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Analytical support on
social protection reforms and
their socio-economic impact

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Pensions, health and long-term care

Iceland

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GVG

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1 Executive Summary

The context for social protection in recent years has been the crisis and expenditure cuts. Nevertheless some progress has been achieved in some areas, both as regards using the social protection system to alleviate the worst consequences of the crisis and in various modifications and rationalizations. Austerity has clearly been a part of the packet, especially as regards expenditures on welfare services (especially health care and education).

Expenditures on transfers to households have however been higher than ever before. That is not just due to higher expenditures on unemployment benefits and activation measures, but also due to increased spending on minimum pensions and some benefits. In many ways the strategy of social protection has been successfully applied in the Icelandic case. The blow to the lower income groups has been mediated and unemployment was significantly reduced.

In the field of pensions the three-tiered Icelandic pension system has faired reasonably well through the crisis, despite increased demand and pressure, while the Occupational Pension Funds lost a significant part of their assets (about 25%). Despite a severe state of the public budget the pension expenditures have been reasonably maintained by targeting expenditures more on lower income households while cutting to higher income groups.

Previous concerns of reform in the pension system have been maintained, but reforms are brought forward at a slower pace. Thus work on simplifying the public pension system has been continued, as has work on increasing rehabilitation and activation, and on modifications of relations between the public social security system and the private sector Occupational Pension System (i.e. modifying the income-testing mechanism). The new government (from June 2013) aims to continue that work with a somewhat changed emphasis, prioritizing the reform of disability assessment and promoting more flexible retirement ages.

In health care the strain of expenditure cuts have became more noticable than before. The cuts due to the crisis came in the wake of five years of considerable pressures for rationalizations and savings and many feel that the system has by now been cut to the bone. Many prominent spokesmen from the medical professions, including high ranking physicians, have come out and expressed decisive concerns, in a very outspoken manner. This is now becoming a major issue of public debate in the country.

Waiting lists for operations have expanded significantly from late 2011 till mid 2013, including a particularly big shift between February 2013 and June 2013. This may be partly due to higher emigration rates of medical staff to other Nordic countries, especially to Norway. Part-time emigration has also become a significant feature (for example doctors and nurses working 10-15 days a month in Norway, while maintaining their positions in Iceland).

The strain on the public which has considerably lost real earnings power is also being felt. Thus the proportion of low income individuals who report unmet needs for medical and dental care has increased rapidly since 2011. Iceland is now amongst the higher ranking countries in Europe in that respect and the health care sector has now moved into a deep crisis.

The long-term care services have however faired well and progressed towards the goals of facilitating longer stay for the elderly in their own homes. This has been achieved with more home care, home nursing, increased daycare services and shor-term rest periods in nursing homes. The sector has however felt the hand of austerity, but the longer stay in own homes has relieved the pressures for increased resources in public institutional care.

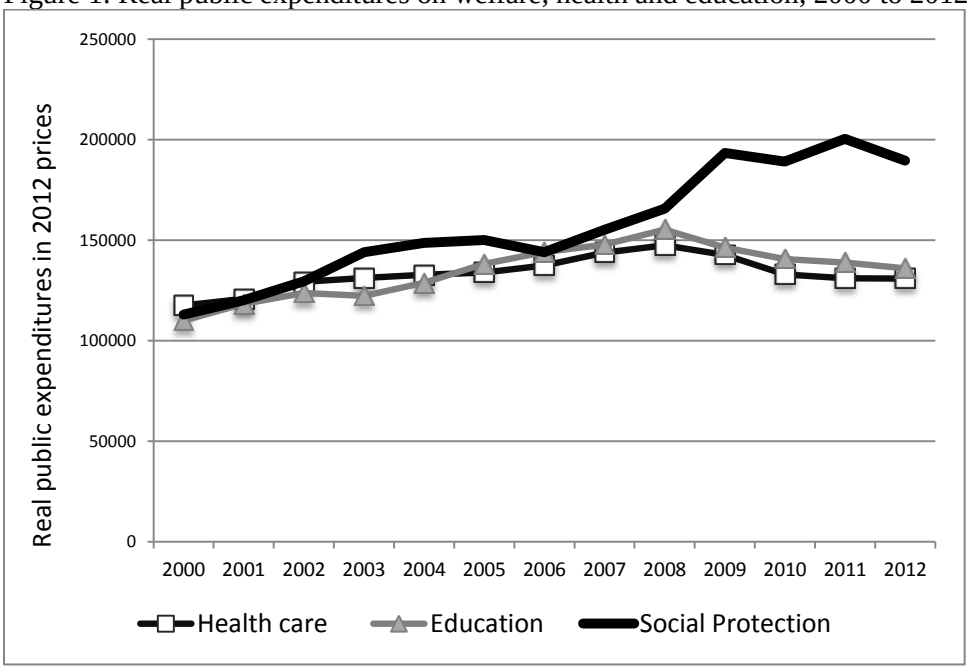
2 Pensions

Introduction: The Social Protection Context

The context for social protection development in Iceland during the past four years has primarily been shaped by the financial crisis which hit the country in October 2008. It was a deep crisis with drastic consequences for public finances and the economy. Iceland was however falling from a great height in living standards and could take some setbacks (Ólafsson and Kristjánsson 2012). Still the situation called for drastic cuts in public expenditures and increased revenues, since the government budget was landed with a 14.5% deficit by the end of 2008.

The strategy of the government that came to power in early 2009 was to soften the crisis consequences for the lower income groups and balance the budget by a mixture of tax rises and expenditure cuts. Public welfare expenditures were more targeted towards the lower and middle income groups. Hence expenditures on transfers to households have in fact been increased, mostly on unemployment benefits and household debt relief, but also on minimum pensions and social assistance. Even though cuts were generally lower on welfare provisions than on administration, investments and maintenance, there were also implemented significant cuts in the areas of welfare services, especially on health care and education, as seen in Figure 1.

Figure 1: Real public expenditures on welfare, health and education, 2000 to 2012.



Source: Statistics Iceland

So even though the overall welfare expenditures in Iceland increased in the wake of the financial crash, both in real values and as % of GDP, the pain of cuts was significantly felt, especially in health care and education (Ólafsson, Kristjánsson and Stefánsson 2012).

In the area of pensions, the Occupational Pension Funds (OPFs) lost about a quarter of their assets and suffered lower return on their remaining assets from 2007 to 2011 than in any other

OECD country (OECD Pensions Outlook 2012), due to the depth of the crisis. Still the assets of the Icelandic OPFs are amongst the largest in relation to GDP amongst OECD-countries, being second to the assets of the Netherlands. Most of the funds cut their pension benefits by 10-20% in nominal values, but at the same time there were significant increases of the nominal value of the benefits due to rising inflation in 2008-10 (pension benefits are indexed to prices).

The Federation of OPFs commissioned a large public investigation into the losses of the funds and their operations during the years leading up to the crisis (Bragason, Eyjólfsson and Frímannsson 2012). On the basis of the report the boards of the funds and the Federation of OPFs set further regulations regarding investment and risk policies as well as regarding administrative and managerial reforms.

On the whole the pension system in Iceland served well to protect the most vulnerable in society against the worst consequences of the crisis, especially the pensioners with the lowest earnings, but nearly everyone got some cuts in real earnings. A new lesson of the crisis is that household debts have emerged as an important issue for social protection, with programs for debt relief and some write-offs. These measures were provided in addition to previous measures, such as rent rebates and subsidies on interest costs of mortgages.

A number of pressing issues remain in the field of pensions. Simplification of the system, higher effective pension ages, sustainability of some parts of the system (especially Occupational Pension Funds for public employees, which have not been fully funded by governments of the last decades, leading to an accumulated debt which is set to fall on tax payers of the future). The interactions between the public social security system (with extensive rules of income-testing of benefits) and the OPFs remains an issue of concern and debate.

Organisations of pensioners, particularly those with disabilities, have been voicing increasing concerns about pensions lagging behind wages in the last couple of years. The new government that came to power in June 2013 has however promised to recall some of the increased cuts implemented in 2009, with more leniency in the income-testing formula. A step towards that goal was implemented during the summer and another larger step will be taken at the beginning of the next year. Hence expenditures on welfare transfers are set to increase by about 10,8% in the next years budget, mainly due to pensions and housing costs (cf. Ministry of Welfare - http://www.velferdarraduneyti.is/frettir-vel/nr/34140).

As will be shown below the situation in the health care sector seems on the other hand to have reached a turning point, with the accumulated pressure of cuts causing an ever growing concern amongst health care personnel and the public.

2.1 System description

2.1.1 Major reforms that shaped the current system

The contemporary pension system in Iceland was built in three main steps. Firstly, with a general legislation on workers' insurance of 1936 and secondly with a universal social security system based on Beveridge's model, implemented in 1946. The main deviation from the Beveridge model was a greater use of income-testing in Iceland, in line with New Zealand's legislation from 1938 (Ólafsson 1999).The third major step was the implementation

of an additional occupational pensions system, which came out of collective bargaining on the labour market in 1969, becoming universal for employees in 1974.

2.1.2 System characteristics

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

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

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

I. A public tax funded pay-as-you-go universal Social Security System (Soc. Sec.) with a defined benefit. The legal basis dates from 1946, originally modelled on Beveridge's plan, but also incorporating significant use of income-testing, in line with New Zealand's legislation from 1938. It has a universal coverage unlike the other two pillars. The Social Security pension has three components: Basic pension (*grunnlífeyrir*); Pension supplement (*tekjutrygging*) and Housing supplement (*heimilisuppbót*). The benefits had a tradition of being rather low in early decades. Hence the growing need for "additional pension" has eventually led to the second pillar in 1969.

II. A funded Occupational Pension System (OPS) with defined contributions, was introduced as a result of collective bargaining between unions and employers' federations. From the beginning employees contributed 4% 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 dates back to 1997. These are voluntary accounts with a defined contribution. Individuals can pay contributions up to 4% tax free (when paid in) and have the right to 2% additional contribution from employers with the first 2%. So altogether 6% have been exempt from direct taxation when paid in, but this was reduced to 4% from the beginning of 2012 (i.e. for the initial 2% employee contribution and the employer share of another 2%). These accounts are managed by occupational funds, banks or private investment

funds and subject to public scrutiny by the Financial Supervisory Authority, as are the OPS funds.

The different pillars have different roles in society and differing effects on the distribution of living standards. The Social Security equalised the income distribution with its minimum guarantee and universal income-tested benefits. It is thus of great importance for alleviating poverty and quite successful in that respect, since Iceland has along with the Scandinavian countries one of the lowest relative 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 mainly on the minimum guarantee (less than 5%). For many of those who have little earnings from the pension funds the minimum guarantee provides a supplement and at present about 16-17% of old-age and disability pensioners get some supplement from the minimum guarantee, many however only a small sum.[1] This proportion was previously higher (from September 2008 through 1st July 2009) but it was reduced somewhat with an introduction of a greater degree of income-testing on the 1st July 2009, as part of austerity measures. The function of the minimum guarantee is primarily that of improving the level of living of those pensioners who have low earnings, whether from the OP funds or other means (employment or other financial earnings).

The second pillar aims to replace the income distribution in the labour market proportionally, without any ceiling. It does thus not significantly equalise the income distribution, but it has been gradually more important for raising the living standards 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. They are paid proportionally 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 from then on (Ísleifsson 2007).

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

The first two pillars are the main building blocks of the Icelandic pension system. The second pillar pays out to pensioners a slightly higher proportion of GDP than the public Social Security System at present (Ólafsson 2012). The importance of the third pillar has declined in the last years due to losses of assets in the financial crash, but also due to the fact that government opened up the pillar for subscribers under age 60, who were allowed to liquidate up to a prescribed sum (1 million ISK per person for 2009). A couple where both have such accounts could thus liquidate 2 million ISK to alleviate their debt burden. This provision still applies and the sum for couples has been raised to 2.5 million ISK for each (max 5 millions for a couple). The liquidation of individual pension accounts contracted somewhat in 2012.

Since the Social Security pillar uses income testing (including income from occupational pension earnings since 2009) to a high degree, the amounts paid to pensioners from Social Security decrease as occupational pensions increase in value, with growing maturity of

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

individuals' rights in the Occupational Pension Funds (cf. Social Security Institution-Staðtölur almannatrygginga 2007 and 2012). Regarding the three components of the Social Security pension (Basic Pension; Income Supplement; Housing Supplement) in 2010 80% of pensioners received full Basic Pension (the first component) without any cuts (which previously was only cut due to employment and financial earnings and not due to occupational pension receipts until from 1st July 2009). Before those changes in the income-testing rules, this component was received without any cuts by 94-95% of old-age pensioners. So pensioners with higher occupational pension earnings got their total earnings reduced by this measure. As regards the second component of Social Security (Pension Supplement, which is income-tested against all other incomes) 3% of old-age pensioners and 39.6% of disability pensioners received their pensions without any cuts (thus the majority of pensioners get this component partly reduced or not at all), and the third component (Household Supplement, also income-tested against all other income, but payable only to single pensioners) was received without any cuts by only about 1% of old-age pensioners and 14.5% of disability pensioners in 2010. It remained similar in 2001 and 2012.

Due to income testing, and increased pension receipts from the Occupational Pension Funds the overall expenditure on Social Security pensions has remained stagnant or decreased as a percentage of GDP in recent years: from 2.5% of GDP in 2002 to 3.1% in 2003; then it decreased to 2.8% in 2006 and increased again to 2.9% in 2007 and 2008. In all these years GDP was increasing, with the lowest growth of 1% in 2008 - the year of the financial collapse. The proportion of Social Security pensions increased however in 2009-2011, with the GDP declining by 6,5% during the year at the same time as the expenditures of Social Security were increased on the whole, not least with 9,6% general rise of the pension amounts and a 20% rise of the minimum pension guarantee on the 1st January 2009. Further increases of social Security Pensions came in 2011 and at the beginning of 2012. The OP funds are paying a somewhat higher proportion of GDP to pensioners in addition to these payments from Social Security (SSI – Staðtölur almannatrygginga 2007 and 2012).

2.1.3 Details on recent reforms

Recent reforms have had three major goals. Firstly there have been reactions to the crisis conditions, aiming at better targeting of pension and social protection expenditures on the very lowest earning groups, while implementing cuts for higher income earning groups, including higher earning pensioners. Secondly, work aiming at simplifying the social security system and facilitating the interactions between it and the Occupatinal Pension Funds has been continued (mainly modifying income-testing mechanisms). Thirdly, extensive effort has been implemented to increase activation of unemployed and disabled individuals. The first and the third goals have been significantly successful while work continues on the third goal. The following are some major steps taken in the area of pensions in the last years.

