing numbers of recipients of old-age, disability and rehabilitation pensions from social security 1986-2009 (diagram on left); and age and sex distribution of disability pensioners in 2009 (diagram on right).



Source: Data from the Social Security Institution Tryggingastofnun (www.tr.is).

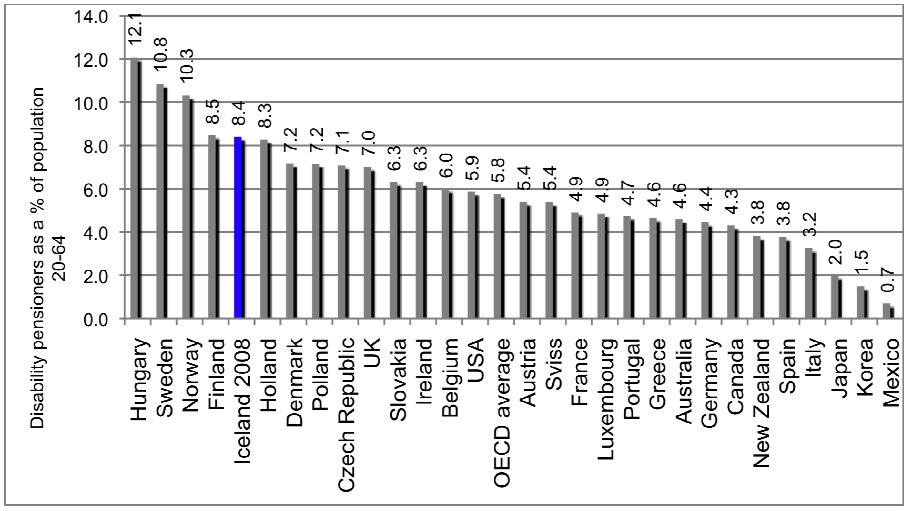
The growth of pension recipients from the public social security system (diagram on left in Figure 2) tells a story of rapid growth of disability (and rehabilitation) pensioners and a relatively stable proportion of the population on old-age pension from social security. There are two interesting dips in the curve for old-age pensioners (in 1992-3 and in 2009). In both cases changes in the income-testing mechanism reduced the number of eligible old-age pensioners in the social security system. In the former period, the decline in the number of pension recipients went down, due to new measures aimed for the first time at income-testing the basic pension component of the social security pension (which had previously been untouched by income-testing against occupational pension earnings). This previously involved an income-testing of the basic pension component against employment and financial earnings (but not against OP pension receipts). The dip in 2009 is, however, due to the measure implemented on 1 July 2009, which involved income-testing the basic pension component of social security against OP pensions (above the threshold of ISK 10,000). This cut the number of recipients of old-age pension from social security from just under 9% of the total population to about 8%. Those thereby excluded from social security are primarily people receiving higher pension payments from the OP funds. Hence, this was an equalisation measure, implemented in order to cut public expenditures due to the financial crisis.

On the right hand side of Figure 2 we show the age distribution of disability pension recipients in social security for males and females separately, in 2009. The number of disability pensioners is significantly larger above the age of about 40 and reaches its zenith at age 65-66, just before the official retirement age. Females have significantly higher rates than males, covering about two thirds of disability pensioners. The two biggest groups of disability pensioners are those registered for musculoskeletal diseases and psychiatric diseases. The latter have been more prominent amongst the newly registered disability pensioners of the last two decades. As the lower lines on

the left diagram in Figure 2 show, the growth in numbers of disability (and rehabilitation) pensioners has indeed been quite rapid, particularly from the early 1990s. It slowed down somewhat in 2006-7 but resumed its speed of increase again in 2008 and 2009.

In Figure 3 we show a comparison of the size of disability pensioners in the OECD countries in 2007 (figures for Iceland are for 2008). Remember that Iceland should have a low proportion of inactive people, since its employment participation rate for working age people is one of the highest in OECD.

Figure 3: The size of disability pensioner populations in OECD countries in 2007. Registered pensioners as a % of population aged 20-64.



Source: OECD.

Hungary has the highest proportion of disability pensioners, but Iceland ranks with the other Nordic countries and Holland. The OECD average is 5.8%, while the Nordic nations are in the region of 7-11%, Sweden and Norway being the highest. Anglo-Saxon countries seem to have lower numbers of disability pensioners, as do some Southern European countries.

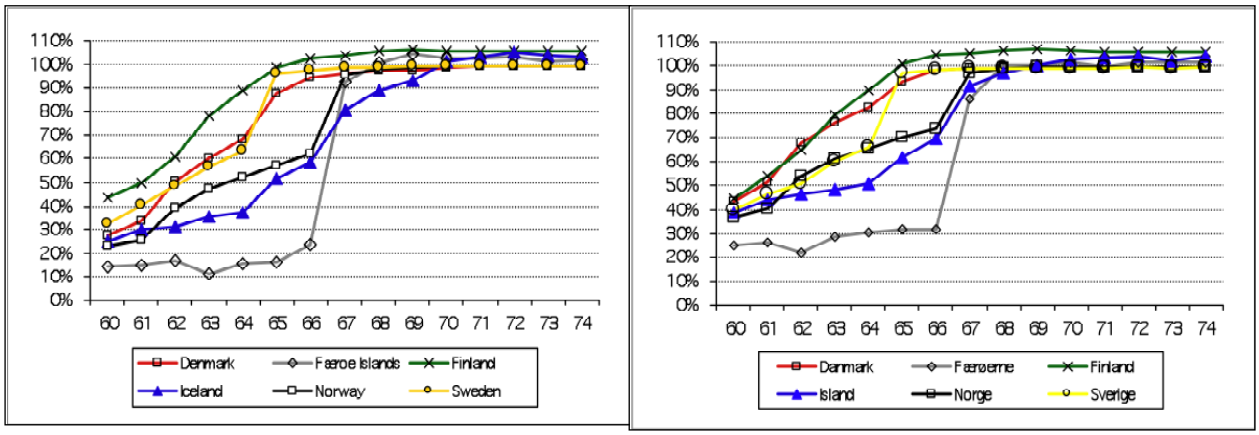
Thus, we can assume that there are relatively many disability pensioners in Iceland, especially, if we consider that relatively few altogether are outside of the labour market. This means that Iceland must have had unusually few individuals on unemployment benefit and sickness benefits, which figures indeed support (Ólafsson 2005). There are incentives for preferring disability pension to unemployment or sickness benefit in the Icelandic welfare system, since the disability pension is higher and carries with it further benefits in terms of reduced medication costs and favourable tax-free child benefits (Herbertsson 2005; Ólafsson 2005 and 2008b).

In Figure 4 we look more closely at exit patterns from the labour market, with a comparison of Iceland to the other Nordic countries.

There we see that active Icelanders withdraw later from the labour market than their counterparts in other Nordic nations, except the Faeroe Islands (which are a part of Denmark). Of the males aged 60-61 less than 30% receive some form of pension in Iceland and Denmark, then, at the age of 62, the Danes rise to 40%, while the Icelandic males remain at a similar level. Less than 40% of males aged 64 receive

some form of pension in Iceland, while there are more than 50% of the Danes, between 60% and 70% of the Norwegians and Swedes and about 90% of the Finns on some form of pension. The proportions for females are generally at least about 10% higher than those for males in Iceland.

Figure 4: Exit from the labour market for males (left diagram) and females (right diagram) in 2007. Proportion of individuals that receive some form of pension, by ages between 60 and 74. Comparison of Nordic countries.



Source: NOSOSKO 2009 (www.nomesko.dk).

By the age of 66, about 60% of Icelandic males receive some pension (and 70% of females), while the figures for the other countries, except Denmark, are close to 100% (they exceed 100%, since pension recipients living abroad are not counted in the total). The official retirement age is 65 in Finland, Norway and Sweden.

Thus, Icelanders exit from the labour market and move into the welfare pension system significantly later than the other Nordic nations, who already exit later than what is common amongst many continental nationals. Still, Iceland has relatively many disability pensioners, or close to the levels of the other Nordic nations.

The indication is, thus, that there may be some dysfunctional workings in the Icelandic pension system, landing too many in disability and too few in other (perhaps more appropriate) programmes of the welfare state. People tend to get stuck in the disability pension scheme, and, since the indication is that rehabilitation measures have for a long time been insufficient, there seems to be a great need for reform in that area (Hannesdóttir, Thorlacius and Ólafsson 2010).

2.1.3 The Pros and Cons of the Icelandic pension system – Discourse and debates

In public debates about the Icelandic pension system of recent years, a few issues have been more prominent than others. Here, we sum up some of the issues that feature good and bad aspects of the pension system, before dealing with reform plans. We start with the positive aspects of the system.

Looked at from outside the country, the Icelandic pension system can be said to be quite successful in alleviating poverty amongst the pensioner population (Ólafsson 1999, OECD 2008; Hagstofa Íslands 2010). And indeed, Iceland seems to have one of

the lowest rates of poverty in the community of advanced nations. This puts Iceland firmly within the Nordic community of welfare states, even though Iceland can be said to deviate somewhat from the Scandinavian model in some respects. The pension system is redistributive, even though this effect is weaker than in the other Nordic nations (Haraldsson and Árnason 2009).

The pension system is not particularly costly compared to other OECD nations (OECD 2009; Eurostat 2009). It has ample incentives and structural features that restrain early exits from the labour market and, in fact, support late retirement. It is, thus, compatible with high rates of employment participation and a wide base for taxation, which is an important means of financing the system.

Welfare services (like extensive child care) and family benefits (including child benefits) support a high fertility rate, so the demographic ageing problem is likely to be less severe than in many European societies (Eydal and Ólafsson 2008).

The funded occupational pension system (OPF) is considered a valuable asset, being one of the largest in relation to GDP amongst OECD nations. In the future it will provide the majority of pension benefits (OECD 2008 and 2009). This seems likely to hold, despite a considerable loss of assets during the present financial crisis.

The most prominent negative aspects are the following. Benefits in the public social security system have often been considered low and the use of income-testing has very been unpopular. Many raise the issue of lack of adequacy with a reference to these points. While the pension promises of the system are amongst the most generous (according to OECD Pensions at a Glance 2009), Iceland is still a considerable way from full maturity of rights in the OP funds. The frequent complaints are that there is too much income-testing in the social security system at this point in time, providing pensioners with earnings that are too low (even though the long-term promises are high).

