Annual National Report 2009

Pensions, Health and Long-term Care

Iceland

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1 Executive Summary

Iceland has a three-pillar pension system, with a good spread of risks and strong funding position for its occupational pensions, indeed with one of the biggest pension funds in relation to GDP amongst the OECD-countries. The tax-funded public social security system has been the focus of quite extensive reform initiatives since 2007. These have aimed at simplifying the system greatly, increasing incentives to work and save with the goal of increasing fairness in the system. Steps have already been taken to achieve some of these aims, such as by changing income-testing formulations in the way of increased use of personal allowances (free brackets, i.e. a part exempt from income-testing) for employment earnings, occupational earnings and financial earnings. The goal for the future is to take further steps in that direction. Thus income-testing will not start at as low earnings levels as before, a distributional feature that favours those with lower earnings more than others.

A new minimum guarantee for pensioners was also introduced and raised by about 20% at the beginning of 2009. This has elevated pensioners with lower earnings outside the Social Security system to a better position than ever before. This will most likely prove to be an important step for pensioners in the present deep financial crisis affecting Icelandic society.

Moves to reform the disability and rehabilitation system, along with increased activation measures, seem also to be likely to be very important now that Iceland is being thrust into higher unemployment levels than ever before, due to the crisis. While these reforms are still under way some novelties have already seen the light of day and big steps are likely to emerge in the very near future. On the whole the year 2008 and 2009 have clearly been a time of big changes in the public social security system.

The Icelandic health care sector seems to be delivering service quality at a high level. It offers highly qualified personnel and has ample advanced means, technical and human, for operations. The system is expensive, given that Iceland has one of the highest expenditure rates in the Nordic countries, as a proportion of GDP. Complaints in recent years have focused on overall costs, waiting times for operations and care facilities, inadequate accommodative facilities for patients (crowded rooms, patients having to lie in their beds in corridors for some time), increased user fees and high costs of medications.

In 2008-9 there have been organisational and operational innovations. Plans for improvements and quality controls are continually implemented and refreshed and there are no significant signs of reduced standards (see above). Waiting lists for operations have in fact been significantly shortened. Public pensions were moved from the Ministry of Health to the Ministry of Social Affairs at the beginning of 2008, a move that is now associated to big changes in matters of social security. A new Sickness Institute was set up in October 2008, under the Ministry of Health, to operate the sickness insurance part of social security and also to strengthen the purchaser role of government against providers of health care services. It is too early to assess the success of that change. Foreseen need for significant expenditure cuts in the health sector in the next years will increase pressure for rationalisation, reorganisation and possibly merging of institutions. Such measures may also affect remuneration levels in the sector, as in the public sector overall.

In recent years the health care sector suffered from difficulties in manning some parts of the services, particularly nursing and auxiliary functions. A greatly increased flow of immigrant labour was notable in this sector. That trend may now be reversing with the onset of the recession and with some of the foreign labour emigrating.

2 Current Status, Reforms and Discourse 2008-2009

2.1 Pensions

2.1.1 System characteristics and functioning

Iceland has a three pillar pension system, in accordance with the World Bank's recommendations (*Averting the Old Age Crisis,* 1994):

I. A public tax funded pay-as-you-go universal Social Security System (Soc. Sec.) with a defined benefit. The legal basis dates from 1946, originally modelled on Beveridge's plan, but also incorporating significant use of income-testing, in line with New Zealand's legislation from 1938. It has a universal coverage, but 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.

II. A funded Occupational Pension System (OPS) with defined contributions, dating from 1969. From the beginning employees contributed 4% of pay and employers another 6%. Nowadays the overall contribution is 12% of total earnings (4% from employees and 8% from employers). The occupational pension became mandatory for employees in 1974 and for all employed persons from 1980. Even though the system is a DC-system, it promises 56% of average career earnings (stipulated in framework legislation from 1997) as a minimum. Contributions are exempt from taxation when paid in, but fully taxed when taken out as earnings. The OPS funds are managed by the labour market partners, the unions and employers' organisations.

III. Individual Pension Accounts (IPA). The framework legislation is from 1997. These are voluntary accounts with a defined contribution. Individuals can pay contributions up to 4% tax free (when paid in) and have the right to 2% additional contribution from employers with the first 2%. So altogether 6% are exempt from direct taxation, i.e. with a delay. These are managed either by occupational funds, banks or private investment funds and subject to public scrutiny by the Financial Supervisory Authority, as are the OPS funds.

The different pillars have different roles in society and differing effects on the distribution of living standards. The Social Security equalised the income distribution with its minimum guarantee and universal income-tested benefits. It is thus of great importance for alleviating poverty and quite successful in that respect, since Iceland has along with the Scandinavian countries one of the lower poverty rates in Europe (Eurostat: EU-SILC data and OECD 2008). It is also of great importance for elderly women, especially widows who have little accumulation of rights in the Occupational Pension Funds or other means of earnings. The great majority of old age pensioners receive some pension from Social Security and only a small minority have to rely solely on the minimum guarantee (less than 5%). For many of those who have little earnings from the pension funds the minimum guarantee provides a supplement and since 1 January about 25% of old age and disability pensioners get some supplement from the minimum guarantee, many however only a small sum.[1] Thus the function of the minimum guarantee is primarily that of improving the level of living of those pensioners that have low other earnings, whether from the OP funds or other means (employment or financial earnings).

The second pillar aims to replace the income distribution in the labour market proportionally, without any roof. It does thus not significantly equalise the income distribution, but it has

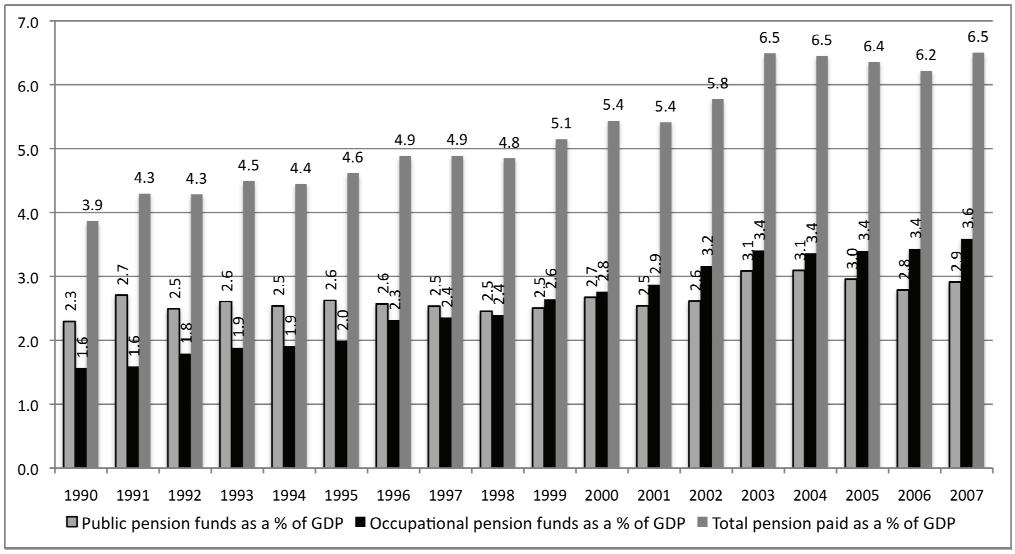
[1] Cf. a personal communication from the Social Security Institute.

been gradually more important for raising the living standard of pensioners by adding to the modest earnings provided by Social Security. The yearly accrual rate for rights in the OPS is 1.4% of pay and the system works on notional accounts. Rights are proportional to pay and indexed during periods of accumulation by a fixed rule. After pensioners start receiving their pension the amount they get is indexed to the cost of living index from then on (Ísleifsson 2007). 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 such cases of negligence.

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

The first two pillars are the main building blocks of the Icelandic pension system. As Figure 1 shows there is not a big difference between their sizes in recent years, but the OPs have been growing in size year by year, surpassing the public Soc. Sec. in 1999. That development is set to continue with new entrants each year, as rights in the occupational pension funds increasingly mature. The present financial crisis may however produce a setback in that trend.

Figure 1: Size of pillars I and II: Expenditures on old-age pensions, % of GDP 1990 to 2007



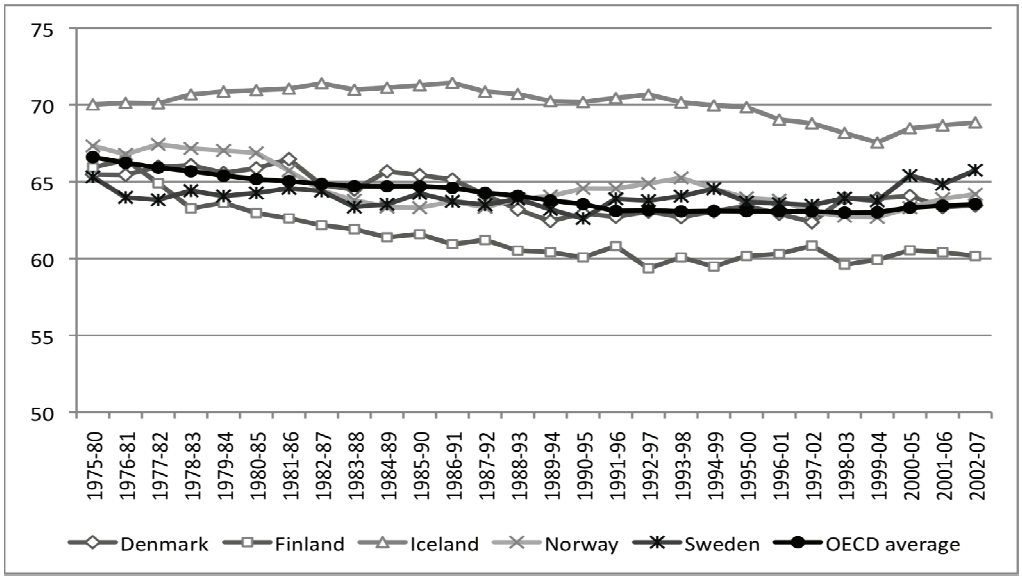
Source: Social Security Institute (Staðtölur almannatrygginga 2008)

Figure 1 also shows that the overall O-A pension expenditures were around 6.5% of GDP in 2007, which is low by international standards (OECD 2007 and SSI, Staðtölur almannatrygginga 2008). The reason is that the Icelandic population is rather young, with low proportion of people at pensionable age, due to high birth rates for decades, which despite a slow decline still remain high by European standards. Another reason for relatively low O-A expenditures is a rather low benefit level in the public Soc. Sec. and extensive use of income-testing there. All O-A Soc. Sec. benefits are income-tested against employment and financial earnings, and only about a fifth of the maximum Soc. Sec. benefit has since 1993 been untouched by income-testing against occupational pensions. So the level of income-testing has been high.

But one of the most important explanations for the overall low expenditure rate is late average retirement age (Olafsson 1999 and 2008c). Icelanders have had the special status of working towards higher age than all other European nationals. This is shown for males in Figure 2, covering the period from 1975. While the effective retirement age has lowered a little from the height of the 1970s and 1980s it still remains very high. In 2002-2007 the age for Icelandic males was about 69 while it was just over 65 for females.