- The new government has appointed a new working group to finalize modifications of the public pension system (06.09.13). The plan seems to involve some changes in the recommendations which was brought before parliament by a working group of the previous government in March 2013. The emphasis continues to aim for a simplification of the pension system and in addition it aims to promote more flexible uptake of pensions (i.e. later retirement), as well as to promote more incentives for the disabled to work.
- The new Minister of Social Affairs and Housing has appointed a working group to deliver recommendations for a reorganisation of the housing system, emphasing more sustainable

financing of public mortgage loans and promoting a stronger market for rented housing (26.07.13).

- Changes in income-testing rules implemented by the new government, softening the income-testing measures against other earnings of old age pensioners. This leaves the first layer of the public pension unaffected by earnings from the Occupational Pension funds (as it was until 1st July 2009). Further measures to reduce income-testing against other incomes are set to take place at the beginning of next year, affecting old-age and disability pensioners equally (announced on 05.07.13).
- A new plan for activation of the unemployed individuals who have fully used their right on unemployment benefit was implemented at the beginning of January 2013 (*Liðsstyrkur*). The number of individuals in that position is rapidly growing from that time on and the plan is to offer all individuals in that position a job, with wages partly subsided by the unemployment fund. This wide ranging measure seems to have been a great success so far.
- At the beginning of 2013 (1st January) the rates for all pensions and benefits in the public system were raised by 3,9% which is close to the inflation rate so real earnings will not significantly increase, but will be maintained.
- Parliamentary recommendation for a plan to improve services to disabled individuals. This involves definition of priorities, goals, evaluations criteria and stages of implementation. The plan emanates from the UN stipulations on rights of disabled persons regarding accessibility, services, employment and evaluations of service qualities (13.01.2012 and specified ministerial guidelines 24.01.2012). On the 18th June 2013 this measure was appointed by the ILO as an example for other countries to follow.
- Income reference for rights to rental rebates from local authorities were increased by 12.5% (29.12.2011)
- Change of legislation on parental leave, following recommendation of the EFTA surveillance authority, involving rules for synchronising rights from work in more than one member country (19.9.2011)
- A program negotiated between the government, local authorities and industry to provide jobs for 0.7% of unemployed in 2012 (16.12.2011)
- Measures implemented by Directorate for Labour to increase access of young unemployed and others seeking work to education (06.09.2011)

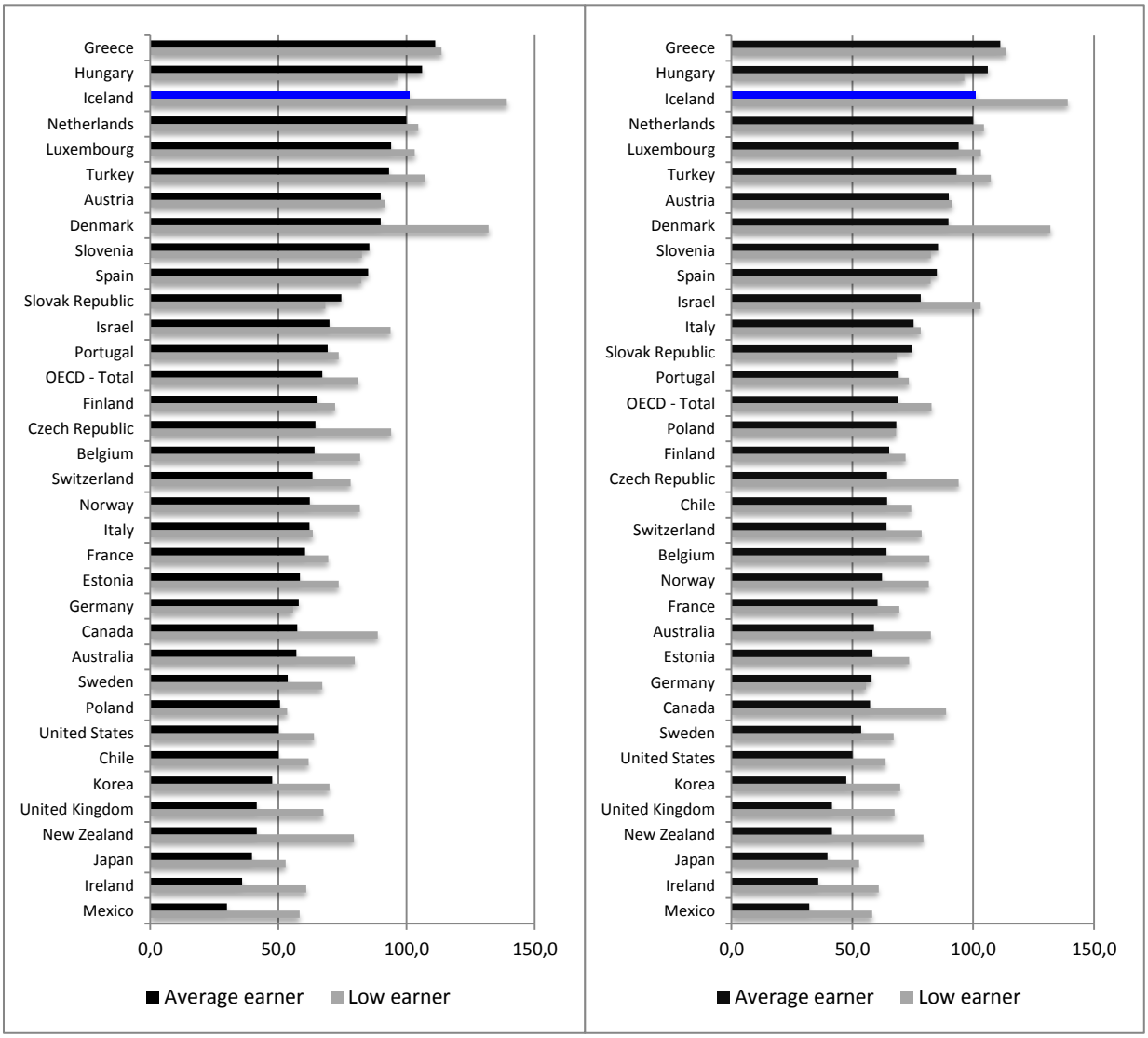
According to the overview provided in OECD's Pension Outlook for 2012 pension reforms in Iceland were quite modest in recent years compared to the member countries (OECD 2012, p. 25).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Iceland has one of the highest replacement rates for its pension system, in relation to former wages (OECD, Pension Outlook 2012). It has also had one of the lowest relative poverty rates for the elderly, a position that in fact improved during the crisis. That was effected with the significant raising of the minimum pension guarantee at the beginning of the crisis and maintained throughout. An important sign of this is the outcome of OECD assessments of Icelandic net replacement rates for low income individuals, which are found to be the highest amongst member countries (op.cit.). This can be seen in the figure below (figure 2).

Figure 2: Net replacement rates for average and low earners, by gender (males on left side; females on right).



Source: OECD 2013

The figure shows both the replacement rate for low income people and the average earner as they appear in the formula for the pension promise as it stands now. This of course assumes constant policy environment and investment returns for the next 40 years, which may however change, as well as taxation levels and many other variables. The figures thus indicate the generosity level of the current system, on the basis of the pension promise. The real earnings of the pensioners at this point in time are however different, also in Iceland, i.e. not quite as generous but still amongst the higher ones (cf. data from EU-SILC). In Iceland the

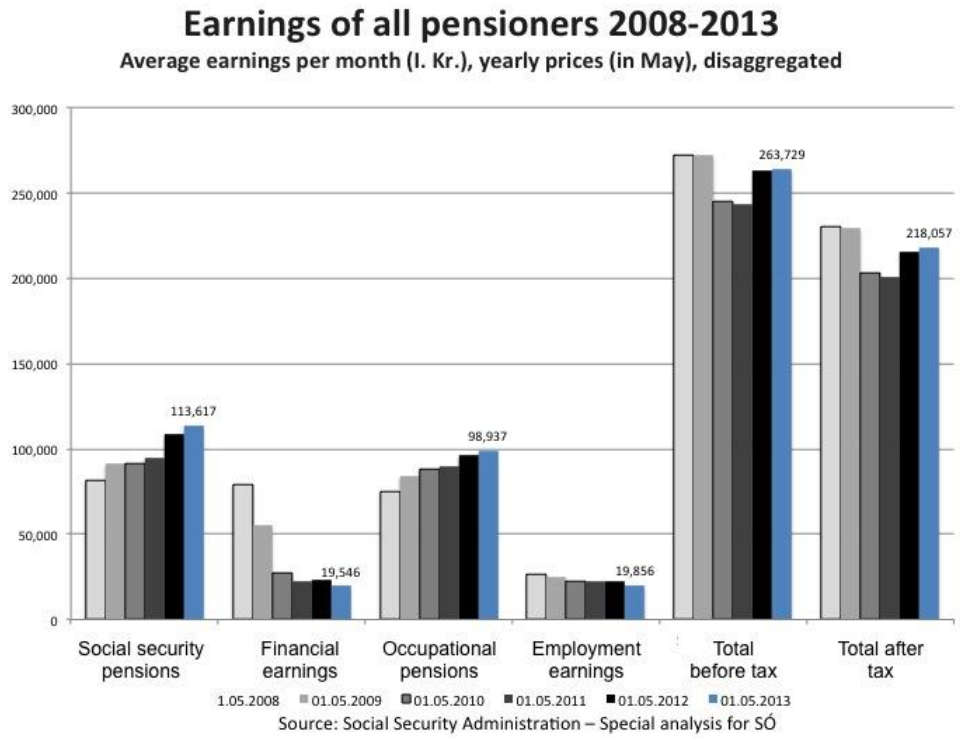
proportion of disposable income for those aged 65 and older out of the income of those 65 and younger is now about 90%, the 8th highest in Europe. [2]

Amongst the Nordic nations it is only Iceland and Denmark that have reasonably high replacement rates, while Finland, Norway and most significantly Sweden have descended the ladder of generosity. This is due to the pension reform implemented in those countries during the last two decades. Those reforms aimed at improving fiscal sustainability of the systems at the cost of lower generosity and higher risk for pension receivers. Iceland and Denmark have the strongest funded Occupational Pension System in the private sector and enjoy more generous pension promises (Ólafsson 2012).

Iceland and Denmark also have the highest replacement rates for the low earners. In case of Iceland it is reflected in the unusually high minimum pension guarantee, which is currently probably the highest in Europe.

The following figure describes the development of pensioners' income in Iceland through the crisis and up to spring 2013.

Figure 3: Earnings development of all pensioners (disability and old-age pensioners together) disaggregated, from 2008 through May 2013.



Source: Social Security Administration

Here we see how the various parts of pensioners' earnings have developed (in nominal values), as well as their total earnings before and after direct taxes (the blue column is for the

2 http://www.ll.is/files/00_2012afram_radstefnufundagogn/RadstefnaLSE2012/Afkoma_eldri_borgara_Islandi_2012_-_Stefan_Olafsson.pdf

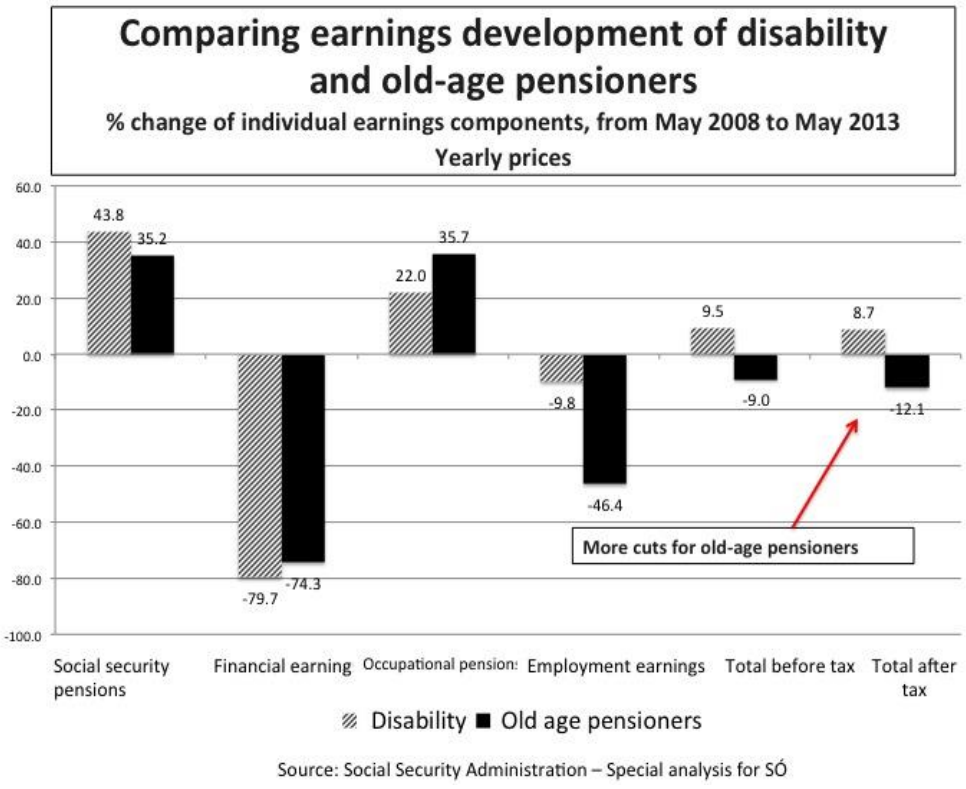
most recent period, May 2013). See the appendix for separate figures for disability and old-age pensioners.

The pension earnings from the public social security increased the most and secondly the earnings from the OPFs, but financial earnings decreased drastically and employment earnings a little. If we look at disability pensioners and OA-pensioners separately (see appendix) the disability pensioners rely more on social security and the greatest increases are visible there, while the OA-pensioners rely more on OPFs. The decline in financial earnings also affects the OA-pensioners more while declining employment earnings affect the disabled more.

These are averages so one must also keep in mind that the pension payments from social security became more targeted towards the lowest income groups during the period, with a disproportional rise in the minimum pension guarantee.

Overall the total earnings before and after taxes maintained their nominal value (but prices grew faster) until 2009 but but decreased aftewards until May 2011. Then came a significant increase in June 2011 and again in early 2012 and a slight increase in 2013. The direct taxation system had a similar effect on average pension earnings through the period, but the tax burden for the lowest earning pensioners was somewhat reduced.

Figure 4: Comparing income development of disability and old-age pensioners through the crisis, May 2008 to May 2013.



Source: Social Security Administration

Figure 4 shows futhermore how the income components of disability and OA pensioners change between the beginning and the end of the period, with indications of differential sharing of the burden of the crisis for the two groups. The elderly with higher pensions

received significantly more cuts in earnings than the disability pensioners, who got better protection from the generous minimum pension guarantee.