Complexity of the social security system (SOCSEC) and difficult interactions with the OPFs is a persistent complaint. Given that the SOCSEC has three component pension types (with different rules of income-testing and entitlements), and some special benefits as well, the degree of complexity is very high indeed. This also affects the monthly delivery of pension payments, When inflation and financial earnings fluctuate, it is difficult for the social security institution to have correct information to base the income-testing calculations on, so deviations occur in many cases. These are then corrected in later months, with unpopular claims for repayments to balance the accounts in each case.

A high degree of income-testing can provide negative incentives for saving and work, though there are clearly other strong incentives for work within the Icelandic system.

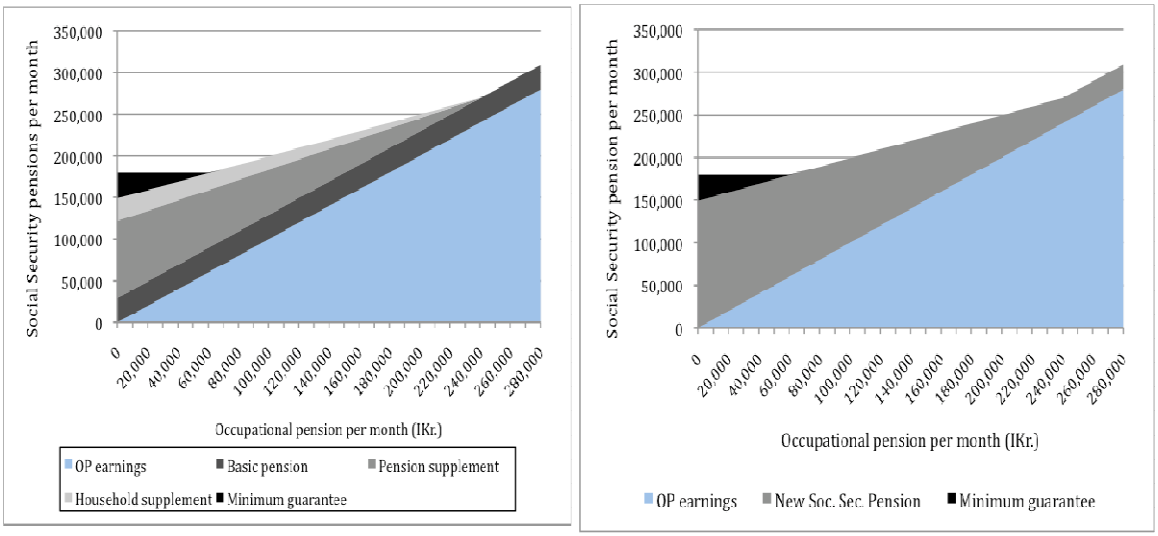
Altogether, Iceland does not have the problems that have been most common amongst the European nations, such as population ageing, excessive early retirement and financing problems, to the same extent. Thus, we can say that the greatest concerns amongst people in Iceland are those of adequacy, injustice related to heavy income-testing, complexity and lack of transparency in the operations of the system, and disproportionately rapid increase of disability pensioners (even though employment participation is high and effective retirement starts very late). Thus, as we have shown, the disability scheme seems to take on too many roles, some of which should be dealt with in other parts of the system (VEA 2009, OECD 2009).

In 2009, the major concerns, however, were related to the financial crisis and the need to cut public expenditures. The government introduced measures with that aim on 1 July 2009, which included some cuts in pension amounts in the social security system. The minimum guarantee for pensioners was left intact, however, and cuts were progressive, increasing with higher pension earnings. On the whole, they were modest compared to cuts in pay in the labour market and for those who became unemployed, but pensioner organisations protested forcefully despite that.

2.1.4 Reform Plans

During 2009, two important reports for reform were published, both on behalf of the Ministry for Social Affairs and Social Security. The first one was the final report of the task force for reorganising the social security system (VEA 2009) and the second one was a report of a working group with the task of suggesting strategies for the reorganisation of vocational rehabilitation and for changes in the disability test (Pálsdóttir et al. 2009). Both of these reports were related to the big issues examined under 2.1.3 above. Firstly, the changes of social security benefits had started to be implemented during 2008, and the final report aimed at outlining the context for the changes already implemented and future goals for such changes. Secondly, the task force worked out its ideas of large-scale simplification of the social security system.

Figure 5: Plan for changes of the structure of the social security pension. Before simplification (left-diagram) and after simplification (right-diagram). Single old-age pensioner: Interactions between social security and occupational pensions. Figures apply for 2009.



Source: VEA Report (2009).

Figure 5 shows the recommendation of the VEA task force for simplification. The example applies to a single old-age pensioner and shows the interactions between occupational pension payments per month (X-scale) and the income tested social security pensions (Y-scale). On the left (before change) we see the three different pension components of the social security pension and how they are cut as

occupational pension earnings increase. The black portion is the minimum guarantee, which was introduced in September 2008 and raised by 20% on the 1 January 2009. On the right hand side is the form after the suggested simplification, with the minimum guarantee as before and the new social security pension replacing the three components. This simplification is also very important for the fact that there are different rules for income-testing within the basic pension component and the other two components of the social security.

The proposed simplification would increase transparency of the system, make payment outcomes for individual pensioners more visible and predictable, as well as facilitate the administration of the pension system and the payments. Various other adjustments to these simplifications need to follow, if implemented. The proposed changes should make it easier to deliver more exact payments from month to month, thus reducing need for reclaims and corrections.

The changes that gradually saw the light of day in 2008 involved measures aimed at providing increased incentives for saving and working (reported in detail in ASISP 2009 Report). This was achieved by introducing higher income thresholds (personal allowances, i.e. income portions that are exempt from income-testing in the social security system). This was designed so that the pensioner would retain more of his employment earnings without cutting the social security pension (thus providing stronger incentives for work, for example amongst disability pensioners). Similarly, there was the idea of implementing an income threshold of ISK 30,000 on occupational pension fund earnings (Pillar 2), thus allowing the pensioner to enjoy a bigger part of his occupational pension saving for improved standard of living. Against that was to be a change that involved the possibility of reducing the basic pension equivalent fully to zero, thus cutting off more from high earners in the occupational pension funds. This was, in effect, a proposal for increasing the overall pension earnings of lower and average income pensioners at the cost of high pension earners in the OP funds.

The austerity measures introduced by the government on 1 July 2009, however, took some of these modifications introduced in 2008 a step back, in the interest of cutting expenditures. Nonetheless, the goals are recommended as a future policy, so hopefully the implementation of the policy will be resumed once the crisis recedes.

The other reform report on behalf of the Ministry of Social Affairs and Social Security (Pálsdóttir et al. 2009) is framed in the spirit of active social policy (OECD 2003, 2005; Zeitlin et al. 2003) and emanates from work on behalf of the government started in 2005, aimed at reorganising the system for activation and rehabilitation, including with a more workability-oriented approach to assessing disability or inhibitions. The working group based its work and recommendations on the UN convention on human rights of persons with disabilities (UN 2006) and recent ideas about social understanding of disabilities, as opposed to solely medical approaches (Traustadóttir 2006).

The recommendations are based on ICD and ICF systems of classifications of diseases or health-related inhibitions from WHO. This report is meant to be a base for reorganising procedures for assessing individuals' rights to disability pension and also to assess the needs for rehabilitation and possibilities for activation measures. The Ministry of Social Affairs and Social Security is planning to reorganise its institutional structures to facilitate changes in this area. The labour market partners have also been active in promoting more rehabilitation and activation, with the

establishment of their own Fund for Rehabilitation Measures (VIRK see www.virk.is). There is still some work to do in synchronising activities in this area carried out in the public sector and in the private sector. This is a task currently undertaken at the ministry in question.

A third report was recently delivered to the Ministry of Social Affairs and Social Security (Hannesdóttir et al. 2010). It is a research report into bases for rehabilitation and activation amongst disability pensioners. The report is based on a representative survey amongst the pensioners in question (a sample of 1,500 individuals). The survey shows that only a small minority of the disability pensioners have actually received vocational/occupational rehabilitation, but that 80% of them want to work (mostly part-time) and receive rehabilitation measures. The attitude towards working is very positive amongst the pensioners.

The research reported in Hannesdóttir et al. (2010) supports the above mentioned hypothesis that there are disproportionally too many individuals on disability pension in Iceland, and probably too few in other areas of the welfare system or in more active employment. There appears to be a great possibility for activating a sizable part of the disability pensioners, even if only to part-time working. Activation to education and general social participation is also relevant as a policy goal for this group. This research is likely to be useful as a tool for planning further reforms and reorganisation in this area in Iceland in the coming months and years.

While the financial crisis, from 2009, effectively put a stop to reforms aimed at increasing incentives for saving and working amongst pensioners, and, thereby improving adequacy of pension earnings, there is still scope for reforms as regards simplifications of the social security pension system. These reforms require the passing of new legislation regarding public pensions and their relationship with the private sector occupational pension funds. Such a reform does require a lot of extra expenditure from the government, but can improve the effectiveness and rationality of the public pension system, as well as improve the workings of the pension system as a whole. It is the stated aim of the government to go ahead with those reforms, as well as with the reorganisation of institutions in that area. Such preparatory work is presently being carried out. Improved synchronisation between measures in the public and private sectors are, however, needed to maximise efficiency and contain costs.

Due to losses of assets in the wake of the financial crisis the Occupational Pension Funds generally cut their pension rights and pension payments by about 10% in 2009. Most of the funds are also cutting again by 10% in 2010, since they had not fully written down their losses in 2009. While this is a blow to old age pensioners in particular, the Social Security System compensates for about a half of this loss due to the income-testing. In that case the income-testing mechanism, which in good years is highly unpopular amongst pensioners (since it reduces the public pension as other earnings go up), actually works to the advantage of pensioners. Thus the Social Security System greatly softens the blow that the crash of the financial markets is enforcing. This does however further strain the finances of the central government.

2.2 Health care

2.2.1 System characteristics and functioning

Since 2007, the legislation on health care in Iceland 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 has the administrative responsibility for the overall system and the Directorate of Health has the main supervisory role, according to a new law from 1 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; 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 areas of the private sector are specialist services, some health care centres, physiotherapists, occupational therapists, psychologists, all dentists and some care homes and old peoples' homes (most often run by voluntary or social organisations). User payments are generally applicable in the private part of the service provisions. For example, care homes and old peoples' homes are partly financed by user payments 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 the government and mainly financed by taxation. The Icelandic system does, however, have its own characteristics (Magnussen, Vrangbaek and Saltman 2009). The main ones are more centralisation in its governance structure, management, regulation, implementation and financing (Ásgeirsdóttir 2009). The roles of local authorities are very small indeed. In that sense, one can say that Iceland as a whole is to some extent comparable to a single local health area in the other Nordic nations, which have large roles in governing and delivering health care services. Due to its relatively small population, Iceland 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 with the state social security institute (SSI), but since 2009 with a new institution, Icelandic Health Insurance (SÍ), which subsidises the cost. Hospitals also provide outpatient services. In general, no referral is needed for the 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 for patients in the system. There are, however, no general penalties or significantly higher fees for directly seeking the 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. Measures are currently being taken to merge the 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 there are a few smaller local hospitals, some operated partly as care homes for the elderly. In some cases these local hospitals have facilities for some minor operations and facilities for 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 among 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% compared to 8.9% on 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 excessively high cost, thus lacking in efficiency and incentives for using less costly available means (OECD 2008b; Suppanz 2008).