Amongst the advanced nations only Japan has a higher effective age of retirement for males. Within Europe Portugal is closest to Iceland (see comparative table in appendix). This late retirement age obviously helps retain expenditures on O-A pensions.

Figure 2: Average effective age of retirement for males, 1975 to 2007



Source: Data come from the OECD (www.oecd.org).

The main reasons for this long-term late age of retirement in Iceland are generally ample job opportunities in the post-war period, a positive attitude to work and an incentive in the pension system for late retirement, since those who retire later do raise their benefit significantly (Herbertsson, Orzag and Orzag, 2000; Herbertsson, 2001).

In the public social security system benefits are raised by 0.5% for each month of delayed take-up from the age of 67 (official age of retirement) up to age 72. The increase of SOC SEC benefit with maximum delay is thus 30%. In the occupational pension system the general rule is that a delayed take-up can apply for the period from 67 to 70 and the pensioner should not profit nor loose from it. The benefit of the delay is thus equal to what was saved in expenditures. Earlier take-up is also possible (to age 62), on the same condition. Conditions may however vary between occupational pension funds.

Yet another important fact is that the number of pension receivers at working age (16-65) is low in Iceland (Olafsson, 2005 and 2008a). This is equally associated to the low unemployment rate and a rather low proportion of disability pensioners, even though their number has increased rather rapidly from the early 1990s onwards. There is no distinct early retirement program, so the disability pension is the only route out of the labour market before old age retirement, in addition to unemployment insurance.

On the whole one can say that the problems that have been most common amongst the European nations in the area of pension systems, particularly as regards pension financing, have not featured in Icelandic pension debates to the same extent (Barr and Dimond, 2008; Whiteford and Whitehouse, 2006; OECD, 2007). Overall O-A pension expenditures are rather

low by OECD standards, mainly due to the above listed reasons. Iceland's problems in the field of pensions are thus different and have generally more to do with internal workings of the pension system and pensioners' levels of living.

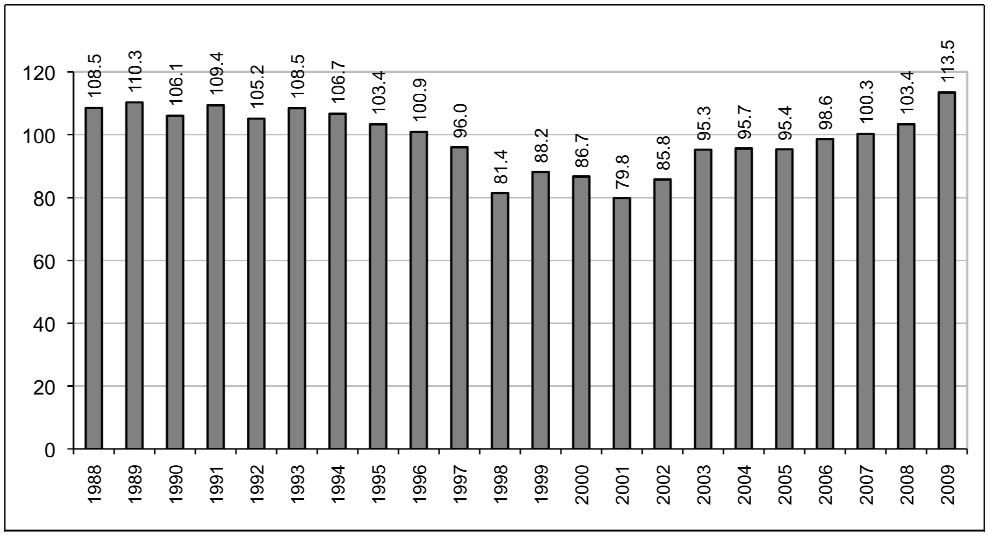
The public social security system has three types of pension benefits: a basic pension (about 9% of average pay); a universal income supplement (about 29% of average pay) and a housing allowance (about 8.5% of average pay). Maximum social security old age pension, for those who have no rights in occupational pension funds or no other income, can thus be about 47% of average pay. On top of that is paid a minimum guarantee (income-tested against all other earnings), bringing the amount to 56% of average pay, which is just over 60% of workers' pay at the beginning of 2009 (SSI, data on www.tr.is and Statistics Iceland).

2.1.2 Minimum guarantee for pensioners and their level of living

The minimum guarantee pension (social security benefits plus the minimum guarantee supplement) has through time had a big political significance in Iceland. It has typically been compared to the lowest pay rate offered in the labour market. Some politicians and employers have emphasised that it should not be allowed to increase above this pay level. Figure 3 shows the development of the effective minimum guarantee as a proportion of the low pay rate, from 1988 to 2009.

As the figure shows the minimum pension was from 3% to 10% above the minimum pay level in the period from 1988 to 1995. After that it lagged behind pay and went as far down as about 80%. Then it was raised again in 2003 and a large rise was again implemented in 2008 and at the beginning of 2009. Altogether the level was raised by about just over 40% to an all time high of 113.5%. This was a part of a policy change and reformulation of the guarantee in 2008.

Figure 3: O-A pensioner's minimum guarantee in relation to minimum pay, 1988-2009 (January).[2]



Source: Data is calculated from SSI (Social Security Institute of Iceland and Labour Organisation (ASI) data on pay rates.

Lastly in this section we give some indication of the generosity of the Icelandic pension system with a reference to OECD assessments of pension promises (see OECD, 2007). While

[2] Data is calculated from SSI (Social Security Institute of Iceland and Labour Organisation (ASI) data on pay rates.

those who are already in the old age pension system are generally not enjoying fully matured rights in the occupational pension funds, they therefore have rather low overall earnings compared to working people and also compared to what pensioners of the future will likely receive. This should be kept in mind when assessing the pension promises, in addition to the usual reservations required in case of pension promises far into the future. They should only be taken as an indicator of the characteristics of the system as it is at this time and the pension promise is of course on the premise that all else will remain similar.

Table 1: Net replacement rates: Iceland and OECD-averages;
Three pay levels: low pay, average and double average

Income groups:	Low: 75% of average pay	Average pay	Double average pay
Iceland 2007	92,0%	84,2%	79,7%
Average for OECD 2007	83,8%	70,1%	60,7%
Iceland's rank	7.	9.	6.
		Heimild:	*OECD: Pensions at a Glance 2007*

On the whole the Icelandic pension system seems to be quite generous compared to the OECD-countries. For low-income earners it should give quite a high level, especially after the raising of the minimum guarantee in 2008 and 2009 (which is in addition to the outcome in Table 1). Replacement rates for the other groups are also good compared to the OECD average. Some of the OECD countries ranking above Iceland in this comparison have significant foreseeable problems of financing of their pension system and thus they may in some cases not be sustainable on present levels of generosity. Of relevance in this context is the fact that the Icelandic OP system is fully funded and it was in general in a good financial condition before the financial crisis of 2008 (Ísleifsson, 2007; NOSOSKO, 2008b). We come back to that in section 3.

While pension promises are not a reflection of pensioners' level of living today (due to immature pension rights in OPs) the figures from EU-SILC surveys indicate that poverty level amongst people 65 years and older have been amongst the lowest in Iceland (Statistics Iceland 2009). Relatively high minimum guarantee has had a role in that in the past and its big increase (20%) on 1 January 2009 has improved the position of the low earners in the pension population significantly. This is of major importance for low income earners in the pensioner population in the present recession.

2.1.3 Reform, Debates and Political Discourse

The Icelandic pension system has typically been reformed in a piecemeal fashion in recent decades. The main complaints in earlier decades were low pension benefits in the public system (the first pillar), too extensive income-testing, income-testing starting at too low a level of earnings and the system being unfair. A major issue of concern has also been the degree of complications in the public social security system. Its three benefit classes, and two types of supplements, have had differing rules of income-testing and qualifying conditions (SSI Staðtölur almannatrygginga 2008). This has meant that the system has been particularly complicated to understand and delivering the right payments has proved to be a significant problem. Thus the Social Security Institute has every year had to adjust its payments, often

claiming some money back from pensioners who got too much due to insufficient data from them on other earnings (most frequently financial incomes and employment earnings). This had generally caused great concerns amongst politicians and administrators, as well of course amongst pensioners. Thus benefit adequacy, income-testing, a complicated system with at times perverse workings and issues of fairness have been the major critical concerns for the public pension system. The occupational pension fund system has on the other hand generally been praised as being a good system, due to its funded nature. That part of the system (the second pillar) is however still providing only rather low benefits to about a half of the pensioner population, due to its lack of maturity at this time (Samtök atvinnulífsins 2006). Thus for the majority of pensioners the pubic social security system is still of great importance, not least to those that have rather low or modest other earnings (NOSOSKO, 2008b).

2.1.4 Major reform of the public pension system

Pensioners have been a loud critical voice in public discussions on the pension system for a number of years. Unfavourable development of basic public pension benefit rates during the period from 1995 to 2004 (see Figure 3 above) produced much cause for concern and criticism of politicians. Pensioners lagged not just behind pay development in the labour market, they also got an increased tax burden as a result of the prevailing tax policy in the same period, which involved a reduction of the personal tax allowance. That increased the income tax burden of the lower income earners disproportionally, hitting pensioners quite hard (Thorláksson, 2007, Ólafsson, 2007, Baldursson et. al., 2008). So pensioners felt strongly that they were left behind in the boom years after 1995. Before the election of 2007 there was serious talk of forming a pensioners' political party to aim for parliamentary representation of these interests. This however did not materialise.

In the spring of 2007 Iceland got a new government (coalition of conservatives and social democrats) that pledged to implement a major reform of the pubic social security system, which was an issue that the social democrats had strongly emphasised while in opposition. Their main spokesman on welfare became the new minister of social affairs (Jóhanna, Sigurðardóttir, who then became prime minister in the interim government of February-April 2009). During the summer of 2007 a task force was commissioned by the Ministry of Social Affairs to undertake a major reform of the social security system, with the prescription to deliver in two parts. Firstly recommendations for short-term improvements were called for (December 2007) and then secondly the task force was to deliver recommendations for long-term restructuring of the system. The goals for the reform were spelled out quite clearly in the government's manifesto.[3] The following are the major goals, with clarifications from the task force itself:

- A radical simplification of the system
  - Simplification of the benefit structure
  - Simplification of organisation and administration of benefits
- Change of the interaction between public and private pension pillars, so as to increase fairness and to increase incentives for work and savings
- Reduce income-testing
  - By increased use of free income brackets
  - By lowering the reduction rate in the income-testing formulas

[3] See the government manifesto at http://www.forsaetisraduneyti.is/frettir/nr/2643.