What figure 4 shows is that increases in the public social protection payments benefited the disability pensioners more while increases in OPFs were more for the benefit of the OA pensioners. While both groups got similar proportional reductions in financial earnings, that component is much more important for OA pensioners and thus more consequential for their overall earnings outcome.

As obvious from the columns for total earnings, before and after taxes, the overall reduction of earnings were more decisive for old age pensioners than for disability pensioners. This is primarily due to the greater reliance of OA people on financial earnings and the disability pensioners benefited more from the generous raising of the minimum pension guarantee, since in more cases they have lower other earnings than the pension, especially if they became disabled at an earlier age. The OA pensioners have obviously more accumulated rights in the OPFs.

Relative poverty rates for the elderly were however reduced during the crisis, from about 15% before to 4-5% after the onset of the crisis. This reflects the fact that many elder widows rely primarily on public social security and they thus were lifted above the poverty line with the generous raising of the minimum pension guarantee. Thus the very lowest earners amongst old-age pensioners were sheltered, even though OA pensioners with average and higher earnings have received significantly reduced total earnings.

2.2.2 Sustainability

Iceland is generally well placed as regards sustainability of its pension system, even though it is not without problems in that area. The prime factors promoting strength and financial sustainability are the following:

- An unusually late effective age of retirement; about 69 for males and 66 for females (cf. OECD 2011).
- A mandatory funded occupational pensions fund scheme (OPFs), with universal coverage for all employed individuals. Presently there are about 140% of GDP in the funds (OECD 2012).
- A significant proportion of middle and higher earnings individuals have individual savings accounts (since 1997).

These are clearly very valuable strengths, set to relief pressure on public finances in the future. The high effective retirement age results into a more flexible and participative society for the elderly, i.e. those that have health to work longer.

Still there are significant weaknesses. The most prominent are the following:

- Unsustainability of the occupational pension scheme for public employees (*Lífeyrissjóður starfsmanna ríkisins* – LSR).
- Vulnerability of OPFs against financial crises and lower prospects for returns on investments in the near debt-burdened future.

- Growing number of immigrants with inadequately accumulated occupational pension rights, due to shorter periods of residence in the country. This may risk higher rates of poverty amongst them when they reach retirement age.

The most serious of the weaknesses is the deficit of the OPF for public employees (LSR), which is due to the fact that governments have not honoured their duty of paying in fully, but accumulated a massive debt (Ísleifsson 2011). This now amounts to about a third of GDP, but would be paid out in decades into the future. What would be required now is for the government to increase payments into the fund by about 0.5% of GDP per year. That would compensate fully for the fund to be actuarially sound and not reliant on pay-as-you-go contribution in the future.

On the whole the strengths of the Icelandic pension system are though more significant than the weaknesses.

2.2.3 Private pensions

As emerges from the description of the pension system in Iceland, private pensions have a large role. The mandatory occupational pensions are the most important factor, but individual pension savings accounts are also of importance. During the crisis the government facilitated access to savings in the individual pension savings accounts, to relief debt burdens during the height of the crisis. This was important for many and allowed a higher level of private consumption, which also had favourable economic consequences.

We showed above how the individual pension earnings developed and that also showed the importance of the private pensions, especially for old-age pensioners. These earnings increased during the crisis despite some cuts in pension rights, due to losses of assets in the financial crisis. The increases were greater than such cuts, since pension payments are indexed to prices. A part of the crisis consequences was a decisive rise in inflation in 2009 and 2010 and that thus automatically increased the pension earnings from the OPFs (net of the cuts).

2.2.4 Summary

On the whole one can say that the Icelandic pension system has favourable characteristics as a three-tiered system, combining the different qualities of public and mandatory private (the occupational pensions administered by the social partners), as well as individual private pensions. An important lesson of the financial crisis is that the risks associated with the funded occupational pensions funds are in fact greater than previously thought. Many are now better aware of the security that is involved in not having all the eggs in the same basket, mixing pay-as-you go pensions with funded pensions.

The Icelandic pension system served well in protecting the public against the negative consequences of the crisis, not least due to the fact that the minimum pension guarantee was significantly raised. Instead pensioners with greater earnings lost more in real earnings.

The pension system remains very sustainable, not least aided by the fact that Icelanders retire quite late compared to other Western nations and with the strong funds behind the occupational pension system. Many pensioners are however now expecting – and in fact demanding – improved adequacy of pensions, with the progress of the economy out of the crisis. It seems likely that increased conflicts may arise over adequacy issues in the near future, but the present government has combatted that tendency somewhat with some

improvements that are already implemented and with promises of further improvements by the beginning of next year.

2.3 Reform debates

The unsustainability of the OPF for public employees and the fact that it offers more generous pension rights than the private sector OPFs has given rise to debates and increasingly strong calls from union leaders and leaders of employment organisations for equalization of pension rights in the labour market[3] (see also Ísleifsson 2011). This could of course both involve equalization by raising the generosity of the private sector funds or lowering the generosity of the public sector fund. Another way would be to delay take-up of pensions, more so in the public sector.

These are however difficult issues since for public sector employees the pension right has for decades been justified by the fact the general pay levels have been lower than in the private sector, but compensated by the better pension rights. Hence changes in generosity levels will supposedly have to be restricted to new members of the funds. These issues are currently the focus of some joint work amongst unions, employers and government.

A report from a consultant on actuarial issues, Benedikt Jóhannesson (2011), showed however that the extent of the problem is indeed exaggerated if one only looks at the deficit of the public OP Fund (LSR). This is due to the fact that as occupational pensions rise the less the pensioner gets from the public social security syetsm and also the more he pays in taxes. Thus the more generous pension rights of public employees are not as valuable as at first sight appears, and equally the fiscal problem of the state is not as severe either.

Apart from this above mentioned issue the calls for and debates about increased adequacy of pensions has emerged with greater force recently, given the drawn out crisis period with lower real earnings than prevailed before the crisis. The promises made by the new government and partly implemented during last summer and further at the beginning of next year may cool the situation and ease tensions which have been growing.

Thirdly, quests for modifications of the pension system, i.e. the public social security system, continue from previous years. The last government put a new legislation for old age pensions to parliament just befoe it left office last spring[4]. This was based on the work of two previous task forces (VEA and AG Commissions), but unfinished as regards disability pensions.

The new government has appointed another group to develop these ideas further, albeit with a slightly different focus and emphasis. One of the drawbacks of the proposals from the previous government is presumably that it will involve significantly increased pubic expenditures – a difficult proposal to honour in the present conditions and not least since the new government also placed a considerable emphasis on lowering taxes.

So for the shorter term, increasing tensions about adequacy issues are most likely, while more basic changes of the pension system seem set to progress at more modest speeds.

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[3] relevant article by the leader of the Federation of Labour: http://www.pressan.is/pressupennar/Lesa_Gylfa_Arnbjornsson/rettlatara-samspil-almannatrygginga-og-lifeyrissjoda

[4] http://www.ll.is/files/00_2012afram_radstefnufundagogn/Kynning_a_frumvarpi_almannatr_mars13.pdf

3 Health care

3.1 System description

3.1.1 System characteristics

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

The Icelandic health care system is primarily publicly funded, administered and supervised. Hospitals are mainly state operated and the majority of the health care personnel is employed by the state. The Ministry of Health, since 2011 the Ministry of Welfare, has the administrative responsibility for the overall system, and the Directorate of Health has the main supervisory role, according to a law from 1st September 2007. The latter now has overall responsibility for supervision of health institutions, health care personnel, prescription of pharmaceutical products, measures for combating substance abuse and quality promotion of all public health services. There is also a special supervisory authority for medicines control and a supervisory commission dealing with prices of medicines. (Ministry of Health[5], NOMOSKO, 2009).

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

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

Health care centres are responsible for primary health services, preventive services (including child health care, maternity care, school health care, immunisation and family planning). The private physicians and specialists generally work according to a contract, previously with the state Social Security Institute (SSI), but since 2009 with a new institution - the Sickness Insurance of Iceland (SÍ), which subsidises the costs. Hospitals also provide out-patient services. In general no referral is needed for use of specialists' services so GPs are not effective as gate-keepers in the operation of the services. Still the prevailing law assumes that

[5] Ministry of Health www.heilbrigdisraduneyti.is, www.velferdarraduneyti.is

the primary health care service should be the first stop in the system for patients. There are though no general penalties or significantly higher fees for patients who directly seek services of a self-employed specialist. Health care centres also provide home nursing services but home help services (for the elderly and long-term patients) are provided by local municipalities' social services. There are measures now being undertaken to merge administrations of home nursing and home help at the municipalities level (Sigurðardóttir 2008).

There is now one major high-tech university hospital in Iceland serving the country (Landsspítali – Háskólasjúkrahús), a teaching hospital in Akureyri (the biggest municipality in the Northern part of the country) and a few smaller local hospitals, some operating 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 are less publicly controlled as it seems to be the case in Denmark, Norway and Sweden (NOMOSKO 2009, Ólafsson 2008a).

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

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

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

The cost of Icelandic health care has however significantly decreased during the crisis, as described in the next section.

3.1.1 Details on recent reforms

As emerged from figure 1 at the beginning of the report the overall health care expenditures have come down significantly during the crisis years, from 2008 through 2012. In table 1 a breakdown of health care expenditures for the period from 2003, when it reached its highest level, before gradually being squeezed for more and more rationalisations can be observed. Notably in 2003 Iceland was amongst the highest European spenders in the group of OECD countries, so presumably some fat could be trimmed off without significant risks to standards and quality of services.

The significant cuts during the crisis thus came in the wake of a longer period of continued pressure for rationalisations and savings.

As the table shows the public expenditures on health care amounted to 8.86% of GDP in 2003 (in addition to that some 1% of GDP was added with private out-of-pocket expenditures in that year). By 2012 the public expenditure level was down to 7.71% of GDP.

Table 1: Public expenditures on health care, from 2003 through 2012 (% of GDP)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
07 Health	8,86	8,44	8,09	7,92	7,89	7,92	8,34	7,88	7,62	7,71
0711 Pharmaceutical products	0,71	0,69	0,59	0,57	0,54	0,63	0,72	0,62	0,57	0,52
0713 Other medical products	0,17	0,16	0,15	0,15	0,16	0,16	0,19	0,2	0,19	0,2
0721 General medical services	0,9	0,88	0,84	0,86	0,86	0,86	0,87	0,87	0,88	0,87
0722 Specialized medical services	0,37	0,35	0,34	0,32	0,32	0,35	0,4	0,38	0,38	0,38
0723 Dental services	0,13	0,13	0,12	0,11	0,1	0,09	0,09	0,08	0,08	0,08
0724 Paramedical services	0,27	0,3	0,28	0,28	0,28	0,28	0,27	0,25	0,25	0,24
0731 General hospital services	4,57	4,19	4,02	3,93	3,92	3,89	4,04	3,73	3,55	3,7
0732 Specialized hospital services	0,08	0,09	0,08	0,08	0,08	0,1	0,13	0,11	0,11	0,1

Source: Statistics Iceland

The most drastic cuts were on pharmaceutical products, from 0.7% of GDP to about 0.5%; on general hospital services from 4.6% in 2003 to 3.6-3.7% in 2011-2012; and on dental services from 0.13% to 0.08%. Expenditures on general medical services (health care centres) and on specialized medical services (primarily in the private sector) remained more or less stable in relation to GDP throughout the period.

The state-run university hospital in Reykjavík (Landsspítalinn) was significantly hit by the cuts resulting into mergers and closures of various regional hospitals and operations. On the whole, the reforms of the last five years have thus primarily been of the austerity kind.

A good result was achieved by reducing the costs of pharmaceutical products, using to a greater extent cheeper medications (generic types) and negotiating lower prices.

Nothing much has happened with one of the sources of high costs in the Icelandic health care sector - the open access to subsidized specialist medical services. Many politicians and specialists have voiced the need to implement gate-keeping functions in general health care centers, but nothing has come of it. Instead the health care centers have continued on a long-term downward trend, with too few general practictioners and a higher average age for those remaining. The replacement flow has been too weak for some time now.

On the more positive side, the last government reversed the development of reducing subsidies of dental services for children, which had lasted for at least a decade, by legalising increased rights for subsidies of children's dental cost. The present government continues that policy and in fact increases the applicability to more age groups. Hence there are significant improvements to be expected in the near future in dental health care for children.

3.2 Assessment of strengths and weaknesses

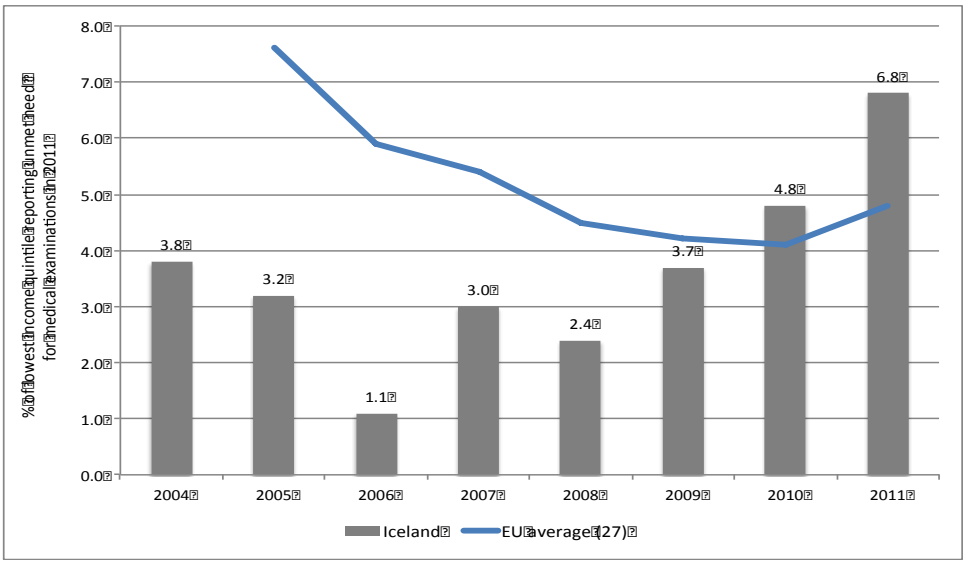
3.2.1 Coverage and access to services

While Iceland has a universal health care system with formal access open to all, the role of user charges has been somewhat more significant than in the other Nordic countries (except for Finland), for example for consultations with medical doctors, for research cost, physiotherapy and for medications. This meant that the cost has been to some extent a

sensitive issue for lower income people and thus maintained a somewhat higher level of inequality effect in the health care services.

With the onset of the financial crisis the access to services was negatively affected as the real earnings power of the population has drastically decreased. As described in figure 5 the accessibility of lower income group of people to health care services turned significantly for the worse, with the size of the part of the lowest income quintile reporting unmet needs for medical examinations almost tripling from 2008 to 2011 (from 2.4% to 6.8%). Iceland surpassed the EU average in 2010 and 2011 for the first time since these measures became available.