The main reasons for the relatively high cost of the Icelandic health care system are a high level of services, high prices of medicines, extensive use of specialist physicians (due to a 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. Moreover, Icelandic physicians are said to be prone to prescribe new and more expensive medications to a greater extent than what is typical in the neighbouring countries (OECD 2009, NOMOSKO, 2009; Ólafsson, 2008a).

2.2.2 Pros and Cons of Iceland's health care system

Last year's report compared some outcomes and characteristics of the Icelandic system to the OECD average, on the basis of OECD health indicators from 2007 and WHO. Now we look at more recent data (OECD 2009 and Iceland's Directorate of Health) and give an overview of the strengths and weaknesses of Iceland's health care record. First the good aspects, then the more negative ones.

Pros:

- Iceland has had the lowest infant mortality rate in OECD for a lengthy period. It is now second to Luxembourg (2007).
- It also has one of the highest life expectancies in OECD, even though the female rate has lowered in recent years

- Along with Sweden it has the lowest premature mortality rate (potential years of life lost) for males.
- It is above the OECD average (but not in the top group) in respect of mortalities due to heart diseases and stroke.
- Overall cancer mortality rates are amongst the lowest (but near average for breast and prostate cancers).
- Mortality rates due to road accidents are just above OECD average.
- Suicide rates are also just above average.
- Infant health (low birth weight) is amongst the best, along with Sweden, Finland and Luxembourg.
- Risky behaviour amongst the youth (smoking, drinking and drug use) is low.
- Daily fruit eating amongst the youth is above average and so are physical activities.
- Adult smoking is amongst the lowest and has declined rapidly.
- Adult alcoholic consumption (litres per capita) is amongst the lowest.
- Health and social sectors are high as regards percentage of civilian employment.
- The number of practising physicians (per 1,000 inhabitants) is very high (7^{th}) amongst OECD nations.
- The number of midwives (per 100,000 inhabitants) is very high, as are psychiatrists and pharmacists.
- The number of nurses (per 1,000 inhabitants) is the 6^{th} highest in OECD, despite frequent complaints of shortages.
- Doctor consultations per capita are below average.
- The number of MRI and CT scanners is amongst the highest (per 1,000 inhabitants).
- Hospital discharges per 1,000 inhabitants are close to OECD average.
- The length of stay for acute care is amongst the lowest in OECD.
- Low rates of treatment for end-stage renal failure or undergoing dialysis.
- Low rates of Caesarean sections per 1,000 births, along with other Nordic nations.
- Consumption of Antidiabetics is very low (DDD[3] per 1,000 inhabitants per day).
- Rather low asthma admission rates, for age 15 and over.
- Very low rates of admissions for diabetes-related acute complications (for age 15 and over).
- Very low in-hospital case fatality rates (within 30 days in 2007), along with other Nordics.
- Very high cervical cancer and breast five-year relative survival rate (2002-2007).
- Lowest cervical cancer mortality rates for females (2005). Also low for colorectal cancer mortality.
- Children vaccination rates are above average for OECD.
- Out-of-pocket expenditures on health care low by international standards, close to Scandinavian level.

Cons:

- Dental health is the sixth worst amongst advanced OECD nations (2005).
- Number of dentists per 100,000 inhabitants is the second highest rate in OECD.
- Dental services are too costly for lower-income earners.

[3] Defined daily dosage

- Rates of overweight or obese children under 11-15 are above OECD average and have increased fast.
- Obesity rate amongst adults is now (2007) the sixth highest in OECD.
- Bad drinking and violent behaviour is too frequent amongst a minority, especially young adults.
- General practitioners are relatively too few, specialists too many (for cost efficiency).
- Consumption of antidepressants is the very highest in OECD (DDD per 1,000 inhabitants per day).
- Admission rates for COPD are above average.
- Expenditures for organised public health and prevention programmes are low. Also in Denmark.
- Expenditures for pharmaceuticals are higher than in other Nordic nations; but slightly under OECD average.

This comprehensive list indicates that Iceland, indeed, has very good service coverage and a high quality of health provision. The negative aspects have a rather low weight relative to the advantages.

In Table 2 we show, however, that all the goals of the Icelandic health care services have not been fully met, as regards erasing differential access to health care services due to lack of affordability. The data, which comes from EU-SILC surveys for 2007, indicate reasons for unmet needs for medical examinations, as reported by respondents from the general public. The table compares outcomes for low-income respondents (lowest 20% of income earners) and the highest 20% of income earners. The reasons for unmet needs offered as reply categories were: "Could not afford to"; "Waiting time"; and "Too far to travel". The responses give useful indication of problem areas and the relative importance of affordability as against effects of queues/waiting lists and differential regional provisions of health care services.

The Nordic countries, which generally form Iceland's most important comparative environment, are shown at the top of the table. It emerges that Iceland has indeed the highest proportion of low-income earners who say they have unmet needs for medical examinations, because they could not afford it, or 3.1% as against between 0.3% to 1.2% in the other countries. Iceland is close to the OECD average of 3.3%. This problem is greatest in Portugal, Greece, Poland and Italy. The Netherlands, the Czech Republic, Austria and Luxembourg are similar to the Scandinavian nations, but no respondents mentioned this in Spain and the UK.

Table 2: Persons reporting an unmet need for a medical examination, selected reasons by income quintile. European countries in 2007.

	Quintile 1 – Low Income			Quintile 5 – High Income		
	Could not afford to	Waiting time	Too far to travel	Could not afford to	Waiting time	Too far to travel
Nordic nations:						
Denmark	0.3		0.1	0.1		
Finland	0.7	0.2		0.0	0.1	
Iceland	3.1	0.8	0.3		1.0	0.2
Norway	1.2	0.2	1.2		0.1	1.1
Sweden	0.8	2.9	0.3	0.2	1.8	0.1
Austria	0.9	0.1	0.1	0.1	0.2	
Belgium	1.4					
Czech Republic	0.4	0.2	0.4		0.5	0.1
France	3.3	0.2	0.1	0.2	0.0	
Greece	9.2	0.5	0.3	0.8	0.2	
Hungary	4.3	0.5	0.4	0.5	0.3	0.1
Ireland	3.6	1.7	0.0	0.4	0.3	0.1
Italy	7.0	2.0	0.2	0.8	1.1	0.0
Luxembourg	1.0	0.4	0.0	0.1	0.1	
Netherlands	0.2	0.2	0.0		0.3	0.0
Poland	7.9	2.1	0.6	0.8	3.8	.2
Portugal	17.9	0.6	0.2	2.1	0.1	
Slovak Republic	2.8	0.7	0.4	0.0	0.4	
Spain	0.0	0.1	0.0		0.2	
United Kingdom	0.0	1.1	0.1		1.4	
Average	3.3	0.8	0.3	0.5	0.7	0.2

Source: EU-SILC (OECD 2009)

Waiting lists as a problem are most common in Sweden, of the Nordic countries (and are in fact the longest in the total group of countries), with Iceland coming second in the Nordic group, with a rate around OECD's average. Waiting is most pronounced as a problem in Poland, Italy and Ireland.

Too far to travel is most frequently mentioned by respondents in Norway, of the Nordic countries, which has also the highest rate among the EU countries. Norway's sparsely populated provincial areas account for that.

The issue of equalising access across income groups is still a task needing consideration in Iceland, although nowadays this is generally not a big issue in Europe's health care systems.

Looking further at waiting lists for major operations in Iceland, in Table 3, we see that the trend of shorter waiting times from the last 3 years continued in the crisis year of 2009, when the health care services were strained in terms of financing and faced some cuts in staffing levels and work volumes.

The table, indeed, shows an impressive progress from 2008-2009 to February 2010, with waiting times for most operations in hospitals being shortened. The most marked deviation from that trend is waiting time for prosthetic replacement of knee joints, which had been shortened from 2008 to mid year 2009, but increased then in the latter part of 2009 and beginning of 2010, with the number of individuals waiting for more than 3 months approaching the level of October 2008.

The most impressive shortening involves cataract surgery, which had the biggest group of waiting patients. This group was cut by more than half in the last 6 months. The other decisive cases of shortening are for operations for incontinence or prolapsed uterus, reduction mammoplasty, partial excision of mammary gland and tonsillectomy and/or adenoidectomy, to mention only a few. On the whole, the results in shortening waiting time in 2009-2010 must be counted as very impressive, given the cuts in expenditures and other restraints associated with the financial crisis.

Table 3: Waiting lists for main operations in hospitals, from October 2008 to February 2010

	Number of people who have waited longer than 3 months, for the specified operation				
	10/2008	02/2009	06/2009	10/2009	02/2010
Procedure:					
Decompression of spinal cord and nerve roots, lumbar area	7	4	5	11	5
Partial or total thyroid excision	4	1	0	0	1
Cataract surgery	1,543	1,224	1,227	1,222	558
Operations on ossicles of ear for hearing improvement	0	0	1	2	2
Tonsillectomy and/or adenoidectomy		51	35	39	24
Tonsillectomy and/or adenoidectomy	117	77	55	59	47
Coronary anastomosis surgery	4	5	0	0	3
Heart valve surgery	4	8	6	5	6
Angiography of heart and/or coronary arteries and PTCA	86	43	4	4	6
Partial excision of mammary gland		46	48	1	0
Reduction mammoplasty	141	134	145	91	84
Repair of inguinal or femoral hernia	7	11	11	29	14
Repair of gastro-oesophageal reflux	1	0	0	12	15
Bariatric operations on stomach	15	1	0	23	7
Cholecystectomy or lithotripsy of biliary tract	4	10	13	13	7
Removal of calculi from kidney and pelvis of kidney/operations for calculus of ureter	2	1	0	2	2
Kidney transplantation	1	0	*	*	0
Extracorporeal shock wave lithotripsy of pelvis of kidney or ureter	0	0	*	*	0
Operations for incontinence or prolapsed uterus	118	129	113	174	109
Operations on prostate	0	2			1
Prostatectomy, transurethral procedures	10	15	7	6	4
Male sterilisation	0	0	2	2	0
Hysterectomy	23	23			29
Female sterilisation	2	6			11
Prosthetic replacement of hip joint	184	132	124	170	141
Arthroscopic exploration of knee joint	0	1	3	0	0
Prosthetic replacement of knee joint	263	174	152	210	247
Vein ligation and stripping on leg	73	72	37	27	27
Aesthetic operations on skin of trunk	0	1	0	0	0

Source: Directorate of Health in Iceland (www.landlaeknir.is).