- Redefine rights of married or cohabiting pensioners
- Introduce a new minimum guarantee for pensioners

The task force delivered short-term recommendations most of which were implemented during the year of 2008. The more significant of these were the following:

- Income-testing due to spouse's earnings were abolished
- Free income bracket of ISK 100,000 per month (about a third of average earnings) introduced for employment earnings of people 67 and older
- Free income bracket of ISK 100,000 per month (about a third of average earnings) introduced for employment earnings of disability pensioners
- Free income bracket of ISK 25,000 per month (about 8% of average earnings) for occupational pensions introduced for disability pensioners
- Free income bracket of ISK 8,300 per month for financial earnings introduced for all pensioners
- Income-testing of earnings from Individual Pension Accounts in the social security system abolished from 1 January 2009
- New minimum guarantee for pensioners introduced on 1 September 2008. Raised by about 20% on 1 January 2009.
- Various special benefits were raised (such as child benefit; age-related supplement for disability pensioners; allowance for institutionalised pensioners in care wards).

Most of these novelties were implemented by way of regulations, rather than laws. They were still a part of a longer-term strategy of reorganising the system and its functioning. The plan is however to rewrite the social security legislation completely, incorporating these measures from 2008-9. On the whole the year 2008 was thus a year of unusually big changes in the public pension system.

The last big change for the occupational pension system had come with new framework legislation in 1997 and in the last years the contribution rate there was raised from 10% to 12% of pay. This framework legislation, which was based on an agreement between the labour market partners from 1995, implemented clearer principles of rights, management of funds, investment strategies, and surveillance of the OP system. It also promoted a change towards a more age-related accumulation of rights, with more rapid accumulation at younger ages (Ísleifsson, 2007).

The changes of 2008 were generally well received by the public, interest groups and politicians of most parties. The big raise of the minimum guarantee for pensioners was a symbolic landmark due to the importance of that issue in political and pubic debate over time. Some of the strongest criticisms of pension policies in parliament and from interest groups have revolved around that. The abolition of income-testing due to spouse's earnings was also a long-term demand from pensioners, particularly disability pensioners' organisations (see ÖBÍ – www.obi.is).

The task force is already well on the way of working out its recommendations for simplifying the social security system. The main ideas have been introduced to the Federation of Old Age Pensioners (see Morgunbladid, 19 April 2009, Olafsson, 2009). These involve a radical simplification of the benefit structure, from three benefit types and two supplements to one benefit type, and one supplement in the form of the new minimum guarantee. A free income bracket (a personal allowance) of 30,000 krónur per month will be introduced on earnings

from the occupational pensions for old age pensioners (comparable to what disability pensioners got in 2008). This means that the first ISK 30,000 from pension funds will not count in the income-testing formula.

Other modifications towards the general goals are also to be introduced, but due to difficulties in the public finances in the wake of the financial crisis since October 2008 the free income bracket for old age pensioners will most likely be financed in the short run with a more extensive income-testing for pensioners with higher than average total pension earnings. Thus income-testing will in that case be lifted so that it takes effect at a higher level of income but the bite of the cut will be increased in the higher rungs of the income ladder. The expressed goal for the future, beyond the present financial difficulties, is to increase free income brackets further.

So a new social security system seems set to take over in the next year or two, with new legislation being planned on the basis of the recommendations from the task force. Work on the legislation will start in summer 2009 after consultations with the public and interest groups about the main principles of the new system.

2.1.5 Major reform of the disability and rehabilitation system

In addition to the above mentioned changes of the public pension system a major overhaul of the disability and rehabilitation system is already underway. This was started by the appointment of a task force, with the goal of redefining the disability-test system and increasing rehabilitation measures in 2005.[4] That initiative was stimulated by growing concerns amongst the labour market partners and occupational pension fund managements about growing number of disability pensioners with a consequent increased financial burden on the funds (Arnbjörnsson, 2004; Samtök atvinnulífsins 2006). Research published in 2005 also emphasised this growth, explained it and revealed that Iceland was lagging behind with its rehabilitation and activation system (Herbertsson, 2005; Olafsson, 2005). The main reason for Iceland lagging behind on this front was the fact that the employment level had been unusually high (high employment participation rates and low unemployment) for most of the post-war period (Statistics Iceland-Landshagir, various years). The need for extensive activation measures was generally not felt. When the number of disability pensioners started to increase at a faster rate from the early 1990s this became a growing concern (Thorlacius and Olafsson, 2008).

The aim for the disability and rehabilitation task force were to develop new means of workability assessment (instead of the prevailing disability assessment test) and to work out new organisational features for implementing the system, somewhat in line with active social policy (OECD, 2005). Following its position report of 5 March 2007 there was set up a new group (with most of the same members) with the task of implementing the required measures. That group has not yet finished its task. In the meantime the labour market partners bargained for setting up of a Rehabilitation Fund (with contributions from employers, pension funds and government) in order to finance rehabilitation and monitor the progress of union members who left work due to sickness or accidents (see VIRK at www.virk.is). The majority of working people have rights for financial support from the unions' sickness funds. Most frequently members have a right to retaining their pay from the employer for up to three

[4] The task force (Bolla-nefndin) was commissioned by the Prime Minister's Office, since the issues concerned were housed in three ministries (Ministry of Health, Ministry of Education and Ministry of Social Affairs). The task force had representations from the main interest organisations, and labour and employers as well as occupational pension funds. In addition there were some specialists included. The first policy forming report can be found here: http://www.obi.is/um-obi/frettir/nr/263 (5 March 2007).

months, depending on length of service. After that they generally have a right to a proportion of their pay for up to 9 months from their sickness fund. The aim of the labour market Rehabilitation Fund (VIRK) is to increase the likelihood of the sick and injured returning to work. After the right in sickness funds are fully utilised they can turn to the social security system, for rehabilitation benefit or disability benefit (or sickness benefit, which however is very low, producing incentives for getting the disability benefit which is the highest) (Herbertsson, 2005).

The Ministry of Social Affairs is also working on reorganisation of the public rehabilitation and activation system (cf. speech of minister Jóhanna Sigurðardóttir at a conference on the "Pension System for the Future", in May 2008). The proposed plan is to aim for an organisational system similar in structure as the Norwegian NAV system. In the Icelandic case this would involve a merging of the Social Security Institute (TR) and the Directorate of Labour (VMST), with local service offices run in cooperation with local social services of the local communes. This new institute of work and welfare would implement a revised system of activation, rehabilitation and VET, in cooperation with the labour market Rehabilitation Fund and the health care and social services. The labour market Rehabilitation fund concentrates on the first year after individuals leave the labour market and it finances various measures. The public institute would concentrate on longer-term inactive individuals and the disabled. The target group would be unemployed people and the disabled. Such a reorganisation of the system is presently considered of the utmost importance due to the very rapid increase in the number of unemployed people as a result of the financial collapse. This was discussed in the election preparation (25 April 2009) and is expected to be a priority issue for the new government taking office in late April or early May.

Research by Thorlacius and Olafsson (2008) has indicated that there is an unfortunate interaction between the level of unemployment and the incidence rate for new disability pensioners. Data from the early 1990s show that when the unemployment rate increases significantly the incidence rate for disability pensioners follows a similar pattern. In the earlier part of the 1990s there was a lag of about one year for the rise in the disability rate but in the 2000s the lag has shortened significantly, so the correlation is more effective in time. The reason for this association between unemployment and extent of disability pensioners may be that those with poorer health and lower productivity may be pushed from the labour market to a disproportional degree when job opportunities become more restricted and when jobs are being cut (Thorlacius and Olafsson, 2009, forthcoming). Another reason may be that there is a financial incentive to get the disability pension which is higher than unemployment benefit or social assistance from local communities (Herbertsson, 2005).

For further details on activities in this area during 2008 and January through April 2009 see the section on the financial crisis and mitigating responses to it.

2.1.6 Assessment

Iceland has a three-pillar pension system, with a good spread of risks and strong funding position for its occupational pensions, indeed with one of the biggest pension funds in relation to GDP amongst the OECD-countries. The tax-funded public social security system has been the focus of quite extensive reform initiatives since 2007. These have aimed at simplifying the system greatly, increasing incentives to work and save with the goal of increasing fairness in the system. Steps have already been taken to achieve some of these aims, such as by changing income-testing formulations in the way of increased use of personal allowances (free brackets, i.e. a part exempt from income-testing) for employment earnings, occupational earnings and financial earnings. The goal for the future is to take further steps in that

direction. Thus income-testing will not start at as low earnings levels as before, a distributional feature that favours those with lower earnings more than others.

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Moves to reform the disability and rehabilitation system, along with increased activation measures, seem also to be likely to be very important now that Iceland is being thrust into higher unemployment levels than ever before, due to the crisis. While these reforms are still under way some novelties have already seen the light of day and big steps are set to emerge in the very near future. On the whole the year 2008 and 2009 have clearly been a time of big changes in the area of the public social security system.

2.2 Health care services

2.2.1 System characteristics and functioning

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 act from the 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 control of all public health services. There is also a special supervisory authority for medicines control and a supervisory commission dealing with prices of medicines. The most important legal acts applicable to the health care system are Health Service Act, the Medical Directorate Act, Patients' Rights Act, Social Security Act, Patients Insurance Act, Communicable Diseases Act and the Physicians' Act (NOMOSKO, 2008).

Despite the large public role in the health care sector in Iceland there is a significant private sector operated alongside the public sector, but this sector is also to a great extent publicly financed. The main aspects of the private practice are specialist services, some health care centres, physiotherapists, occupational therapists, psychologists, all dentists and some nursing homes and old peoples' homes (most often run by voluntary or social organisations). User fees are generally applicable in the private parts of the service provisions. Thus nursing homes and old peoples' homes are partly financed by user charges and partly by the public authorities.

Health care centres are for example 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 to the state Social Security Institute (SSI), which subsidises the cost. Hospitals also provide out-patient services. In general no referral is needed for use of specialists' services. But the prevailing law assumes that the primary health care service should be the fist stop in the system for patients. There are no penalties nor higher fees for directly applying to a specialist. Health care centres also provide home nursing services but home help services (for the elderly and long-term sick) are provided by local municipalities' social services.

There is now one major high-tech university hospital in Iceland serving the country (Landsspítali-Háskólasjúkrahús), a teaching hospital in Akureyri (the biggest municipality in the Northern part of the country) and lastly a few smaller local hospitals, some operated partly

as nursing homes for the elderly. In some cases these local hospitals have facilities for some minor operations and facilities for birth and maternity care.

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

While financing of health care services is mainly public in all the Nordic countries, Iceland has a larger role for central government in that area, while the other countries have a larger role for local and municipal authorities.

The Icelandic health care system has for a number of years ranked with the more costly ones in Europe, as a proportion of GDP. In 2006 it consumed about 9.6% of GDP when the OECD average was 9.0% (Table 2). 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.

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 lack of referral for the use of their services. Even though the cost of using specialists is higher for patients than in the other Nordic countries the state subsidises it significantly). Maintaining a high level of health care services in the more sparsely populated areas of the country is also relatively expensive. Icelandic physicians are also said to be prone to subscribe new and more expensive medications than what is typical in the neighbouring countries (NOMOSKO, 2008; Olafsson, 2008a). The relatively high cost of the health care system has been a growing concern of governments in recent years.