Figure 5: Proportion of lowest income group with unmet need for medical examinations; Iceland and EU average compared, 2004 to 2011.

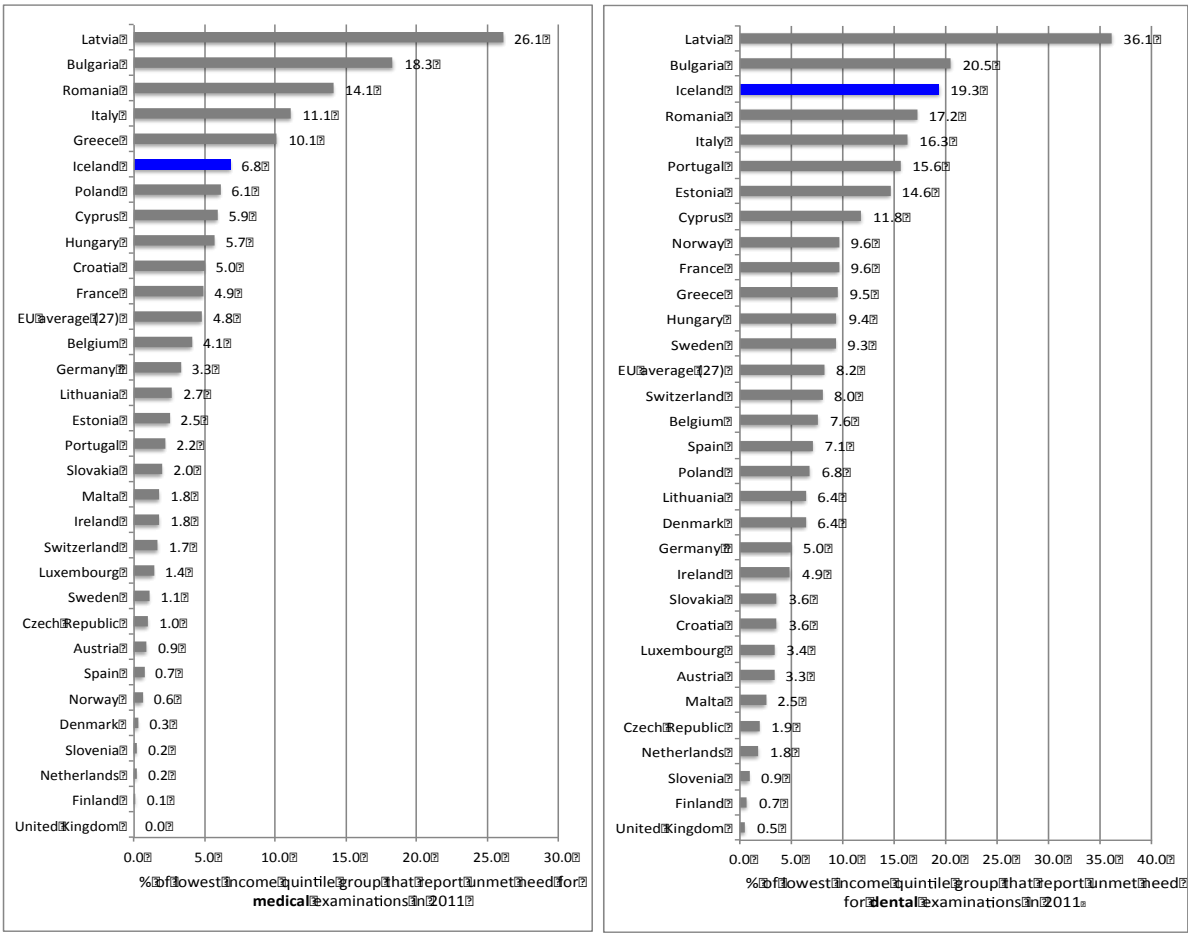


Source: EU-SILC.

Figure 6 compares Iceland and other EU member states on unmet needs for dental examinations for 2011.

With this change during the crisis Iceland has exited the group of the Nordic nations and is now near the top of this European problem rank, along with less prosperous nations in Southern and Eastern Europe. Iceland has the 6th largest group of low income people reporting unmet needs for medical examinations and the third largest group with unmet needs for dental examinations in 2011. This is a rapid deterioration since 2008 and should be taken very seriously.

Figure 6: Unmet need for medical and dental examinations reported by members of the lowest income quintile, in 2011



Source: EU-SILC

Dental services are fully private in Iceland and as previously mentioned the level of subsidies for dental costs has been declining continually for the last decade or two. While the situation for children is now improving the position for low income adults is clearly unacceptable at present.

An interesting and important report appeared recently on the extent and characteristics of user costs in the Icelandic health care system. The report was written by Ingimar Einarsson (2013) for the Society for Cancer Prevention (*Krabbameinsfélagið*). It surveys data on user costs in the health care and focuses specifically on cost related to treatment of cancer and compares it with the a comparable situation in Sweden. In 2011 Iceland's total expenditures on health care amounted to 9.3% of GDP, placing Iceland on the 20th place amongst OECD nations. That is a great change after having previously been amongst the top spenders on health care. Of those 9.3% about 1.8% of GDP is out-of-pocket expenditures for households. That share has doubled since 1980 and is higher than in other Nordic countries (NOMESKO 2011; Ólafsson 2008). This has also increased during the crisis, at the same time that disposable household earnings have significantly decreased (Einarsson 2013).

The previous government implemented a new system for cost sharting on pharmaceutical products, aiming at equalizing subsidies between types of diseases and sheltering those with serious and long-term diseases. Still, the maximum cost for users is higher than in Norway

and Sweden and the cost of treatment for cancer patients has increased. The public sickness insurance (SÍ) has not had a contract with specialist medical practitioners since 2011 and from that time the fees for visits have increased significantly more than other prices and more than the subsidy from the sickness insurance. Hence the user cost rises.

While user costs have for long been somewhat higher in Iceland than in other Nordic countries the situation has deteriorated in Iceland during the crisis, as exemplified by the data on unmet needs for medical and dental examinations. This increases the influence of inequality on health conditions in Iceland.

3.2.2 Quality and performance indicators

Before the crisis, Iceland ranked amongst the countries that provide the general public with the highest standards of health care. We have pointed to such indicators in earlier asisp reports, including material from OECD's Health at a Glance and World Health Organization's indicators. In fact, earlier this year two internationally comparative academic evaluations of qualities of health care services in Western countries appeared, one in *European Journal of Public Health* (Mackenbach and McKee 2013), benchmarking the qualities of health care services in 43 European countries. The study uses 27 indicators with most of the data referring to 2008, i.e. before the crisis hit. Iceland has the third highest ranking in that study, thus confirming again that Iceland indeed had a very high standard of health care services before the crisis.

The other study appeared in *The Lancet* (Karanikolos et. al. 2013). That study examined the impact of the crisis and austerity measures on health care systems in European countries and how the crisis affected common indicators of health of the nations. This study reveals that Iceland has been successful in maintaining high quality health care services, despite significant expenditure cuts. The authors specifically compare Iceland's outcomes with that of Spain, Portugal and Greece. Those countries are found to have done significantly worse, with indicators showing declining health outcomes, including a growing rate of suicides during the crisis, which however was not the case in Iceland. The data in that study covers mainly the earlier part of the crisis.

The statistics on cuts in health care expenditures and unmet needs for medical services amongst low income group of people described above indicate that standards seem to have been kept in the earlier part of the crisis. From 2011 onwards the strain of cuts in the hospital services came to be felt in a growing way. Earlier asisp reports for Iceland indeed showed that waiting lists for major operations (other than emergency or life-threatening conditions) did not increase between 2009 and 2011. This was probably due to concerted effort of the health care staff.However as the crisis and the cuts have continued, the strain on outcomes has become more visible. Recent data on waiting lists and waiting time for major operations in the hospital services clearly indicate a rapidly deteriorating situation in 2012 and 2013 (Directorate of Health - *Landlæknir* 2013).

The report on waiting lists and waiting time from the Directorate of Health (June 2013) confirm this setback. In some cases there are decisive increases in waiting from February 2013 to June 2013. Thus the number of individuals waiting for heart or coronary operations (excluding emergency and life threatening cases) increased by 43% from February to June 2013. These types of operations have declined in numbers, by 8% from 2012 and 9% from 2011. That list however is not particularly large. The most numerous waiting list is for

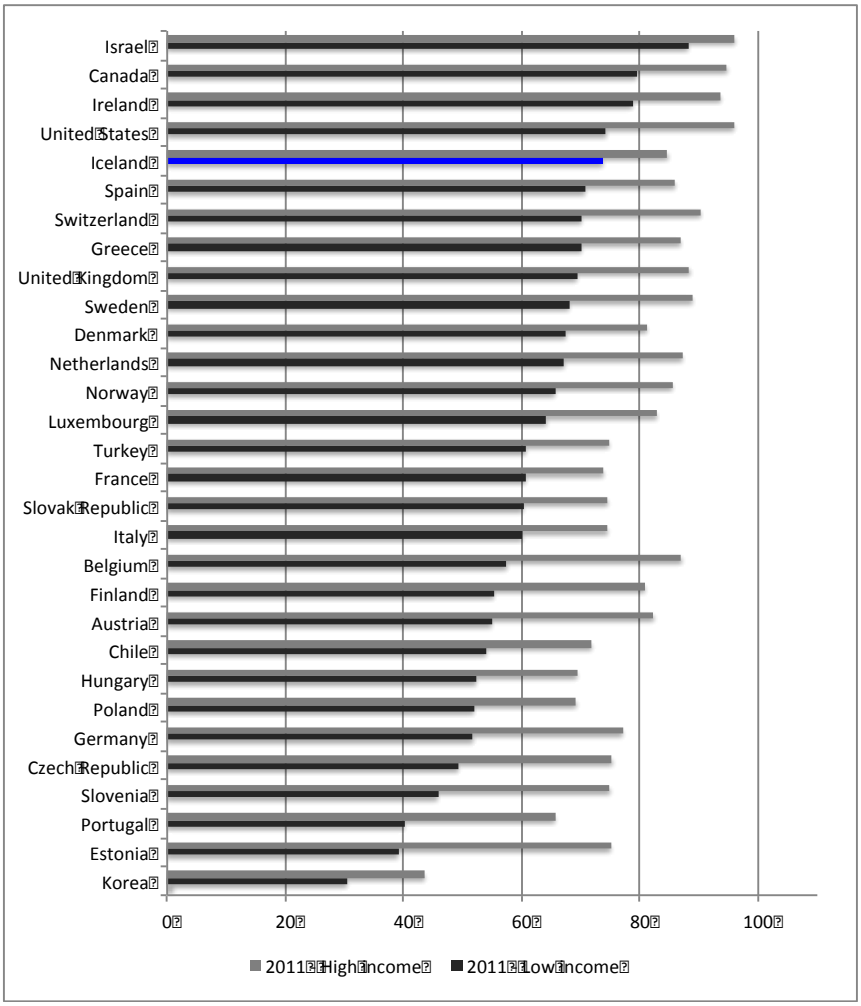
cataract surgery on eyes, with about 1150 individuals who have waited for 3 months or more. This increased by 34% from 2012 and tripled from 2011.

The number waiting for operation on hernia increased by 30% from February this year. There is also an increase on the list for bariatric operations on stomach. The number of women waiting for the removal of uterus has rarely been larger and increased by 60% from February this year. Waiting lists for replacements of hip joints and knee joints have in both cases increased by 28% since February this year.There are however also cases of fewer numbers on waiting lists for specific operations, but these tend to be cases where lists were not long enough. There are also cases of little positive change, but negative changes seem quite decisive (Directorate of Health - *Landlæknir* 2013).

In sum one can say that the condition with waiting lists for operations has changed for the worse in 2012 and 2013, after relatively good outcomes for the earlier part of the crisis, i.e. up to autumn 2011.

By 2011 Iceland was still amongst the nations reporting the highest self-assessed health, according to OECD data.

Figure 7: Self-assessed health condition: Proportion reporting "Good health", by lowest and highest income quintiles in 2011



Source: OECD data bank

Iceland ranks on the fifth place as regards to good health amongst low income group of people, significantly ahead of the other Nordic nations. The difference between good health scores amongst the lowest and highest income quintiles is also relatively low in Iceland compared to the other OECD countries, including the other Nordic countries.

So the indication is that even by 2011 Iceland was doing well as regards general indicators of public health. Even though the access to health for the lower income group of people has worsened by the time, the consequences for health status probably take longer to show through in basic quality indicators. Those who refrain from seeing a doctor due to cost reasons probably do so mainly in cases where ailments are of less consequential types.

The question of whether the health status of the Icelandic population has at all deteriorated due to the setbacks in service provision and accessibility remains still unanswered. It will most likely take another two years for the verdict to be obtained on that issue.

3.2.3 Sustainability

Currently, the concerns about emigration of medical personnel from Iceland to Norway and other Nordic countries, due to the crisis, have greatly increased. The majority of emigrants from the health care sector are specialized physicians and nurses and the preferred destination is Norway or Sweden and eventually Denmark This is easy to do for health care personnel, particularly for specialist physicians, since many of them are originally educated in the other Nordic countries. In addition, there has been a large demand for nurses and other health care personnel in Norway in recent years.

Emigration is a threat to the sustainability of the health care service since human capital is restricted in that area and physicians are a particularly mobile group. For quite some time now there has been an insufficient renewal of general practicioners for the health care centers and with paying conditions being less than competitive compared to Norway the overall incentive for working in Iceland seem set to be worse than before. Managers of the University Hospital (*Landsspítalinn*) are already discussing eventual alternatives of recruiting specialist doctors from Pakistan and India, which would be a new development in Iceland.

Another threat is part-time emigration to Norway, i.e. an increasing number of specialists and nurses are now working part-time in Norway or other Nordic countries for 10-14 days a month, without leaving their positions at the University Hospital in Reykjavík. This they do in order to pep up their salaries. This may be a partial explanation for the increased number on waiting lists for operations in the last year and a half.

The former government had planned to start the construction of a new University Hospital, with a number of new buildings at the site of the old one, which by now is relatively worn out and inadequate. The present government seems set to put those plans for a new hospital on ice and this has caused great concerns amongst the staff who complain loudly about poor and deteriorating conditions at their work places. Inadequate maintenance for some time has aggravated the problem, since most concerned people expected the new hospital to be on the agenda for the near future. Thus this issue has added to the list of complaints in the specialized hospital sector.

Complaints about inadequate renewals of high tech medical machinery during the last austerity years is also an issue of grave concern. Many key equipments are said to be already too old and breakdown frequency thus increases. Talk of insufficient machinery thus adds to concerns with inadequate housing conditions at the University Hospital. But how has the

situation developmed from 2000 to 2011, according to statistics on number of key equipment per 100.000 population? Table 2 gives an indication.