Finally, looking at relative numbers of consultations with doctors in general practices and consultations with specialists, we can establish that in Iceland there are significantly more consultations with specialists (1,585 per 1,000 inhabitants in 2007)

than there are in Denmark (804), Finland (1,310) and Norway (1,174). Particularly revealing is that in Denmark consultations with doctors in general practices are 3,685 (per 1,000 inhabitants) as against 2,754 in Iceland (NOMESCO 2009, p. 126). The system in Denmark clearly uses GPs to a much greater extent than in Iceland and specialists are, on the other hand, used in a more restricted manner, which presumably reduces overall health care costs.

2.2.3 Reform, Debates and Political Discourse

The biggest issues of concern and criticism in the field of health care in recent years have been the overall cost of the health care system, waiting times for some types of operations, inadequate hospital facilities as regards patient accommodation, shortage or high turnover of nurses and high user costs, which are a persistent issue of complaint, especially as regards prices of medications and dental care.

Government measures have generally aimed at addressing these issues and with the present financial crisis the issue of cost cutting has obviously been given the highest priority. Still some other measures of reform are being kept alive.

Measures implemented during the 1990, such as the merger of the two largest hospitals into the university hospital (Landspítali), the formation of the seven health care regions throughout the country, and the creation of the health care services for the Reykjavík area, were subject to rationalisations in 2007. Those reorganisations, however, have not generally involved much transfer of power to the local level and the health care economist Tinna Ásgeirsdóttir (2009) describes them as involving increased centralisation and devolution at the same time. Financing and superior authority continues to be fully at the ministerial level. The changes are aiming at improving management and surveillance by means of increased mergers and cooperation of institutions within the regions. This is logical when aiming for economies of scale.

The government, which came into power in May 2007, put a stronger emphasis on reorganisation within the health care sector to improve economic efficiency, by strengthening the purchaser role of the government and cost-benefit assessments, in line with frequent recommendations from the OECD (2008b). To that end the government split the state social security institution (SSI) into two institutions, one for pensions and transfers (still going by the same name – SSI) and the other dealing solely with health insurance and the purchaser role (Icelandic Health Insurance – SÍ). This measure was to be modelled on British organisational features of utilising market-like effects in the health care system. It still remains to be seen if these novelties prove successful. Renegotiating terms for the various private providers during the crisis, with sizable cuts in costs, will perhaps be the ultimate test case.

Some of the reform programmes from former years, thus, continue to be of importance, such as the above mentioned one (until 2010), and the national public plan for health priorities, in force until 2010, the quality and care plan (also until 2010), pharmaceutical policy until 2012, as well as various government measures to lower costs of pharmaceuticals, for example by means of introducing a joint Nordic market for such products and directing the use of medications increasingly towards cheaper generic drugs. Nothing much has yet been done to implement a greater gate-keeping role of GPs in giving access to specialists, even though the goal of present legislation from 2007 is to make the health care centres the first stop of patients in the

system. The present Minister of Health did, however, set up a working group on 3 November 2009 to look into ways of implementing measures towards that end, particularly aimed at examining the pros and cons of the Danish system for managing choices within the service.

The present government has had to implement extensive cuts in health care expenditures and there is more to come in the next two years, in accordance with the IMF restoration programme. In December 2009, the Ministry of Health published a report of a task force reviewing and developing measures aimed at rationalising extensively, while at the same time managing to preserve the health care services, i.e. its volume, security and quality (Heimisdóttir et al. 2009). This report built on recommendations of another similar report from September (Gunnlaugsdóttir et al. 2009). The reports outlined plans for cutting down operations by shifting tasks between institutions, mainly by concentrating them more than previously. This involved operations of surgery units (reducing their numbers), merging facilities for risky birth services and changing the roles of smaller regional hospitals. Increased use of outpatient services instead of using inpatient services in the more expensive hospitals was also suggested.

During 2009, administrative mergers of seven health care institutions in the Western Health Region were also undertaken and the Icelandic Health Insurance (SÍ) has worked to renegotiate contracts with various groups of private providers and providers of medications.

In January, the Ministry of Health received another report of a task force reviewing the organisations and operations of administrative institutions in the health care sector, with the aim of suggesting merging opportunities and reorganisation of tasks (Ólafsson et al. 2010). This group sought lessons from the experiences of comparable institutions in other Nordic countries, while bearing in mind the smaller scale of the institutional environment in Iceland, due to a smaller population. Thus, the aim was to provide for separate institutions for some functions which in other countries are more often departments of larger institutions in. The task force specifically recommended a merger of the Directorate of Health and the Public Health Institute into a stronger Directorate of Public Health and Welfare, aiming specifically to seek synchronisation and scale effects for more effective and less costly functioning. The Ministry of Health has decided to implement this recommendation soon. Other recommendations concerned changes in the area of administration related to the pharmaceutical sector and health protection at workplaces.

In December, the Directorate of Health published a report outlining a stepped-up effort to monitor and assess the operations in the hospital sector, with special regard to the effects of cuts and austerity measures on the security and quality of the services to date. How the hospitals will react to further financial cuts will be particularly monitored.

In August 2009, a working group of the Ministry of Health (Sigurdsson et al. 2009) delivered a policy paper on actions to counter negative psychological and social consequences of the financial crisis. The group review, in particular, the experiences of the financial crisis in Finland and Sweden at the beginning of the 1990s. The danger of negative effects on children and youth were particularly emphasised, as well as the important role of activation and various preventive measures.

The government decided in 2009 to go ahead with plans for new buildings for the national University Hospital (Landspítali), with funding coming from the occupational pension funds. This is also seen as a case of stimulus for the construction industry and the economy in general, since this is a very large project. The importance of the OPFs is clear, when one bears in mind that the government is itself unable to finance such new expenditures, due to the financial crisis. The OPFs do, however, have ample capital, which needs secure investment options, which are not easily found after the collapse of the Icelandic Stock Exchange in 2008. The form of the project is, thus, one of a public-private mix. The Minister of Health has initiated this work and planning and design work has already started, with construction activities possibly starting in late 2010 or early 2011. This project will alleviate one of the great concerns within the health care sector in recent years, namely inadequate accommodation facilities for patients within the hospital, as well as too much distribution of activity centres within the University Hospital. It is, for example, now operated on two major campuses, one of which will be closed with the advent of the new buildings. This should make the operation of the hospital more efficient in the longer run.

Thus, while the Icelandic health care sector is presently facing a very stringent test, due to great needs for expenditure cuts, there are clearly some signs of success in preserving the security and quality of services to date. Waiting lists have actually been significantly reduced in 2009 and, despite increased pressure on staff at various levels, there are also healthy signs of stamina and effort to do better. Plans for new buildings for the national University Hospital are an important sign of the goal of government and staff to fight to preserve the high standard of the Icelandic health care system, despite the temporary difficulties. The next two years will decide how well that goal will be achieved.

2.3 Long-term care

2.3.1 System characteristics and functioning

In Iceland the care services for the frail elderly and disabled or long-term sick are collectively the responsibility of the government, local authorities and third sector voluntary organisations. Governments primarily finance the services both at central and local level, but also within the third sector organisations, which frequently receive contracts for government funding of operational costs, such as charges on a per bed/person per day basis. Voluntary organisations dealing with individuals from particular disease groups and disability organisations are particularly active in providing services to their members (see www.obi.is). Many care homes for the elderly are also of this type, reflecting a very healthy relationship between the government, local authorities and the civil society voluntary sector in the provision of welfare services. This form has the added benefit of often producing employment opportunities for people with disabilities. 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 society, such as the Icelandic one (Egilsdóttir and Sigurðardóttir 2009).

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 1 January 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 stay 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.

Within the Nordic community, Iceland has for some years had the reputation of having a relatively large number of long-term care beds in institutions. This is somewhat surprising, given that the demographic composition of the Icelandic nation is such that it has a lower proportion of people above the age of 65, and the number of disabled people under 65 is 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 care 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 the central government carried a larger share of the costs.

Table 4 shows a comparison of provisions of long-term care in Iceland and the other Nordic nations. It shows both the proportion of the elderly, by age groups, living in institutions or care homes and people receiving home help designed to make it possible for people to live in their own accommodation for longer. Home help services are generally carried out by local authorities or by private providers on their behalf.

Table 4: Use of long-term care in Iceland, in comparison to the other Nordic countries, 2007-8. Proportion of people in relevant age groups living in institutions or receiving home help.

Elderly (65+):	Denmark	Finland	Iceland	Norway	Sweden
Elderly living in institutions or in service housing (%):					
65-74 years	1.2	1.8	1.6	2.4	1.2
75-79 years	3.6	5.2	5.9	6.2	4.2
80+ years	14.1	18.4	23.9	23.7	16.6
Total 65/67+ years	5.0	6.8	8.7	10.8	6.4
Elderly receiving home help (%):					
Total 65+ years	18.1	6.3	20.4	12.1	9.2
Includes residents in nursing homes, sheltered housing, housing where care is provided and long-term stays in housing units. Home help is to residents in their own homes, excluding service housing.					

Disabled:	Denmark	Finland	Iceland	Norway	Sweden
Disabled under 65 living in institutions (%):					
% of ages 18-64:	0.4	0.5	0.4	0.5	0.4
Disabled under 65 receiving home help (%):					
% of ages 18-64:	0.8	0.2	1.2	0.7	0.2
Data applies to residents in special-care housing units as well as to people admitted to institutions. Home help is to residents living in their own home					

Source: NOSOSKO 2009.

As the table shows, Norway has now the highest proportion of people 65 or older living in institutions or care homes, 10.8%, as against 8.7% in Iceland, which comes second. For people 80+ both Norway and Iceland have around 25% living in institutions while the other Nordic nations range between 14% and 18%. Norway has the highest rate for the younger age groups (ages 65-79), which explains the highest overall rate for 65+.