As indicated by Table 2 Iceland has a relatively high standard of health services and enjoys also a relatively high standard of quality of health.

As regards quality of services Iceland seems to have well equipped hospital services and relatively good performance indicators (for example as regards preventive screening, availability of advanced technology, doctor consultations, hospital discharges, and low rates of in-hospital case-fatality rates within 30 days after admission). Iceland has very good 5-year survival rates for breast and cervical cancer and also a good performance in cases of strokes and lung cancer. On the downside Iceland has a very high level of antidepressant consumption and a relatively high level of antibiotics consumption. This has featured somewhat in public debate and health authorities have cautioned doctors to limit the use of these medications. Consumption of antidiabetics and anticholesterols is however low (OECD, Health at a Glance 2007). The overall level of consumption of medications, across the board, is not particularly high in Iceland.

Table 2: Health indicators: Iceland and OECD averages, around 2006

Variables:	Iceland M	Iceland F	Iceland Total	OECD average M	OECD average F	OECD average Total
DEMOGRAPHICS						
Share of population aged 65 and over, 2005			11.7			14.7
HEALTH STATUS						
Life expectancy at birth, years	79.2	83.1	81.2	75.7	81.4	78.6
Mortality rates, age-standardised per 100.000 population						
Breast cancer, females		23.9	23.9		22.0	22.0
Prostate cancer	33.0		33.0	24.7		24.7
Ischemic heart disease	160.8	61.6		141.6	72.7	
Stroke	46.5	37.1		68.5	54.4	
Lung cancer	38.0	38.0		58.0	20.0	
Suicide	17.2	6.3	11.7	19.2	5.7	12.1
Road accidents	9.4	4.4	7.1	15.9	5.1	10.3
Infant mortality rates, (deaths per 1000 live births)			2.3			5.4
Average number of DMF1) teeth, 12 year old children			2.1			1.6
AIDS incidence rates per million			3.4			18.8
NON-MEDICAL DETERMINANTS OF HEALTH						
Alcohol consumption in litres per capita, population 15 years and over			7.1			9.5
Smoking, percentage of population 15 and over smoking daily	19.5	19.5	19.5	29.8	19.3	24.3
Percentage of adult population2) with BMI3) over 30 (obese)	12.0	12.0	12.0	14.0	15.0	14.6
HEALTH CARE RESOURCES AND UTILISATION						
Doctor consultations per capita			6.5			6.8
Hospital discharges per 1.000 population			172.0			163.0
Average length of stay for acute care			5.4			6.3
Coronary revascularisation procedures (angioplasty and coronary bypass) per 100 000 population			246.0			249.0
Caesarean sections per 100 live births			16.4			23.6
Pharmaceutical consumption						
Antidepressants, consumption, DDD4) per 1000 people per day			95.0			47.0
Antibiotics consumption, DDD4) per 1000 people per day			23.0			21.0
Medical technologies						
MRI units, number per million population			20.3			9.8
CT-scanners, number per million population			23.7			20.6
HEALTH EXPENDITURE AND FINANCING						
Total health expenditure as a share (%) of GDP			9.5			9.0
Public share of total expenditure on health (%)			83.0			73.0
QUALITY OF CARE						
In-hospital case-fatality rates within 30 days after admission						
Acute myocardial infarction			6.4			10.2
Ischemic stroke			5.8			10.1
Hemorrhagic stroke			30.6			25.1
Cancer, 5 year relative survival rates						
Breast cancer, females		89.4	89.4		83.6	83.6
Cervical cancer		76.4	76.4		71.6	71.6
Screening						
Mammography screening, percentage of women aged 50-69 screened 2005		61.0	61.0		54.7	54.7
Cervical screening rates, percentage of women aged 20-69 screened 2005		72.0	72.0		58.8	58.8

Source: OECD Health at a Glance 2007 and WHO data bank

Icelanders enjoy high life expectancy, compared to other OECD-nations and one of the lowest infant mortality rates. The quality of teeth in 12-year old children however leaves something to be desired. That is often associated in commentary with high cost of dental services, which are primarily private with a rather restricted level of reimbursements (NOMESCO, 2008). Non-medical determinants of health (alcohol consumption, smoking and obesity) play with the health care system in the sense that they are less of a threat than commonly amongst other OECD-nations, i.e. they have rather low prevalence rates.

The Directorate of Health has issued recommendations for quality assessments on the basis of specified quality indicators, in accordance with the health plan until 2010 (Talnabrunnur-Newsletter, January 2009, pp. 2-3). The indicators refer to safety, right timing of operations, efficient servicing, equal rights of access and treatment, user-directed service and successful servicing. The Directorate lays a great emphasis on improved record keeping of productivity and results in the health care services and aims to increase international comparisons. Hence there is an increased emphasis on the use of internationally comparable indicators, such as from WHO and NOMESCO.

The Directorate also keeps a record of waiting lists for specific operations (available at www.landlaeknir.is/Pages/915). The longest waiting lists in February 2009 were for Cataract surgery (1224 had been waiting for more than three months), Prosthetic replacement of knee joint (174) and hip joint (132), and for Angiography of heart and/or coronary arteries and PTCA (43; this list has been cut largely in the last two years and was for example halved between 2008-2009). In general there is no wait in case of acute or life-threatening cases.

2.2.2 User-charges in the health care sector

On the whole Iceland has a slightly higher level of out-of-pocket user charges for health care services than the other Nordic nations (measured as a proportion of GDP), such as for specialist physicians, dentists, physiotherapists, occupational therapists, home nursing, x-ray tests and also for medications (Lyfjagreiðslunefnd, 2007-8; Olafsson, 2008a). Medications are highly priced in Iceland and on top of that the share of users in the cost is somewhat higher than in the other Nordic countries, followed closely by Norway. This has thus been an issue of some concern amongst consumers.

2.2.3 Reform, Debates and Political Discourse

The issues of greatest concern and criticism in the field of health 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, lack of nurses, high user costs, and inadequate facilities for elderly patients.

Governments have repeatedly set increasing pressure on the state hospitals to rationalise and cut operating costs. A major effort was initialised in the year 2000 to merge the two advanced hospitals in Reykjavik, for rationalisation. This has proved to be controversial and the need for further cuts has not disappeared. Various continued efforts have been implemented and while some results are positive more is needed, not least now after the financial collapse of October 2008. Government has in the last years prepared a major new construction scheme for the National University Hospital in Reykjavík (Landsspítali-Háskólasjúkrahús). These plans were primarily aimed at improving the functioning of the hospital services, saving expenditures and improving the facilities for the individual patients. Cutting waiting time has also been a continued issue and one in which significant results have emerged in the last years (cf. above). In order to deal with such ailments of the system governments have continually tried out various measures, as well as to improve the service qualities in general. New methods of public management have been tried along with reorganisations in various sectors of the system. The above-mentioned quality indicators of the health plan until 2010 are an important feature of this effort.

Running up to the period of most concern here (2008 and onwards) an important new legislation took effect on 1 September in 2007. The act is based on the principle that all citizens are entitled to equal care and assistance during illness irrespective of their financial situation or place of residence. The tasks and roles of hospitals are laid down in the act at the same time that a new system of health districts was put in place, with seven districts. The local primary health care centres should be the first place of contact for patients and it is established that general care and nursing should be carried out at the place of residence of the patient, an issue of great importance for elderly people. Institutionalisation of elderly people has been at a somewhat higher level in Iceland than in the other Nordic countries (NOSOSCO, 2008a), which is high by OECD standards.

Pharmaceutical issues have featured largely in the work of the Ministry of Health in 2007 and 2008. A new policy for that field was passed in early 2007 covering the policy period from 2007 to 2012. The policy covers issues of availability of medications, their quality, safety, increased cooperation with neighbouring countries as regards procurement, and lastly issues of pricing. The last issue has continued to be a major concern of Icelandic governments. Icelandic health authorities took an initiative in trying to activate an inter-Nordic market for pharmaceuticals and other goods and services for the health sector. The aim was primarily to obtain procurements, not least of medications, at better prices, due to the strong concern for high cost of medicines for both government and individual patients. Efforts were also made to connect better to the European market. In 2008, there was also an initiative making it easier for Icelandic consumers to order medicines directly from the neighbouring countries. On 7 November a regulation was signed by the Minister for Health making it possible for Icelanders to buy some medications by post (via controlled channels on the internet) from the other Nordic countries.

A running national public plan for health priorities is in force until 2010. This plan sets priorities for health and care and is in line with WHO guidelines. The plan is assessed periodically and when goals have been obtained new ones are set and others are revised and emphasised further. Issues emphasised recently are reductions of obesity and improved cancer preventions, by scaling up screening activities. In connection with this there is also operational a plan by the health authorities for increasing the number of doctors, nurses and assistant nurses, and physiotherapists, of whom there has been a perceived shortage. Staff for these roles has increasingly been recruited from abroad (often with language difficulties), but government has also implemented a plan to increase the number of student nurses by 50% (NOSOSKO, 2008a, pp. 14-15). Complaints of decline in accessibility of general medical practitioners have also been common in recent years.

A newly revised plan, called *Quality and Care until the year 2010,* has also been implemented by the authorities. The aim of that is to ensure that quality and safety are secured at all levels of the service. The plan defines the roles of institutions and their division of labour, quality requirements, spells out quality indicators, clinical instructions and requirements for electronic registrations. Priorities have been set for reducing consumption of alcohol, drugs and tobacco; improved health of children (class related ailments, mental and dental health and accidents); improved conditions of the elderly (maximum waiting in nursing homes for the needy elderly not to exceed 90 days; 80% of 80 years and older should have good enough health to be able to live in own accommodation with support; improved dental and bone conditions); general mental health (reduce suicide rates by 15%); heart and brain conditions (reduce fatalities by 30% for males and 20% for females; reduce cases of brain hemorrhage by 30%); cancer preventions (reduce general fatalities by 10%; by 30% due to prostate cancer in males and breast cancer in females; reduce the use of artificial tanning benches). Lastly there is the goal of reducing general accidents by 25% and also fatal accidents by the same amount (Ministry of Health, 2007a and 2007b).

Another novelty from the end of 2007 was that psychologists were then for the first time accepted in the public health care system as being entitled to a contract to the state Social Security Institute, which makes possible some reimbursing of their service costs. Previously only customers of psychiatric doctors were entitled to that facility. This increased service was particularly aimed at children and adolescents.

On the 3 June 2008 a new webpage for inter-Nordic social security information, Nordic Social Security Portal, was opened (http://nordsoc.org/). The aim is to facilitate information attainment for people moving between the Nordic countries and taking up residence and work in another country. The portal is designed to provide guidance on which country's legislation

a person is subject to in different situations. Information is also available on which benefits a person is entitled to. By going to the portal individuals can find the right authority in the right country and the contact links to the relevant institutions.

On the 27 June 2008 the Ministry of Health announced that waiting times for services in hospitals were now shorter than one year ago, as a result of actions to improve efficiency. This trend has continued until February 2009.