Table 2: Key medical equipment per population in Iceland, from 2000 to 2011

	2000	2005	2006	2007	2008	2009	2010	2011
Computed tomography scanners (CAT)	2,1	2,4	2,6	3,2	3,1	3,5	3,8	4,1
Magnetic Resonance Imaging Units (MRI)	1,1	2	2	1,9	1,9	2,2	2,2	2,2
Radiation therapy equipment	1,4	1,4	1,3	1,3	1,3	1,3	1,3	1,3
Lithotriptors	0,4	0,3	0,3	0,3	0,3	0,3	0,3	0,3
Mammographs	1,8	1,7	1,6	1,6	1,6	1,6	1,6	1,6
Gamma cameras	1,4	1,3	1,3	1,3	1,3	1,3	1,3	0,6
Angio-graphy units	1,4	1,3	1,3	1,3	1,3	1,6	1,6	1,6

Source: Statistics Iceland

Accessibility to CT scanners has doubled from 2000 to 2011 and so has the number of MRI equipment in relation to the population. There is no sign of reduced number of these equipment after the onset of the crisis. They may however be relatively old. But still data from OECD indicate that Iceland has more of these types of medical equipment than all the other OECD-countries (OECD 2012, p. 75). There have not been significant changes in the other types of equipment in the table, but small reductions in the number are visible for radiation therapy equipment, mammographs and gamma cameras, but the number of angio-graphy units has increased.

So, if Iceland has had a setback with ageing equipment it is indeed a fall from the highest standard of accessibility compared to the average of OECD-countries.

Whether the construction of a new hospital will be delayed only for a short period of time or for a longer-term remains yet unclear. If postponed for a longer time a considerable effort in maintenance work would be required for conditions to improve. So the future of the high tech hospital services is to a significant extent undecided at present.

3.2.4 Summary

The health care system in Iceland had been cost rationalized during the years leading up to the crisis. After the crisis hit the sector took significant further expenditure cuts, moving Iceland from the status of being amongst the highest spenders on health care towards the median for the OECD-countries. While the system stood well before the crisis and it also reacted well to the difficulties in the first crisis years, the last two years have seen a rapid change of mood amongst medical staff and users alike. Waiting lists for hospital operations have lengthened significantly during the last year and the community health care centres have seemed to continue on a downward slide. By now there are serious concerns about declining standards of quality and negative prospects, not least due to increased emigration of medical staff to Norway and Scandinavia, where there are ample opportunities for well paid jobs in health care.

The tough financial situation has amongst other things increased user fees and lower real earnings of households have made it more difficult to meet these. Figures on unmet need for health care and dental health care amongst low income households thus show a decisive

increase in the proportion affected. Thus we are seeing a declining standard of access to the services. Governments, both the previous and the present, have however increased the subsidies of dental care cost for young children, which has been an important countermeasure.

3.3 Reform debates

Reform debates in health care services have for some time now focused on the need for a large scale renewal at the University Hospital (*Landsspítalinn*). Prominent doctors, politicians and the general public have spoken in one voice on the issue. In fact that medical staff has in general passed a point of tolerance as regards the issue has been clear for the last year and a half. Criticisms of the state of affairs have thus been extensive and unusually loud lately.

As the new government recently announced its new budget for the next year, it emerged that plans for construction of a new hospital were put on hold and that in fact the University Hospital (the main high tech hospital in the country) was due to get the same allocation as last year and that a special provision for the renewal of equipment that was implemented last year has also been cut. This was met with an uproar amongst the staff and the public and the medical director of the hospital resigned from his job in protest. Hence the athmosphere in the flagship of Icelandic health care services is dismal to say the least. In a way it seems that a prolongued period of rationalizations and cost cutting, which was then followed by further drastic cuts due to the crisis, have taken its toll and in a way lead to conditions threatening a downward spiral. That is indeed the tone of prominent physicians.

It now seems that there will be some supplementary allocations to health care and the University Hospital in parliament, but the situation will still remain critical.

Given the high level that Iceland was falling from, and the generally good quality of health conditions in Iceland compared to most other countries (at least up to 2011), one should expect some of the criticisms to be overstated (OECD 2012). But on the whole it appears that the limit of tolerance in the sector has been reached, and that will have consequences and may cause a serious medical brain drain.

The new government has announced its interest in promoting further public-private mix in service provision in health care. When the Independence Party (the party of the right) was last in government it had started to prepare the ground for strengthening the governments buyer role and analysing the costs in the health care system with the aim of increasing the role of private service providers. The party frequently refers to Sweden's approach which has gone down that role to a significant degree in the last decade. It is thus likely that significant steps in that direction will be taken in the near future.

At the same time the government is strongly committed to balancing the budget already by next year and then it has promised significant tax cuts. Hence the context seems to be set for further austerity environment in public provisions while at the same time increasingly promoting private provisions, which may lead to higher user fees and increased divisions in access to services.

The bigger issues of a longer term, such as the weak position of health care centers and limited access to general practicioners is not been addressed yet and the lack of a gate-keeping function restricting the access of the public to subsidized expensive specialist medical doctors is neither addressed.

But on the whole, the last decade has fundamentally changed the position of Iceland as regards health care provision. The country has moved from having one of the very highest health care expenditures to a lower position on the OECD rank of expenditures. That provides a different context and as is frequenty said in public discussion - the system has been trimmed to the bone. Prominent spokesmen from the medical professions have warned repeatedly that Iceland may face significant reductions in standards of health care with serious consequences.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The legislation that shaped the structure of the present long-term-care system in Iceland dates back to 1983. Services in nursing homes, old-age homes or hospitals are based on legislation no. 125/1999 on elderly care. This was previously the responsibility of the Ministry of Health but with the transfer of the responsibility for the issues relating to the elderly and disabled from the Ministry of Health to the Ministry of Social Affairs, effective from 1st January 2008, a new basis for reorganisation was laid, as well as a policy shift from medical consideration to more social emphasis in shaping policies for these groups (Sigurðardóttir 2008 and Guðmundsson and Sigurðardóttir 2009). From then on all services to the elderly should be defined and operated as local services under the supervision of local authorities. A main goal would be to make it possible for the elderly to reside in their own accommodation for as long as possible. The new form should be fully implemented no later than 2012 (Sigurðardóttir 2008). The state would continue to define policies and supervise the operations so that they are in accordance with the law and stated aims. This responsibility has now been transferred to the new Ministry of Welfare as of 1st January 2011 (see asisp 2011 report for an account of the new ministry).

4.1.2 System characteristics

In Iceland, the care services for the frail elderly and disabled or long-term patients are collectively the responsibility of the government, local authorities and third sector voluntary organisations (mainly not-for-profit). Governments primarily finance the services (both at central and local level), but also for the third sector organisations, which frequently receive contracts with the government paying the operational costs, (i.e. charges on a per-bed/person-per-day basis). Voluntary organisations of individuals belonging to a particular disease groups and the organisations of the disabled are particularly active in providing services to their members[6]. Many service homes for the elderly are also of this type, reflecting a very active relationship between the government, local authorities and the civil society voluntary sector in the provision of welfare services[7]. This form has the added benefit of often producing employment opportunities for people with disabilities. In addition to these formal services, significant informal services are also provided by relatives and neighbours, which make a

[6] See for example www.obi.is; www.saa.is; www.sjalfsbjorg.is

[7] www.hrafnista.is; www.eir.is; www.grund.is; http://www.island.is/efriarin/busetumal/-hjukrunarheimili-umsokn

difference in a tightly knit small-scale society, such as the Icelandic one (Egilsdóttir and Sigurðardóttir 2009; Sigurðardóttir 2010; NOMESKO 2011).

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

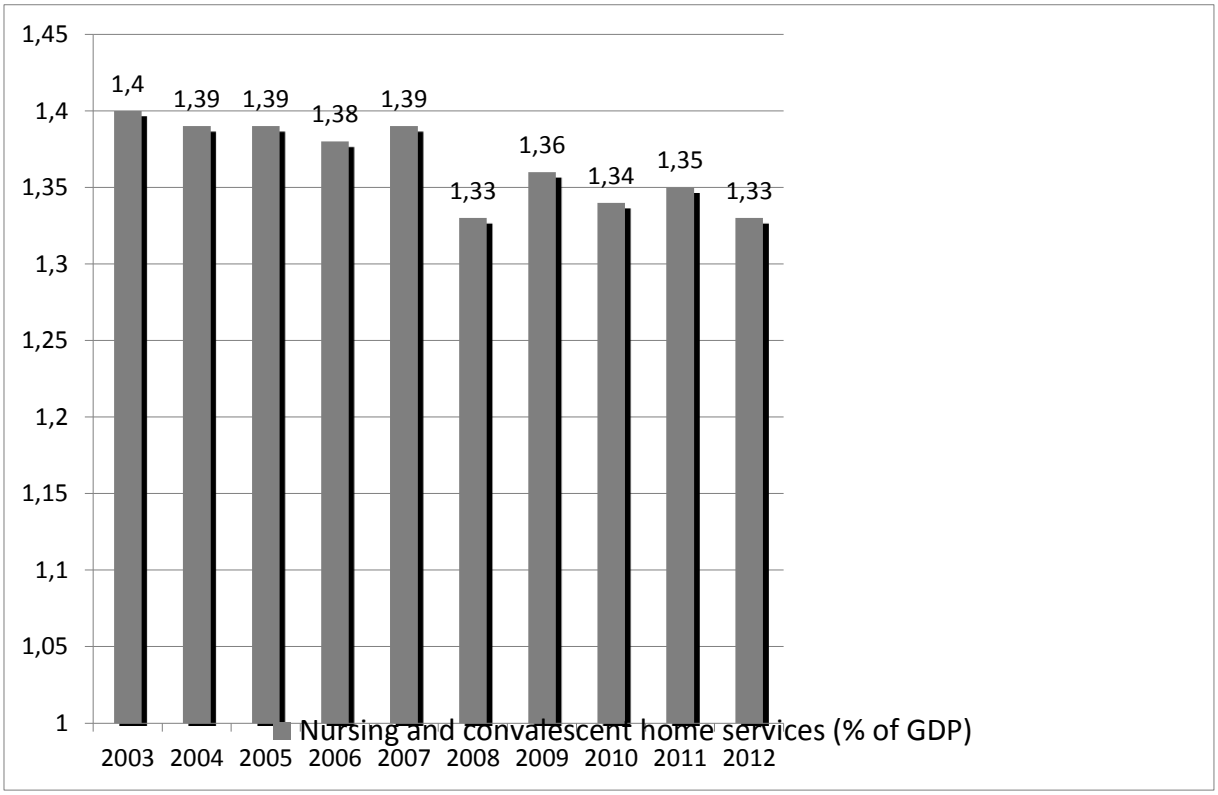
This is somewhat surprising, given that the demographic composition of the Icelandic nation is such that it has a lower proportion of people aged above 65, and the number of disabled people under 65 are not significantly larger in Iceland either. In some cases this ample supply of places in institutions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

However it is particularly interesting that Iceland has by now the highest proportion of elderly people receiving home help, equally amongst the Nordic and EU countries (Fujisawa and Colombo 2009). It has been the major policy goal in recent years to reduce the number of people living in institutions and increase the possibilities for people to stay as long as possible in private homes (the ratio of home ownership amongst elderly Icelanders is very high; cf. Ólafsson and Jóhannesson 2007). Norway has a similar rate of elderly individuals living in institutions or service housing but a lower rate for home help, whereas Denmark comes second to Iceland in that category.

4.1.3 Details on recent reforms in the past 2-3 years

Austerity measures in health care services and public services in general have been defining the context for the long-term care sector in Iceland since 2008. In figure 8 one can see the development of expenditures on main service provisions of the LTC-sector from 2003 through 2012. The slope is generally downward with a significant jump from 2007 to 2008, from a level of 1.39-1.40% of GDP to a level of 1.33 to 1.36%.

Figure 8: Public expenditures on nursing homes and convalent home services to the sich and elderly, 2003 to 2012.

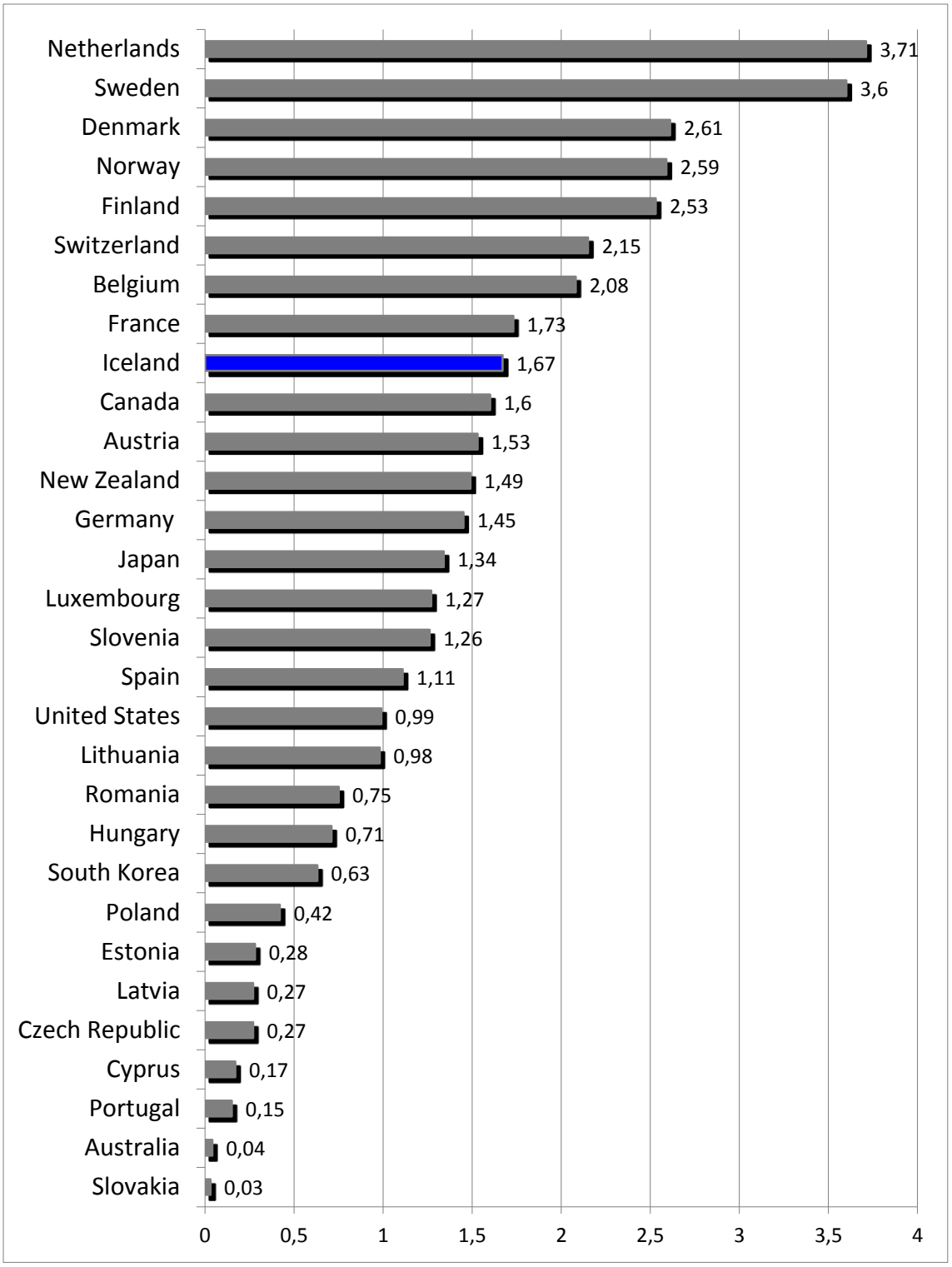


Source: Statistics Iceland

Iceland's overall expenditures on LTC in 2010 approximated to 1.67% of GDP, as shown above.