When we look at the use of home help amongst the elderly as a whole (ages 65+), we see that Iceland has by far the highest rate, 20.4% as against 12.1% in Norway, but Denmark comes second in that category with 18.1%. The rate is lowest in Finland. A recent OECD study compared the rates of use of institutions and home help in member countries (Fujisawa and Colombo 2009, p. 18). In this study Norway had the highest rate and Denmark and Sweden were in 4th and 5th places. The figures for Iceland in this study lacked the numbers for recipients of home help. When we add those to the comparison, it seems that Iceland has the highest rate within the OECD community as regards long-term care in institutions and/or with home help for the elderly.

In the lower part of Table 4 we have comparable figures for people under the age of 65, most of which refer to disabled or long-term sick individuals. There, we see that the rates for institutionalisation are about the same in all the Nordic nations (0.4-0.5% of people at ages 18-64). The use/provision of home help is, however, different, with Iceland having the highest rate (1.2%) and Denmark and Norway following with 0.7-0.8%. Finland and Sweden are at the bottom with 0.2%.

On the whole, it thus seems that Iceland is rather far progressed in provision of long-term care for the elderly as well as for the disabled and long-term sick.

Table 5: Current health expenditure by function of health care, 2007.
The share of long-term care out of total health care expenditures.

	Inpatient*	Outpatient**	Long-term care	Medical goods	Collective services	Total
Iceland	33	29	19	16	4	100
Norway	32	26	26	13	3	100
Finland	30	32	12	18	8	100
Denmark	30	33	21	13	3	100
Sweden	29	40	8	17	6	100
Austria	36	28	13	18	6	100
France	36	23	11	21	9	100
Poland	33	27	6	29	5	100
Czech Republic	32	31	4	26	7	100
Luxembourg (2006)	30	30	18	11	11	100
OECD	29	31	12	21	7	100
Germany	29	29	12	20	9	100
Hungary	29	26	3	36	6	100
Switzerland	29	32	19	12	7	100
Belgium	29	24	17	18	13	100
New Zealand	29	33	14	12	13	100
Korea	28	36	2	28	6	100
Portugal (2006)	25	46	1	25	3	100
Spain	25	37	9	24	6	100
Japan (2006)	24	33	16	22	5	100
Slovak Republic	23	31	0.4	38	9	100
Average	29	31	10	23	8	100

* Refers to curative -rehabilitative care in inpatient and day-care settings. ** Includes home care and ancillary services

Source: OECD Health Data 2009.

Despite these relatively high rates of service provisions these figures seem to indicate, there has been a significant trend of lower residential rates for the elderly in such institutions, and increased rates of staying in own accommodation for longer, often with improved home help from local communities and in privately operated residential housing designed for the elderly.

In Table 5 we assess this differently by comparing current health expenditures by function of health care. Here, the picture is somewhat different. Norway and Denmark have the highest proportion of total health care expenditures marked for long-term care (26% and 21%) and Iceland comes next with 19%. Switzerland is the only other OECD country with comparable rate for long-term care expenditure share, followed by Luxembourg and Belgium.

It is also interesting to observe in the table that the share of health expenditures going on medical goods is lower in the Nordic countries than in most of the other OECD countries. Apart from that and a relatively high expenditure share on long-term care in the Nordic countries, there are not significant differences here between the Nordics and others.

2.3.2 Reform, Debates and Political Discourse

There have been significant complaints in Iceland in recent years about inadequate caring facilities, especially for the frail elderly. The main concern has tended to be inadequate supply of care facilities for those needing extensive nursing and care. Another frequent complaint is that too many elderly have to share rooms with strangers in homes for the elderly, and also in care homes for people in need of more intensive care.

Recent governments have been favourable to the policy goals of improving quantity and quality in long-term care for the frail elderly. The Minister of Social Affairs announced a new policy emphasis for that area on 27 June 27 2008, aiming at more independence for the elderly and less sharing of rooms in accommodation along with improved standards of the accommodation. Then, on 10 October 2009, the present minister announced new measures to finance significant building activities for that purpose, by means of long-term loans from the state mortgage fund, which in turn finances itself significantly through the occupational pension funds. This again is considered to be part of important stimulus measures for the economy, like the plan for the construction of a new University Hospital. Similarly, building work on the new Auditorium for Music in Reykjavík, a major investment in cultural foundations for the performing arts is being continued, also in the name of stimulus measures. In all these cases, financing from the OPFs plays an important role. Apart from these above-mentioned plans, the scope for large-scale reforms is, of course, very restrained by the prevailing financial crisis, since the government has to prioritise various emergency measures.

3 Impact of Financial and Economic Crisis on Social Protection

As outlined in last year's report, Iceland had a more spectacular financial crash than most other nations, when the extreme bubble economy burst with the fall of the major banks in October 2008, in conjunction with a collapse of the stock market and the currency. An important part of this was a loss of trust in politics, business and finances, internally as well as externally. All of this, in turn, led to an unusually deep economic recession that was predicted to reach its zenith in late 2009 and to bottom out in early 2010 (IMF 2010, Buiter and Siebert 2008, Ólafsson 2008, Daníelsson and Zoega 2009).

We are now in a position to take stock of the experiences so far and review the outcomes and consequences for social protection and welfare, as well as to assess the measures undertaken by the government to alleviate the worst consequences. The situation now, a year and a half into the crisis, seems to be that the setback is turning out to be less serious than predicted, and in many ways I think that Iceland can be taken as an example of a society where government measures have to some extent successfully counteracted the worst consequences, with social protection measures, tax measures and debt relief measures.

Given the major problems of balancing the government budget and shouldering the costs of the financial collapse, Icelandic politicians and the public have, of course,

hotly debated on how to prioritise ways of adjusting. This has particularly concerned views on the relative weight of tax increases as against cuts in government expenditures and services, including social protection. This was one of the issues focused on in a stabilisation pact between the labour movement, employers' organisations and the government in summer 2009 (*Stöðugleikasáttmálinn - Stabilisation Pact*, available at www.island.is). It was decided that the measure of tax increases and cuts would be administered in close to equal proportions. The political opposition, the Independence Party (IP) and the Progressive Party (PP), which formed the ruling governments from 1995 to 2007, have taken a firm opposition to tax increases, particularly the Independence Party, which has been heavily influenced by neoliberal policies. The government consists of the Social Democratic Alliance (SDA) and the Left-Green Party (LG), which defines its policy emphasis as one modelled on the Scandinavian welfare model. This government is the first two-party leftwing government in the history of the Icelandic republic, and its formation is one of the political consequences of the financial collapse, which was widely perceived as being caused by the policies of the former, more neoliberal governments of the IP and PP parties.

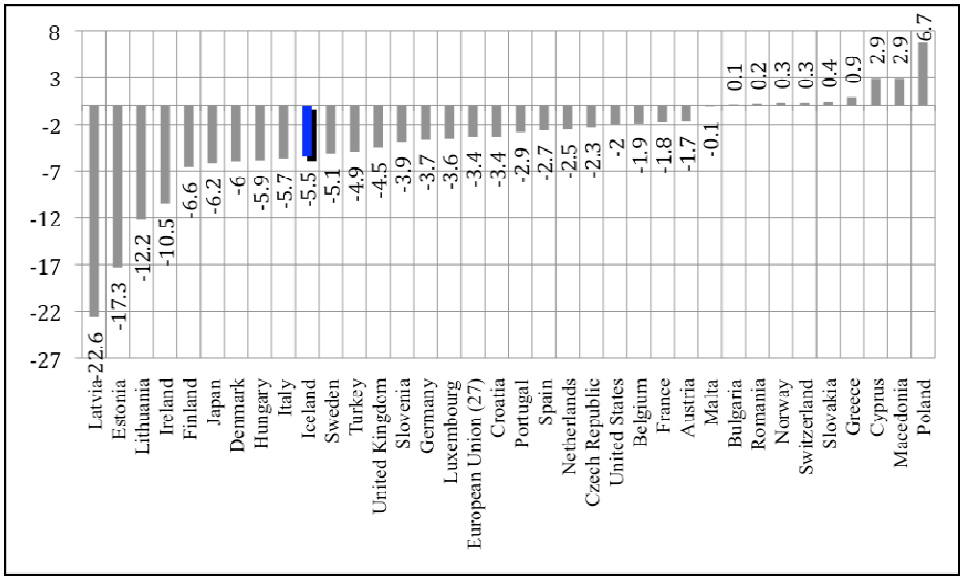
Thus, in accordance with the stated egalitarian policy goals, the present government has tried to protect the welfare state as much as possible and to shelter the lower income groups against consequences of the crisis. Hence, low income pensioners have been protected with the large raise of the minimum pension guarantee, low earnings in the labour market were slightly raised in 2009, and the tax burden on the lowest income groups was slightly reduced in 2009 and 2010, while taxes on average and higher incomes were significantly raised. The debt burden of households, due to inflated mortgages and loans for the purchase of cars, have been a major issue amongst the public, and despite extensive governmental measures, it remains an issue of great concern. Finally, the greatly increased unemployment, which is at an unprecedented level, has been a major problem and concern, both for the government and the public. We will analyse these issues closer hereafter.

On the whole one has to bear in mind that the government has limited possibilities to implement its goals due to the difficult finances, which are dictated by the IMF condition of balancing the budget in a period of 3-4 years. Increasing government debt is not an option, so the measures, to a large extent, involve choosing between various painful options. Yet policy emphasis, of course, also makes a difference in that context. Large-scale cuts in the structure of the welfare state (focusing on pensions and health care) are perceived to have great long-term consequences, whereas increased tax burdens can be seen as more of a short-term adjustment measure, which, however, reduces living standards further. Neoliberals emphasise the risk of negative effects of tax increases on employment participation and economic growth, whereas welfare-oriented policy makers emphasise the importance of using social protection and the welfare state to cushion the consequences of the crisis. The balancing of these orientations is very much the task of policy and governance in Iceland now.

3.1 The extent of the crisis and its welfare consequences

The predictions of IMF, OECD, Eurostat and the Icelandic Central Bank were that GDP would contract by about 10%, most of it taking place in 2009. In early March, Statistics Iceland delivered the verdict on economic growth in 2009, and the contraction turned out to be 6.5%, instead of the predicted 10%. In Figure 6 we show the accumulated growth record for EU and OECD nations for 2008 and 2009 together. This is the period from the start of the crisis to the end of the first full year of recession for most. Iceland's accumulated contraction for the two years is 5.5% (there was a growth of 1% in 2008), which is not that much above the EU average of 3.4%.