A major organisational change took place in the health sector at the beginning of 2008 (1 January). Then the pensions part of social security and matters concerning the elderly population were moved from the Ministry of Health to the Ministry of Social Affairs (becoming the Ministry of Social Affairs and Security). This primarily involved the move of the State Social Security Institute (SSI) out of the health care field. At the same time the affairs of sickness insurance were separated from the social security system and with a new legislation passed in Parliament in September 2008 a new institute of Sickness Insurance (Sjúkratryggingar Íslands – SÍ) was established, starting operations on the 1 October 2008. That institute also aimed to increase cost analysis in the health care sector and to strengthen the purchaser role of government, as against private and public providers of health services. This was a controversial act, with the Left-Green opposition party being the most critical of the plan, claiming that it was a means of increasing privatisation in the health care sector. Government denied this and said that the aim was more in the way of rationalisation by means of improved cost accounting and possibly facilitating outsourcing of more functions than before (cf. announcement from the former minister on the 17 March 2008). Some however consider outsourcing a form of privatisation and remain doubtful of that as a policy goal.

On the 30 December 2008 home nursing, which had been the role of central government, was merged with the Reykjavík municipal home help services, to be effective from 1 January 2009.

In February 2009 a new government took office, with the new Minister of Health coming from the Left-Green Party. It remains to be seen whether there will be changes in the role assigned for the new Sickness Insurance Institute.

The former minister of health had introduced modest user charges for hospitalisation on 1 January 2009 and also introduced new plans for rationalising in the organisation and tasks of a few regional hospitals, for cost reductions. In politics the new user charges were criticised and amongst the concerned health personnel the plans for reorganisation were strongly opposed. The new minister announced on his third day in office that the new user charges for hospitals and health care centres implemented on 1 January were abolished. Also in February this year he abolished the former plans (from 7 January) for reorganisation of regional hospital services and announced that new plans would be drawn up in cooperation with the relevant staff. He also announced that cost savings were to be made in the health sector by rationalising and cutting pay benefits of staff (mainly physicians and specialists), rather than by reducing manpower overall. He has also issued new guidelines for use of medicines, aiming to a greater extent towards more use of cheaper brands. So a considerable change in policy emphasis seems to be likely with the new government, as it aims for further big cuts in public expenditures due to the financial crisis (see further in section 3).

2.2.4 Assessment

The Icelandic health care sector seems to be delivering service quality at a high level. It offers highly qualified personnel and has ample advanced means, technical and human, for

operations. The system is expensive, given that Iceland has one of the highest expenditure rates in the Nordic countries, as a proportion of GDP. Complaints in recent years have focused on overall costs, waiting times for operations and care facilities, inadequate accommodative facilities for patients (crowded rooms, patients having to lie in their beds in corridors for some time), increased user fees and high costs of medications.

In 2008-9 there have been organisational and operational innovations. Plans for improvements and quality controls are continually implemented and refreshed and there are no significant signs of reduced standards (see above). Waiting lists for operations have actually been significantly shortened in the last years. Public pensions were moved from the Ministry of Health to the Ministry of Social Affairs at the beginning of 2008, a move that is now associated with big changes in matters of social security. A new Sickness Institute was set up in October 2008, under the Ministry of Health, to operate the sickness insurance part of social security and also to strengthen the purchaser role of government against providers of health care services. It is too early to assess the success of that change and given change of ministers in charge, with a new one having been an opponent of some of the reorganisational measures started in 2008, the future is somewhat uncertain as regards some of these steps. Foreseen need for significant expenditure cuts in the health sector in the next years will increase pressure for rationalisation, reorganisation and possibly merging of institutions. Such measures may also affect remuneration levels in the sector, as in the public sector overall.

In recent years the health care sector suffered from difficulties in manning some parts of the services, particularly nursing and auxiliary functions. A greatly increased flow of immigrant labour was notable in this sector. That trend may now be reversing with the onset of the recession and with some of the foreign labour emigrating.

2.3 Long-term care

2.3.1 System characteristics and functioning

Long-term care of the frail elderly and long-term sick or disabled individuals has been a collective task of central government and local communities in Iceland. Government finances significantly provisions of institutional facilities but also operational costs (often on a charge per bed/day basis) of privately operated service homes and institutions, often run by voluntary social organisations.

On the whole Iceland appears to have ample facilities in old age residential homes and nursing for the elderly and disabled, compared to the other Nordic nations. Thus 8.9% of 65/67 and older individuals live in institutions or service housing in Iceland in 2007, higher only in Norway (11.7%), while the other countries ranged between 5.2% and 6.8%. The use of home help seems to be at an even higher level in Iceland in the same year, 21.4% of the elderly receiving some home help (from local municipality social services), while the other Nordic countries range between 8.9% and 17% (NOSOSKO, 2008, p. 137). So old age caring seems to be institutionalised at a rather high level in Iceland.

Looking at the disabled under 65 years of age Iceland has a higher proportion receiving home help and a similar level of individuals living in institutions or service housing. For some time now the disabled have enjoyed revenues from the only TV lotto operated in Iceland (along with sports clubs and youth work) and this has improved the housing standard of many individuals with special needs who yet are capable of living with other individuals in similar conditions (enjoying supervision from social workers). There are also some long-term care wards in hospitals and special institutions (NOSOSKO, 2008a, p. 154).

Despite these relatively high rates of service provisions that 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 longer, often with improved home help from local communities and in privately operated residential housing designed for the elderly.

As Table 3 shows the decline in the size of the groups that stay in institutions is most marked for people at ages 70 to 89. There is a significant cut in the institutional rates for those, while those aged 90 and over seem to have a persistently high rate, over 50%. Similarly there is no significant trend for the group of 65 to 70 year olds.

Table 3: Proportion of different age groups residing in old age homes, nursing homes and hospitals, 1993 to 2007

	65-66	67-69	70-74	75-79	80-84	85-89	90 and older
1993	0,8	1,1	3,9	8,8	19,4	37,2	55,6
1994	1	1,5	3,6	9,2	18,3	35,3	52,6
1995	1,4	0,9	3,1	9	18,3	37,4	56,9
1996	0,9	1,5	3,5	9,1	18,8	33,5	53,1
1997	1,1	1,4	3,1	8,4	19,4	32,8	54,5
1998	0,9	1,6	3	7,9	17,9	31,8	52,1
1999	1	1,5	3,2	7,4	19,2	32,0	53,0
2000	1	1,6	2,6	7,5	18,6	32,6	53,1
2001	1	1,8	3	7,2	16,1	32,1	50,8
2002	0,7	1,4	2,7	7,3	15,9	32,3	51,4
2003	0,6	1,2	3,1	7,3	15,4	32,9	48,2
2004	0,9	1,3	3,1	7,6	15,8	34,4	50,0
2005	1,4	1,6	3,1	6,5	14,6	31,5	52,1
2006	0,8	0,9	2,4	6	13,9	32,7	52,2
2007	0,4	1,1	2,4	5,9	13,7	29,0	52,8

Source: Statistics Iceland

In a way this trend is a second stage progress in caring for the needy elderly, from institutional care to making it possible for them to stay longer in their home, with increased home help, day care, transportation and other services.[5] Normalisation, assimilation and participation in the world of the disabled are of a related kind (Traustadóttir, 2006).[6]

2.3.2 Reform, Debates and Political Discourse

Caring facilities for the elderly have been criticised greatly in recent years. The main complaints have been lack of sufficient number of beds for those sick and needing extensive nursing and care. Given that Iceland has amongst the highest rate of long-term care beds in hospitals and nursing homes (Cf. OECD Health at a Glance 2007, p. 65) this issue is somewhat surprising and has much to do with interest group politics. Another issue of concern in this context is that in residential homes for the elderly there is too much sharing of rooms and a consequent lack of privacy. This has been a strongly voiced complaint for a number of years now. As already indicated the number of beds for needy elderly overall in the country is large, compared to the other Western countries. But this complaint of lack of

[5] See Reykjavik city council site for information on servces for the elderly and disabled at http://www.rvk.is/desktopdefault.aspx/tabid-848, and http://dev.reykjavik.is/DesktopDefault.aspx/tabid-35/?cID=9&uID=6 for the disabled.

[6] See further the web site for disability research in Iceland on www2.hi.is/page/fotlunarfraedi.

privacy is a strong sign of demands for a higher standard, which government has voiced its will to head.

On 27 June 2008 the Minister of Social Affairs and Security announced a new strategy plan for elderly care. The following are the main points of emphasis:

- The elderly get adequate individual support so they can stay as long as possible in their own homes.
- The elderly and their next of kin should have easy access to all information about rights and services.
- Social Security will be simplified and the rights of the elderly better defined
- The right of old people to independent living and personal independence will be respected
- The elderly shall have options of varied forms of accommodation
- Places for day care, rest and short term care will be increased in number
- Quality benchmarks for services to the elderly will be implemented
- Surveillance of services for the elderly will be increased and improved
- New requirements will be implemented for building and design of nursing homes and for renovations of older accommodation
- User payments for old age residential and nursing accommodation will be changed so as to make it possible for old people to maintain their financial independence and allowances for inmates will be terminated (the idea is that instead of the institutions taking the pension earnings of the inmates, and they instead receiving a very modest allowance or pocket money, the pensioners should rather retain their pensions and pay the cost according to a given plan).
- The number of nursing beds will be increased until need is met.
- Sharing of rooms in nursing homes will be greatly reduced.
- The goal is that all care work will be manned with qualified and ambitious personnel.
- The overall responsibility for services to the elderly will be moved to the local communities, no later than by 2012.

Already on 12 August the Minister of Social Affairs announced a plan for increasing the number of available private beds and servicing facilities for the frail and sick elderly. The plans for a new university hospital are also meant to improve accommodative facilities of the elderly and long-term sick needing institutions. But the main emphasis has been on increasing home help and other services, making it possible and easier for people to stay longer in their own accommodation.

A growing concern for that goal has however been difficulties in recruiting enough people to man these caring jobs. In recent years an increasing part of labour in that field has been immigrant workers (mainly females) who often have inadequate language capabilities to communicate to the elderly and sick. That difficulty has however been associated to the boom years of the bubble economy and now with the recession coming on strongly the supply of willing and available Icelandic labour for such jobs may be increasing.

Issues of work participation for the disabled were moved from local communities to the Directorate of Labour, as a part of policy change, aiming at more integration and normalisation.

Subsidies for rented accommodation to the tenants were raised, for the first time since the year 2000. Grants for purchase of cars for disabled people with mobility restrictions were raised by 20%, and conditions for the support eased, for the first time in nine years. This was implemented at the end of February 2009.