Iceland is above the EU average but significantly below the level of the Netherlands, Sweden and other Nordic nations, that top the expenditure league in that sector. Switzerland, Belgium and France are also above Iceland. One explanation for a lower rank of Iceland is the smaller proportion of elderly in the total population. In 2012 Iceland had 12.6% of elderly aged 65 and older while Denmark had 17.3%, Finland 18.1%, Norway 15.4% and Sweden 18.8% (Eurostat 2013). So if everything else was equal, Iceland should have indeed had a significantly lower proportion of GDP spent on LTC, at least for the elderly. In 2010 Iceland was on the ninth place on the expenditure rank but was 0n the tenth place a year before (in 2009).

Figure 9: Expenditures on long-term care, % of GDP in 2010.



Source: Eurostat

While the long-term care sector of the Icelandic welfare system is significantly smaller than the pensions and health care sectors, it is a fast growing sector with the ageing of society and rising levels of ambition for welfare services. Iceland seems to be at quite a high level in

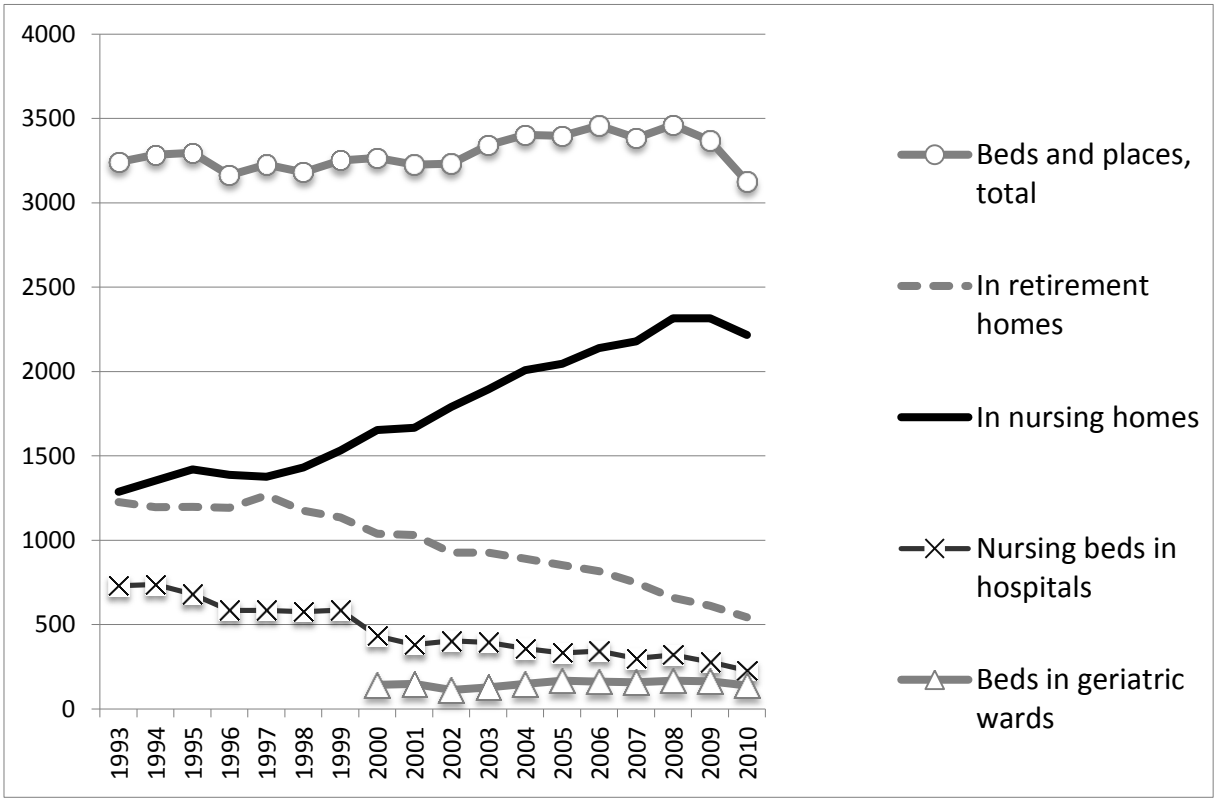
terms of volumes of services and facilities, as well as quality in this sector (cf. OECD Health Data 2012; also Fujisawa and Colombo 2009).

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The legislation on elderly care from 1999 states that the prime goal is to support the elderly in staying in their own homes for as long as possible, by increasing home-nursing, home-help and by providing daycare as well as short restting periods in nursing homes. This is meant to reduce the need for institutional care. This should thus reduce the supply or need for institutional places and the elderly should enter institutions (primarily nursing homes) later and thus stay there for shorter periods than previously.

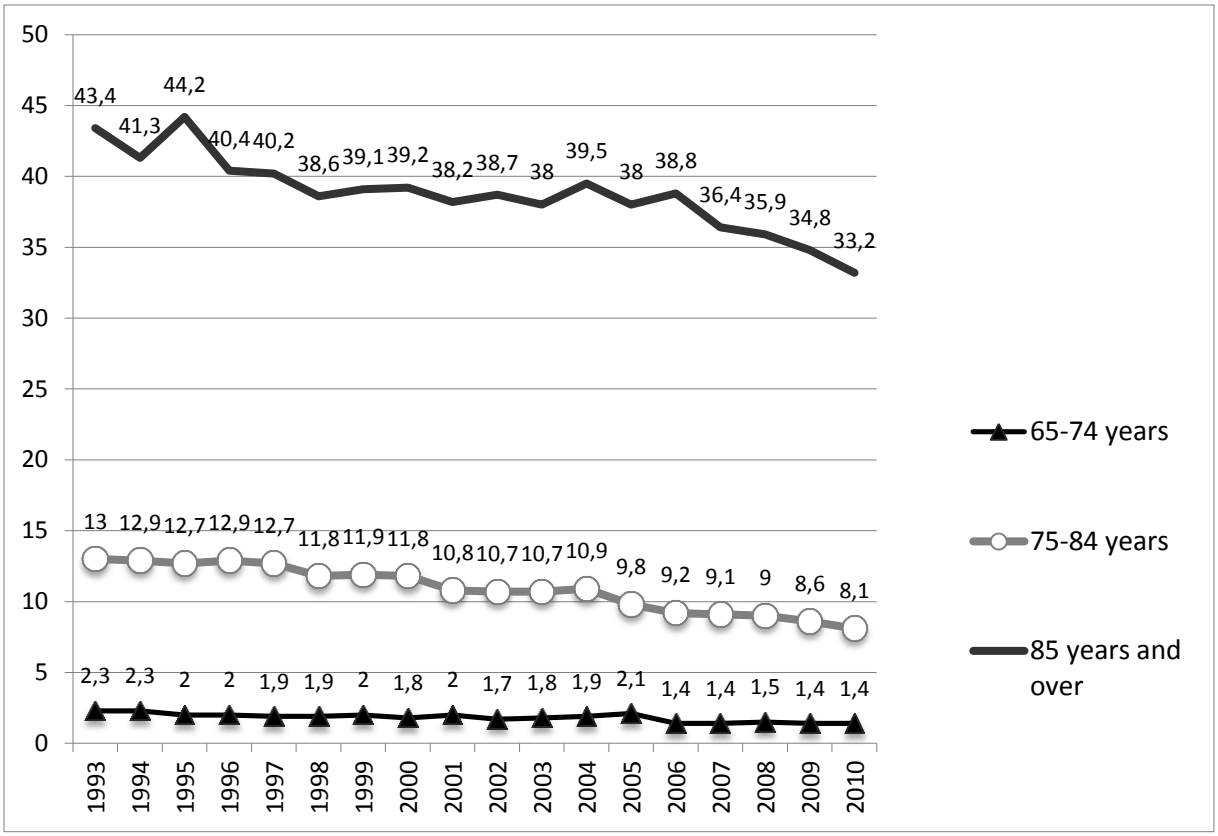
Figure 10: Changing pattern of services for the elderly, from 1993 to 2010 (in Numers).



Source: Statistics Iceland

The overall number of beds and places has remained at a similar level for most of the period even though the absolute number of elderly has increased. The number of beds in nursing homes has increased while places in retirement homes have been declining since 1997. The number of nursing places in hospitals have in general contracted significantly while the number in geriatric wards has remained at a similar level during the 2000s. Thus a major change in the characteristics of the services provisions has been taking place in a rather short period of time – this in fact is in line with the policy goals.

Figure 11: Proportions of age groups in institutional care, 1993 to 2010

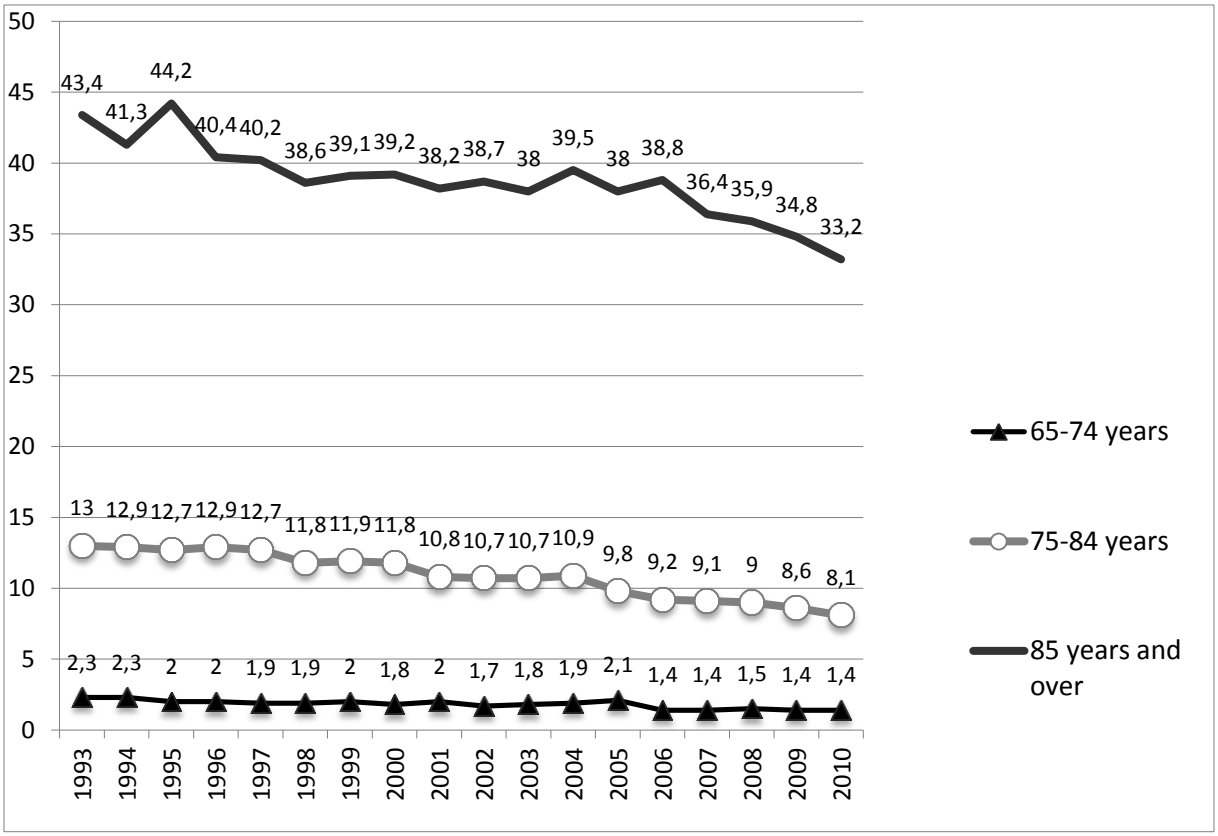


Source: Statistics Iceland

Figure 11 shows that the proportion of age groups of the elderly living in institutional care declined in all age groups, even for those aged over 80 (from 44% in 1995 to 33% in 2010).

Figure 12 shows the increase in the provision of home-help up to 2011, for different groups of receivers. The provision to homes of the elderly has increased most decisively and continually, with an increase of 36% from 2000.