Figure 6: Accumulated contraction of GDP in 2008 and 2009 (%) in EU and OECD countries.



Source: Eurostat.

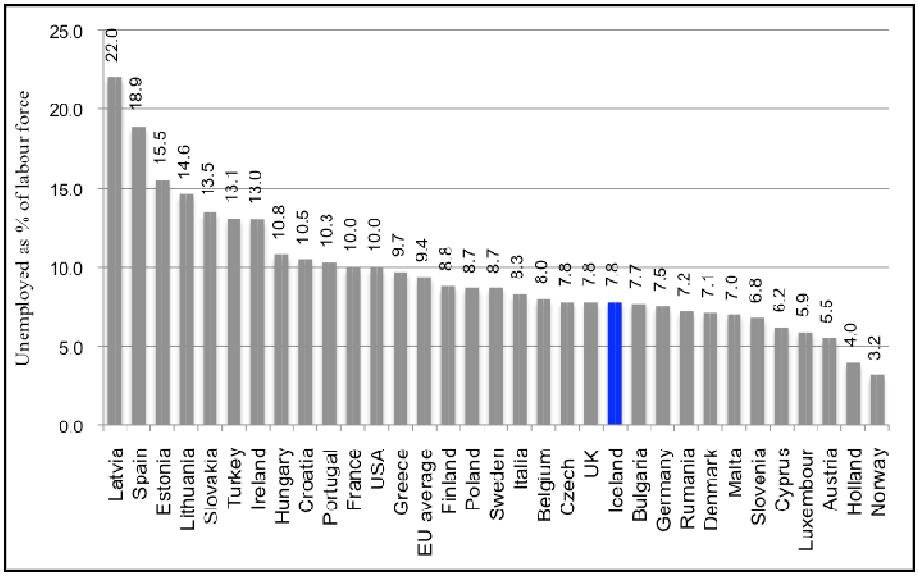
Nine countries have a more dismal outcome than Iceland, with the Baltic states of Latvia, Lithuania and Estonia facing the worst situation and Ireland closely following suit. Then comes Finland, with a rather surprisingly large contraction (6.6%). Denmark also has a greater contraction than Iceland, when the two years are counted together, as do Hungary and Italy. The overall debt position of the Icelandic government is bad, but the latest report from the IMF (April 2010) clearly indicates that it is manageable. The gross debt of the government is now (March 2010) estimated at about 123% of GDP, and when looked at in the context of prognoses for other western nations in the next few years, the indication is that many nations will have a worse debt situation, and some already do. Looking further at net debt, taking account of assets against the gross debts, the net financial position of the Icelandic government is 41% in the negative (IMF 2010).

Figure 7 shows a comparison of unemployment rates in November 2009. The prediction was that at that time Iceland would have about 10% unemployment, but the standardised OECD rate is 7.8% at that time, measured by the comparable EUROSTAT labour market surveys. Registered unemployment in Iceland is about 1%

higher, since it includes some individuals on part-time unemployment benefit and working part-time (cf. Directorate of Labour-www.vinnumalastofnun.is).

On the whole, one can, thus, say that the setback for the Icelandic economy is not as bad as expected. This indicates that there should be possibilities to adjust reasonably well and avoid or soften the worst consequences. There are, however, clear negative welfare consequences. The most serious ones, from the perspective of social protection, are unemployment, debt burden of households (and companies) and reduced overall purchasing power. The unemployment rate, even though not particularly high by international standards, is difficult for Iceland, as it is considerably higher than ever experienced since the Great Depression of the 1930s.

Figure 7: Unemployment rate in November 2009 in EU and OCD countries.



Source: Eurostat.

The debt burden is particularly difficult, since Icelandic homes were highly indebted before the crash, on a level with those of Denmark and the USA. The financial collapse, however, has increased this debt burden in two unfortunate ways. Those who had debts (mortgages and consumer debts) in Icelandic krona became the victims of increased inflation associated with the collapse. Private debts are generally indexed to the price index, so both the principal and the interest rates were greatly increased on these loans. An even worse scenario emerged for those who had debts in foreign currencies. With the collapse of the Icelandic krona in 2008, both the principal and the debt burden were doubled. Most loans on cars were of this kind and many households had such loans, but a minority of households even had mortgages in foreign denominations. Tackling this issue is one of the bigger challenges for the government, which is seriously short of money to alleviate such problems.

Purchasing power is likely to be reduced by about 20% as a result of the crisis, in particular due to the inflationary effects of the collapse of the currency. Already, the purchasing power of real wages has come down by about 15%, so some more is to come (Hagstofa Íslands-www.hagstofa.is). While this is big by any standard, it is likely to have the effect of helping Iceland to gain a quick recovery when the

economy has bottomed out. Looking back in history, one can also say that this is not unprecedented (Ólafsson 2008b). Short-term recessions in post-war Iceland were typically solved with devaluations and related reductions of the purchasing power of the population (inflation, in particular prices of imports, shot up immediately while pay remained on nominal value).

One important influence of the crisis on social protection has to do with the loss of assets of the occupational pension funds (OPFs). The losses by the end of 2008 were estimated to be in the region of 20-25%. Most likely the funds did not write down the whole of their losses last year. As a result of the consequent negative return on the funds' assets for the reference period, the OPFs generally cut their accumulated rights and current pension payments by about 10% in 2009, and in 2010 further cuts are already emerging. It seems likely that the additional cuts this year will be in the region of 10% again, varying somewhat between funds. The only funds exempt from this requirement are the two funds of public employees, which have a governmental guarantee for their pension promises. These funds cover close to a fifth of all employees in Iceland (Ísleifsson 2007).

An interesting feature of the Icelandic pension system in this situation is the generally unpopular income-testing characteristic of pillar I, which will now work the other way round, and compensate those losing a part of their occupational pensions. Thus, some 40%-50% of the reduced occupational pension will be compensated with an increase from the public social security (if governmental finances allow a normal working of the rules of the system).

3.2 Countervailing measures for the unemployed and indebted households

The protective government measures, implemented to ease the consequences of the crisis on individuals and households, have primarily focused on issues related to debt relief and unemployment.[4] As mentioned above, the other general measures, such as cuts and tax increases have aimed to shelter low-income earners and, as such, they have been conducive to the goals of social protection.

The government has also initiated a novel feature within the administration that goes by the name of "Welfare Surveillance"[5]. This involves bringing together representatives from key institutions, interest groups and the research community to survey welfare developments in order to spot any negative welfare consequences early and to suggest ways of tackling them. The WS works in many special issue groups and has a unitary steering group that pulls the threads together. The WS has already issued a few status reports and recommendations to the Minister of Social Affairs.

The Ministry of Social Affairs has also taken part in the EU's European Year for Combating Poverty and Social Exclusion and has already started various small projects in that area. This is an interesting experiment to the alleviate negative welfare consequences of the crisis and is instigated at least partly by lessons drawn from the Finnish crisis of the early 1990s, where a number of serious long-term consequences are believed to have resulted, not least for young school leavers in the recession years

4 The Government has opened a special website to monitor its activities in relation to the crisis and the resurrection of the financial sector and economy, at www.island.is.

5 WS - http://www.felagsmalaraduneyti.is/velferdarvaktin/

who got stuck outside the labour market even after the economy started moving forward again (Sigurðsson et al. 2008; Kalela 2001). The Finns talk about the "lost generation" in this respect and there is considerable emphasis within the Icelandic administration to try to avoid similar consequences if possible.

In October 2009, a Ministry of Social Affairs working group delivered a policy paper to the minister about measures to increase work activation, rehabilitation and education amongst young unemployed individuals (Halldórsdóttir et al. 2009). The unemployment level is highest amongst the young age groups, and those with lower education levels are very prominent in that group. This is due to the fact that the construction sector was particularly badly hit, as well as consumer-based service fields, which are badly hit by reduced spending of the general public. Fishing and related export and service industries, on the other hand, are doing reasonably well. Similarly, public services have not been cut down to an extent that would seriously affect the overall unemployment rate.

The task force emphasises the need to strengthen the obligation of young unemployed individuals to take part in various activation or education measures. They also emphasise measures within the secondary educational system to seriously counter tendencies towards early school-leaving, which has been at a rather high level in Iceland in recent years, which, amongst other things, has been due to ample job and earnings opportunities that have prevailed in Iceland for a long time (Ólafsson and Arnardóttir 2008). The Directorate of Labour (*Vinnumálastofnun*) has stepped up various activation measures and, in cooperation with the public educational system and the educational facilities of the labour market partners (*Starfsmenntastöðvar atvinnulífsins - Labour market educational centres*), increased opportunities for education have been supplied. Universities have also facilitated increased entry levels.

The Ministry of Social Affairs has also made contracts with local authorities and some third sector organisations (such as the Red Cross) aimed at increasing job opportunities for the young unemployed. There is also an increased emphasis on giving students jobs during the summer holidays of 2010. In addition to these extensive tailored measures for the young unemployed, the government and the OPFs have made an agreement (the Stabilisation Pact with unions and employers) to use investment money from the funds to give extra job opportunities, in construction, road and other public works. Tax benefits for households who undertake renovation work on their housing have also been implemented and are expected to facilitate job creation for construction workers. Measures aimed at initialising the large-scale construction of enlargements or new developments within the energy intensive, aluminium industry, which have been seen by many as important stimulus measures however, have been postponed due to delays in the implementation of the IMF programme. These delays stem from the unsolved issue between Iceland, the UK and the Netherlands over the repayment of deposit insurance funds associated with the Icesave accounts of the Icelandic National Bank (Landsbanki), which were operated in these countries. It is hoped that this situation will be eased in the latter part of 2010 and 2011. The Left-Green party, one of the two governmental parties, is, however, in significant opposition with that policy, so there will presumably be a limit to the extent of possible measures in that area.