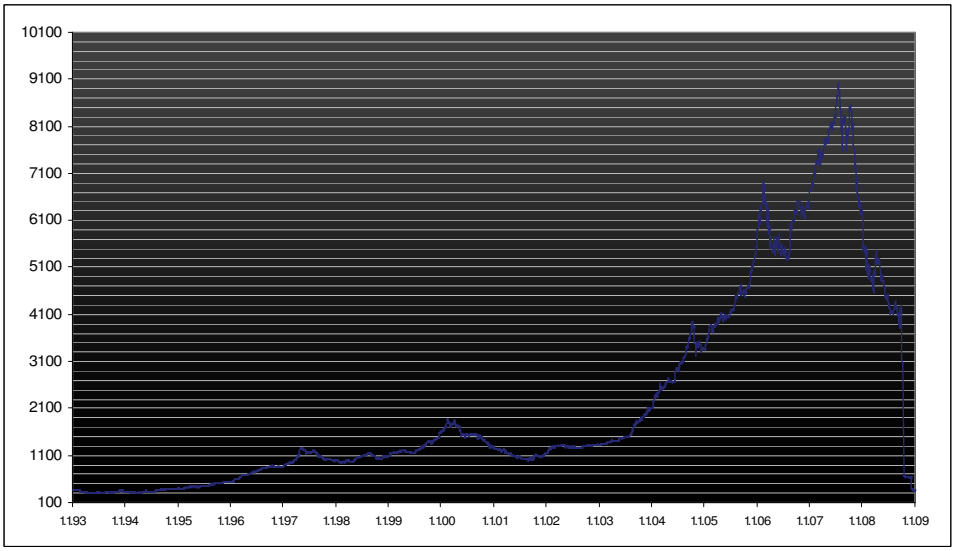
Subsidies for social housing were increased at the beginning of 2009.

A new book on rights for caring and working for parents of young children, by Guðný Björk Eydal and Ingólfur Gíslason, was published in November 2008. The study, *Equal Rights to Earn and Care*, compares the Icelandic system of paternal leaves and care provisions between Western countries and finds the Icelandic system quite advanced and the authors brand it as pioneering.

3 Impact of Financial and Economic Crisis on Social Protection

Iceland was hit by a financial collapse at the beginning of October 2008. The collapse was dramatic in the sense that more than 90% of the country's banking system went bankrupt within a period of two weeks. The collapse was a consequence of en extreme bubble economy which had built up, mainly from 2003. The bubble was most notable in a phenomenal increase in the stock market index, which went from just over 1000 in 2003 to well above 9000 in late 2007. It then fell significantly in 2008, before the final collapse in October. This is reckoned to be one of the biggest bubbles recorded and the collapse is accordingly big, as is the financial cost (Daníelson and Zoega, 2009; IMF, 2008; Buiter and Sibert, 2008, Olafsson, 2008b).

Figure 4: Icelandic stock exchange index 1993 to 2009



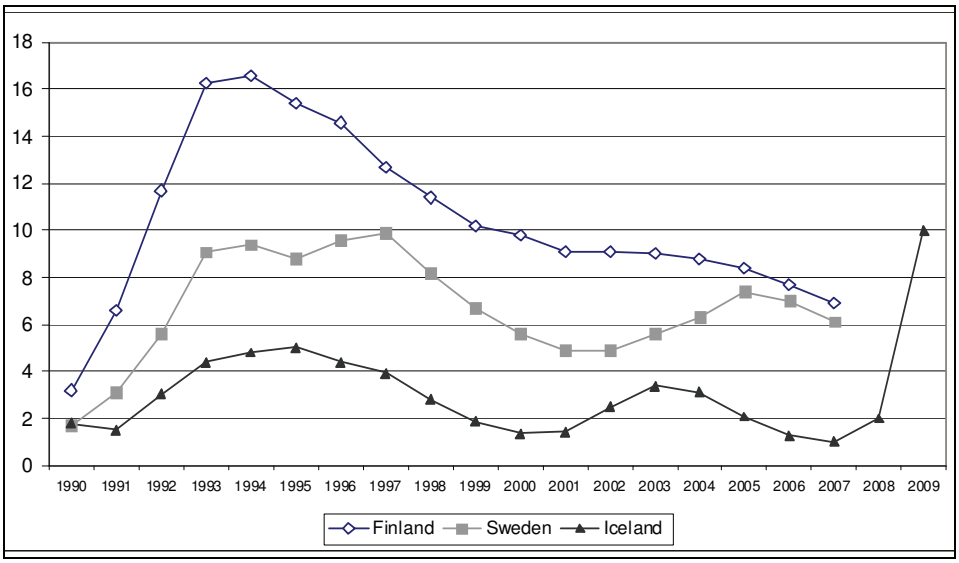
Source: Icelandic Stock Exchange (www.nasdaqomxnordic.com/)

Associated to the bubble and the collapse was an overvaluation of the currency (Krona) during the upswing years and a big fall in the currency started before Easter in 2008 and this was again exasperated in the wake of the collapse of the banking sector. Thus Iceland entered a fourfold crisis: a banking crisis, a currency crisis, an economic crisis followed and the incidence also involved a crisis of trust, both amongst foreign lenders to Icelandic banks and amongst the Icelandic population, which was greatly dismayed that this could have happened. Prevailing economic doctrines and political powers were subject to fierce criticism and finally toppled in an election on the 25 April 2009, which brought in an unprecedented shift to the democratic left.

The extent of the crisis can be gauged by means of the common economic indicators. GDP is estimated by IMF and the Central bank of Iceland to fall by about 10% in 2009 and 2010, most of it coming through in 2009. While this is a large reduction in the national economy it is not altogether unprecedented (Olafsson, 2008b). In 1967-9 a similar cut materialised, due to a crisis in the fishing sector, the main export sector. Starting in 1970 was one of the more prosperous decades in the post-war period. Between 1988 and 1993 a stagnation period produced about an 8% cut in the gross national product. The Icelandic economy has thus been prone to significant fluctuations in the generally prosperous post-war period, and to a great extent the nation has learned to adjust to such changes.

The second important consequence of the crisis is an imminent cut in real purchasing power of the population, which again has been a common experience associated to economic downturns. This time the official prediction is that the cut will be in the region of 20-25%, due mainly to prices galloping ahead of wages and also due to shorter working hours (less overtime and extra work and reduced benefits). This is a big cut but it comes in the wake of a rather long period of increases in purchasing power, which were indeed above the OECD average from 1995 to 2007. So the majority of the population should be able to weather that cut in purchasing power. Many will though be landed in dire straits.

Figure 5: Unemployment in Iceland, Finland and Sweden 1990-2009. Iceland's figure for 2009 is an estimate.



Source: OECD data bank (www.oecd.org).

Thirdly is an unprecedented increase in the unemployment rate, estimated to top at about 10% by the end of 2009. As seen in Figure 4 this is however lower than the maximum unemployment rate in Finland during its financial crisis at the beginning of the 1990s, that went up to 18%. The Swedes managed to combat the situation better with extensive activation

measures in the labour market, they topped at around 10%. Many European nations have had to live with 10% unemployment rates or more for longer periods. This is still serious for Iceland, which traditionally is a great "work society", having for longer periods had the highest employment participation rates in the OECD and long working hours for some groups (Olafsson, 2008c). Thus it has typically been the way of Icelandic households to solve financial difficulties, mainly associated to own housing investments, to work their way out of the straits. This will now be more difficult than ever before, especially for those heavily indebted.

Another difficulty with the high unemployment rate in Iceland is the fact that unemployment benefits are rather low. Employees have a general right to 70% of their former pay (up to a limit which is close to average wages) and after three months they fall onto a flat rate public unemployment benefit, which is about a half of average wages. For many who become unemployed the fall in earnings is big. The biggest number of those unemployed is from the construction industry, then commerce and the financial sector.[7] The unemployment rate is higher for males than females and somewhat higher for younger people. There is not a significant sign of greatly increased early retirement yet (www.vinnumalastofnun.is - Directorate of Labour).

That brings us to the fourth consequence of the crisis for households, and that is the difficult debt burden. Associated to the bubble economy after 2003 was also a housing bubble, i.e. an overinvestment in housing and a big rise in the price of homes. Those who bought a flat or a house after 2004, at inflated prices with heavier debt loads than previously known in the country (which traditionally has had a very high rate of home ownership), are in a particularly difficult situation now (ASI 2009; Central Bank of Iceland, Survey of debt levels 2009[8]). The groups most affected are young families, often with young children, mainly in the ages of 25 to 40. Some people were offered to take mortgage loans in foreign currencies in the bubble period, which was tempting due to long-term higher interest rates in Iceland than in the neighbouring countries. Those who took such foreign mortgage loans went into a particularly deep debt burden when the Icelandic Krona collapsed, some even doubling their debt burden. Those with their loans in Icelandic Krona have not suffered as great an increase in debt servicing, but due to indexing of the principal loan sum their real assets decrease due to the inflation following the currency collapse. Inflation is however set to come down rapidly in the spring and summer of 2009, according to a recent Central Bank prognosis.

When many of these above mentioned consequences go together (unemployment, cut in purchasing power and a heavy debt burden), the situation is clearly very serious. Fortunately it is still well within 5% of those who are unemployed that involve unemployment of both adults in the same family (Directorate of labour, personal communication, April 2009). But even only one unemployed in a family that has to suffer a big cut in earnings and a significantly bigger debt burden than before will no doubt spell serious problems.

Many people have also lost extensive savings, not least the elderly. Government finances are also in a difficult position, with an estimated deficit on the public budget of around 13% in 2009 (cf. Ministry of Finance; available on www.island.is). The resurrection program agreed between the IMF and the government assumes that this deficit will be evened out in a period of 3-4 years. That will mean tough decisions on cuts in expenditures and some tax increases. So the room for government to combat the situation is very tight indeed, as regards stimulus programs or increased welfare measures to soften the blow to households and businesses. We come later on to what government has done to combat the crisis, but we turn first to direct consequences of the crisis for the pension system.

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7 The Directorate for Labour collects statistics on characteristics of the unemployed (www.vinnumalastofnun.is).

8 Available at http://cb.is/lisalib/getfile.aspx?itemid=6922.

The crisis is set to have a great influence on social protection in Iceland, for various reasons. Looking first at the pension system, we noted in the section on pensions that pensioners are in a better position at the start of the crisis, due to unprecedentedly large increases in the minimum guarantee (about 20%) and a significant increase of general social security benefits (9.6%) on 1 January 2009, while wages were unchanged or even decreasing somewhat. Cuts in purchasing power will thus be smaller for pensioners than for the working public.
From the structure of the pension system in Iceland we can say that the occupational pensions (OPs) are most likely to be affected, due to their funded nature and the collapse of the stock market and the currency. The Icelandic occupational pension funds are large, in relation to the GDP, in fact amongst the largest in the OECD (134% of GDP in 2007), as can be seen from Table 2 in the Appendix. Iceland also has the second largest assets in private pension accounts, after the USA.
These assets in the pension funds have of course been reduced significantly. Given the size of Iceland's financial crisis the cut (shown in Table 3) by the end of October was however less than in Ireland and USA, who top the rank of losses at that time point. The reason that Icelandic pension funds have not lost more (which might have been expected, if only looking at the Icelandic stock exchange index in Figure 3) is the fact that a significant part of their investments are abroad (about 25-30%; cf. Ísleifsson, 2007). Those assets have increased in Icelandic Krona value with the fall of the currency, despite lowered values in foreign markets.