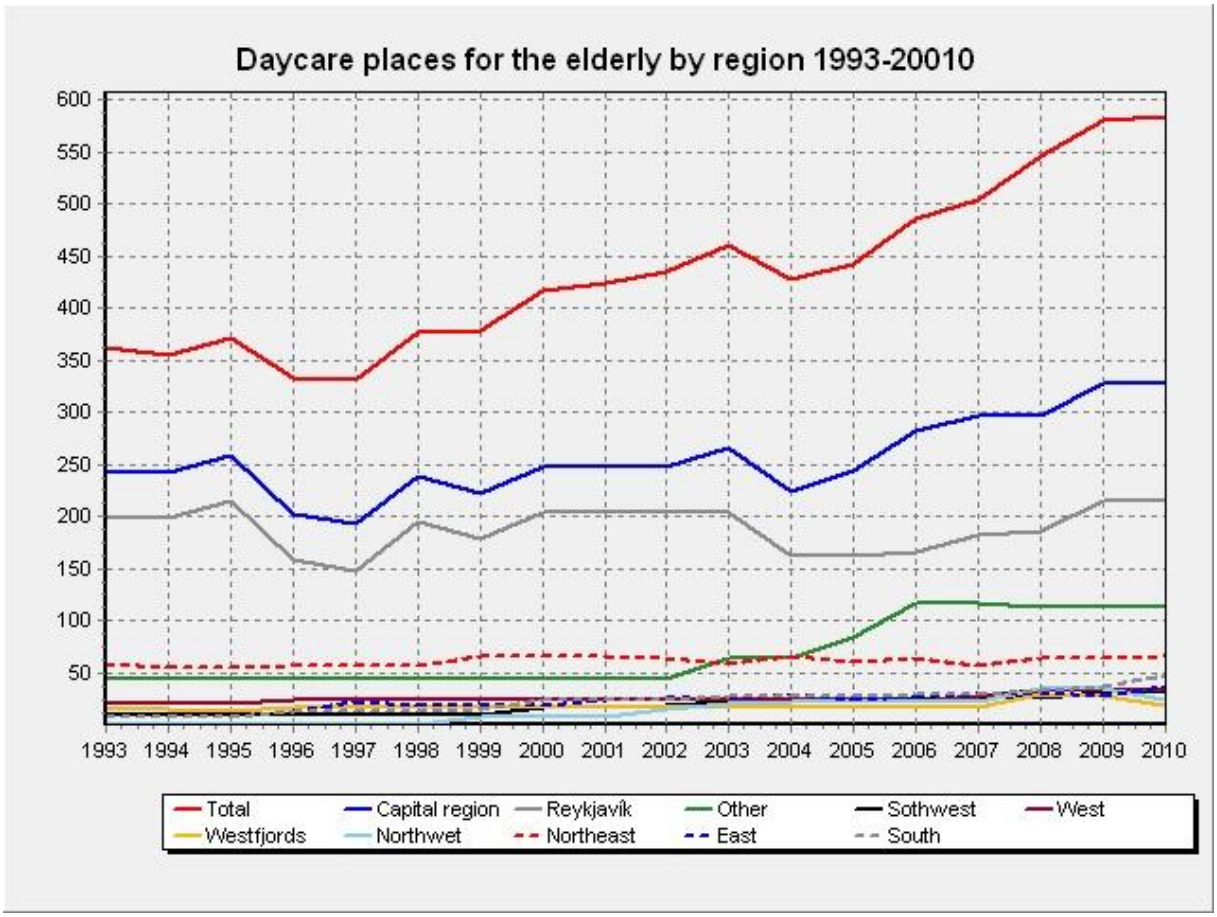
Figure 12: Receivers of home-help from municipalities, 1993 to 2011



Source: Statistics Iceland

The provision to homes with handicapped individuals increased significantly from 2000 to 2009 but has contracted since. Provisions to other households have also somewhat declined.

Figure 13: Day care places for the elderly, by regions, 1993-2010



Source: Statistics Iceland

As indicated above increasing access to daycare for the elderly was also supposed to facilitate longer stay in own homes and as shown in figure 13 this has been forthcoming, not least in the capital area. The progress in this aspect though differs from region to region.

Lastly, this factual review compares the Nordic countries as regards the main features of the care provisions for the elderly and disabled, for 2010 and 2011.

Table 3: Access to services: Elderly and disabled citizens in 2010 and 2011

	Denmark	Finland	Iceland	Norway	Sweden
Elderly living in institutions or service housing					
65-74	1,1	1,5	1,6	2	1
75-79	3,3	4	5,1	6	3,7
80+	13,5	14,7	21,4	22,7	16
Total 65+	4,5	5,6	7,9	8,9	5,7
Elderly receiving home help					
65-74	4,8	1,8	7,8	3	2,3
75-79	14,7	5,6	23,1	8	7,2
80+	38,7	16,7	43,3	24,1	23,6
Total 65+	14,6	6,5	20,9	10,1	9,1
Disabled living in institutions or service housing					
% of population under age 65	0,4	0,5	0,4	0,5	0,4
Disabled receiving home help					
% of population under age 65	0,7	0,2	1,2	0,8	0,2

Source: NOSOSKO 2012

Norway still has the highest proportion of elderly living in institutions, with 8.9% of the 65+ group and nearly 23% of those aged 80+. Iceland follows closely with 7.9% of the total group and 21% of the 80+ group. The other countries range between 14% and 16% for the oldest group.

By far the largest group of elderly citizens receive home-help in Iceland (20.9% of the total group and 43% of the 80+ group). Denmark is second in line (14.6% of 65+ and 38.7% of 80+). Finland lags most behind with 6.5% for the whole group and 16.7% for the 80+.

All countries have a similar proportion of population under age 65 living in institutions or service housing, 0.4-0.5% overall. There is, however, a significant difference in the extent of home-help provisions to the disabled, with Iceland having the highest proportion (1.2% of ages 65 and younger) and Finland and Sweden the lowest (0.2%).

On the whole the Icelandic LTC sector seems to score favourably compared to the LTC sectors of the other Nordic nations.

4.2.2 Quality and performance indicators

As institutional places for LTC have been reduced in numbers in the last decade the supply of home-help and daycare places has increased. This indicates that the quality of life has been improved by facilitating longer stay in own homes for the elderly (OECD and EC June 2013).

The Icelandic National Audit Office (*Ríkisendurskoðun*), which is an independent monitoring body of the parliament, published a report on assessments of the quality of nursing homes (Ríkisendurskoðun February 2012) and one on general care services for the elderly (Ríkisendurskoðun November 2012). The former one found that the supply of nursing beds remained constant between 2008 and 2010 despite a 7% increase of inhabitants aged 80+. At

the same time waiting lists for such beds were reduced by 45% (due to people staying longer in their own homes). Average length of stay in operational beds was also reduced from 3.8 to 2.9 years. The average length of waiting for such beds decreased from 248 days to 119 days. So that is an improved operation of the system as a whole. At the same time the operational costs increased, however, more than the earnings, making the financial situation somewhat more difficult.

The nursing index (measuring the requirement for services per inmate) rose from 1.02 to 1.03, since on average the new entrants are older and more frail when they move to nursing homes than previously (Ríkisendurskoðun February 2012). The overall work volume increased at the same time so it seems that the burden or pressure per employee did not increase.

The other report from Ríkisendurskoðun (November 2012) mapped the transformation in the LTC services which was described above. Due to reductions in beds in old-age care institutions the number of individuals in care in such institutions decreased by about 27% between 2006 and 2011. Still, those waiting for such places declined in numbers by about 61% and the waiting time declined as well by 50% (see also Directorate of Health Talnabrunnur 2013). So, with changed period and looking at the overall sector (not just nursing homes, as the former report did) the outcome pattern is the same. The report also finds that the assessment of the need for care by applicants became more professional and coherent at the same time, making it more difficult to get places. The RAI (Residential assessment index) is the prime assessment tool. The National Audit Office recommends that the RAI assessment be used more closely as a basis for pricing of the services in contracts with the government.

The services in the care institutions were found to have improved in the period, based on number of hours of care spent on each inmate as well as the overall work volume of care. Personal spaces improved in terms of quality also during the period, thus it became more common that people had private rooms with private bathrooms. On the whole the quality of services are found to be the best in the Reykjavik area.

4.2.3 Summary

The development of the long-term care sector in Iceland in recent years has been a success story, unlike the development of the health care and hospital services. The governments have actually increased construction of nursing homes during the crisis years and at the same time the transition from institutional care towards longer stay in own homes for the elderly has succeeded to a great extent. This has been aided by increased home nursins and home-help.

At the same time we see waiting lists for nursing home places being shortened, not least because people come there later and stay shorter. When individuals come later to the institutions they are indeed more frail and have higher service needs. This has in fact been met with a more intense service provision, despite cost restraints. The pressure on care staff has however increased somewhat.

On the whole one can say that Iceland has a long-term care service at a very high level, even compared to the other Nordic countries.

4.3 Reform debates

On the whole, there has not been much public discussion about reforming the LTC sector. The reduction of waiting lists has eased the strain which previously was a cause for concern and complaints. The improvement of facilities, with more private rooms in new nursing homes another source for complaints has also improved, as the reference to the National Audits Office's report above indicated. Thus new nursing homes have been opened in many regions in recent years. The need for improvements on that front is still there and waiting lists still remain, even though the situation has significantly improved.

A frequent complaint about a large proportion of foreign service staff in caring institutions, including nursing homes, is still common. This means that the staff sometimes has difficulties communicating with the inmates. This would best be dealth with by improving language teaching for immigrants, since the use of their labour in the LTC sector does not seem likely to be reduced in the near future.

On the whole, the development of the LTC sector has progressed favourably in recent years and that is reflected in more modest reform debates.

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Annex – Key publications

[Pensions]

EYDAL, GUÐNÝ AND ÓLAFSSON, STEFÁN (eds. 2012). *Þróun velferðarinnar 1988-2008* (Welfare Developments 1988 to 2008). Reykjavík: Social Sciences Research Institute.

This is a state of the arts analysis of welfare developments in all major areas of welfare in Iceland, up to the onset of the financial crisis. The book, about 370 pages long, shows a trend of convergence in the period towards the other Nordic welfare states as regards welfare expenditures and service provisions. Longer-term deviations however still remain, such as greater reliance on work and less generous public support systems. Pensions and benefits tend to be income-tested to a greater degree in Iceland than in the other Nordic nations.

There was marked progress in areas of family policies, service provisions, adjustments to the fast growing immigrant population and health status continued to be at a high standard, even though problems of obesity are growing fast. Income distribution became more unequal in the period but relative poverty rates did not change much. Hence the trend towards more income inequality affected more the population above the median. While relative poverty rates are similar or lower in Iceland than in the other Nordic countries the complaints of financial difficulties (difficulty with making ends meet) has been significantly greater in Iceland.

BRAGASON, Hrafn, Héðinn Eyjólfsson and Guðmundur Heiðar Frímannsson (2012), *Úttekt á fjárfestingarstefnu, ákvarðanatöku og lagalegu umhverfi lífeyrissjóðanna í aðdraganda bankahrunsins 2008* (Assessment of investment policy, decision-making and legal environment of the Icelandic Pension funds prior to the banking crisis of 2008), volumes I to IV. Reykjavík: Landssamband lífeyrissjóða (Federation of Occupational Pension Funds), page/retrieved from: http://ll.is/?i=70.

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

GUNNARSSON, ÁRNI ET. AL. (2013). Greinargerð starfshóps með tillögum um endurskoðun almannatryggingalaga um einföldun bótakerfis vegna ellilífeyris (Report of a working group on reforms of the pension system with simplifications of benefits and old-age pensions). Reykjavík: Available at Ministry of Welfare (http://www.velferdarraduneyti.is-/media/Rit_2013/Greinargerd_um_einfoldun_botakerfis_ellilifeyris_feb2013.pdf).

This report is the result of continuing work on simplification of the public social security benefits system. The work started in 2007 and has resulted in two reports to the ministry, in addition to various piecemeal changes in the benfits structures undertaken in 2008. The former report (VEA 2009) layed the ground for simplifications of pension layers but this report has a somewhat different approach to income-testing rules. The new government that came to power in June 2013 has appointed a new group to work further on these issues but

with a somewhat different agenda, placing emphasis on capabilities assessment for the disabled and introducing more flexible retirement ages.

JÓHANNESSON, BENEDIKT (2013). Þróun bóta til öryrkja frá 2008 til 2013 (Development of pension benefits for disability pensioners 2008 to 2013). Reykjavík: Talnakönnun.

This report surveys the development of various measures of benefits and pay during the period in question. The finding is that the average benefits for disability pensioners have lagged behind the development of minimum pay during the crisis. When the total earnings of pensioners are surveyed the decline in real earnings are greater than in the basic rates.

KRISTJÁNSSON, ARNALDUR SÖLVI (2012). Þróun bótakerfisins (Development of the transfers system), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008*.

In this study the author traces the development of the Icelandic transfer system from 1988 to 2008. He analyses how the generosity and the rights of individual transfer payments evolve, with a reference to previous studies as well as public records.
The main characteristics of the development were that the generosity of the transfer system as a whole declined, especially in the period 1995-2006. The most notable change was undoubtedly the adoption of a new parental leave scheme in 2000, which increased both the generosity and rights substantially in that area. The transfer aspects that lagged most behind up to 2008 where child benefits and mortgage rebate benefits. The payable amounts declined (in real terms) almost every year in 1988-2008. The reason was that benefits amounts did not keep up with either inflation or wages.

MINISTRY OF WELFARE (2013). Tillögur til að vinna gegn fátækt (Recommendations for work against poverty). Reykjavík: Ministry of Welfare (http://www.velferdarraduneyti.-is/media/Rit_2013/Farsaeldarskyrsla--24042013.pdf).

Last year the Lutheran Church and the Red Cross, in cooperation with NGOs and Social workers at the University of Iceland, produced a report emphasizing a new approach to combating poverty (*Farsæld – Baráttan gegn fátækt*). The approach emphasized facilitation of social and economic participation, education and empowerment. The aim was to be pro-active and targeted at the long-term poor. The idea is to promote a social contract for further education about welfare, human rights, social capital, empowerment and participation. The Minister of Welfare appointed a working group with the goal of specifying recommendations to further these goals. The group delivered its report in Mars 2013. These involved a restructuring of benefits for families and housing, better coordination of services, interdisciplinary teams at health care centres and more cooperation between health care centres and the social services of local communities. Universal day care services for all children aged one and above, free dental services for children and a special program for immigrant children.

MINISTRY OF WELFARE (2013b). Greinargerð um fjárhagsstöðu heimilanna (Survey of financial conditions of households). Reykjavík: Ministry of Welfare (http://www.velferdarraduneyti.is/media/Rit_2013/Greinargerd-um-fjarhagsstodu-heimilanna_april2013.pdf).

The Ministry appointed a working group to survey the progress with debt relief measures of households, relying on work of the Central Bank of Iceland (Ólafsson and Vignisdóttir), Ólafsson, Kristjánsson and Stefánsson (2012) and the IMF (2012). The report showed how mediating policies have turned the debt problem around, leading to lower average debt levels than before the crisis and higher subsidies of interest costs of mortgages. Still the real disposable earnings of households are significantly lower than before the crisis, hence the debt situation is still an increased burden for households, compared to the situation before 2008. The report surveys also the different socio-demographic groups and how they have faired.

ÓLAFSSON, STEFÁN (2012). Lífeyrisþegar – fjöldi og afkoma (Pensioners – demography and living standards), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008.*

In this study the position of pensioners if profiled. The discussion of growing numbers is set in the context respectively of the aging problem and the activation problem. The latter part of the study analyses expenditure data as well as new data on income adequacy of disability and old-age pensioners.

Growth of old-age pensioners has been rather rapid in the period but increasing level of income-testing has meant that the growth of O-A pensioners has been slower than the demographic growth rates. From the beginning of the 1990s the number of disability pensioners increased quite rapidly, causing great concerns amongst the operators of the occupational pension funds from the early 2000s onwards. The rate of growth has however slowed down in the last part of our period – and also in fact during the crisis.