The biggest concern of the government is the debt burden of households in the wake of the crash. As we outlined in last year's report, the government initiated many measures aimed at alleviating these extensive problems for households, particularly

households with lower earnings. The stated aim of the government is to review the result of the measures and to adjust them accordingly. Since March 2009, a number of changes and novelties have emerged in that area. The last policy packet of measures for debt-ridden families dates from 17 March 2010. The status quo of these measures is as follows:

- Mortgage loans (Icelandic and foreign nominated) can be rescheduled, so as to carry only the repayment burden that prevailed before the financial collapse. This generally involves a 20-40% reduction of debt burden.
- The time frame of the debts thus rescheduled is increased by a maximum of 3 years. What remains of the debts by then will be written off. About 45% of households with Icelandic krona loans have taken this option and 42% of those with foreign currency mortgage loans.
- Similar measures are available for car loans (many of which are in foreign currencies). This rescheduling provides a 15-20% reduction of debt servicing. About 15% of households have taken this option.
- The Ministry of Social Affairs is presently negotiating with the private companies that provided these car loans to write off the remaining debt above the value of the collateral (i.e. the car in question). This will significantly reduce the debt burden of car loans, in addition to the previous measures.
- The government has instigated measures for the worst cases of debt burden, i.e. amongst those with unsustainable debts, to settle some write-offs outside court with the Public Mortgage Loan Fund (*Íbúðalánasjóður*) and the banks.
- The banks have generally offered their debtors adjustments of their debt levels down to 80-110% of their assets (depending on personal financial conditions). Those who have excessive asserts behind their debts will have to reduce their assets.
- About 5% of Icelandic mortgages have been frozen, i.e. repayments are awaiting rescheduling or restructuring.
- Relatively few households have opted for special restructuring through the courts.
- About 14% of those households that have mortgages with the banks have opted for a lowering of the remains of the debt principal to 80-110% of the value of their assets.
- The government has announced its plan to set up an Ombudsman office for debtor households. The aim is to provide information and to strengthen the bargaining position of heavily indebted households in their dealings with banks and other creditors, siding with the debtors where needed. This service is available for all, including self-employed mortgage debtors and those of foreign nationality.
- The office of the Ombudsman for debtors will also take over the public advisory office for family finances, thus creating a one-stop shop for related services in that area. That service for debtors was greatly increased in 2009.
- Various other related minor adjustments have been implemented.

On the whole, the measures would seem to be capable of making a big difference to the position of debtor households who found their position deteriorate drastically with the financial crisis, when preconditions drastically changed for the worse. In a nationally representative survey amongst the public (18 years and older), undertaken for the Federation of Labour in June 2009, about 19% said they need special measures to be able to handle their debts servicing. The survey was repeated in December 2009 and then about 17% said the same, indicating a slightly improved situation. About 87% said in December that they have made use of some of the measures offered, whereas about 70% had done so in June. Between June and December the new general measures for rescheduling the debt burden had been implemented (see www.asi.is and www.island.is).

The Central Bank of Iceland did a major survey of the debt position of all households in Iceland at the beginning of 2009. This survey covered all debts (mortgages, car loans, consumer loans) and related them to the values of the family's assets and later added the family income to the picture. In June 2009 the bank's conclusion was that about 22% of households had difficult or unsustainable debts, whereas about 78% should be able to deal with their problems (data available on www.sedlabanki.is).

In March 2010, the bank updated its survey and still finds about 20-25% of households with a very difficult debt or financial position. The assessment of the bank is that the government measures had helped about a quarter to a fifth to solve sustainability problems. So it appears that the measures have only stopped the problem from getting worse, instead of reducing it significantly. This result is somewhat at variance to the results from the Gallup survey of December done for the Federation of Labour. The message seems to be that further measures may be needed to alleviate the problem, but problems of financing obviously forbid any easy solutions. It remains to be seen how the government can tackle this issue, which is of primary importance.

On the whole one can say that the consequences of the financial crisis for living standards in Iceland have been very serious indeed. The government has aimed to alleviate the worst consequences, particularly directing its limited financial resources towards lower-income households. This is reflected in social protection developments since the time of the crash in October 2008, such as the raising of the minimum pension guarantee and increases in general social security pension and benefit payments on 1 January 2009, some increases in the amount of the basic unemployment benefit, increases in child benefits and tax rebates for mortgage interests. This is also reflected in the distribution of the increased tax burden (against which low-income earners have largely been sheltered) and with the general aim of preserving the public welfare system intact. Difficult problems remain and even though the economy may be bottoming out at the present time, the standard of living consequences are likely to continue to surface into the next year or two. Further tax increases and cuts in public expenditures seem inevitable in the next two years, in order to balance the state budget and to start paying debts. Consequently, it is likely that two years of testing conditions both for the government and the general public are to follow.

Iceland applied for membership of the European Union in July 2009 and negotiations for the terms of membership seem set to start in the near future. While this is obviously a major policy issue for Iceland it has not featured greatly in public debate in general so far, nor in regard to issues of pensions, health and long-term care. The

reason is that the agenda in public discussions has been unusually loaded with issues concerning the financial crisis and the ICESAVE savings accounts issue with UK and The Netherlands (which has been blown greatly out of proportion by the political opposition in order to strain the stamina of the governing parties). This EU membership issue has thus so far been crowded out of the discussion, but it will no doubt get its place on the agenda once the immediate issues of the crisis become solved and as the negotiations progress.

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4 Abstracts of Relevant Publications 2009 - April 2010

[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

[R2] VEA (ÓLAFSSON, S., BALDURSDÓTTIR, S.L., MAGNÚSSON, H. AND SIGURÐSSON, Á.Þ.)**,** "Nýskipan almannatrygginga" (Reorganisation of Social Security in Iceland – Recommendations of a Task Force for the Ministry of Social Affairs), October 2009 (available on www.ts.hi.is).

This is a report of a task force set up in 2007, with the task of making recommendations for the reorganisation of the Icelandic pension system. The main goals were to greatly simplify the system and improve the interactions between the public social security system and the pension system of the labour market partners' occupational pension funds. The group delivered recommendations in three parts, first in December 2007 (short-term measures), then in September 2008 (recommendations for a new minimum guarantee for pensioners) and the final report in October 2009 with a plan for a new holistic design, outlining structural priorities for pension benefit structures and new emphasis on income-testing rules, as well as radical suggestions for simplifications of the structure of the pensions within the social security system. This involves moving from a three component pension structure to one main component of the public pension, and also simplifying the related benefit structure around the core pension.

[R3; R4] HANNESDÓTTIR, GUÐRÚN, THORLACIUS, S. AND ÓLAFSSON, S. "Örorka og virk velferðarstefna" (A Survey of work participation, rehabilitation and activation of disability pensioners). A report of Social Research Centre of the University of Iceland, 2010.

This report examines the extent of work participation of disability pensioners, early retirement and social conditions of disability pensioners. The report is based on public data as well as on a survey amongst the pensioners in question. The report was done with a grant from the Federation of

Occupational Pension Funds and the Ministry of Social Affairs. The data is meant to facilitate policy-making for reorganising rehabilitation and activation measures, as well as to increase information about the social conditions of disability pensioners. The results show that people with disabilities (as reflected in data from EU-SILC) have a higher employment participation rate in Iceland than in other OECD countries. The group of disability pensioners is relatively large in Iceland, mainly because the disability pension scheme seems to be taking on an excessively large role, as against the unemployment benefit scheme, sickness benefit schemes or social assistance.

Most disability pensioners have a very positive attitude towards working, but most say they can only work part-time, for health reasons. Only a small minority has taken part in vocational rehabilitation, with good result, but about 80% would like to have the opportunity to take part in rehabilitation.

[R4] PÁLSDÓTTIR, V. et al., "Drög að starfshæfnimati – Skýrsla faghóps um aðferðir við mat á starfshæfni" (Report of a Ministry of Social Affairs task group assessing methods of employability/disability, with recommendations for reform), September 2009**.**

The objective of this work is to examine various options for reforming the methods of assessing workability/disability of individuals with health deficiencies or inhibitions (physical or mental) and to provide recommendations for reform in the present system of disability assessment. Work in this area started in 2005, in cooperation between the ministry and the labour market partners as well as the main interest organisations of pensioners. The group based its work on various policy recommendations, such as from OECD's report Transforming Disability into Ability (2003) and UN's International Convention on Human Rights of Persons with Disabilities. The final recommendations build on ICD and ICF systems of classifying diseases and types of health inhibitions. The implementation of these recommendations will presumably be tied to further work of reorganisation of institutions in the activation/disability/rehabilitation sector.

[R4] RAFNSDÓTTIR, G. L., "Líðan í kjölfar efnahagshruns – samanburður þriggja hópa" (Life Qualities in the Wake of an Economic Collapse - Comparing Three Groups), an article in Jóhannesson, G. and Björnsdóttir, H., Rannsóknir í félagsvísindum X. Reykjavík: Social Science Research Institute, University of Iceland 2009 (pp.789-798).

This paper reports a study of the conditions of people who lost their jobs in the wake of the financial collapse in Iceland in October 2008. The study utilises the context of the crisis as a backdrop to study the importance of work in the life of people. The study focuses on individuals who previously worked in the over-expanded banking sector of Iceland, but who lost their job in the crisis. A questionnaire was administered to them and also to individuals who still work in the banking sector. The results show that the emotional condition of both groups, those who lost their jobs and those who retained their jobs, got worse in the crisis. Thus, increased strain and anxiety were evident. The situation was tough, as expected, and worse so amongst the unemployed. Women were also more negatively affected than men.

[R5] KRISTJÁNSSON, A. S. AND ÓLAFSSON, S., "Heimur hátekjuhópanna – Um þróun tekjuskiptingar á Íslandi 1992-2007" (*On the Development of Income Distribution in Iceland 1993-2007*), in *Stjórnmál og stjónsýsla*, vol. 5, no. 1, 2009, pp. 93-121.

> *This is a study of income distribution development in Iceland from 1993 to 2007, using data from the public tax authorities. The data allow delineation of income distribution trends, since they are comparable from year to year. They also allow an assessment of the structure of the distribution, by means of Gini coefficients, decile shares as well as percentile shares (for example the top 1% share and composition) and disaggregation of the various factors shaping the development, such as employment earnings, pension earnings, benefits, financial earnings, as well as assessing the effects of taxation on the distribution.*
>
> *The results indicate that the Icelandic income distribution changed unusually fast from 1995 and with increased pace from 2003, when the extreme bubble economy gained momentum. Pension earnings and specific benefits lagged behind earnings in the labour market, and financial earnings galloped drastically ahead of all other income components, especially after 2003. The redistributive effects of taxes and benefits were significantly reduced, so the distribution having before been one of the most egalitarian in the West became much more unequal. The Gini coefficient for couples households' total disposable earnings went from 0.24 in 1993 to about 0.28 in 2007 excluding capital gains, but from 0.21 up to 0.43 fully including capital gains.*

[R5] EYDAL, GUÐNÝ BJÖRK, "Fjárhagsaðstoð sveitarfélaga Norðurlanda á krepputímum: Hjálp til sjálfshjálpar?" (Social Assistance by Local Municipalities in the Nordic Countries: Help Towards Self-help?), Halldór S. Guðmundsson and Silja Bára Ómarsdóttir (eds.), *Rannsóknir í félagsvísindum X*. Reykjavík: Social Research Institute, University of Iceland, pp. 53-67.