Table 4: Nominal and real pension fund returns in selected OECD countries, January-October 2008

Country	Real	Nominal
Ireland	-33,4	-30,0
United States	-25,8	-21,5
Iceland	-25,2	-14,4
Hungary	-25,0	-20,0
Australia (1)	-24,4	-20,3
Canada	-23,9	-21,0
OECD average	-22,7	-18,9
Poland	-20,9	-17,3
Japan	-19,4	-17,6
Netherlands	-18,7	-16,1
Belgium (2)	-17,9	-13,4
United Kingdom	-17,2	-13,3
Norway	-17,1	-13,5
Finland (3)	-16,0	-12,0
Switzerland	-12,6	-10,2
Portugal	-12,4	-9,7
Austria (2)	-11,7	-8,4
Sweden (2,4)	-11,2	-7,4
Spain (2)	-10,8	-6,6
Denmark	-10,5	-7,0
Germany	-10,1	-7,1
Mexico (5)	-10,0	-5,0
Slovak Republic (6)	-9,7	-5,2
Italy (2,7)	-9,5	-5,6
Turkey	-7,6	2,5
Korea (2)	-2,5	3,3
Czech Republic (2)	-4,8	1,9
Greece (2)	-4,7	-0,6

Source: OECD Private Pensions Outlook, December 2008.

The OECD estimates do however not cover the total losses for the countries, since losses have continued to pile up after October 2008. In Iceland it is estimated that the overall losses may have reached 30% by April 2009, and the next months are insecure, given the ongoing international financial crisis.

As a consequence of these losses most Icelandic occupational pension funds have announced that they will be cutting their pensions by 10% in 2009. 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 employees in Iceland.
An interesting feature of the Icelandic pension system in this situation is the generally unpopular income-testing characteristic of pillar I, which now will work the other way round, and compensate those loosing a part of their occupational pensions. Thus some 40% of the reduced pension will be compensated with an increase from the public social security (i.e. if governmental finances allow a normal working of the rules of the system).

3.1 What government has done to combat the crisis

Despite very difficult financial position of the state, due to falling incomes and rising expenditures, the government has implemented various emergency measures to combat the crisis and ease the burden of households in the situation. The following is a list of the more important measures aimed at households:[9]

- Increased subsidisation of interest cost of loans (by about 25%)
- Option of freezing of loan servicing for up to three years
- Refinancing options for reducing debt burden (lengthening of repayment period, changes of terms)
- Readjusting repayment for those stranded with their burden, with possibility of a controlled (through court action) cut in actual debts
- The different measures make possible between 10 and 50% reduction of debt burden, more for those who have lower incomes, own less and also for those who have more young children
- Child benefit raised
- Reduced user fees in health care sector
- Unemployment benefit raised on 1 January 2009, by close to 10%
- Reduced medication cost for the unemployed
- Allowance to free up a certain amount from individuals' and families' pension saving accounts (the third pillar of the pension system), to ease debt burden
- Easier terms for delaying or avoiding bankruptcy procedures
- Easing of terms for liabilities behind mortgage loans (to avoid collapse of a family's finance spreading to next of kin etc.)
- Temporary freezing of repayment of mortgage loans in foreign currencies (until the currency revives)
- A welfare monitoring activity was set up, with the aim of identifying weakness in the welfare provision in the face of the crisis. The goal is to get early warnings of impending crisis consequences, that government or the community could tackle in time.
- New activation measures in labour market
- Option of part-time unemployment benefit against part pay (to reduce layoffs)
- New tax benefits for maintenance work and construction to facilitate more employment opportunities

[9] Government has opened a special web site to monitor its activities in relation to the crisis and the resurrection of the financial sector and economy, at www.island.is.

- Plan for 6.000 new jobs to combat unemployment (a third connected to energy intensive industry); this amounts to a third of the present number of unemployed individuals, if successful
- Various measures for helping firms to continue operations despite a heavy debt burden

Many measures have thus been implemented, mainly in February-April period, when an interim minority government was reigning. Elections on the 25 April will deliver a new government with a majority in parliament and more measures are expected to further the struggle against the crisis. Foremost of the general economic measures is the program of restructuration carried out in cooperation with the IMF. That aims to revive the banks, stabilise the currency, lower interest rates (which will be important for debt ridden firms and households), and restore confidence. Many also believe that Iceland should apply for membership of EU and take up the Euro, to further the causes of stability and trust and a stronger currency in the globalised world of the future.

3.2 Assessment

As happened in the financial crises in Finland and Sweden at the beginning of the 1990s, the public finances of Icelandic government are now set to be heavily pressed with a consequent severe strain on the welfare system of the country. Still the welfare system is of the utmost importance for easing the difficulties that many families will suffer. Given the size of the Icelandic financial collapse, the consequences are likely to be severe. Government has already implemented many means of combating the negative consequences, despite the very limited financial resources. Still the part of the public that is hardest hit feels that too little is being done and they are also infused with a sense of injustice, for having to bear burdens inflicted on them by others. Many also feel that the governing authorities from the last decade failed in their tasks of securing the interests of the majority. So the situation is fragile.

The pension system that Icelanders enjoy is one of the stronger systems, as regards the funded occupational pensions as an integral part of the country's three pillar system. While the funds have suffered a sizable reduction of their assets (about 30% by April) they are only cutting their pension payments by up to 10% at the most. And a part of that cut will be compensated by the public social security. So the pension system is mostly intact despite the severe blow.

The unemployment problem is novel for Iceland and will put a great strain on the community, even though the extent (about 10%) is not excessive by European standards. Unemployment benefits are rather low and Iceland lags behind in activation and rehabilitation measures. That is an area in which major new efforts will have to be tried.

The good news is that reforms of the public social security system and the rehabilitation and activation system already underway will address these accumulating problems. Thus the planned reforms of the public pensions will involve raised benefit levels to low earning pensioners, at the cost of higher pension earners. Thus a transfer may be implemented without increasing the overall cost to government. Money will be directed more to where it is mostly needed. Similarly intended reforms in the field of work, activation and rehabilitation can play a decisive role in the present problems. On the whole it thus seems that the directions of reforms and changes have a fair chance of playing a role in combating the crisis.

At the same time expenditures will have to be cut in various sectors of the welfare state and in the health care sector. Some improvements that have been implemented in recent years may thus endure a setback. The general public will suffer significant cuts in living standards. But the fall is from a high position so there is some room for adjustments. Iceland has for a considerable period compared favourably with many neighbouring countries in the Western

world. Quality of life has been good in the country (Iceland was for example at the top of the UN's Human Development Index in 2007). The infrastructure of the society is thus strong and can take some significant setbacks, without eroding the social fabric permanently. Still the task of maintaining stability, equally in economy and society, will be great in the coming few years.

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4 Abstracts of Relevant Publications 2008-April 2009

[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.

[R5] GALLUP ORGANIZATION OF ICELAND (Capacent-Gallup), «Hagir og viðhorf eldri borgara – Viðhorfsrannsókn», undertaken for the Reykjavík City Council, 2008. Retrieved from: www.rvk.is .

"A Survey of living Conditions amongst the Elderly"

This was a representative survey of amongst 1000 Reykjavík inhabitants 80 years of age or older, done in November 2007 through January 2008. The aim was to assess the social conditions of this group of pensioners and their use of services in the locality. In 2007 a similar survey was done amongst pensioners aged 67-80. The following are some important results of these surveys:

Amongst the 80+ group 63% say their general health is good and about two thirds do some exercise or movement regularly. About 40% say the services of local health centres have improved in the past five years while only 8% say the services have become worse. While the elderly on average say reasonable disposable earnings for them would be about 33% higher than they actually are only about 20% of the group say they have financial worries (often 5.1%, sometimes 5.1% or rarely 10.3%). The rest (80%) say they never have financial worries. When asked about being lonely 8.6% say they are often lonely, 11.3% say sometimes and 9.4% rarely. Just over 70% say they are never lonely.

The comparable figures for the age group 67-80 are slightly different. About 72% of that group say their general health is good and close to 80% do some exercise regularly. About 43% say the health care services have improved and 14% say it has gone worse in the last 5 years. They emphasise a greater need for higher disposable earnings (63% higher on average) and 11% say they often have financial worries, another 11.2% say sometimes and about 15% say rarely. So about 63% of this group say they never have financial worries (as against 80% of the 80+ group). This younger group is on the other hand not as frequently lonely (3.9% say often lonely, 8.6% sometimes and 8.9% rarely). So 78% of the younger group say they are never lonely as against 71% of the 80+ group.

[R4] ÓLAFSSON, S. & ARNARDÓTTIR, J.R., "*From School to Work: The Case of Iceland", In: Olofsson, J., & Alexandru Panican, A. (eds.), Transition from school to work in the Nordic countries*, TemaNord 2008:584.

This study shows that a long-term condition of high-demand for labour has meant that the interactions between the educational system and the labour market have been particularly consequential. Ample job opportunities in an overheated labour market, which has not been very particular about specific skill requirements, have frequently distracted youngsters from staying at school and finishing their secondary level studies. It has also given those who stick to schools many opportunities to hold on to part-time jobs along with their studies. Opportunities for paid work during summer holidays have also typically been ample. This situation has provided for a strong

influence of the labour market on the educational system and educational attainment. Many youngsters in Iceland have significant experiences of the labour market before they come to their varying school leaving age. Those who leave school early are also likely to get jobs soon, thus barring them from many of the risks often associated with early school leaving or drop-out.

The ample job opportunities similarly have affected the conditions for pensioners and that is reflected for example in an unusually late retirement age.

[R5] ÓLAFSSON, S., «Íslenska efnahagsundrið», an article in the journal *Stjórnmál og stjórnsýsla* (Politics and Administration), Autumn 2008.

"Iceland's economic miracle"

This article surveys economic development and some indicators of level of living in Iceland during the post-war period, leading up to the economic collapse 2008. It also explains the financial crisis and applies the main causes to the new open financial environment following total globalisation in Iceland from 1995 onwards, a change of politics towards increasing laissez-faire policies, as well as to an unrestrained environment of acquisitiveness which the new global and political environments fostered.

[R4] THORLACIUS, S. & ÓLAFSSON, S., «Sveiflur í atvinnuleysi og örorku 1992-2006», 2008**.**

"Fluctuations in unemployment and incidence of disability pensioners 1992-2006"

Objective: To examine and explain the effect of unemployment on the number of disability pensioners in Iceland by examining changes in this relationship from 1992 to 2006. Material and methods: Information on gender and place of residence of new recipients of disability pension in Iceland and corresponding information on unemployment for each year in the period 1992 to 2006. The variables were correlated and disaggregated by gender and regions
within Iceland.