On the whole the Icelandic pension system has a strong position relative to many European pension systems. Effective retirement age is amongst the highest in the West, employment participation amongst disability pensioners is amongst the highest in OECD-countries and the funded part of the system remains strong. Pensioners have on the whole lagged somewhat behind other income groups during the period, with considerable fluctuations though, particularly amongst old-age pensioners. Disability pensioners lagged significantly behind labour market groups from 1998 to 2007.

ÓLAFSSON, STEFÁN (2012). Velferðarríkið og þróun velferðarútgjalda (The welfare state and developments of welfare expenditures), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008.*

This study deals with characteristics of the Icelandic welfare state and welfare expenditure developments during the period from 1988 to 2008. At the beginning of the period Iceland was something of a laggard in welfare expenditures compared to the other Nordic states. This reflected a relatively younger population, lower benefit generosity levels and more use of income-testing in the social security system.

The biggest part of the chapter analyses the welfare expenditures in relation to the sizes of the main groups of beneficiaries (the elderly, the young and the unemployed). On the whole Iceland catches up with the Nordic nations in the field of welfare expenditures during the period. Still Iceland remains at the bottom, with slightly lower level of generosity than Norway.

The main reasons for growing expenditures in Iceland are increased cost of health care services and family policy related expenditures. Hence the new birth leave provision increased expenditures significantly, complementing reduced expenditures on child benefits and housing mortgage subsidies. Income-testing in the social security system was also increased during the period, which retained cost increases. Iceland retains its status as a service-intensive welfare state with relatively modest highly income-tested benefits. The exceptionalism of the Icelandic welfare state is though generally less marked than at the beginning of the period.

SVEINLAUGSSON, KRISTJÁN (2011). Lífeyrissjóðir – skiptir stærð máli? (Occupational pensionfunds – Does size matter). MA thesis, Department of Business Administration, University of Iceland (available at: http://skemman.is/stream/get/1946/7287/19497/-1/Kristj%C3%A1n_Sveinlaugsson_ritger%C3%B0.pdf).

This thesis surveys issues of size and efficiency of occupational pension funds,with a particular reference to Sweden. Then it studies the Icelandic occupational pension funds and gives an account of development in terms of merging of funds. It also assesses the relevance of fund size for return on investments and operational costs. It finds that size does not matter for rates of return on investments but that it significantly affects cost of operations, with larger funds being more economical. Then the study draws some conclusions for merging of funds in the Icelandic context.

[Health care]

ÁSGEIRSDÓTTIR, TINNA (2012). Heilsa og lífskjör (Health and qualities of life), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008*.

Health and standard of living are strongly connected, in Iceland as elsewhere in the Western countries. Good health benefits people through enhanced well-being, which in itself is of great value. Thus, one can say that health, as such, is a part of an individual's total welfare and quality of life. Additionally, health is connected to other factors that influence our quality of life indirectly, such as our personal income potential. In this study, the general development of the Icelandic nation's state of health over the years 1988-2008 is surveyed and analysed. Life expectancy and state of health are covered, in addition to health maintenance and treatment. The discussion of development is put in context through comparisons with the OECD-countries. In short, the health of Icelanders has been good in the aforementioned period, but it has come at a high cost in the form of other opportunities for quality of life forgone. Regarding the health-care system, it must be considered highly extensive, which also is the case for individual's right to choose between different health-related services. Throughout history, Iceland's health-care system has been expensive. However, its operation costs have declined proportionally towards the end of the period in question.

EYJÓLFSDÓTTIR, HARPA SIF (2012). Social capital, self-rated health and the importance of sleep: The case of Iceland in 2007 and 2009. Masters thesis at CHESS, Stockholm University.

The frequently studied concept of social capital has often been related to health, but the conceptualisation and measurement of the concept is an on-going debate. The main aim of this thesis is to study the relationship of four different indicators of social capital; informal social capital, formal social capital, trust towards institutions and trust towards others, with self-rated physical health and self-rated mental health in Iceland in 2009, shortly after a harsh economic crash. Insomnia symptoms are studied as a possible mediator or moderator in the relationship. Furthermore, longitudinal data on informal social capital are used to see the causal effect of social capital on health and to see if informal social capital decreased after the economic collapse. Population-based panel data from Iceland in 2007 and 2009 is used to perform both cross-sectional analysis (n = 3,243) and longitudinal analysis (n = 3,131). The main results are that the four indicators of social capital all relate differently to physical and mental self-rated health, and insomnia symptoms seem to mediate the relationship between social capital and health, especially physical health. Surprisingly, informal social capital did increase during the economic collapse. The panel analysis further suggests that having poor informal social capital has causal effects on poor self-rated mental health when adjusted for symptoms of insomnia, age, gender, family status, education and smoking.

GUNNARSDÓTTIR, ANNA LILJA (2012). Skipulag heilbrigðisþjónustu og ráðstöfun fjármuna - Ráðgjafahópur velferðarráðherra (Organization of the health care sector and expenditures – Report of a Ministerial Advisory group). Reykjavík: Ministry of Welfare (available at http://www.velferdarraduneyti.is/rit-og-skyrslur-vel/nr/33750).

This report is the conclusion of a major work of assessment of expenditures and organization in the health care sector. The Boston Consulting Group contributed to the work at an earlier stage (see their report here: http://www.velferdarraduneyti.is/rit-og-skyrslur-vel/nr/33074). The present report is the culmination of the overall work, delivered in detailed recommendations to the Ministry. The work was undertaken in 9 subgroups, each dealing with separate aspects of the health care sector. The recommendations refer to cengtralized electronic journals for all patients; Coordination of registration and publications of health care information; Strengthened service steering; Increased influence of users on the service they receive; Merging of institutions and reorganization of surgery and services related to births; Reorganization of patients' transportations; Better coordination of service provisions for the elderly in all regions of the country; Special program for fighting obesity; Better organization of purchases of resources.

[Long term care]

EYDAL, GUÐNÝ AND HALLDÓR GUÐMUNDSSON (2012). Félags- og velferðarþjónusta sveitarfélaga (Social and welfare services of the municipalities), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008*.

Social service in Iceland has a strong historical tradition for being a part of the local authority's role. Still an integral legislation was introduced some years later than in other Nordic countries. The study starts by describing the historical and legislative development of financial assistance benefits, child protection service and home care for elderly and then illuminating evolvement of same social service in the period 1988 until 2008. The focus is on development in foregoing three areas of social services, the coverage and its trait in twenty

years period from 1988-2008. The discussion is based on literature review and statistical data from public sources.

The conclusions drawn are that local authority's social services have gone through a period of transition and modernization, both in settings and professionalization along with emphasis on user rights and participation. At the same time municipalities have had a scope to develop different policy and practice in social service so there is some variety in the standards of services provided in different municipalities..

FÉLAGSVÍSINDASTOFNUN HÍ (SOCIAL SCIENCES RESEARCH INSTITUTE - 2013). Ofbeldi gegn fötluðum konum (Violence against disabled women). Report to the Ministry of Welfare. Reykjavík: Social Sciences Research Institute, University of Iceland (available at http://www.velferdarraduneyti.is/media/Rit_2013/ofb_fatladar-konur-skyrsla_mai2013.pdf - August 29th 2013).

This is a report on research into violence, based on in depth interviews with 13 disabled women who had experienced violence, ranging from bullying in youth to sexual abuse by relatives or staff of institutions caring for the disabled. The originators of the sexual violence were both from within the family and from outside it. These are examples of extreme experiences, not necessarily typical for the position of all disabled women, state the authors of the report. Still the report gives a valuable insight into what can happen to individuals who have little strength to defend themselves. All kinds of violence were involved, mental, financial, sexual and physical. Most had also experiences of cover-ups and apathy against the problem. The importance of increased information and education about the risks and responses was an important lesson from the study.

GUÐMUNDSSON, HALLDÓR S. (2012). Starfsendurhæfing, virkni og aðlögun að vinnumarkaðinum (Vocational rehabilitation, activation and adjustment to the labour market), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008*.

This study discuss social service in vocational rehabilitation in Iceland over a twenty years period, 1988-2008. It starts by describing the municipal social services' main role regarding vocational rehabilitation and adjustment to the labour market. Firstly by discussing the role of state and municipalities and then by presenting development in the area of service for disable people, national social security insurance and the directorate of labour.

Then by defining few terms related to vocational rehabilitation and describing emphasis on integrated services. Finally by presenting the main traits in development of services. Findings indicate that the development can be associated to increased expenses in rehabilitation pension and advancement of social service at municipality level. At the same time questions are raised if this development has resulted in scarcity of public policy in the area. The chapter concludes with an encouragement to formation of integral policy in the area of vocational rehabilitation.

MINISTRY OF WELFARE (2013). Framtíðarþing um farsæla öldrun – Niðurstaða og tillögur (Futures council on a good life in old age – Conclusions and recommendations). Reykjavík: Ministry of Welfare (available at: http://www.velferdarraduneyti-.is/media/Rit_2013/Framtidarthing-um-farsaela-oldrun_Lokaskyrsla_2013.pdf).

This report is the result of the European year on active aging in 2012. The work was undertaken by all major stakeholders and delivered at a large conference and with the publication of the report. It surveys the pros and cons of aging, expectatioons of the community to the aged, expectations of the aged to the community. It also defines what is meant by good aging and surveys how the goals can be reached.

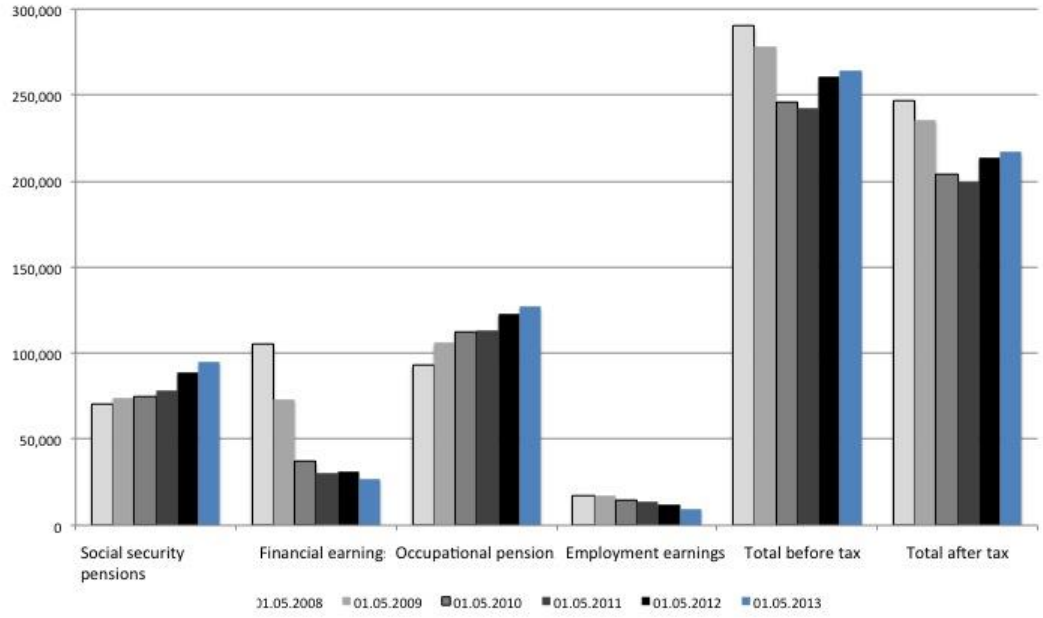
SIGURGEIRSDÓTTIR, SIGURVEIG H. (2012). Þróun veferðar í þágu aldraðra (Development of welfare services for the elderly), in Eydal and Ólafsson (eds), *Þróun velferðarinnar 1988-2008*.

During the last 20 years the ideology in care of older people in Iceland has changed rapidly. A special Act on the Affairs of the Elderly was implemented in Iceland in 1982 and marked a turning point in the welfare services of older people. The Act emphasized what kind of services older people are entitled to and who should provide it. Upon review of the Act an increased emphasis has been placed on self-determination of older people and the service arrangements more clearly stated. The ideology of ageing in place, supporting older people to live at home as long as possible has replaced the earlier ideas that the best solution for older people was to move into residential and nursing homes. This chapter clarifies the development of the services and discusses its organizational structure and the increased and changed services. The contribution of the main service providers is analyzed; the formal caregivers, such as the state and municipalities and the informal caregivers such as family and friends. The basic research in the field is discussed and a comprehensive picture of the development of welfare services for older people described.

Appendix: Further data

Earnings of old-age pensioners 2008-2013

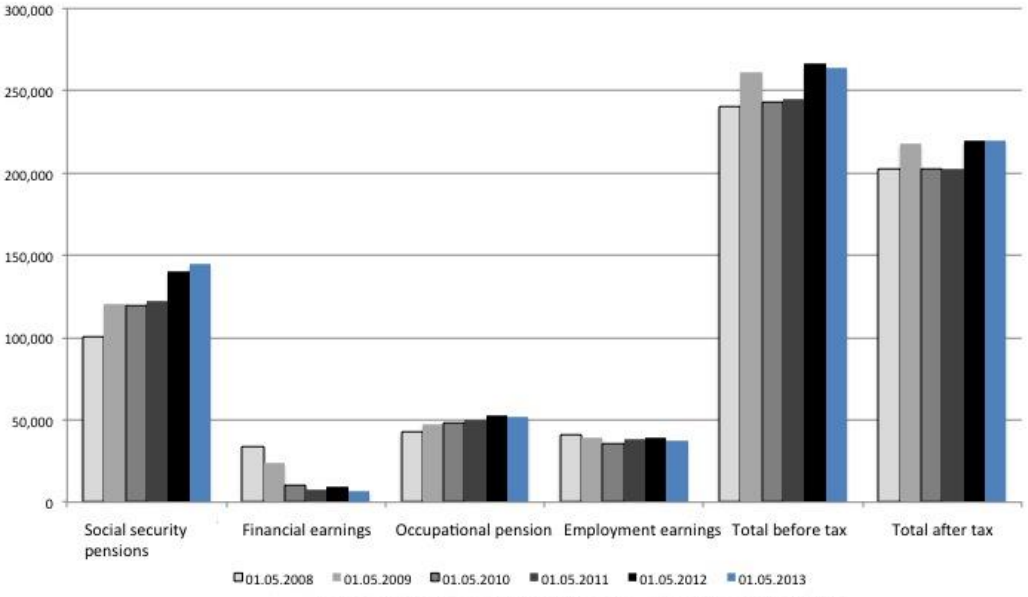
Average earnings per month (I. Kr.), yearly prices (in May), disaggregated



Source: Social Security Administration – Special analysis for SÓ

Earnings of disability pensioners 2008-2013

Average earnings per month (I. Kr.), yearly prices (in May), disaggregated



Source: Social Security Administration – Special analysis for SÓ

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