> *In this study Guðný B. Eydal examines the policies and conditions of excluded and/or low income earners in the Nordic countries, with a special focus on Iceland. She describes the legal framework and the differing and common policy emphases. The fact that the provision is on municipal level has for a long time had the result that social assistance has varied somewhat between municipalities in the country. Only lately has the Ministry of Social Affairs laid down a framework for more common standards. The empirical part shows that Iceland has had fewer recipients of social assistance than the other Nordic countries and in all the countries the rates of recipients has gone down from the early 1990s towards the 2000s. The author also deals with the way social assistance is and is not conditioned with requirements to participate in activation measures and finds Iceland lagging somewhat behind in developments in that area.*

[R5] NJÁLS, H., "Lífsskilyrði barnafjölskyldna", an article in Jóhannesson, G. and Björnsdóttir, H., Rannsóknir í félagsvísindum X. Reykjavík: Social Science Research Institute, University of Iceland 2009 (pp.153-167).

> *This paper reports about a study of child poverty in Iceland, using data from the Icelandic part of EU-SILC. A particular focus is on single parents and the research question is what explains the rather difficult position of single parents, mainly mothers. The findings show the extent of differential standards*

of living of family types, comparing households of single parents to couples' households. The result indicates a sizable difference between these groups, in terms of, for example, housing and general deprivation indicators. The author stresses low wages for working parents as causes of poverty and inadequate welfare benefits for those relying on the welfare state.

[H] Health

[H1; H4; H5] ÁSGEIRSDÓTTIR, T. L**.,** "The Icelandic Health Care System", in MAGNUSSEN, JON, KARSTEN VRANGBAEK AND RICHARD SALTMAN, *Nordic Health Care Systems: Recent Reforms and Current Policy Challenges.* London: McGrawHill – Open University 2009.

This is a chapter in a book on the Nordic health care systems in a comparative focus. The chapter on Iceland is a stand-alone chapter unlike the others, while the others are more interlinked around themes. The chapter describes the organisational structure and values of the Icelandic system, dealing equally with financial and managerial issues, as well as general challenges and problems facing the system. Ásgeirsdóttir also shows Iceland's deviations from the core model of the Scandinavian health care systems, which consists primarily in more centralisation within the Icelandic system. She also describes recent changes, such as mergers of the biggest hospitals in the capital area, formations of new health care regions and reorganisation of the local health centres in the Reykjavik area. This is a well-balanced overview of the system, while perhaps being to some extent influenced by OECD recommendations from recent years, emphasising a larger role for private providers, and shaping up incentives in order to facilitate further use of less costly means of running the system.

[H2] BJARNASON, TH., **"**Vímuefnaneysla íslenskra unglinga í alþjóðlegum samanburði 1995-2007" (*Drug use amongst Icelandic Teenagers in an International Comparison*). Report from the Centre for Preventive Studies at the University of Akureyri, 2009.

This report provides an international comparison of drug abuse amongst the Icelandic youth in an international comparison, by using ESPAD survey material, covering the period from 1995 up to 2007. The samples are nationally representative for this age group and use similar methodologies and the same questionnaire. The results indicate that drug and alcohol use has gone down in Iceland in the period in question, probably due to effective preventive measures. In comparison to other countries, the Icelandic youth have a rather special position. Thus, a larger part of the 15-16 year olds have never used drugs or alcohol in their life and the users are a small proportion by international standards. Similarly, smoking is less common in Iceland than in most other European nations. On the other hand, those Icelandic youngsters who do drink often drink heavily and get involved in rather varied types of problems.

[H2] ARNARSON, A. AND BJARNASON, TH., "Þyngd, líkamsmynd og lífsánægja íslenskra skólabarna" (*Weight, Self-Image and Life Satisfaction amongst Icelandic School Children*), in Jóhannesson, G. and Björnsdóttir, H., Rannsóknir í félagsvísindum, X. Reykjavík: Social Science Research Institute, University of Iceland 2009, pp. 315-324.

This is a study into the rapidly growing problem of overweight in Iceland. The study uses the Body Mass Index and correlates it to the variables of attitudes to weight restriction measures, self-image indicators and to life satisfaction measures. The BMI was found to grow with age amongst the youngsters and also to be higher amongst boys than amongst girls. Girls had more concerns about their weight and possible overweight. Boys are found to be significantly more satisfied with their body than girls, despite having more overweight incidence. The general conclusion is that a sizable part of the Icelandic youth is now overweight and this should be a growing concern amongst parents and health care personnel.

[H2] ÁSGEIRSDÓTTIR, T. and KERRY ANNE McGEARY, "Alcohol and Labour Supply: The case of Iceland", in European Journal of Health Economics (2009), 10:455-465.

This is the only available study on this subject, which uses Icelandic data, and it yields surprising results. Tómasson et al. (2004) unexpectedly found no effect of probable alcohol abuse on sick leave. This is inconsistent with the international literature (Manning et al. 1991). A logical next step would be to examine the effect of probable alcohol abuse on other important labour-market outcomes. The data allow for an analysis of probable misuse of alcohol and labour-supply choices. The current study reports the association between alcohol problems and labour-supply choices, using nationally representative survey data collected by Gallup Iceland in 2002. Labour-supply choices are considered with reference to possible effects of policies already in force, as well as proposed changes to current policies. Contrary to intuition, but in agreement with the previously mentioned Icelandic study, adverse effects of probable misuse of alcohol on employment status or hours worked are not confirmed within this sample.

[H7] RICE, JIM, "The Operationalisation of Disability in Policy and Practice", in Jóhannesson, G. and Björnsdóttir, H., Rannsóknir í félagsvísindum X. Reykjavík: Social Science Research Institute, University of Iceland 2009, pp. 263-272.

In November the Ministry of Health published its action plan with its policy until 2011. The policy is meant to forward the government's goal of placing increased emphasis on preventive measures and improved health results in all areas, as well as to facilitate healthier life styles amongst the general population. The main focus areas are exercise and mobility, healthy diet and mental health. The aim is to improve societal conditions that promote better health of all inhabitants. In the first part of the plan goals and means for the action plan for improved health are outlined, specifically for five target groups: All nationals; children at preschool age; children in primary schools; teenagers and youngsters in secondary schools; and adults.

[L] Long-term care

[L] JÓNSDÓTTIR, STEINUNN AND SIGURÐARDÓTTIR, S.H., "Stefnumótun og löggjöf í búsetumálum eldri borgara", in Halldór S. Guðmundsson and Silja Bára Ómarsdóttir (eds.), *Rannsóknir í félagsvísindum X*. Reykjavík: Social Research Institute, University of Iceland, pp. 145-158.

> *This is a study of legislation and policy in the field of special housing for the elderly. The authors examine the development of legislation from the early 1980s to the present, emphasising the differential orientation and emphasis on policy priorities. The paper particularly emphasises the recent changes in legislation and what they mean for ideology and professionalism in the care services. The focus is on more social and less medical aspects of organising the services. They also show that even though there is a large supply of care facilities in the country, there is still a shortage in the capital area of Reykjavík. So the supply is stronger in the provincial areas, where housing also tends to be more ample. The authors also emphasise the need for more information, better coordination of services and better design of the facilities.*

[L] SVAVARSDÓTTIR, S.J., "Er endurhæfing geðfatlaðra að skila árangri?" (Is Rehabilitation of Individuals with Mental Disabilities Giving Positive Results?", in Halldór S. Guðmundsson and Silja Bára Ómarsdóttir (eds.), *Rannsóknir í félagsvísindum X*. Reykjavík: Social Research Institute, University of Iceland, pp. 159-170.

> *This is a study done at the National University Hospital (Landspítali) in order to assess the results of rehabilitation measures. The focus is on the patients themselves, i.e. their experience of and attitudes towards social rehabilitation. The main aim was to find the best methods. The study also surveys the measures available at the hospital and maps the available cooperating parties in the field outside the hospital. The results were then compared to a similar study done ten years ago. The main difference in satisfaction with the measures was between those who had been employed after the treatment and those who were not working. No significant differences in outcomes emerge for age and residence.*

5 List of Important Institutions

Tryggingastofnun Ríkisins – Social Insurance Administration

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. The Ministry of Social Affairs and Social Security (Félags- og tryggingamálaráðuneytið) is responsible for the supervision of all activities of Tryggingastofnun. The main office of Tryggingastofnun is in Reykjavik with agencies outside Reykjavík for the benefit of residents who live outside the capital area. The SSI publishes a yearly report and also a yearly statistical report on social security developments (such as expenditures and benefit levels, as well as figures on use of services – Staðtölur almannatrygginga).

Sjúkratryggingar Íslands – Icelandic Health Insurance

Contact person: Steingrímur Ari Arason
Address: Laugavegur 116, 105 Reykjavík
Webpage: www.tr.is/sjtr

This institute administers the national residence-based state provided health insurance and occupational accident insurance, in accordance with the legislation on health 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 Icelandic Health Insurance was only established in 2008, it is still being shaped. It was, in fact, split from the Social Insurance Administration and still operates in close cooperation with 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 public and the government and promotes information on rights and policies and also provides a centralised data bank for the 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 the government or private organisations and interests. The institute is subdivided in centres that specialise in 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.

Hagræðistofnun 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 the government or private organisations and interests. The institute also publishes reports and occasional books on matters of the social sciences.

Heilbrigðisráðuneyti – Ministry of Health

Address: Vegmúla 3 - 150 Reykjavik, Iceland
Webpage: http://eng.heilbrigdisraduneyti.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 the Ministry deals with are public health, patient rights, operation of hospitals, health centres and other providers of health services, promotion of information technology in the health services in Iceland, pharmaceutical affairs and health insurances.

Félags- og tryggingamálaráðuneytið - Ministry of Social Affairs and Social Security

Address: Hafnarhusinu vid Tryggvagotu - 150 Reykjavik, Iceland
Webpage: http://eng.felagsmalaraduneyti.is

The tasks of the Ministry cover inter alia the issues affairs of the disabled, immigrants, employment & gender equality, housing, family affairs and refugees.

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 reports 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 reports 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.

Viðskiptaráðuneytið - Ministry of Business Affairs

Address: Solvholsgotu 7, 150 Reykjavik, Iceland
Webpage: http://www.vidskiptaraduneyti.is

The Ministry of Business Affairs is responsible for all labour and business-related issues like competition, consumer affairs, financial services and markets, merchants and trade, capital movements, imports and foreign investments, insurance, company law.

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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