Results: Two big fluctuations occurred in the rate of new disability pension receivers during the study period, with significant increases in disability from 1993 to 1995 and again from 2003 onwards. Both of these fluctuations are associated with considerable increases in the unemployment rate. The extent of new disability pensioners declined again when the level of unemployment went down, even though not to the same relative extent. In the upswing from 2003 a delay of about a year in the increase of disability pensioners' numbers, following the rise in unemployment rate, became more prominent and the overall rate of new disability pensioners reached new highs. The relationship applies equally to the capital area as well as the provincial areas as a whole. There is though a small deviation in three of the seven provincial areas, with less decline of the disability rate on the downswing.

Conclusion: Health and capability condition determine the overall disability rate, but fluctuations over time are related to environmental conditions in the labour market, especially the unemployment rate. The features of the welfare system, especially the benefit and rehabilitation system, as well as the extent and character of activation measures in the labour market also influence the number of disability pensioners. A new method of disability assessment from late 1999 may have had some influence on the relationship during the latter part of the period and increasing applications from people with mental and psychiatric deficiencies seems to have had a significant influence on the growing disability rate during the last few years.

[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

[H3] BARÐADÓTTIR, B. & JÓNSDÓTTIR, S., «Félagsleg heimaþjónusta - viðhorf notenda», March 2008.

"Social home-help services – A Survey of Users' Atittudes"

The purpose of the survey was twofold. On the one hand to get information from users of social services from Reykjavik City Council about their attitudes to the services, and secondly to assess if the services are fulfilling the users' needs for services. Participants were people who have been using the services since 2004. A questionnaire with 36 questions was sent to a random sample of 375 users. About 60% took part in the survey.

Main conclusions are that 62% consider they are getting sufficient services whereas 38% said the services were lacking. About 80% say their requests were partly or fully met when they applied for services. About 10% say their needs were not met. About 74% say they are satisfied with the amount of services provided and about 90% are satisfied with the timing of the service provided. That is an improvement from a former survey. Altogether 76% say the service is useful to them while about 10% say the use to them is very little or rather little.

[H7] DIÐRIKSDÓTTIR, K. L., «Kvennasmiðjan – Leið til aukinna lífsgæða. Áhrif endurhæfingar á einstæðar mæður með langvarandi félagslegan vanda». April 2008.

"Womens' factory – Influence of rehabilitation amongst single mothers with long-term social problems".

This is an evaluation of a program for rehabilitation of single mothers who have had significant social problems for longer time. Sixty four women who had finished the program at least one year ago were surveyed to see how they were doing and how they assess the influence of the program activities for their own position. The majority say their quality of life has improved significantly. Their self-identity has improved and become more positive and they sense a better chance of participating in work and society than before. Thus about 92% of the women surveyed say their life quality is better and 94% say they are more self-assured. About 71% of the women are now in employment or education. Thus those who manage to finish the rehabilitation program obtain great improvements in their life conditions but there is still a substantial drop-out from the program, or about 40% of those who start participating. Between a quarter and a fifth of the women are on disability pension and some of them felt the program was not fully suitable for them.

[H2] MINISTRY OF HEALTH, «Heilsustefna: Heilsa er allra hagur», 2008. Retrieved from: www.heilbrigdisraduneyti.is .

"Health policy: Health is for everybody"

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, good nourishment and mental health. The aim is to improve

societal conditions that promote better health of all inhabitants. In the first part of the plan are outlined goals and means for the action plan for improved health specifically for five target groups: All nationals; Children at preschool age; Children in primary schools; Teenagers and youngsters in secondary schools; and Adults.

[H3] ÓLAFSSON**,** S.**, "**Social and Personal Costs of Arthritis and Rhematic Diseases", Report for the Nordic Council of Ministers-ThemaNord 2008: 583, 2008.

Musculoskeletal conditions are the most common cause of severe pain, physical disability and temporary absence from work amongst the advanced nations. They are estimated to consume up to 3% of gross domestic product in Western countries in an average year. Arthritis and rheumatic diseases are a large part of these conditions and they are thus a major burden on society's health and social care services. They are even more pronounced as sources of personal burdens and reduced participation in employment and society in general. Women are on the whole significantly more affected by rheumatic diseases than men. The present pilot report surveys these differing cost environments in Denmark, Finland, Iceland, Norway and Sweden. A special emphasis is placed on the role of out-of-pocket user costs for users of the health care system and for patients with rheumatic diseases in particular. The work was carried out for the Nordic Rheuma Council (NRR).

[H2] REYKJAVÍK CITY COUNCIL's "Strategic Plan for Welfare Development in 2008". Retrieved from: www.rvk.is .

Main goals:

- *Housing: Effort to help those in hardest need in the housing market, in cooperation with the state and other municipalities. The aim is that everybody has a roof over their head.*
- *Strengthening of local service centres.*
- *Integration, development and increased service for the elderly and disabled living in private accommodation.*
- *Increased emphasis on child protection, preventive measures against risk behaviours and special help for poor children in risk situations.*
- *Improved quality of life for long-term receivers of financial assistance from the city, with emphasis on rehabilitation and vocational training.*
- *Improved service for immigrants and refugee asylum seekers.*
- *Movement of tasks from state to municipalities. Reykjavík city should have an initiative for receiving tasks relating to near-servicing of the elderly and disabled.*

Continued emphasis on interests of the elderly, as with the continued construction of service apartments; improved home help service; increased facilities for day-care, rest and nursing for the frail elderly and disabled.

Emphasis is placed on increased cooperation with the citizens in these areas.

[L] Long-term care

[L] EYDAL, G. B. & GÍSLASON, I. V., "Equal Rights to Earn and Care – Parental Leave in Iceland", Published by: Social Science Research Institute at University of Iceland. Háskóli Íslands, 2008.

The interplay between gender relations, the labour market, care and fertility is at the centre of debates on the future of Europe. This book intervenes in that debate by discussing the example of a country that took a radical step to change gender relations in a crucial area, namely the caretaking of babies. In the year 2000 Iceland

decided to change the law on parental leave by extending the leave, providing generous economic compensation and dividing it so that a third was for the father, a third for the mother and a third that the parents could share as they liked. The role of the fathers' part in the leave is novel and in particular the extent of its use in the Icelandic context. Here six authors, who have followed the changes in the wake of the law, present their findings.The results indicate that by taking gender equality seriously Europe could overcome many of the problems faced today such as the low labour market participation of women, gender division of care and diminishing fertility rates. Chapters are: Paid Parental leave in Iceland – history and context; Fertility trends in Iceland in a Nordic comparative perspective; Icelandic parents' perception of parental leave; "You are regarded as weird if you don't use the paternity leave"; Policies promoting care from both parents - the case of Iceland; Summary and conclusions.

5 List of Important Institutions

Tryggingastofnun Ríkisins – Social Security Institute

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

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

Sjúkratryggingar Íslands – Sickness Insurance Institute

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

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

Landssamband lífeyrissjóða – Federation of Occupational Pension Funds

Contact person: Hrafn Magnsson
Address: Sætún 1, 105 Reykjavík
Webpage: www.ll.is/

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

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

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

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

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 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 that the Ministry deals with are Public Health, Patient rights, Operation of Hospitals, Health Centers and other providers of health services, Promotion of Information Technology in the health services in Iceland, Pharmaceutical affairs and Health Insurances.

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 report on varying topics and regularly issues statistical information.

SA hagdeild – Employers' Federation of Iceland, research department

Contact person: Hannes Sigurðsson
Address: Borgartún 35, 105 Reykjavík
Webpage: www.sa.is

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

Talnakönnun – Statistical Research Inc.

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

This is a private consultancy company, specialising in pension issues and related matters. The company is particularly influential as an advisor to pension funds, regarding assessments of

actuarial issues and funding matters, as well as in disseminating various data and information.

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.

Annex

Table 1:

Average effective age of retirement versus the official age, 2002-2007[a]					
Men			Women		
	Effective	Official		Effective	Official
Mexico	73.0	65	Mexico	75.0	65
Korea	71.2	60	Korea	67.9	60
Japan	69.5	63	Japan	66.5	61
Iceland	68.9	67	Portugal	65.5	65
Portugal	66.6	65	Iceland	65.3	67
New Zealand	66.5	65	Ireland	64.9	65
Sweden	65.7	65	Turkey	64.3	58
Ireland	65.6	65	Switzerland	64.1	64
Switzerland	65.2	65	United States	63.9	65.8
United States	64.6	65.8	New Zealand	63.9	65
Australia	64.4	65	Norway	63.2	67
Norway	64.2	67	Spain	63.1	65
Turkey	63.5	60	Sweden	62.9	65
Denmark	63.5	65	Australia	62.2	63
Canada	63.3	65	United Kingdom	61.9	60
United Kingdom	63.2	65	Canada	61.9	65
Greece[b]	62.4	58	Netherlands	61.3	65
Czech Republic	62.2	62	Denmark	61.3	65
Germany	62.1	65	Finland	61.0	65
Netherlands	61.6	65	Germany	61.0	65
Poland	61.4	65	Greece[b]	60.9	58
Spain	61.4	65	Italy[b]	60.8	57
Italy[b]	60.8	57	Luxembourg	60.3	65
Finland	60.2	65	France[b]	59.5	60
Hungary	59.7	62	Czech Republic	58.5	59
Belgium[b]	59.6	60	Belgium[b]	58.3	60
Slovak Republic	59.3	62	Hungary	58.2	60
Luxembourg	59.2	65	Austria	57.9	60
Austria	58.9	65	Poland	57.7	60
France[b]	58.7	60	Slovak Republic	54.5	62
OECD average	63.5	63.6	OECD average	62.3	62.7

a) The average effective age of retirement is defined as the average age of exit from the labour force during a 5-year period. Labour force (net) exits are estimated by taking the difference in the participation rate for each 5-year age group (40 and over) at the beginning of the period and the rate for the corresponding age group aged 5-years older at the end of the period. The official age corresponds to the age at which a pension can be received irrespective of whether a worker has a long insurance record of years of contributions.

b) For Belgium and France, workers can retire at age 60 with 40 years of contributions; for Greece, at age 58 with 35 years of contributions; and for Italy, at 57 (56 for manual workers) with 35 years of contributions.

Source: OECD estimates derived from the European and national labour force surveys.

Table 2: Importance of pension funds' assets relative to the size of the economy. OECD countries, % of GDP 2007

	Occupational	Private
Iceland	134,0	12,9
Netherlands	132,2	
Switzerland	119,4	
Australia	105,4	
United Kingdom (1)	86,1	
Total OECD	75,5	
United States	74,32	13,3
Finland	71,0	
Canada	55,3	
Ireland	46,6	
Denmark	32,4	
Japan	20,0	
Portugal	13,7	0,3
Poland	12,2	12,1
Mexico	12,1	8,9
New Zealand	11,1	4,0
Hungary	10,9	10,9
Sweden	8,7	
Spain	7,5	4,8
Norway	7,0	
Austria	4,7	
Czech Republic	4,7	4,7
Slovak Republic	4,2	2,8
Germany	4,1	
Belgium	4,0	
Italy	3,3	0,2
Korea	3,1	
Turkey	1,2	0,5
France	1,1	
Luxembourg (2)	1,0	

Source: OECD Global Pension Statistics

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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/employment_social/progress/index_en.html